

HELPING FAMILIES IN MENTAL HEALTH CRISIS ACT OF
2016

JULY 6, 2016.—Committed to the Committee of the Whole House on the State of
the Union and ordered to be printed

Mr. UPTON, from the Committee on Energy and Commerce,
submitted the following

R E P O R T

[To accompany H.R. 2646]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (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, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

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 2016”.

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

Sec. 1. Short title; table of contents.

TITLE I—ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE

- Sec. 101. Assistant Secretary for Mental Health and Substance Use.
- Sec. 102. Improving oversight of mental health and substance use programs.
- Sec. 103. National Mental Health and Substance Use Policy Laboratory.
- Sec. 104. Peer-support specialist programs.
- Sec. 105. Prohibition against lobbying using Federal funds by systems accepting Federal funds to protect and advocate the rights of individuals with mental illness.
- Sec. 106. Reporting for protection and advocacy organizations.
- Sec. 107. Grievance procedure.
- Sec. 108. Center for Behavioral Health Statistics and Quality.
- Sec. 109. Strategic plan.
- Sec. 110. Authorities of centers for mental health services and substance abuse treatment.
- Sec. 111. Advisory councils.
- Sec. 112. Peer review.

TITLE II—MEDICAID MENTAL HEALTH COVERAGE

- Sec. 201. Rule of construction related to Medicaid coverage of mental health services and primary care services furnished on the same day.
- Sec. 202. Optional limited coverage of inpatient services furnished in institutions for mental diseases.
- Sec. 203. Study and report related to Medicaid managed care regulation.
- Sec. 204. Guidance on opportunities for innovation.
- Sec. 205. Study and report on Medicaid emergency psychiatric demonstration project.
- Sec. 206. Providing full-range of EPSDT services to children in IMDs.
- Sec. 207. Electronic visit verification system required for personal care services and home health care services under Medicaid.

TITLE III—INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE

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

TITLE IV—COMPASSIONATE COMMUNICATION ON HIPAA

- Sec. 401. Sense of Congress.
- Sec. 402. Confidentiality of records.
- Sec. 403. Clarification of circumstances under which disclosure of protected health information is permitted.
- Sec. 404. Development and dissemination of model training programs.

TITLE V—INCREASING ACCESS TO TREATMENT FOR SERIOUS MENTAL ILLNESS

- Sec. 501. Assertive community treatment grant program for individuals with serious mental illness.
- Sec. 502. Strengthening community crisis response systems.
- Sec. 503. Increased and extended funding for assisted outpatient grant program for individuals with serious mental illness.
- Sec. 504. Liability protections for health professional volunteers at community health centers.

TITLE VI—SUPPORTING INNOVATIVE AND EVIDENCE-BASED PROGRAMS

Subtitle A—Encouraging the Advancement, Incorporation, and Development of Evidence-Based Practices

- Sec. 601. Encouraging innovation and evidence-based programs.
- Sec. 602. Promoting access to information on evidence-based programs and practices.
- Sec. 603. Sense of Congress.

Subtitle B—Supporting the State Response to Mental Health Needs

- Sec. 611. Community Mental Health Services Block Grant.

Subtitle C—Strengthening Mental Health Care for Children and Adolescents

- Sec. 621. Telehealth child psychiatry access grants.
- Sec. 622. Infant and early childhood mental health promotion, intervention, and treatment.
- Sec. 623. National Child Traumatic Stress Initiative.

TITLE VII—GRANT PROGRAMS AND PROGRAM REAUTHORIZATION

Subtitle A—Garrett Lee Smith Memorial Act Reauthorization

- Sec. 701. Youth interagency research, training, and technical assistance centers.
- Sec. 702. Youth suicide early intervention and prevention strategies.
- Sec. 703. Mental health and substance use disorder services on campus.

Subtitle B—Other Provisions

- Sec. 711. National Suicide Prevention Lifeline Program.
- Sec. 712. Workforce development studies and reports.
- Sec. 713. Minority Fellowship Program.
- Sec. 714. Center and program repeals.
- Sec. 715. National violent death reporting system.
- Sec. 716. Sense of Congress on prioritizing Native American youth and suicide prevention programs.
- Sec. 717. Peer professional workforce development grant program.
- Sec. 718. National Health Service Corps.
- Sec. 719. Adult suicide prevention.
- Sec. 720. Crisis intervention grants for police officers and first responders.
- Sec. 721. Demonstration grant program to train health service psychologists in community-based mental health.

Sec. 722. Investment in tomorrow's pediatric health care workforce.
 Sec. 723. CUTGO compliance.

TITLE VIII—MENTAL HEALTH PARITY

Sec. 801. Enhanced compliance with mental health and substance use disorder coverage requirements.
 Sec. 802. Action plan for enhanced enforcement of mental health and substance use disorder coverage.
 Sec. 803. Report on investigations regarding parity in mental health and substance use disorder benefits.
 Sec. 804. GAO study on parity in mental health and substance use disorder benefits.
 Sec. 805. Information and awareness on eating disorders.
 Sec. 806. Education and training on eating disorders.
 Sec. 807. GAO study on preventing discriminatory coverage limitations for individuals with serious mental illness and substance use disorders.
 Sec. 808. Clarification of existing parity rules.

TITLE I—ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE

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

(a) ASSISTANT SECRETARY.—Section 501(c) of the Public Health Service Act (42 U.S.C. 290aa) is amended to read as follows:

“(c) ASSISTANT SECRETARY AND DEPUTY ASSISTANT SECRETARY.—

“(1) ASSISTANT SECRETARY.—

“(A) APPOINTMENT.—The Administration shall be headed by an official to be known as the Assistant Secretary for Mental Health and Substance Use (hereinafter in this title referred to as the ‘Assistant Secretary’) who shall be appointed by the President, by and with the advice and consent of the Senate.

“(B) QUALIFICATIONS.—In selecting the Assistant Secretary, the President shall give preference to individuals who have—

“(i) a doctoral degree in medicine, osteopathic medicine, or psychology;

“(ii) clinical and research experience regarding mental health and substance use disorders; and

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

“(2) 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, including attorneys, as are necessary to administer the activities to be carried out through the Administration.”

(b) TRANSFER OF AUTHORITIES.—The Secretary of Health and Human Services shall delegate to the Assistant Secretary for Mental Health and Substance Use 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.

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

(1) in paragraph (17), by striking “and” at the end;

(2) in paragraph (18), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

“(19) evaluate, in consultation with the Assistant Secretary for Financial Resources, the information used for oversight of grants under programs related to mental and substance use disorders, including co-occurring disorders, administered by the Center for Mental Health Services;

“(20) periodically review Federal programs and activities relating to the diagnosis or prevention of, or treatment or rehabilitation for, mental illness and substance use disorders to identify any such programs or activities that have proven to be effective or efficient in improving outcomes or increasing access to evidence-based programs;

“(21) establish standards for the appointment of peer-review panels to evaluate grant applications and recommend standards for mental health grant programs; and”

(d) STANDARDS FOR GRANT PROGRAMS.—Section 501(d) of the Public Health Service Act (42 U.S.C. 290aa(d)), as amended by subsection (c), is further amended by adding at the end the following:

“(22) in consultation with the National Mental Health and Substance Use Policy Laboratory, and after providing an opportunity for public input, set stand-

ards for grant programs under this title for mental health and substance use services, which may address—

- “(A) the capacity of the grantee to implement the award;
 - “(B) requirements for the description of the program implementation approach;
 - “(C) the extent to which the grant plan submitted by the grantee as part of its application must explain how the grantee will reach the population of focus and provide a statement of need, including to what extent the grantee will increase the number of clients served and the estimated percentage of clients receiving services who report positive functioning after 6 months or no past-month substance use, as applicable;
 - “(D) the extent to which the grantee must collect and report on required performance measures; and
 - “(E) the extent to which the grantee is proposing evidence-based practices and the extent to which—
 - “(i) 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; or
 - “(ii) if no evidence-based practice exists for a population of focus, the way in which the grantee will implement adaptations of evidence-based practices, promising practices, or cultural practices.”
- (e) MEMBER OF COUNCIL ON GRADUATE MEDICAL EDUCATION.—Section 762 of the Public Health Service Act (42 U.S.C. 290o) is amended—
- (1) in subsection (b)—
 - (A) by redesignating paragraphs (4), (5), and (6) as paragraphs (5), (6), and (7), respectively; and
 - (B) by inserting after paragraph (3) the following:
 - “(4) the Assistant Secretary for Mental Health and Substance Use;”;
 - (2) in subsection (c), by striking “(4), (5), and (6)” each place it appears and inserting “(5), (6), and (7)”.
 - (f) CONFORMING AMENDMENTS.—Title V of the Public Health Service Act (42 U.S.C. 290aa et seq.), as amended by the previous provisions of this section, is further amended—
 - (1) 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”; and
 - (2) by striking “Administrator” each place it appears (including in any headings) and inserting “Assistant Secretary”, except where the term “Administrator” appears—
 - (A) in each of subsections (e) and (f) of section 501 of such Act (42 U.S.C. 290aa), including the headings of such subsections, within the term “Associate Administrator”;
 - (B) in section 507(b)(6) of such Act (42 U.S.C. 290bb(b)(6)), within the term “Administrator of the Health Resources and Services Administration”;
 - (C) in section 507(b)(6) of such Act (42 U.S.C. 290bb(b)(6)), within the term “Administrator of the Centers for Medicare & Medicaid Services”;
 - (D) in section 519B(c)(1)(B) of such Act (42 U.S.C. 290bb-25b(c)(1)(B)), within the term “Administrator of the National Highway Traffic Safety Administration”; or
 - (E) in each of sections 519B(c)(1)(B), 520C(a), and 520D(a) of such Act (42 U.S.C. 290bb-25b(c)(1)(B), 290bb-34(a), 290bb-35(a)), within the term “Administrator of the Office of Juvenile Justice and Delinquency Prevention”.
 - (g) REFERENCES.—After executing subsections (a), (b), and (f), 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.

SEC. 102. IMPROVING OVERSIGHT OF MENTAL HEALTH AND SUBSTANCE USE PROGRAMS.

Title V of the Public Health Service Act is amended by inserting after section 501 of such Act (42 U.S.C. 290aa) the following:

“SEC. 501A. IMPROVING OVERSIGHT OF MENTAL HEALTH AND SUBSTANCE USE PROGRAMS.

“(a) ACTIVITIES.—For the purpose of ensuring efficient and effective planning and evaluation of mental and substance use disorder programs and related activities, the Assistant Secretary for Planning and Evaluation, in consultation with the Assistant Secretary for Mental Health and Substance Use, shall—

- “(1) collect and organize relevant data on homelessness, involvement with the criminal justice system, hospitalizations, mortality outcomes, and other measures the Secretary deems appropriate from across Federal departments and agencies;

“(2) evaluate programs related to mental and substance use disorders, including co-occurring disorders, across Federal departments and agencies, as appropriate, including programs related to—

“(A) prevention, intervention, treatment, and recovery support services, including such services for individuals with a serious mental illness or serious emotional disturbance;

“(B) the reduction of homelessness and involvement with the criminal justice system among individuals with a mental or substance use disorder; and

“(C) public health and health services; and

“(3) consult, as appropriate, with the Assistant Secretary, the Behavioral Health Coordinating Council of the Department of Health and Human Services, other agencies within the Department of Health and Human Services, and other relevant Federal departments.

“(b) **RECOMMENDATIONS.**—The Assistant Secretary for Planning and Evaluation shall develop an evaluation strategy that identifies priority programs to be evaluated by the Assistant Secretary and priority programs to be evaluated by other relevant agencies within the Department of Health and Human Services. The Assistant Secretary for Planning and Evaluation shall provide recommendations on improving programs and activities based on the evaluation described in subsection (a)(2) as needing improvement.”.

SEC. 103. NATIONAL MENTAL HEALTH AND SUBSTANCE USE POLICY LABORATORY.

Title V of the Public Health Service Act (42 U.S.C. 290aa et seq.) is amended by inserting after section 501A, as added by section 102 of this Act, the following:

“SEC. 501B. NATIONAL MENTAL HEALTH AND SUBSTANCE USE POLICY LABORATORY.

“(a) **IN GENERAL.**—There shall be established within the Administration a National Mental Health and Substance Use Policy Laboratory (referred to in this section as the ‘Laboratory’).

“(b) **RESPONSIBILITIES.**—The Laboratory shall—

“(1) continue to carry out the authorities and activities that were in effect for the Office of Policy, Planning, and Innovation as such Office existed prior to the date of enactment of the Helping Families in Mental Health Crisis Act of 2016;

“(2) identify, coordinate, and facilitate the implementation of policy changes likely to have a significant effect on mental health, mental illness, and the prevention and treatment of substance use disorder services;

“(3) collect, as appropriate, information from grantees under programs operated by the Administration in order to evaluate and disseminate information on evidence-based practices, including culturally and linguistically appropriate services, as appropriate, and service delivery models;

“(4) provide leadership in identifying and coordinating policies and programs, including evidence-based programs, related to mental and substance use disorders;

“(5) recommend ways in which payers may implement program and policy findings of the Administration and the Laboratory to improve outcomes and reduce per capita program costs;

“(6) in consultation with the Assistant Secretary for Planning and Evaluation, as appropriate, periodically review Federal programs and activities relating to the diagnosis or prevention of, or treatment or rehabilitation for, mental illness and substance use disorders, including by—

“(A) identifying any such programs or activities that are duplicative;

“(B) identifying any such programs or activities that are not evidence-based, effective, or efficient; and

“(C) formulating recommendations for coordinating, eliminating, or improving programs or activities identified under subparagraph (A) or (B) and merging such programs or activities into other successful programs or activities; and

“(7) carry out other activities as deemed necessary to continue to encourage innovation and disseminate evidence-based programs and practices, including programs and practices with scientific merit.

“(c) **EVIDENCE-BASED PRACTICES AND SERVICE DELIVERY MODELS.**—

“(1) **IN GENERAL.**—In selecting evidence-based best practices and service delivery models for evaluation and dissemination, the Laboratory—

“(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

or serious emotional disturbance, 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.

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

“(3) CONSULTATION.—In carrying out the duties under this subsection, the Laboratory shall consult with—

“(A) representatives of the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism, on an ongoing basis;

“(B) other appropriate Federal agencies;

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

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

SEC. 104. PEER-SUPPORT SPECIALIST PROGRAMS.

(a) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Comptroller General of the United States shall conduct a study on peer-support specialist programs in up to 10 States (to be selected by the Comptroller General) that receive funding from the Substance Abuse and Mental Health Services Administration and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report containing the results of such study.

(b) CONTENTS OF STUDY.—In conducting the study under subsection (a), the Comptroller General of the United States shall examine and identify best practices in the selected States related to training and credential requirements for peer-specialist programs, such as—

(1) hours of formal work or volunteer experience related to mental and substance use disorders conducted through such programs;

(2) types of peer support specialist exams required for such programs in the States;

(3) codes of ethics used by such programs in the States;

(4) required or recommended skill sets of such programs in the State; and

(5) requirements for continuing education.

SEC. 105. PROHIBITION AGAINST LOBBYING USING FEDERAL FUNDS 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 “; and”; 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 using Federal funds to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local, or tribal government in policymaking and administrative processes within the executive branch of that government.”.

SEC. 106. REPORTING FOR PROTECTION AND ADVOCACY ORGANIZATIONS.

(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 Illness Act (42 U.S.C. 10824(a)) is 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) using data from the existing required annual program progress reports submitted by each system funded under this title, a detailed accounting for each such system 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. 107. 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 Secretary shall establish an independent grievance procedure for persons described in subsection (a)(9).”.

SEC. 108. CENTER FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY.

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

(1) in section 501(b) (42 U.S.C. 290aa(b)), by adding at the end the following:

“(4) The Center for Behavioral Health Statistics and Quality.”;

(2) in section 502(a)(1) (42 U.S.C. 290aa–1(a)(1))—

(A) in subparagraph (C), by striking “and” at the end;

(B) in subparagraph (D), by striking the period at the end and inserting “; and”; and

(C) by inserting after subparagraph (D) the following:

“(E) the Center for Behavioral Health Statistics and Quality.”; and

(3) in part B (42 U.S.C. 290bb et seq.) by adding at the end the following new subpart:

“Subpart 4—Center for Behavioral Health Statistics and Quality

“SEC. 520L. CENTER FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY.

“(a) ESTABLISHMENT.—There is established in the Administration a Center for Behavioral Health Statistics and Quality (in this section referred to as the ‘Center’). The Center shall be headed by a Director (in this section referred to as the ‘Director’) appointed by the Secretary from among individuals with extensive experience and academic qualifications in research and analysis in behavioral health care or related fields.

“(b) DUTIES.—The Director of the Center shall—

“(1) coordinate the Administration’s integrated data strategy by coordinating—

“(A) surveillance and data collection (including that authorized by section 505);

“(B) evaluation;

“(C) statistical and analytic support;

“(D) service systems research; and

“(E) performance and quality information systems;

“(2) recommend a core set of measurement standards for grant programs administered by the Administration; and

“(3) coordinate evaluation efforts for the grant programs, contracts, and collaborative agreements of the Administration.

“(c) BIENNIAL REPORT TO CONGRESS.—Not later than 2 years after the date of enactment of this section, and every 2 years thereafter, the Director of the Center shall submit to Congress a report on the quality of services furnished through grant programs of the Administration, including applicable measures of outcomes for individuals and public outcomes such as—

“(1) the number of patients screened positive for unhealthy alcohol use who receive brief counseling as appropriate; the number of patients screened positive for tobacco use and receiving smoking cessation interventions; the number of patients with a new diagnosis of major depressive episode who are assessed for suicide risk; the number of patients screened positive for clinical depression with a documented followup plan; and the number of patients with a documented pain assessment that have a followup treatment plan when pain is present; and satisfaction with care;

“(2) the incidence and prevalence of substance use and mental disorders; the number of suicide attempts and suicide completions; overdoses seen in emergency rooms resulting from alcohol and drug use; emergency room boarding; overdose deaths; emergency psychiatric hospitalizations; new criminal justice

involvement while in treatment; stable housing; and rates of involvement in employment, education, and training; and

“(3) such other measures for outcomes of services as the Director may determine.

“(d) STAFFING COMPOSITION.—The staff of the Center may include individuals with advanced degrees and field expertise as well as clinical and research experience in mental and substance use disorders such as—

“(1) professionals with clinical and research expertise in the prevention and treatment of, and recovery from, substance use and mental disorders;

“(2) professionals with training and expertise in statistics or research and survey design and methodologies; and

“(3) other related fields in the social and behavioral sciences, as specified by relevant position descriptions.

“(e) GRANTS AND CONTRACTS.—In carrying out the duties established in subsection (b), the Director may make grants to and enter into contracts and cooperative agreements with public and nonprofit private entities.

“(f) DEFINITION.—In this section, the term ‘emergency room boarding’ means the practice of admitting patients to an emergency department and holding such patients in the department until inpatient psychiatric beds become available.”

SEC. 109. STRATEGIC PLAN.

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

(1) by redesignating subsections (l) through (o) as subsections (m) through (p), respectively; and

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

“(l) STRATEGIC PLAN.—

“(1) IN GENERAL.—Not later than December 1, 2017, and every 5 years thereafter, the Assistant Secretary shall develop and carry out a strategic plan in accordance with this subsection for the planning and operation of evidence-based programs and grants carried out by the Administration.

“(2) COORDINATION.—In developing and carrying out the strategic plan under this section, the Assistant Secretary shall take into consideration the report of the Interdepartmental Serious Mental Illness Coordinating Committee under section 301 of the Helping Families in Mental Health Crisis Act of 2016.

“(3) PUBLICATION OF PLAN.—Not later than December 1, 2017, and every 5 years thereafter, the Assistant Secretary shall—

“(A) submit the strategic plan developed under paragraph (1) to the appropriate committees of Congress; and

“(B) post such plan on the Internet website of the Administration.

“(4) CONTENTS.—The strategic plan developed under paragraph (1) shall—

“(A) identify strategic priorities, goals, and measurable objectives for mental and substance use disorder activities and programs operated and supported by the Administration, including priorities to prevent or eliminate the burden of mental illness and substance use disorders;

“(B) identify ways to improve services for individuals with a mental or substance use disorder, including services related to the prevention of, diagnosis of, intervention in, treatment of, and recovery from, mental or substance use disorders, including serious mental illness or serious emotional disturbance, and access to services and supports for individuals with a serious mental illness or serious emotional disturbance;

“(C) ensure that programs provide, as appropriate, access to effective and evidence-based prevention, diagnosis, intervention, treatment, and recovery services, including culturally and linguistically appropriate services, as appropriate, for individuals with a mental or substance use disorder;

“(D) identify opportunities to collaborate with the Health Resources and Services Administration to develop or improve—

“(i) initiatives to encourage individuals to pursue careers (especially in rural and underserved areas and populations) as psychiatrists, psychologists, psychiatric nurse practitioners, physician assistants, occupational therapists, clinical social workers, certified peer support specialists, licensed professional counselors, or other licensed or certified mental health professionals, including such professionals specializing in the diagnosis, evaluation, or treatment of individuals with a serious mental illness or serious emotional disturbance; and

“(ii) a strategy to improve the recruitment, training, and retention of a workforce for the treatment of individuals with mental or substance use disorders, or co-occurring disorders;

“(E) identify opportunities to improve collaboration with States, local governments, communities, and Indian tribes and tribal organizations (as such

terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)); and

“(F) specify a strategy to disseminate evidenced-based and promising best practices related to prevention, diagnosis, early intervention, treatment, and recovery services related to mental illness, particularly for individuals with a serious mental illness and children and adolescents with a serious emotional disturbance, and substance use disorders.”.

SEC. 110. AUTHORITIES OF CENTERS FOR MENTAL HEALTH SERVICES AND SUBSTANCE ABUSE TREATMENT.

(a) **CENTER FOR MENTAL HEALTH SERVICES.**—Section 520(b) of the Public Health Service Act (42 U.S.C. 290bb–31(b)) is amended—

(1) by redesignating paragraphs (3) through (15) as paragraphs (4) through (16), respectively;

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

“(3) collaborate with the Director of the National Institute of Mental Health to ensure that, as appropriate, programs related to the prevention and treatment of mental illness and the promotion of mental health are carried out in a manner that reflects the best available science and evidence-based practices, including culturally and linguistically appropriate services;”;

(3) in paragraph (5), as so redesignated, by inserting “through policies and programs that reduce risk and promote resiliency” before the semicolon;

(4) in paragraph (6), as so redesignated, by inserting “in collaboration with the Director of the National Institute of Mental Health,” before “develop”;

(5) in paragraph (8), as so redesignated, by inserting “, increase meaningful participation of individuals with mental illness in programs and activities of the Administration,” before “and protect the legal”;

(6) in paragraph (10), as so redesignated, by striking “professional and paraprofessional personnel pursuant to section 303” and inserting “paraprofessional personnel and health professionals”;

(7) in paragraph (11), as so redesignated, by inserting “and telemental health,” after “rural mental health,”;

(8) in paragraph (12), as so redesignated, by striking “establish a clearinghouse for mental health information to assure the widespread dissemination of such information” and inserting “disseminate mental health information, including evidenced-based practices,”;

(9) in paragraph (15), as so redesignated, by striking “and” at the end;

(10) in paragraph (16), as so redesignated, by striking the period and inserting “; and”; and

(11) by adding at the end the following:

“(17) consult with other agencies and offices of the Department of Health and Human Services to ensure, with respect to each grant awarded by the Center for Mental Health Services, the consistent documentation of the application of criteria when awarding grants and the ongoing oversight of grantees after such grants are awarded.”.

(b) **DIRECTOR OF THE CENTER FOR SUBSTANCE ABUSE TREATMENT.**—Section 507 of the Public Health Service Act (42 U.S.C. 290bb) is amended—

(1) in subsection (a)—

(A) by striking “treatment of substance abuse” and inserting “treatment of substance use disorders”; and

(B) by striking “abuse treatment systems” and inserting “use disorder treatment systems”; and

(2) in subsection (b)—

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

(B) in paragraph (4), by striking “individuals who abuse drugs” and inserting “individuals who use drugs”;

(C) in paragraph (9), by striking “carried out by the Director”;

(D) by striking paragraph (10);

(E) by redesignating paragraphs (11) through (14) as paragraphs (10) through (13), respectively;

(F) in paragraph (12), as so redesignated, by striking “; and” and inserting a semicolon; and

(G) by striking paragraph (13), as so redesignated, and inserting the following:

“(13) ensure the consistent documentation of the application of criteria when awarding grants and the ongoing oversight of grantees after such grants are awarded; and

“(14) work with States, providers, and individuals in recovery, and their families, to promote the expansion of recovery support services and systems of care oriented towards recovery.”.

SEC. 111. ADVISORY COUNCILS.

Section 502(b) of the Public Health Service Act (42 U.S.C. 290aa-1(b)) is amended—

- (1) in paragraph (2)—
 - (A) in subparagraph (E), by striking “and” after the semicolon;
 - (B) by redesignating subparagraph (F) as subparagraph (I); and
 - (C) by inserting after subparagraph (E), the following:
 - “(F) for the advisory councils appointed under subsections (a)(1)(A) and (a)(1)(D), the Director of the National Institute of Mental Health;
 - “(G) for the advisory councils appointed under subsections (a)(1)(A), (a)(1)(B), and (a)(1)(C), the Director of the National Institute on Drug Abuse;
 - “(H) for the advisory councils appointed under subsections (a)(1)(A), (a)(1)(B), and (a)(1)(C), the Director of the National Institute on Alcohol Abuse and Alcoholism; and”;
- (2) in paragraph (3), by adding at the end the following:
 - “(C) Not less than half of the members of the advisory council appointed under subsection (a)(1)(D)—
 - “(i) shall have—
 - “(I) a medical degree;
 - “(II) a doctoral degree in psychology; or
 - “(III) an advanced degree in nursing or social work from an accredited graduate school or be a certified physician assistant; and
 - “(ii) shall specialize in the mental health field.”.

SEC. 112. PEER REVIEW.

Section 504(b) of the Public Health Service Act (42 U.S.C. 290aa-3(b)) is amended by adding at the end the following: “In the case of any such peer review group that is reviewing a grant, cooperative agreement, or contract related to mental illness treatment, not less than half of the members of such peer review group shall be licensed and experienced professionals in the prevention, diagnosis, or treatment of, or recovery from, mental or substance use disorders and have a medical degree, a doctoral degree in psychology, or an advanced degree in nursing or social work from an accredited program.”.

TITLE II—MEDICAID MENTAL HEALTH COVERAGE

SEC. 201. RULE OF CONSTRUCTION RELATED TO MEDICAID COVERAGE OF MENTAL HEALTH SERVICES AND PRIMARY CARE SERVICES FURNISHED ON THE SAME DAY.

Nothing in title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) shall be construed as prohibiting separate payment under the State plan under such title (or under a waiver of the plan) for the provision of a mental health service or primary care service under such plan, with respect to an individual, because such service is—

- (1) a primary care service furnished to the 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; or
- (2) a mental health service furnished to the 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.

SEC. 202. OPTIONAL LIMITED COVERAGE OF INPATIENT SERVICES FURNISHED IN INSTITUTIONS FOR MENTAL DISEASES.

(a) IN GENERAL.—Section 1903(m)(2) of the Social Security Act (42 U.S.C. 1396b(m)(2)) is amended by adding at the end the following new subparagraph:

“(I)(i) Notwithstanding the limitation specified in the subdivision (B) following paragraph (29) of section 1905(a) and subject to clause (ii), a State may, under a risk contract entered into by the State under this title (or under section 1115) with a medicaid managed care organization or a prepaid inpatient health plan (as defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation)), make a monthly capitation payment to such organization or plan for enrollees with the organization or plan who are over 21 years of age and under 65 years of age and are receiving inpatient treatment in an institution for mental diseases (as defined in section 1905(i)), so long as each of the following conditions is met:

- “(I) The institution is a hospital providing inpatient psychiatric or substance use disorder services or a sub-acute facility providing psychiatric or substance use disorder crisis residential services.

“(II) The length of stay in such an institution for such treatment is for a short-term stay of no more than 15 days during the period of the monthly capitation payment.

“(III) The provision of such treatment meets the following criteria for consideration as services or settings that are in lieu of services or settings covered under the State plan:

“(aa) The State determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the State plan.

“(bb) The enrollee is not required by the managed care organization or prepaid inpatient health plan to use the alternative service or setting.

“(cc) Such treatment is authorized and identified in such contract, and will be offered to such enrollees at the option of the managed care organization or prepaid inpatient health plan.

“(ii) For purposes of setting the amount of such a monthly capitation payment, a State may use the utilization of services provided to an individual under this subparagraph when developing the inpatient psychiatric or substance use disorder component of such payment, but the amount of such payment for such services may not exceed the cost of the same services furnished through providers included under the State plan.”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply beginning on July 5, 2016, or the date of the enactment of this Act, whichever is later.

SEC. 203. STUDY AND REPORT RELATED TO MEDICAID MANAGED CARE REGULATION.

(a) STUDY.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall conduct a study on coverage under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) of services provided through a Medicaid managed care organization (as defined in section 1903(m) of such Act (42 U.S.C. 1396b(m)) or a prepaid inpatient health plan (as defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation)) with respect to individuals over the age of 21 and under the age of 65 for the treatment of a mental health disorder in institutions for mental diseases (as defined in section 1905(i) of such Act (42 U.S.C. 1396d(i))). Such study shall include information on the following:

(1) The extent to which States, including the District of Columbia and each territory or possession of the United States, are providing capitated payments to such organizations or plans for enrollees who are receiving services in institutions for mental diseases.

(2) The number of individuals receiving medical assistance under a State plan under such title XIX, or a waiver of such plan, who receive services in institutions for mental diseases through such organizations and plans.

(3) The range of and average number of months, and the length of stay during such months, that such individuals are receiving such services in such institutions.

(4) How such organizations or plans determine when to provide for the furnishing of such services through an institution for mental diseases in lieu of other benefits (including the full range of community-based services) under their contract with the State agency administering the State plan under such title XIX, or a waiver of such plan, to address psychiatric or substance use disorder treatment.

(5) The extent to which the provision of services within such institutions has affected the capitated payments for such organizations or plans.

(b) REPORT.—Not later than three years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a).

SEC. 204. GUIDANCE ON OPPORTUNITIES FOR INNOVATION.

Not later than one year after the date of the enactment of this Act, the Administrator of the Centers for Medicare & Medicaid Services shall issue a State Medicaid Director letter regarding opportunities to design innovative service delivery systems, including systems for providing community-based services, for individuals with serious mental illness or serious emotional disturbance who are receiving medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.). The letter shall include opportunities for demonstration projects under section 1115 of such Act (42 U.S.C. 1315), to improve care for such individuals.

SEC. 205. STUDY AND REPORT ON MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT.

(a) COLLECTION OF INFORMATION.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services,

shall, with respect to each State that has participated in the demonstration project established under section 2707 of the Patient Protection and Affordable Care Act (42 U.S.C. 1396a note), collect from each such State information on the following:

(1) The number of institutions for mental diseases (as defined in section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i))) and beds in such institutions that received payment for the provision of services to individuals who receive medical assistance under a State plan under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or under a waiver of such plan) through the demonstration project in each such State as compared to the total number of institutions for mental diseases and beds in the State.

(2) The extent to which there is a reduction in expenditures under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) or other spending on the full continuum of physical or mental health care for individuals who receive treatment in an institution for mental diseases under the demonstration project, including outpatient, inpatient, emergency, and ambulatory care, that is attributable to such individuals receiving treatment in institutions for mental diseases under the demonstration project.

(3) The number of forensic psychiatric hospitals, the number of beds in such hospitals, and the number of forensic psychiatric beds in other hospitals in such State, based on the most recent data available, to the extent practical, as determined by such Administrator.

(4) The amount of any disproportionate share hospital payments under section 1923 of the Social Security Act (42 U.S.C. 1396r-4) that institutions for mental diseases in the State received during the period beginning on July 1, 2012, and ending on June 30, 2015, and the extent to which the demonstration project reduced the amount of such payments.

(5) The most recent data regarding all facilities or sites in the State in which any individuals with serious mental illness who are receiving medical assistance under a State plan under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or under a waiver of such plan) are treated during the period referred to in paragraph (4), to the extent practical, as determined by the Administrator, including—

(A) the types of such facilities or sites (such as an institution for mental diseases, a hospital emergency department, or other inpatient hospital);

(B) the average length of stay in such a facility or site by such an individual, disaggregated by facility type; and

(C) the payment rate under the State plan (or a waivers of such plan) for services furnished to such an individual for that treatment, disaggregated by facility type, during the period in which the demonstration project is in operation.

(6) The extent to which the utilization of hospital emergency departments during the period in which the demonstration project was is in operation differed, with respect to individuals who are receiving medical assistance under a State plan under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or under a waiver of such plan), between—

(A) those individuals who received treatment in an institution for mental diseases under the demonstration project;

(B) those individuals who met the eligibility requirements for the demonstration project but who did not receive treatment in an institution for mental diseases under the demonstration project; and

(C) those individuals with serious mental illness who did not meet such eligibility requirements and did not receive treatment for such illness in an institution for mental diseases.

(b) REPORT.—Not later than two years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report that summarizes and analyzes the information collected under subsection (a). Such report may be submitted as part of the report required under section 2707(f) of the Patient Protection and Affordable Care Act (42 U.S.C. 1396a note) or separately.

SEC. 206. PROVIDING FULL-RANGE OF EPSDT SERVICES TO CHILDREN IN IMDS.

Section 1905(a)(16) of the Social Security Act (42 U.S.C. 1396d(a)(16)) is amended by inserting before the semicolon at the end the following: “, and, effective January 1, 2019, the full-range of early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for such individuals whether or not such screening, diagnostic, and treatment services are furnished by the provider of inpatient psychiatric hospital services for individuals under age 21”.

SEC. 207. ELECTRONIC VISIT VERIFICATION SYSTEM REQUIRED FOR PERSONAL CARE SERVICES AND HOME HEALTH CARE SERVICES UNDER MEDICAID.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by inserting after subsection (k) the following new subsection:

“(1)(1) Subject to paragraphs (3) and (4), with respect to any amount expended for personal care services or home health care services requiring an in-home visit by a provider that are provided under a State plan under this title (or under a waiver of the plan) and furnished in a calendar quarter beginning on or after January 1, 2019 (or, in the case of home health care services, on or after January 1, 2023), unless a State requires the use of an electronic visit verification system for such services furnished in such quarter under the plan or such waiver, the Federal medical assistance percentage shall be reduced—

“(A) in the case of personal care services—

“(i) for calendar quarters in 2019 and 2020, by .25 percentage points;

“(ii) for calendar quarters in 2021, by .5 percentage points;

“(iii) for calendar quarters in 2022, by .75 percentage points; and

“(iv) for calendar quarters in 2023 and each year thereafter, by 1 percentage point; and

“(B) in the case of home health care services—

“(i) for calendar quarters in 2023 and 2024, by .25 percentage points;

“(ii) for calendar quarters in 2025, by .5 percentage points;

“(iii) for calendar quarters in 2026, by .75 percentage points; and

“(iv) for calendar quarters in 2027 and each year thereafter, by 1 percentage point.

“(2) Subject to paragraphs (3) and (4), in implementing the requirement for the use of an electronic visit verification system under paragraph (1), a State shall—

“(A) consult with agencies and entities that provide personal care services, home health care services, or both under the State plan (or under a waiver of the plan) to ensure that such system—

“(i) is minimally burdensome;

“(ii) takes into account existing best practices and electronic visit verification systems in use in the State; and

“(iii) is conducted in accordance with the requirements of HIPAA privacy and security law (as defined in section 3009 of the Public Health Service Act);

“(B) take into account a stakeholder process that includes input from beneficiaries, family caregivers, personal care or home health care services workers, and other stakeholders, as determined by the State in accordance with guidance from the Secretary; and

“(C) ensure that individuals who furnish personal care services, home health care services, or both under the State plan (or under a waiver of the plan) are provided the opportunity for training on the use of such system.

“(3) Paragraphs (1) and (2) shall not apply in the case of a State that, as of the date of the enactment of this subsection, requires the use of any system for the electronic verification of visits conducted as part of both personal care services and home health care services.

“(4)(A) In the case of a State described in subparagraph (B), the reduction under paragraph (1) shall not apply—

“(i) in the case of personal care services, for calendar quarters in 2019; and

“(ii) in the case of home health care services, for calendar quarters in 2023.

“(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that demonstrates to the Secretary that the State—

“(i) has made a good faith effort to comply with the requirements of paragraphs (1) and (2) (including by taking steps to adopt the technology used for an electronic visit verification system); or

“(ii) in implementing such a system, has encountered unavoidable system delays.

“(5) In this subsection:

“(A) The term ‘electronic visit verification system’ means, with respect to personal care services or home health care services, a system under which visits conducted as part of such services are electronically verified with respect to—

“(i) the type of service performed;

“(ii) the individual receiving the service;

“(iii) the date of the service;

“(iv) the location of service delivery;

“(v) the individual providing the service; and

“(vi) the time the service begins and ends.

“(B) The term ‘home health care services’ means services described in section 1905(a)(7) provided under a State plan under this title (or under a waiver of the plan).

“(C) The term ‘personal care services’ means personal care services provided under a State plan under this title (or under a waiver of the plan), including services provided under section 1905(a)(24), 1915(c), 1915(i), 1915(j), or 1915(k) or under a wavier under section 1115.

“(6)(A) In the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system operated by the State or a contractor on behalf of the State, the Secretary shall pay to the State, for each quarter, an amount equal to 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such system, and 75 per centum of so much of the sums for the operation and maintenance of such system.

“(B) Subparagraph (A) shall not apply in the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system that is not operated by the State or a contractor on behalf of the State.”

(b) COLLECTION AND DISSEMINATION OF BEST PRACTICES.—Not later than January 1, 2018, the Secretary of Health and Human Services shall, with respect to electronic visit verification systems (as defined in subsection (l)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), collect and disseminate best practices to State Medicaid Directors with respect to—

(1) training individuals who furnish personal care services, home health care services, or both under the State plan under title XIX of such Act (or under a waiver of the plan) on such systems and the operation of such systems and the prevention of fraud with respect to the provision of personal care services or home health care services (as defined in such subsection (l)(5)); and

(2) the provision of notice and educational materials to family caregivers and beneficiaries with respect to the use of such electronic visit verification systems and other means to prevent such fraud.

(c) RULES OF CONSTRUCTION.—

(1) NO EMPLOYER-EMPLOYEE RELATIONSHIP ESTABLISHED.—Nothing in the amendment made by this section may be construed as establishing an employer-employee relationship between the agency or entity that provides for personal care services or home health care services and the individuals who, under a contract with such an agency or entity, furnish such services for purposes of part 552 of title 29, Code of Federal Regulations (or any successor regulations).

(2) NO PARTICULAR OR UNIFORM ELECTRONIC VISIT VERIFICATION SYSTEM REQUIRED.—Nothing in the amendment made by this section shall be construed to require the use of a particular or uniform electronic visit verification system (as defined in subsection (l)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)) by all agencies or entities that provide personal care services or home health care under a State plan under title XIX of the Social Security Act (or under a waiver of the plan) (42 U.S.C. 1396 et seq.).

(3) NO LIMITS ON PROVISION OF CARE.—Nothing in the amendment made by this section may be construed to limit, with respect to personal care services or home health care services provided under a State plan under title XIX of the Social Security Act (or under a waiver of the plan) (42 U.S.C. 1396 et seq.), provider selection, constrain beneficiaries’ selection of a caregiver, or impede the manner in which care is delivered.

(4) NO PROHIBITION ON STATE QUALITY MEASURES REQUIREMENTS.—Nothing in the amendment made by this section shall be construed as prohibiting a State, in implementing an electronic visit verification system (as defined in subsection (l)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), from establishing requirements related to quality measures for such system.

TITLE III—INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE

SEC. 301. INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 3 months after the date of enactment of this Act, the Secretary of Health and Human Services, or the designee of the Sec-

retary, shall establish a committee to be known as the “Interdepartmental Serious Mental Illness Coordinating Committee” (in this section referred to as the “Committee”).

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

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

(c) RESPONSIBILITIES.—Not later than 1 year after the date of enactment of this Act, and 5 years after such date of enactment, the Committee shall submit to Congress a report including—

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

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

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

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

(C) quality of mental and substance use disorder treatment services; and

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

(3) a plan to improve outcomes for individuals with serious mental illness or serious emotional disturbances, including reducing incarceration for such individuals, reducing homelessness, and increasing employment; and

(4) specific recommendations for actions that agencies can take to better coordinate the administration of mental health services for people with serious mental illness or serious emotional disturbances.

(d) COMMITTEE EXTENSION.—Upon the submission of the second report under subsection (c), the Secretary shall submit a recommendation to Congress on whether to extend the operation of the Committee.

(e) MEMBERSHIP.—

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

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

(B) The Director of the National Institutes of Health.

(C) The Assistant Secretary for Health of the Department of Health and Human Services.

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

(E) The Attorney General of the United States.

(F) The Secretary of Veterans Affairs.

(G) The Secretary of Defense.

(H) The Secretary of Housing and Urban Development.

(I) The Secretary of Education.

(J) The Secretary of Labor.

(K) The Commissioner of Social Security.

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

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

(A) at least 2 members shall be individuals with lived experience with serious mental illness or serious emotional disturbance;

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

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

(D) at least 2 members shall be—

(i) a licensed psychiatrist with experience treating serious mental illnesses or serious emotional disturbances;

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

- (iii) a licensed clinical social worker with experience treating serious mental illness or serious emotional disturbances; or
 - (iv) a licensed psychiatric nurse, nurse practitioner, or physician assistant with experience treating serious mental illnesses or serious emotional disturbances;
 - (E) at least 1 member shall be a licensed mental health professional with a specialty in treating children and adolescents with serious emotional disturbances;
 - (F) at least 1 member shall be a mental health professional who has research or clinical mental health experience working with minorities;
 - (G) at least 1 member shall be a mental health professional who has research or clinical mental health experience working with medically underserved populations;
 - (H) at least 1 member shall be a State certified mental health peer specialist;
 - (I) at least 1 member shall be a judge with experience adjudicating cases within a mental health court;
 - (J) at least 1 member shall be a law enforcement officer or corrections officer with extensive experience in interfacing with individuals with a serious mental illness or serious emotional disturbance, or in a mental health crisis; and
 - (K) at least 1 member shall be a homeless services provider with experience working with individuals with serious mental illness, with serious emotional disturbance, or having mental health crisis.
- (3) **TERMS.**—A member of the Committee appointed under paragraph (2) shall serve for a term of 3 years, and may be reappointed for one or more additional 3-year terms. Any member appointed to fill a vacancy for an unexpired term shall be appointed for the remainder of such term. A member may serve after the expiration of the member’s term until a successor has been appointed.
- (f) **WORKING GROUPS.**—In carrying out its functions, the Committee may establish working groups. Such working groups shall be composed of Committee members, or their designees, and may hold such meetings as are necessary.
- (g) **SUNSET.**—The Committee shall terminate on the date that is 6 years after the date on which the Committee is established under subsection (a)(1).

TITLE IV—COMPASSIONATE COMMUNICATION ON HIPAA

SEC. 401. SENSE OF CONGRESS.

- (a) **FINDINGS.**—Congress finds the following:
- (1) The vast majority of individuals with mental illness are capable of understanding their illness and caring for themselves.
 - (2) Persons with serious mental illness (in this section referred to as “SMI”), including schizophrenia spectrum, bipolar disorders, and major depressive disorder, may be significantly impaired in their ability to understand or make sound decisions for their care and needs. By nature of their illness, cognitive impairments in reasoning and judgment, as well as the presence of hallucinations, delusions, and severe emotional distortions, they may lack the awareness they even have a mental illness (a condition known as anosognosia), and thus may be unable to make sound decisions regarding their care, nor follow through consistently and effectively on their care needs.
 - (3) Persons with mental illness or SMI may require and benefit from mental health treatment in order to recover to the fullest extent of their ability; these beneficial interventions may include psychiatric care, psychological care, medication, peer support, educational support, employment support, and housing support.
 - (4) Persons with SMI who are provided with professional and supportive services may still experience times when their symptoms may greatly impair their abilities to make sound decisions for their personal care or may discontinue their care as a result of this impaired decisionmaking resulting in a further deterioration of their condition. They may experience a temporary or prolonged impairment as a result of their diminished capacity to care for themselves.
 - (5) Episodes of psychiatric crises among those with SMI can result in neurological harm to the individual’s brain.
 - (6) Persons with SMI—

(A) are at high risk for other chronic physical illnesses, with approximately 50 percent having two or more co-occurring chronic physical illnesses such as cardiac, pulmonary, cancer, and endocrine disorders; and

(B) have three times the odds of having chronic bronchitis, five times the odds of having emphysema, and four times the odds of having COPD, are more than four times as likely to have fluid and electrolyte disorders, and are nearly three times as likely to be nicotine dependent.

(7) Some psychotropic medications, such as second generation antipsychotics, significantly increase risk for chronic illnesses such as diabetes and cardiovascular disease.

(8) When the individual fails to seek or maintain treatment for these physical conditions over a long term, it can result in the individual becoming gravely disabled, or developing life-threatening illnesses. Early and consistent treatment can ameliorate or reduce symptoms or cure the disease.

(9) Persons with SMI die 7 to 24 years earlier than their age cohorts primarily because of complications from their chronic physical illness and failure to seek or maintain treatment resulting from emotional and cognitive impairments from their SMI.

(10) It is beneficial to the person with SMI and chronic illness to seek and maintain continuity of medical care and treatment for their mental illness to prevent further deterioration and harm to their own safety.

(11) When the individual with SMI is significantly diminished in their capacity to care for themselves long term or acutely, other supportive interventions to assist their care may be necessary to protect their health and safety.

(12) Prognosis for the physical and psychiatric health of those with SMI may improve when responsible caregivers facilitate and participate in care.

(13) When an individual with SMI is chronically incapacitated in their ability to care for themselves, caregivers can pursue legal guardianship to facilitate care in appropriate areas while being mindful to allow the individual to make decisions for themselves in areas where they are capable.

(14) Individuals with SMI who have prolonged periods of being significantly functional can, during such periods, design and sign an advanced directive to predefine and choose medications, providers, treatment plans, and hospitals, and provide caregivers with guardianship the ability to help in those times when a patient's psychiatric symptoms worsen to the point of making them incapacitated or leaving them with a severely diminished capacity to make informed decisions about their care which may result in harm to their physical and mental health.

(15) All professional and support efforts should be made to help the individual with SMI and acute or chronic physical illnesses to understand and follow through on treatment.

(16) When individuals with SMI, even after efforts to help them understand, have failed to care for themselves, there exists confusion in the health care community around what is currently permissible under HIPAA rules. This confusion may hinder communication with responsible caregivers who may be able to facilitate care for the patient with SMI in instances when the individual does not give permission for disclosure.

(b) SENSE OF CONGRESS.—It is the sense of the Congress that, for the sake of the health and safety of persons with serious mental illness, more clarity is needed surrounding the existing HIPAA privacy rule promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act (42 U.S.C. 1320d–2 note) to permit health care professionals to communicate, when necessary, with responsible known caregivers of such persons, the limited, appropriate protected health information of such persons in order to facilitate treatment, but not including psychotherapy notes.

SEC. 402. CONFIDENTIALITY OF RECORDS.

Not later than one year after the date on which the Secretary of Health and Human Services first finalizes regulations updating part 2 of title 42, Code of Federal Regulations (relating to confidentiality of alcohol and drug abuse patient records) after the date of enactment of this Act, the Secretary shall convene relevant stakeholders to determine the effect of such regulations on patient care, health outcomes, and patient privacy. The Secretary shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate, and make publicly available, a report on the findings of such stakeholders.

SEC. 403. CLARIFICATION OF CIRCUMSTANCES UNDER WHICH DISCLOSURE OF PROTECTED HEALTH INFORMATION IS PERMITTED.

(a) **IN GENERAL.**—Not later than one year after the date of enactment of this section, the Secretary of Health and Human Services shall promulgate final regulations clarifying the circumstances under which, consistent with the provisions of subpart C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.) and regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), a health care provider or covered entity may disclose the protected health information of a patient with a mental illness, including for purposes of—

(1) communicating (including with respect to treatment, side effects, risk factors, and the availability of community resources) with a family member of such patient, caregiver of such patient, or other individual to the extent that such family member, caregiver, or individual is involved in the care of the patient;

(2) communicating with a family member of the patient, caregiver of such patient, or other individual involved in the care of the patient in the case that the patient is an adult;

(3) communicating with the parent or caregiver of a patient in the case that the patient is a minor;

(4) considering the patient’s capacity to agree or object to the sharing of the protected health information of the patient;

(5) communicating and sharing information with the family or caregivers of the patient when—

(A) the patient consents;

(B) the patient does not consent, but the patient lacks the capacity to agree or object and the communication or sharing of information is in the patient’s best interest;

(C) the patient does not consent and the patient is not incapacitated or in an emergency circumstance, but the ability of the patient to make rational health care decisions is significantly diminished by reason of the physical or mental health condition of the patient; and

(D) the patient does not consent, but such communication and sharing of information is necessary to prevent impending and serious deterioration of the patient’s mental or physical health;

(6) involving a patient’s family members, caregivers, or others involved in the patient’s care or care plan, including facilitating treatment and medication adherence, in dealing with patient failures to adhere to medication or other therapy;

(7) listening to or receiving information with respect to the patient from the family or caregiver of such patient receiving mental illness treatment;

(8) communicating with family members of the patient, caregivers of the patient, law enforcement, or others when the patient presents a serious and imminent threat of harm to self or others; and

(9) communicating to law enforcement and family members of the patient or caregivers of the patient about the admission of the patient to receive care at a facility or the release of a patient who was admitted to a facility for an emergency psychiatric hold or involuntary treatment.

(b) **COORDINATION.**—The Secretary of Health and Human Services shall carry out this section in coordination with the Director of the Office for Civil Rights within the Department of Health and Human Services.

(c) **CONSISTENCY WITH GUIDANCE.**—The Secretary of Health and Human Services shall ensure that the regulations under this section are consistent with the guidance entitled “HIPAA Privacy Rule and Sharing Information Related to Mental Health”, issued by the Department of Health and Human Services on February 20, 2014.

SEC. 404. DEVELOPMENT AND DISSEMINATION OF MODEL TRAINING PROGRAMS.

(a) **INITIAL PROGRAMS AND MATERIALS.**—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall develop and disseminate—

(1) a model program and materials for training health care providers (including physicians, emergency medical personnel, psychologists, counselors, therapists, behavioral health facilities and clinics, care managers, and hospitals) regarding the circumstances under which, consistent with the standards governing the privacy and security of individually identifiable health information promulgated by the Secretary under subpart C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.) and regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), the protected health information of patients with a mental illness may be disclosed with and without patient consent;

- (2) a model program and materials for training lawyers and others in the legal profession on such circumstances; and
- (3) a model program and materials for training patients and their families regarding their rights to protect and obtain information under the standards specified in paragraph (1).
- (b) PERIODIC UPDATES.—The Secretary shall—
 - (1) periodically review and update the model programs and materials developed under subsection (a); and
 - (2) disseminate the updated model programs and materials.
- (c) CONTENTS.—The programs and materials developed under subsection (a) shall address the guidance entitled “HIPAA Privacy Rule and Sharing Information Related to Mental Health”, issued by the Department of Health and Human Services on February 20, 2014.
- (d) COORDINATION.—The Secretary shall carry out this section in coordination with the Director of the Office for Civil Rights within the Department of Health and Human Services, the Assistant Secretary for Mental Health and Substance Use, the Administrator of the Health Resources and Services Administration, and the heads of other relevant agencies within the Department of Health and Human Services.
- (e) INPUT OF CERTAIN ENTITIES.—In developing the model programs and materials required by subsections (a) and (b), the Secretary shall solicit the input of relevant national, State, and local associations, medical societies, and licensing boards.
- (f) FUNDING.—There are authorized to be appropriated to carry out this section \$4,000,000 for fiscal year 2018, \$2,000,000 for each of fiscal years 2019 and 2020, and \$1,000,000 for each of fiscal years 2021 and 2022.

TITLE V—INCREASING ACCESS TO TREATMENT FOR SERIOUS MENTAL ILLNESS

SEC. 501. ASSERTIVE COMMUNITY TREATMENT GRANT PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

Part B of title V of the Public Health Service Act (42 U.S.C. 290bb et seq.) is amended by inserting after section 520L the following:

“SEC. 520M. ASSERTIVE COMMUNITY TREATMENT GRANT PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

“(a) IN GENERAL.—The Assistant Secretary shall award grants to eligible entities—

- “(1) to establish assertive community treatment programs for individuals with serious mental illness; or
- “(2) to maintain or expand such programs.

“(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall be a State, county, city, tribe, tribal organization, mental health system, health care facility, or any other entity the Assistant Secretary deems appropriate.

“(c) SPECIAL CONSIDERATION.—In selecting among applicants for a grant under this section, the Assistant Secretary may give special consideration to the potential of the applicant’s program to reduce hospitalization, homelessness, and involvement with the criminal justice system while improving the health and social outcomes of the patient.

“(d) ADDITIONAL ACTIVITIES.—The Assistant Secretary shall—

- “(1) not later than the end of fiscal year 2021, submit a report to the appropriate congressional committees on the grant program under this section, including an evaluation of—
 - “(A) cost savings and public health outcomes such as mortality, suicide, substance abuse, hospitalization, and use of services;
 - “(B) rates of involvement with the criminal justice system of patients;
 - “(C) rates of homelessness among patients; and
 - “(D) patient and family satisfaction with program participation; and
- “(2) provide appropriate information, training, and technical assistance to grant recipients under this section to help such recipients to establish, maintain, or expand their assertive community treatment programs.

“(e) AUTHORIZATION OF APPROPRIATIONS.—

“(1) IN GENERAL.—To carry out this section, there is authorized to be appropriated \$5,000,000 for the period of fiscal years 2018 through 2022.

“(2) USE OF CERTAIN FUNDS.—Of the funds appropriated to carry out this section in any fiscal year, no more than 5 percent shall be available to the Assistant Secretary for carrying out subsection (d).”

SEC. 502. STRENGTHENING COMMUNITY CRISIS RESPONSE SYSTEMS.

Section 520F of the Public Health Service Act (42 U.S.C. 290bb-37) is amended to read as follows:

“SEC. 520F. STRENGTHENING COMMUNITY CRISIS RESPONSE SYSTEMS.

“(a) IN GENERAL.—The Secretary shall award competitive grants—

“(1) to State and local governments and Indian tribes and tribal organizations to enhance community-based crisis response systems; or

“(2) to States to develop, maintain, or enhance a database of beds at inpatient psychiatric facilities, crisis stabilization units, and residential community mental health and residential substance use disorder treatment facilities, for individuals with serious mental illness, serious emotional disturbance, or substance use disorders.

“(b) APPLICATION.—

“(1) **IN GENERAL.—**To receive a grant or cooperative agreement under subsection (a), an entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

“(2) **COMMUNITY-BASED CRISIS RESPONSE PLAN.—**An application for a grant under subsection (a)(1) shall include a plan for—

“(A) promoting integration and coordination between local public and private entities engaged in crisis response, including first responders, emergency health care providers, primary care providers, law enforcement, court systems, health care payers, social service providers, and behavioral health providers;

“(B) developing a plan for entering into memoranda of understanding with public and private entities to implement crisis response services;

“(C) expanding the continuum of community-based services to address crisis intervention and prevention; and

“(D) developing models for minimizing hospital readmissions, including through appropriate discharge planning.

“(3) **BEDS DATABASE PLAN.—**An application for a grant under subsection (a)(2) shall include a plan for developing, maintaining, or enhancing a real-time Internet-based bed database to collect, aggregate, and display information about beds in inpatient psychiatric facilities and crisis stabilization units, and residential community mental health and residential substance use disorder treatment facilities, to facilitate the identification and designation of facilities for the temporary treatment of individuals in mental or substance use disorder crisis.

“(c) DATABASE REQUIREMENTS.—A bed database described in this section is a database that—

“(1) includes information on inpatient psychiatric facilities, crisis stabilization units, and residential community mental health and residential substance use disorder facilities in the State involved, including contact information for the facility or unit;

“(2) provides real-time information about the number of beds available at each facility or unit and, for each available bed, the type of patient that may be admitted, the level of security provided, and any other information that may be necessary to allow for the proper identification of appropriate facilities for treatment of individuals in mental or substance use disorder crisis; and

“(3) enables searches of the database to identify available beds that are appropriate for the treatment of individuals in mental or substance use disorder crisis.

“(d) EVALUATION.—An entity receiving a grant under subsection (a)(1) shall submit to the Secretary, at such time, in such manner, and containing such information as the Secretary may reasonably require, a report, including an evaluation of the effect of such grant on—

“(1) local crisis response services and measures of individuals receiving crisis planning and early intervention supports;

“(2) individuals reporting improved functional outcomes; and

“(3) individuals receiving regular followup care following a crisis.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, \$5,000,000 for the period of fiscal years 2018 through 2022.”.

SEC. 503. INCREASED AND EXTENDED FUNDING FOR ASSISTED OUTPATIENT GRANT PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

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

(1) in paragraph (1), by striking “2018” and inserting “2022”; and

(2) in paragraph (2), by striking “is authorized to be appropriated to carry out this section \$15,000,000 for each of fiscal years 2015 through 2018” and insert-

ing “are authorized to be appropriated to carry out this section \$15,000,000 for each of fiscal years 2015 through 2017, \$20,000,000 for fiscal year 2018, \$19,000,000 for each of fiscal years 2019 and 2020, and \$18,000,000 for each of fiscal years 2021 and 2022”.

SEC. 504. LIABILITY PROTECTIONS FOR HEALTH PROFESSIONAL VOLUNTEERS AT COMMUNITY HEALTH CENTERS.

Section 224 of the Public Health Service Act (42 U.S.C. 233) is amended by adding at the end the following:

“(q)(1) For purposes of this section, a health professional volunteer at an entity described in subsection (g)(4) shall, in providing a health professional service eligible for funding under section 330 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 (4)(C). The preceding sentence is subject to the provisions of this subsection.

“(2) In providing a health service to an individual, a health care practitioner shall for purposes of this subsection be considered to be a health professional volunteer at an entity described in subsection (g)(4) 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), or through offsite programs or events carried out by the entity.

“(B) The entity is sponsoring the health care practitioner pursuant to paragraph (3)(B).

“(C) The health care practitioner 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 practitioner may receive repayment from the entity described in subsection (g)(4) for reasonable expenses incurred by the health care practitioner in the provision of the service to the individual.

“(D) Before the service is provided, the health care practitioner or the 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 practitioner is limited pursuant to this subsection.

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

“(3) Subsection (g) (other than paragraphs (3) and (5)) and subsections (h), (i), and (l) apply to a health care practitioner 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 (4) and subject to the following:

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

“(B) With respect to an entity described in subsection (g)(4), a health care practitioner is not a health professional volunteer at such entity unless the entity sponsors the health care practitioner. For purposes of this subsection, the entity shall be considered to be sponsoring the health care practitioner if—

“(i) with respect to the health care practitioner, the entity 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 practitioner is deemed to be an employee of the Public Health Service.

“(C) In the case of a health care practitioner who is determined by the Secretary pursuant to subsection (g)(1)(E) to be a health professional volunteer at such entity, this subsection applies to the health care practitioner (with respect to services performed on behalf of the entity sponsoring the health care practitioner pursuant to subparagraph (B)) for any cause of action arising from an act or omission of the health care practitioner occurring on or after the date on which the Secretary makes such determination.

“(D) Subsection (g)(1)(F) applies to a health care practitioner for purposes of this subsection only to the extent that, in providing health services to an individual, each of the conditions specified in paragraph (2) is met.

“(4)(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.

“(B) Not later 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 professional volunteers, will be paid pur-

suant to this section 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 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.

“(5)(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 (3)(B); and

“(ii) reports under paragraph (4)(B) may be submitted to the Congress.”.

TITLE VI—SUPPORTING INNOVATIVE AND EVIDENCE-BASED PROGRAMS

Subtitle A—Encouraging the Advancement, Incorporation, and Development of Evidence-Based Practices

SEC. 601. ENCOURAGING INNOVATION AND EVIDENCE-BASED PROGRAMS.

Section 501B of the Public Health Service Act, as inserted by section 103, is further amended, by inserting after subsection (c) the following new subsection:

“(d) PROMOTING INNOVATION.—

“(1) IN GENERAL.—The Assistant Secretary, in coordination with the Laboratory, may award grants to States, local governments, Indian tribes or tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act), educational institutions, and nonprofit organizations to develop evidence-based interventions, including culturally and linguistically appropriate services, as appropriate, for—

“(A) evaluating a model that has been scientifically demonstrated to show promise, but would benefit from further applied development, for—

“(i) enhancing the prevention, diagnosis, intervention, treatment, and recovery of mental illness, serious emotional disturbance, substance use disorders, and co-occurring disorders; or

“(ii) integrating or coordinating physical health services and mental and substance use disorder services; and

“(B) expanding, replicating, or scaling evidence-based programs across a wider area to enhance effective screening, early diagnosis, intervention, and treatment with respect to mental illness, serious mental illness, and serious emotional disturbance, primarily by—

“(i) applying delivery of care, including training staff in effective evidence-based treatment; or

“(ii) integrating models of care across specialties and jurisdictions.

“(2) CONSULTATION.—In awarding grants under this paragraph, the Assistant Secretary shall, as appropriate, consult with the advisory councils described in section 502, the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism, as appropriate.

“(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated—

“(A) to carry out paragraph (1)(A), \$7,000,000 for the period of fiscal years 2018 through 2020; and

“(B) to carry out paragraph (1)(B), \$7,000,000 for the period of fiscal years 2018 through 2020.”.

SEC. 602. PROMOTING ACCESS TO INFORMATION ON EVIDENCE-BASED PROGRAMS AND PRACTICES.

Part D of title V of the Public Health Service Act is amended by inserting after section 543 of such Act (42 U.S.C. 290dd-2) the following:

“SEC. 544. PROMOTING ACCESS TO INFORMATION ON EVIDENCE-BASED PROGRAMS AND PRACTICES.

“(a) **IN GENERAL.**—The Assistant Secretary shall improve access to reliable and valid information on evidence-based programs and practices, including information on the strength of evidence associated with such programs and practices, related to mental and substance use disorders for States, local communities, nonprofit entities, and other stakeholders by posting on the website of the National Registry of Evidence-Based Programs and Practices evidence-based programs and practices that have been reviewed by the Assistant Secretary pursuant to the requirements of this section.

“(b) **NOTICE.**—

“(1) **PERIODS.**—In carrying out subsection (a), the Assistant Secretary may establish an initial period for the submission of applications for evidence-based programs and practices to be posted publicly in accordance with subsection (a) (and may establish subsequent such periods). The Assistant Secretary shall publish notice of such application periods in the Federal Register.

“(2) **ADDRESSING GAPS.**—Such notice may solicit applications for evidence-based practices and programs to address gaps in information identified by the Assistant Secretary, the Assistant Secretary for Planning and Evaluation, the Assistant Secretary for Financial Resources, or the National Mental Health and Substance Use Policy Laboratory, including pursuant to priorities identified in the strategic plan established under section 501(l).

“(c) **REQUIREMENTS.**—The Assistant Secretary shall establish minimum requirements for applications referred to in this section, including applications related to the submission of research and evaluation.

“(d) **REVIEW AND RATING.**—The Assistant Secretary shall review applications prior to public posting, and may prioritize the review of applications for evidence-based practices and programs that are related to topics included in the notice established under subsection (b). The Assistant Secretary shall utilize a rating and review system, which shall include information on the strength of evidence associated with such programs and practices and a rating of the methodological rigor of the research supporting the application. The Assistant Secretary shall make the metrics used to evaluate applications and the resulting ratings publicly available.”.

SEC. 603. SENSE OF CONGRESS.

It is the sense of the Congress that the National Institute of Mental Health should conduct or support research on the determinants of self-directed and other violence connected to mental illness.

Subtitle B—Supporting the State Response to Mental Health Needs

SEC. 611. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT.

(a) **FORMULA GRANTS.**—Section 1911(b) of the Public Health Service Act (42 U.S.C. 300x(b)) is amended—

(1) by redesignating paragraphs (1) through (3) as paragraphs (2) through (4), respectively; and

(2) by inserting before paragraph (2) (as so redesignated), the following:

“(1) providing community mental health services for adults with a serious mental illness and children with a serious emotional disturbance as defined in accordance with section 1912(c);”.

(b) **STATE PLAN.**—Subsection (b) of section 1912 of the Public Health Service Act (42 U.S.C. 300x-1) is amended to read as follows:

“(b) **CRITERIA FOR PLAN.**—In accordance with subsection (a), a State shall submit to the Secretary a plan that, at a minimum, satisfies the following criteria:

“(1) **SYSTEM OF CARE.**—The plan provides a description of the system of care of the State, including as follows:

“(A) **COMPREHENSIVE COMMUNITY-BASED HEALTH SYSTEMS.**—The plan shall—

“(i) identify the single State agency to be responsible for the administration of the program under the grant, including any third party who administers mental health services and is responsible for complying with the requirements of this part with respect to the grant;

“(ii) provide for an organized community-based system of care for individuals with mental illness, and describe available services and resources in a comprehensive system of care, including services for individuals with mental health and behavioral health co-occurring disorders;

“(iii) include a description of the manner in which the State and local entities will coordinate services to maximize the efficiency, effectiveness, quality, and cost effectiveness of services and programs to produce the best possible outcomes (including health services, rehabilitation services, employment services, housing services, educational services, substance use disorder services, legal services, law enforcement services, social services, child welfare services, medical and dental care services, and other support services to be provided with Federal, State, and local public and private resources) with other agencies to enable individuals receiving services to function outside of inpatient or residential institutions, to the maximum extent of their capabilities, including services to be provided by local school systems under the Individuals with Disabilities Education Act;

“(iv) include a description of how the State—

“(I) promotes evidence-based practices, including those evidence-based programs that address the needs of individuals with early serious mental illness regardless of the age of the individual at onset;

“(II) provides comprehensive individualized treatment; or

“(III) integrates mental and physical health services;

“(v) include a description of case management services;

“(vi) include a description of activities that seek to engage individuals with serious mental illness or serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication between individuals, families, caregivers, and treatment providers; and

“(vii) as appropriate to and reflective of the uses the State proposes for the block grant monies—

“(I) a description of the activities intended to reduce hospitalizations and hospital stays using the block grant monies;

“(II) a description of the activities intended to reduce incidents of suicide using the block grant monies; and

“(III) a description of how the State integrates mental health and primary care using the block grant monies.

“(B) MENTAL HEALTH SYSTEM DATA AND EPIDEMIOLOGY.—The plan shall contain an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children and presents quantitative targets and outcome measures for programs and services provided under this subpart.

“(C) CHILDREN’S SERVICES.—In the case of children with serious emotional disturbance (as defined in accordance with subsection (c)), the plan shall provide for a system of integrated social services, educational services, child welfare services, juvenile justice services, law enforcement services, and substance use disorder services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (such system to include services provided under the Individuals with Disabilities Education Act).

“(D) TARGETED SERVICES TO RURAL AND HOMELESS POPULATIONS.—The plan shall describe the State’s outreach to and services for individuals who are homeless and how community-based services will be provided to individuals residing in rural areas.

“(E) MANAGEMENT SERVICES.—The plan shall—

“(i) describe the financial resources available, the existing mental health workforce, and the workforce trained in treating individuals with co-occurring mental and substance use disorders;

“(ii) provide for the training of providers of emergency health services regarding mental health;

“(iii) describe the manner in which the State intends to expend the grant under section 1911 for the fiscal year involved; and

“(iv) describe the manner in which the State intends to comply with each of the funding agreements in this subpart and subpart III.

“(2) GOALS AND OBJECTIVES.—The plan establishes goals and objectives for the period of the plan, including targets and milestones that are intended to be met, and the activities that will be undertaken to achieve those targets.”.

(c) 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.—A State shall expend not less than 10 percent of the amount the State receives for carrying out this subpart in

each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset.”.

(d) ADDITIONAL PROVISIONS.—Section 1915(b) of the Public Health Service Act (42 U.S.C. 300x–4(b)) is amended—

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

“(1) IN GENERAL.—A funding agreement for a grant under section 1911 is that the State involved will maintain State expenditures for community mental health services at a level that is not less than the average of the amounts prescribed by this paragraph (prior to any waiver under paragraph (3)) for such expenditures by such State for each of the two fiscal years immediately preceding the fiscal year for which the State is applying for the grant.”;

(2) in paragraph (2)—

(A) by striking “subsection (a)” and inserting “paragraph (1)”; and

(B) by striking “principle” and inserting “principal”;

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

“(3) WAIVER.—

“(A) IN GENERAL.—The Secretary may, upon the request of a State, waive the requirement established in paragraph (1) in whole or in part, if the Secretary determines that extraordinary economic conditions in the State in the fiscal year involved or in the previous fiscal year justify the waiver.

“(B) DATE CERTAIN FOR ACTION UPON REQUEST.—The Secretary shall approve or deny a request for a waiver under this paragraph not later than 120 days after the date on which the request is made.

“(C) APPLICABILITY OF WAIVER.—A waiver provided by the Secretary under this paragraph shall be applicable only to the fiscal year involved.”;

and

(4) in paragraph (4)—

(A) by amending subparagraph (A) to read as follows:

“(A) IN GENERAL.—

“(i) DETERMINATION AND REDUCTION.—The Secretary shall determine, in the case of each State, and for each fiscal year, whether the State maintained material compliance with the agreement made under paragraph (1). If the Secretary determines that a State has failed to maintain such compliance for a fiscal year, the Secretary shall reduce the amount of the allotment under section 1911 for the State, for the first fiscal year beginning after such determination is final, by an amount equal to the amount constituting such failure for the previous fiscal year about which the determination was made.

“(ii) ALTERNATIVE SANCTION.—The Secretary may by regulation provide for an alternative method of imposing a sanction for a failure by a State to maintain material compliance with the agreement under paragraph (1) if the Secretary determines that such alternative method would be more equitable and would be a more effective incentive for States to maintain such material compliance.”; and

(B) in subparagraph (B)—

(i) by inserting after the subparagraph designation the following: “SUBMISSION OF INFORMATION TO THE SECRETARY.—”; and

(ii) by striking “subparagraph (A)” and inserting “subparagraph (A)(i)”.

(e) APPLICATION FOR GRANT.—Section 1917(a) of the Public Health Service Act (42 U.S.C. 300x–6(a)) is amended—

(1) in paragraph (1), by striking “1941” and inserting “1942(a)”; and

(2) in paragraph (5), by striking “1915(b)(3)(B)” and inserting “1915(b)”.

Subtitle C—Strengthening Mental Health Care for Children and Adolescents

SEC. 621. TELEHEALTH CHILD PSYCHIATRY ACCESS GRANTS.

Title III of the Public Health Service Act is amended by inserting after section 330L of such Act (42 U.S.C. 254c–18) the following new section:

“SEC. 330M. TELEHEALTH CHILD PSYCHIATRY ACCESS GRANTS.

“(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in coordination with other relevant Federal agencies, shall award grants to States, political subdivisions of States, Indian tribes, and tribal organizations (for purposes of this section, as such terms are de-

defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)) to promote behavioral health integration in pediatric primary care by—

“(1) supporting the development of statewide child psychiatry access programs; and

“(2) supporting the improvement of existing statewide child psychiatry access programs.

“(b) PROGRAM REQUIREMENTS.—

“(1) IN GENERAL.—A child psychiatry access program referred to in subsection (a), with respect to which a grant under such subsection may be used, shall—

“(A) be a statewide network of pediatric mental health teams that provide support to pediatric primary care sites as an integrated team;

“(B) support and further develop organized State networks of child and adolescent psychiatrists to provide consultative support to pediatric primary care sites;

“(C) conduct an assessment of critical behavioral consultation needs among pediatric providers and such providers’ preferred mechanisms for receiving consultation and training and technical assistance;

“(D) develop an online database and communication mechanisms, including telehealth, to facilitate consultation support to pediatric practices;

“(E) provide rapid statewide clinical telephone or telehealth consultations when requested between the pediatric mental health teams and pediatric primary care providers;

“(F) conduct training and provide technical assistance to pediatric primary care providers to support the early identification, diagnosis, treatment, and referral of children with behavioral health conditions or co-occurring intellectual and other developmental disabilities;

“(G) inform and assist pediatric providers in accessing child psychiatry consultations and in scheduling and conducting technical assistance;

“(H) assist with referrals to specialty care and community or behavioral health resources; and

“(I) establish mechanisms for measuring and monitoring increased access to child and adolescent psychiatric services by pediatric primary care providers and expanded capacity of pediatric primary care providers to identify, treat, and refer children with mental health problems.

“(2) PEDIATRIC MENTAL HEALTH TEAMS.—In this subsection, the term ‘pediatric mental health team’ means a team of case coordinators, child and adolescent psychiatrists, and licensed clinical mental health professionals, such as a psychologist, social worker, or mental health counselor.

“(c) APPLICATION.—A State, political subdivision of a State, Indian tribe, or tribal organization seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a plan for the rigorous evaluation of activities that are carried out with funds received under such grant.

“(d) EVALUATION.—A State, political subdivision of a State, Indian tribe, or tribal organization that receives a grant under this section shall prepare and submit an evaluation of activities carried out with funds received under such grant to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require, including a process and outcome evaluation.

“(e) MATCHING REQUIREMENT.—The Secretary may not award a grant under this section unless the State, political subdivision of a State, Indian tribe, or tribal organization involved agrees, with respect to the costs to be incurred by the State, political subdivision of a State, Indian tribe, or tribal organization in carrying out the purpose described in this section, to make available non-Federal contributions (in cash or in kind) toward such costs in an amount that is not less than 20 percent of Federal funds provided in the grant.

“(f) AUTHORIZATION OF APPROPRIATIONS.—To carry this section, there are authorized to be appropriated \$9,000,000 for the period of fiscal years 2018 through 2020.”.

SEC. 622. INFANT AND EARLY CHILDHOOD MENTAL HEALTH PROMOTION, INTERVENTION, AND TREATMENT.

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

“SEC. 399Z-2. INFANT AND EARLY CHILDHOOD MENTAL HEALTH PROMOTION, INTERVENTION, AND TREATMENT.

“(a) GRANTS.—The Secretary shall—

“(1) award grants to eligible entities, including human services agencies, to develop, maintain, or enhance infant and early childhood mental health promotion, intervention, and treatment programs, including—

“(A) programs for infants and children at significant risk of developing, showing early signs of, or having been diagnosed with mental disorders including serious emotional disturbance; and

“(B) multigenerational therapy and other services that support the caregiving relationship; and

“(2) ensure that programs funded through grants under this section are evidence-informed or evidence-based models, practices, and methods that are, as appropriate, culturally and linguistically appropriate, and can be replicated in other appropriate settings.

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

“(1) ELIGIBLE CHILD.—The term ‘eligible child’ means a child from birth to not more than 5 years of age who—

“(A) is at risk for, shows early signs of, or has been diagnosed with a mental disorder, including serious emotional disturbance; and

“(B) may benefit from infant and early childhood intervention or treatment programs or specialized preschool or elementary school programs that are evidence-based or that have been scientifically demonstrated to show promise but would benefit from further applied development.

“(2) ELIGIBLE ENTITY.—The term ‘eligible entity’ means a nonprofit institution that—

“(A) is accredited or approved by a State mental health or education agency, as applicable, to provide for children from infancy to 5 years of age mental health promotion, intervention, or treatment services that are evidence-based or that have been scientifically demonstrated to show promise but would benefit from further applied development; and

“(B) provides programs described in subsection (a) that are evidence-based or that have been scientifically demonstrated to show promise but would benefit from further applied development.

“(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 INTERVENTION AND TREATMENT PROGRAMS.—An eligible entity may use amounts awarded under a grant under subsection (a)(1) to carry out the following:

“(1) Provide age-appropriate mental health promotion and early intervention services or mental disorder treatment services, which may include specialized programs, for eligible children at significant risk of developing, showing early signs of, or having been diagnosed with a mental disorder, including serious emotional disturbance. Such services may include social and behavioral services as well as multigenerational therapy and other services that support the caregiving relationship.

“(2) Provide training for health care professionals with expertise in infant and early childhood mental health care with respect to appropriate and relevant integration with other disciplines such as primary care clinicians, early intervention specialists, child welfare staff, home visitors, early care and education providers, and others who work with young children and families.

“(3) Provide mental health consultation to personnel of early care and education programs (including licensed or regulated center-based and home-based child care, home visiting, preschool special education, and early intervention programs) who work with children and families.

“(4) Provide training for mental health clinicians in infant and early childhood promising and evidence-based practices and models for mental health treatment and early intervention, including with regard to practices for identifying and treating mental and behavioral disorders of infants and children resulting from exposure or repeated exposure to adverse childhood experiences or childhood trauma.

“(5) Provide age-appropriate assessment, diagnostic, and intervention services for eligible children, including early mental health promotion, intervention, and treatment services.

“(e) MATCHING FUNDS.—The Secretary 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 subsection (d), to make available non-Federal contributions (in cash or in kind) toward such costs in an amount that is not less than 10 percent of the total amount of Federal funds provided in the grant.

“(f) AUTHORIZATION OF APPROPRIATIONS.—To carry this section, there are authorized to be appropriated \$20,000,000 for the period of fiscal years 2018 through 2022.”.

SEC. 623. NATIONAL CHILD TRAUMATIC STRESS INITIATIVE.

Section 582 of the Public Health Service Act (42 U.S.C. 290hh-1; relating to grants to address the problems of persons who experience violence related stress) 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 practices for identifying and treating mental disorders, behavioral disorders, and physical health conditions 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”;

(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, report, and make publicly available NCTSI-wide child treatment process and outcome data regarding the early identification and delivery of evidence-based 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 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 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”;

(7) in subsection (j) (as so redesignated), by striking “\$50,000,000” and all that follows through “2006” and inserting “\$46,887,000 for each of fiscal years 2017 through 2021”.

TITLE VII—GRANT PROGRAMS AND PROGRAM REAUTHORIZATION

Subtitle A—Garrett Lee Smith Memorial Act Reauthorization

SEC. 701. YOUTH INTERAGENCY RESEARCH, TRAINING, AND TECHNICAL ASSISTANCE CENTERS.

Section 520C of the Public Health Service Act (42 U.S.C. 290bb-34) is amended—

(1) by striking the section heading and inserting “**SUICIDE PREVENTION TECHNICAL ASSISTANCE CENTER.**”;

(2) in subsection (a), by striking “and in consultation with” and all that follows through the period at the end of paragraph (2) and inserting “shall estab-

lish 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 regarding the prevention of suicide among all ages, particularly among groups that are at high risk for suicide.”;

(3) by striking subsections (b) and (c);

(4) by redesignating subsection (d) as subsection (b);

(5) in subsection (b), as so redesignated—

(A) by striking the subsection heading and inserting “RESPONSIBILITIES OF THE CENTER.—”;

(B) in the matter preceding paragraph (1), by striking “The additional research” and all that follows through “nonprofit organizations for” and inserting “The center established under subsection (a) shall conduct activities for the purpose of”;

(C) by striking “youth suicide” each place such term appears and inserting “suicide”;

(D) in paragraph (1)—

(i) by striking “the development or continuation of” and inserting “developing and continuing”; and

(ii) by inserting “for all ages, particularly among groups that are at high risk for suicide” before the semicolon at the end;

(E) in paragraph (2), by inserting “for all ages, particularly among groups that are at high risk for suicide” before the semicolon at the end;

(F) in paragraph (3), by inserting “and tribal” after “statewide”;

(G) in paragraph (5), by inserting “and prevention” after “intervention”;

(H) in paragraph (8), by striking “in youth”;

(I) in paragraph (9), by striking “and behavioral health” and inserting “health and substance use disorder”; and

(J) in paragraph (10), by inserting “conducting” before “other”; and

(6) by striking subsection (e) and inserting the following:

“(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated \$5,988,000 for each of fiscal years 2017 through 2021.

“(d) REPORT.—Not later than 2 years after the date of enactment of the Helping Families in Mental Health Crisis Act of 2016, the Secretary shall submit to Congress a report on the activities carried out by the center established under subsection (a) during the year involved, including the potential effects of such activities, and the States, organizations, and institutions that have worked with the center.”.

SEC. 702. YOUTH SUICIDE EARLY INTERVENTION AND PREVENTION STRATEGIES.

Section 520E of the Public Health Service Act (42 U.S.C. 290bb–36) is amended—

(1) in paragraph (1) of subsection (a) and in subsection (c), by striking “substance abuse” each place such term appears and inserting “substance use disorder”;

(2) in subsection (b)(2)—

(A) by striking “each State is awarded only 1 grant or cooperative agreement under this section” and inserting “a State does not receive more than 1 grant or cooperative agreement under this section at any 1 time”; and

(B) by striking “been awarded” and inserting “received”; and

(3) by striking subsection (m) and inserting the following:

“(m) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated \$35,427,000 for each of fiscal years 2017 through 2021.”.

SEC. 703. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES ON CAMPUS.

Section 520E–2 of the Public Health Service Act (42 U.S.C. 290bb–36b) is amended—

(1) in the section heading, by striking “AND BEHAVIORAL HEALTH” and inserting “HEALTH AND SUBSTANCE USE DISORDER”;

(2) in subsection (a)—

(A) by striking “Services,” and inserting “Services and”;

(B) by striking “and behavioral health problems” and inserting “health or substance use disorders”; and

(C) by striking “substance abuse” and inserting “substance use disorders”;

(3) in subsection (b)—

(A) in the matter preceding paragraph (1), by striking “for—” and inserting “for one or more of the following:”; and

(B) by striking paragraphs (1) through (6) and inserting the following:

“(1) Educating students, families, faculty, and staff to increase awareness of mental health and substance use disorders.

“(2) The operation of hotlines.

“(3) Preparing informational material.

“(4) Providing outreach services to notify students about available mental health and substance use disorder services.

“(5) Administering voluntary mental health and substance use disorder screenings and assessments.

“(6) Supporting the training of students, faculty, and staff to respond effectively to students with mental health and substance use disorders.

“(7) Creating a network infrastructure to link colleges and universities with health care providers who treat mental health and substance use disorders.”;

(4) in subsection (c)(5), by striking “substance abuse” and inserting “substance use disorder”;

(5) in subsection (d)—

(A) in the matter preceding paragraph (1), by striking “An institution of higher education desiring a grant under this section” and inserting “To be eligible to receive a grant under this section, an institution of higher education”;

(B) in paragraph (1)—

(i) by striking “and behavioral health” and inserting “health and substance use disorder”; and

(ii) by inserting “, including veterans whenever possible and appropriate,” after “students”; and

(C) in paragraph (2), by inserting “, which may include, as appropriate and in accordance with subsection (b)(7), a plan to seek input from relevant stakeholders in the community, including appropriate public and private entities, in order to carry out the program under the grant” before the period at the end;

(6) in subsection (e)(1), by striking “and behavioral health problems” and inserting “health and substance use disorders”;

(7) in subsection (f)(2)—

(A) by striking “and behavioral health” and inserting “health and substance use disorder”; and

(B) by striking “suicide and substance abuse” and inserting “suicide and substance use disorders”; and

(8) in subsection (h), by striking “\$5,000,000 for fiscal year 2005” and all that follows through the period at the end and inserting “\$6,488,000 for each of fiscal years 2017 through 2021.”.

Subtitle B—Other Provisions

SEC. 711. NATIONAL SUICIDE PREVENTION LIFELINE PROGRAM.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.) is amended by inserting after section 520E–2 (42 U.S.C. 290bb–36b) the following:

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

“(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall maintain the National Suicide Prevention Lifeline Program (referred to in this section as the ‘Program’), authorized under section 520A and in effect prior to the date of enactment of the Helping Families in Mental Health Crisis Act of 2016.

“(b) ACTIVITIES.—In maintaining the Program, the activities of the Secretary shall include—

“(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.

“(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated \$7,198,000 for each of fiscal years 2017 through 2021.”.

SEC. 712. WORKFORCE DEVELOPMENT STUDIES AND REPORTS.

(a) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Assistant Secretary for Mental Health and Substance Use, in consultation with

the Administrator of the Health Resources and Services Administration, shall conduct a study, and publicly post on the appropriate Internet website of the Department of Health and Human Services a report, on the mental health and substance use disorder workforce in order to inform Federal, State, and local efforts related to workforce enhancement.

(b) **CONTENTS.**—The report under this section shall contain—

(1) national and State-level projections of the supply and demand of mental health and substance use disorder health workers, including the number of individuals practicing in fields deemed relevant by the Secretary;

(2) an assessment of the mental health and substance use disorder workforce capacity, strengths, and weaknesses as of the date of the report, including the capacity of primary care to prevent, screen, treat, or refer for mental health and substance use disorders;

(3) information on trends within the mental health and substance use disorder provider workforce, including the number of individuals entering the mental health workforce over the next five years;

(4) information on the gaps in workforce development for mental health providers and professionals, including those who serve pediatric, adult, and geriatric patients; and

(5) any additional information determined by the Assistant Secretary for Mental Health and Substance Use, in consultation with the Administrator of the Health Resources and Services Administration, to be relevant to the mental health and substance use disorder provider workforce.

SEC. 713. MINORITY FELLOWSHIP PROGRAM.

Title V of the Public Health Service Act (42 U.S.C. 290aa et seq.) is 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 racial and ethnic minorities; and

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

“(b) **TRAINING COVERED.**—The fellowships under subsection (a) shall be for postbaccalaureate training (including for master’s and doctoral degrees) for mental health professionals, including in the fields of psychiatry, nursing, social work, psychology, marriage and family therapy, mental health counseling, and substance use and addiction counseling.

“(c) **AUTHORIZATION OF APPROPRIATIONS.**—To carry out this section, there are authorized to be appropriated \$12,669,000 for each of fiscal years 2017, 2018, and 2019 and \$13,669,000 for each of fiscal years 2020 and 2021.”.

SEC. 714. CENTER AND PROGRAM REPEALS.

Part B of title V of the Public Health Service Act (42 U.S.C. 290bb et seq.) is amended by striking the second section 514 (42 U.S.C. 290bb–9), relating to methamphetamine and amphetamine treatment initiatives, and sections 514A, 517, 519A, 519C, 519E, 520D, and 520H (42 U.S.C. 290bb–8, 290bb–23, 290bb–25a, 290bb–25c, 290bb–25e, 290bb–35, and 290bb–39).

SEC. 715. NATIONAL VIOLENT DEATH REPORTING SYSTEM.

The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, is encouraged to improve, particularly through the inclusion of additional States, the National Violent Death Reporting System as authorized by title III of the Public Health Service Act (42 U.S.C. 241 et seq.). Participation in the system by the States shall be voluntary.

SEC. 716. SENSE OF CONGRESS ON PRIORITIZING NATIVE AMERICAN YOUTH AND SUICIDE PREVENTION PROGRAMS.

(a) **FINDINGS.**—The Congress finds as follows:

(1) Suicide is the eighth leading cause of death among American Indians and Alaska Natives across all ages.

(2) Among American Indians and Alaska Natives who are 10 to 34 years of age, suicide is the second leading cause of death.

(3) The suicide rate among American Indian and Alaska Native adolescents and young adults ages 15 to 34 (19.5 per 100,000) is 1.5 times higher than the national average for that age group (12.9 per 100,000).

(b) SENSE OF CONGRESS.—It is the sense of Congress that the Secretary of Health and Human Services, in carrying out programs for Native American youth and suicide prevention programs for youth suicide intervention, should prioritize programs and activities for individuals who have a high risk or disproportional burden of suicide, such as Native Americans.

SEC. 717. PEER PROFESSIONAL WORKFORCE DEVELOPMENT GRANT PROGRAM.

(a) IN GENERAL.—For the purposes described in subsection (b), the Secretary of Health and Human Services shall award grants to develop and sustain behavioral health paraprofessional training and education programs, including through tuition support.

(b) PURPOSES.—The purposes of grants under this section are—

(1) to increase the number of behavioral health paraprofessionals, including trained peers, recovery coaches, mental health and addiction specialists, prevention specialists, and pre-masters-level addiction counselors; and

(2) to help communities develop the infrastructure to train and certify peers as behavioral health paraprofessionals.

(c) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall be a community college or other entity the Secretary deems appropriate.

(d) GEOGRAPHIC DISTRIBUTION.—In awarding grants under this section, the Secretary shall seek to achieve an appropriate national balance in the geographic distribution of such awards.

(e) SPECIAL CONSIDERATION.—In awarding grants under this section, the Secretary may give special consideration to proposed and existing programs targeting peer professionals serving youth ages 16 to 25.

(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated \$10,000,000 for the period of fiscal years 2018 through 2022.

SEC. 718. NATIONAL HEALTH SERVICE CORPS.

(a) DEFINITIONS.—

(1) 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”.

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

(b) ELIGIBILITY TO PARTICIPATE IN LOAN REPAYMENT PROGRAM.—Section 338B(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”.

SEC. 719. ADULT SUICIDE PREVENTION.

(a) GRANTS.—

(1) AUTHORITY.—The Assistant Secretary for Mental Health and Substance Use (referred to in this section as the “Assistant Secretary”) may award grants to eligible entities in order to implement suicide prevention efforts amongst adults 25 and older.

(2) PURPOSE.—The grant program under this section shall be designed to raise suicide awareness, establish referral processes, and improve clinical care practice standards for treating suicide ideation, plans, and attempts among adults.

(3) RECIPIENTS.—To be eligible to receive a grant under this section, an entity shall be a community-based primary care or behavioral health care setting, an emergency department, a State mental health agency, an Indian tribe, a tribal organization, or any other entity the Assistant Secretary deems appropriate.

(4) NATURE OF ACTIVITIES.—The grants awarded under paragraph (1) shall be used to implement programs that—

(A) screen for suicide risk in adults and provide intervention and referral to treatment;

(B) implement evidence-based practices to treat individuals who are at suicide risk, including appropriate followup services; and

(C) raise awareness, reduce stigma, and foster open dialogue about suicide prevention.

(b) **ADDITIONAL ACTIVITIES.**—The Assistant Secretary shall—

(1) evaluate the activities supported by grants awarded under subsection (a) in order to further the Nation’s understanding of effective interventions to prevent suicide in adults;

(2) disseminate the findings from the evaluation as the Assistant Secretary considers appropriate; and

(3) provide appropriate information, training, and technical assistance to eligible entities that receive a grant under this section, in order to help such entities to meet the requirements of this section, including assistance with—

(A) selection and implementation of evidence-based interventions and frameworks to prevent suicide, such as the Zero Suicide framework; and

(B) other activities as the Assistant Secretary determines appropriate.

(c) **DURATION.**—A grant under this section shall be for a period of not more than 5 years.

(d) **AUTHORIZATION OF APPROPRIATIONS.**—

(1) **IN GENERAL.**—There is authorized to be appropriated to carry out this section \$30,000,000 for the period of fiscal years 2018 through 2022.

(2) **USE OF CERTAIN FUNDS.**—Of the funds appropriated to carry out this section in any fiscal year, the lesser of 5 percent of such funds or \$500,000 shall be available to the Assistant Secretary for purposes of carrying out subsection (b).

SEC. 720. CRISIS INTERVENTION GRANTS FOR POLICE OFFICERS AND FIRST RESPONDERS.

(a) **IN GENERAL.**—The Assistant Secretary for Mental Health and Substance Use may award grants to entities such as law enforcement agencies and first responders—

(1) 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; and

(2) to establish collaborative law enforcement and mental health programs, including behavioral health response teams and mental health crisis intervention teams comprised of mental health professionals, law enforcement officers, and other first responders, as appropriate, to provide on-site, face-to-face, mental and behavioral health care services during a mental health crisis, and to connect the individual in crisis to appropriate community-based treatment services in lieu of unnecessary hospitalization or further involvement with the criminal justice system.

(b) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out this section \$9,000,000 for the period of fiscal years 2018 through 2020.

SEC. 721. DEMONSTRATION GRANT PROGRAM TO TRAIN HEALTH SERVICE PSYCHOLOGISTS IN COMMUNITY-BASED MENTAL HEALTH.

(a) **ESTABLISHMENT.**—The Secretary of Health and Human Services shall establish a grant program under which the Assistant Secretary of Mental Health and Substance Use Disorders may award grants to eligible institutions to support the recruitment, education, and clinical training experiences of health services psychology students, interns, and postdoctoral residents for education and clinical experience in community mental health settings.

(b) **ELIGIBLE INSTITUTIONS.**—For purposes of this section, the term “eligible institutions” includes American Psychological Association-accredited doctoral, internship, and postdoctoral residency schools or programs in health service psychology that—

(1) are focused on the development and implementation of interdisciplinary training of psychology graduate students and postdoctoral fellows in providing mental and behavioral health services to address substance use disorders, serious emotional disturbance, and serious illness, as well as developing faculty and implementing curriculum to prepare psychologists to work with underserved populations; and

(2) demonstrate an ability to train health service psychologists in psychiatric hospitals, forensic hospitals, community mental health centers, community

health centers, federally qualified health centers, or adult and juvenile correctional facilities.

(c) **PRIORITIES.**—In selecting grant recipients under this section, the Secretary shall give priority to eligible institutions in which training focuses on the needs of individuals with serious mental illness, serious emotional disturbance, justice-involved youth, and individuals with or at high risk for substance use disorders.

(d) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated to carry out this section \$12,000,000 for the period of fiscal years 2018 through 2022.

SEC. 722. INVESTMENT IN TOMORROW'S PEDIATRIC HEALTH CARE WORKFORCE.

Section 775(e) of the Public Health Service Act (42 U.S.C 295f(e)) is amended to read as follows:

“(e) **AUTHORIZATION OF APPROPRIATIONS.**—To carry out this section, there is authorized to be appropriated \$12,000,000 for the period of fiscal years 2018 through 2022.”.

SEC. 723. CUTGO COMPLIANCE.

Section 319D(f) of the Public Health Service Act (42 U.S.C. 247d–4(f)) is amended by striking “\$138,300,000 for each of fiscal years 2014 through 2018” and inserting “\$138,300,000 for each of fiscal years 2014 through 2016 and \$58,000,000 for each of fiscal years 2017 and 2018”.

TITLE VIII—MENTAL HEALTH PARITY

SEC. 801. ENHANCED COMPLIANCE WITH MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE REQUIREMENTS.

(a) **COMPLIANCE PROGRAM GUIDANCE DOCUMENT.**—Section 2726(a) of the Public Health Service Act (42 U.S.C. 300gg–26(a)) is amended by adding at the end the following:

“(6) **COMPLIANCE PROGRAM GUIDANCE DOCUMENT.**—

“(A) **IN GENERAL.**—Not later than 6 months after the date of enactment of the Helping Families in Mental Health Crisis Act of 2016, the Inspector General of the Department of Health and Human Services, in coordination with the Secretary, the Secretary of Labor, or the Secretary of the Treasury, shall issue a compliance program guidance document to help improve compliance with this section.

“(B) **EXAMPLES ILLUSTRATING COMPLIANCE AND NONCOMPLIANCE.**—

“(i) **IN GENERAL.**—The compliance program guidance document required under this paragraph shall provide illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986 based on investigations of violations of such sections, including—

“(I) examples illustrating requirements for information disclosures and nonquantitative treatment limitations; and

“(II) descriptions of the violations uncovered during the course of such investigations.

“(ii) **NONQUANTITATIVE TREATMENT LIMITATIONS.**—To the extent that any example described in clause (i) involves a finding of compliance or noncompliance with regard to any requirement for nonquantitative treatment limitations, the example shall provide sufficient detail to fully explain such finding, including a full description of the criteria involved for medical and surgical benefits and the criteria involved for mental health and substance use disorder benefits.

“(iii) **ACCESS TO ADDITIONAL INFORMATION REGARDING COMPLIANCE.**—In developing and issuing the compliance program guidance document required under this paragraph, the Inspector General of the Department of Health and Human Services may—

“(I) enter into interagency agreements with the Inspector General of the Department of Labor and the Inspector General of the Department of the Treasury to share findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986; and

“(II) enter into an agreement with a State to share information on findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986.

“(C) RECOMMENDATIONS.—The compliance program guidance document shall include recommendations to avoid violations of this section and encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. Such internal controls may include a compliance checklist with illustrative examples of nonquantitative treatment limitations on mental health and substance use disorder benefits, which may fail to comply with this section in relation to nonquantitative treatment limitations on medical and surgical benefits.

“(D) UPDATING THE COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—The compliance program guidance document shall be updated every 2 years to include illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986.”

(b) ADDITIONAL GUIDANCE.—Section 2726(a) of the Public Health Service Act (42 U.S.C. 300gg–26(a)) is amended by adding at the end the following:

“(7) ADDITIONAL GUIDANCE.—

“(A) IN GENERAL.—Not later than 6 months after the date of enactment of the Helping Families in Mental Health Crisis Act of 2016, the Secretary, in coordination with the Secretary of Labor and the Secretary of the Treasury, shall issue guidance to group health plans and health insurance issuers offering group or individual health insurance coverage to assist such plans and issuers in satisfying the requirements of this section.

“(B) DISCLOSURE.—

“(i) GUIDANCE FOR PLANS AND ISSUERS.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use for disclosing information to ensure compliance with the requirements under this section (and any regulations promulgated pursuant to this section).

“(ii) DOCUMENTS FOR PARTICIPANTS, BENEFICIARIES, CONTRACTING PROVIDERS, OR AUTHORIZED REPRESENTATIVES.—The guidance issued under this paragraph may include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use to provide any participant, beneficiary, contracting provider, or authorized representative, as applicable, with documents containing information that the health plans or issuers are required to disclose to participants, beneficiaries, contracting providers, or authorized representatives to ensure compliance with this section, any regulation issued pursuant to this section, or any other applicable law or regulation, including information that is comparative in nature with respect to—

“(I) nonquantitative treatment limitations for both medical and surgical benefits and mental health and substance use disorder benefits;

“(II) the processes, strategies, evidentiary standards, and other factors used to apply the limitations described in subclause (I); and

“(III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and mental health and substance use disorder benefits.

“(C) NONQUANTITATIVE TREATMENT LIMITATIONS.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that group health plans and health insurance issuers offering group or individual health insurance coverage may use regarding the development and application of nonquantitative treatment limitations to ensure compliance with this section (and any regulations promulgated pursuant to this section), including—

“(i) examples of methods of determining appropriate types of nonquantitative treatment limitations with respect to both medical and

surgical benefits and mental health and substance use disorder benefits, including nonquantitative treatment limitations pertaining to—

- “(I) medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;
- “(II) limitations with respect to prescription drug formulary design; and
- “(III) use of fail-first or step therapy protocols;
- “(ii) examples of methods of determining—
 - “(I) network admission standards (such as credentialing); and
 - “(II) factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;
 - “(iii) examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of nonquantitative treatment limitations;
 - “(iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans or issuers in performing a nonquantitative treatment limitation analysis;
 - “(v) examples of how specific evidentiary standards may be used to determine whether treatments are considered experimental or investigative;
 - “(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;
 - “(vii) examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for individuals with a serious mental illness and types of medical management techniques;
 - “(viii) examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship between the covered mental health or substance use disorder benefit and a traditional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment; and
 - “(ix) additional illustrative examples of methods, processes, strategies, evidentiary standards, and other factors for which the Secretary determines that additional guidance is necessary to improve compliance with this section.

“(D) PUBLIC COMMENT.—Prior to issuing any final guidance under this paragraph, the Secretary shall provide a public comment period of not less than 60 days during which any member of the public may provide comments on a draft of the guidance.”.

(c) IMPROVING COMPLIANCE.—

(1) IN GENERAL.—In the case that the Secretary of Health and Human Services, the Secretary of Labor, or the Secretary of the Treasury determines that a group health plan or health insurance issuer offering group or individual health insurance coverage has violated, at least 5 times, section 2726 of the Public Health Service Act (42 U.S.C. 300gg-26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), or section 9812 of the Internal Revenue Code, the appropriate Secretary shall audit plan documents for such health plan or issuer in the plan year following the Secretary's determination in order to help improve compliance with such section.

(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to limit the authority, as in effect on the day before the date of enactment of this Act, of the Secretary of Health and Human Services, the Secretary of Labor, or the Secretary of the Treasury to audit documents of health plans or health insurance issuers.

SEC. 802. ACTION PLAN FOR ENHANCED ENFORCEMENT OF MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE.

(a) PUBLIC MEETING.—

(1) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall convene a public meeting of stakeholders described in paragraph (2) to produce an action plan for improved Federal and State coordination related to the enforcement of mental health parity and addiction equity requirements.

(2) STAKEHOLDERS.—The stakeholders described in this paragraph shall include each of the following:

- (A) The Federal Government, including representatives from—
 - (i) the Department of Health and Human Services;
 - (ii) the Department of the Treasury;
 - (iii) the Department of Labor; and
 - (iv) the Department of Justice.
 - (B) State governments, including—
 - (i) State health insurance commissioners;
 - (ii) appropriate State agencies, including agencies on public health or mental health; and
 - (iii) State attorneys general or other representatives of State entities involved in the enforcement of mental health parity laws.
 - (C) Representatives from key stakeholder groups, including—
 - (i) the National Association of Insurance Commissioners;
 - (ii) health insurance providers;
 - (iii) providers of mental health and substance use disorder treatment;
 - (iv) employers; and
 - (v) patients or their advocates.
- (b) **ACTION PLAN.**—Not later than 6 months after the public meeting under subsection (a), the Secretary of Health and Human Services shall finalize the action plan described in such subsection and make it plainly available on the Internet website of the Department of Health and Human Services.
- (c) **CONTENT.**—The action plan under this section shall—
- (1) reflect the input of the stakeholders invited to the public meeting under subsection (a);
 - (2) identify specific strategic objectives regarding how the various Federal and State agencies charged with enforcement of mental health parity and addiction equity requirements will collaborate to improve enforcement of such requirements;
 - (3) provide a timeline for implementing the action plan; and
 - (4) provide specific examples of how such objectives may be met, which may include—
 - (A) providing common educational information and documents to patients about their rights under Federal or State mental health parity and addiction equity requirements;
 - (B) facilitating the centralized collection of, monitoring of, and response to patient complaints or inquiries relating to Federal or State mental health parity and addiction equity requirements, which may be through the development and administration of a single, toll-free telephone number and an Internet website portal;
 - (C) Federal and State law enforcement agencies entering into memoranda of understanding to better coordinate enforcement responsibilities and information sharing, including whether such agencies should make the results of enforcement actions related to mental health parity and addiction equity requirements publicly available; and
 - (D) recommendations to the Secretary and Congress regarding the need for additional legal authority to improve enforcement of mental health parity and addiction equity requirements, including the need for additional legal authority to ensure that nonquantitative treatment limitations are applied, and the extent and frequency of the applications of such limitations, both to medical and surgical benefits and to mental health and substance use disorder benefits in a comparable manner.

SEC. 803. REPORT ON INVESTIGATIONS REGARDING PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

(a) **IN GENERAL.**—Not later than 1 year after the date of enactment of this Act, and annually thereafter for the subsequent 5 years, 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, shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report summarizing the results of all closed Federal investigations completed during the preceding 12-month period with findings of any serious violation regarding compliance with mental health and substance use disorder coverage requirements under section 2726 of the Public Health Service Act (42 U.S.C. 300gg-26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section 9812 of the Internal Revenue Code of 1986.

(b) **CONTENTS.**—Subject to subsection (c), a report under subsection (a) shall, with respect to investigations described in such subsection, include each of the following:

- (1) The number of open or closed Federal investigations conducted during the covered reporting period.

(2) Each benefit classification examined by any such investigation conducted during the covered reporting period.

(3) Each subject matter, including compliance with requirements for quantitative and nonquantitative treatment limitations, of any such investigation conducted during the covered reporting period.

(4) A summary of the basis of the final decision rendered for each closed investigation conducted during the covered reporting period that resulted in a finding of a serious violation.

(c) **LIMITATION.**—Any individually identifiable information shall be excluded from reports under subsection (a) consistent with protections under the health privacy and security rules promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

SEC. 804. GAO STUDY ON PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

Not later than 3 years after the date of enactment of this Act, the Comptroller General of the United States, in consultation with the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury, shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report detailing the extent to which group health plans or health insurance issuers offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, Medicaid managed care organizations with a contract under section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)), and health plans provided under the State Children’s Health Insurance Program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) comply with section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section 9812 of the Internal Revenue Code of 1986, including—

(1) how nonquantitative treatment limitations, including medical necessity criteria, of such plans or issuers comply with such sections;

(2) how the responsible Federal departments and agencies ensure that such plans or issuers comply with such sections, including an assessment of how the Secretary of Health and Human Services has used its authority to conduct audits of such plans to ensure compliance;

(3) a review of how the various Federal and State agencies responsible for enforcing mental health parity requirements have improved enforcement of such requirements in accordance with the objectives and timeline described in the action plan under section 802; and

(4) recommendations for how additional enforcement, education, and coordination activities by responsible Federal and State departments and agencies could better ensure compliance with such sections, including recommendations regarding the need for additional legal authority.

SEC. 805. INFORMATION AND AWARENESS ON EATING DISORDERS.

(a) **INFORMATION.**—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) may—

(1) update information, related fact sheets, and resource lists related to eating disorders that are available on the public Internet website of the National Women’s Health Information Center sponsored by the Office on Women’s Health, to include—

(A) updated findings and current research related to eating disorders, as appropriate; and

(B) information about eating disorders, including information related to males and females;

(2) incorporate, as appropriate, and in coordination with the Secretary of Education, information from publicly available resources into appropriate obesity prevention programs developed by the Office on Women’s Health; and

(3) make publicly available (through a public Internet website or other method) information, related fact sheets and resource lists, as updated under paragraph (1), and the information incorporated into appropriate obesity prevention programs, as updated under paragraph (2).

(b) **AWARENESS.**—The Secretary may advance public awareness on—

(1) the types of eating disorders;

(2) the seriousness of eating disorders, including prevalence, comorbidities, and physical and mental health consequences;

(3) methods to identify, intervene, refer for treatment, and prevent behaviors that may lead to the development of eating disorders;

(4) discrimination and bullying based on body size;

- (5) the effects of media on self-esteem and body image; and
- (6) the signs and symptoms of eating disorders.

SEC. 806. EDUCATION AND TRAINING ON EATING DISORDERS.

The Secretary of Health and Human Services may facilitate the identification of programs to educate and train health professionals and school personnel in effective strategies to—

- (1) identify individuals with eating disorders;
- (2) provide early intervention services for individuals with eating disorders;
- (3) refer patients with eating disorders for appropriate treatment;
- (4) prevent the development of eating disorders; or
- (5) provide appropriate treatment services for individuals with eating disorders.

SEC. 807. GAO STUDY ON PREVENTING DISCRIMINATORY COVERAGE LIMITATIONS FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS AND SUBSTANCE USE DISORDERS.

Not later than 2 years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress and make publicly available a report detailing Federal oversight of group health plans and health insurance coverage offered in connection with such plans (as such terms are defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91), including Medicaid managed care plans under section 1903 of the Social Security Act (42 U.S.C. 1396b), to ensure compliance of such plans and coverage with sections 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and 9812 of the Internal Revenue Code of 1986 (in this section collectively referred to as the “parity law”), including—

- (1) a description of how Federal regulations and guidance consider non-quantitative treatment limitations, including medical necessity criteria and application of such criteria to medical, surgical, and primary care, of such plans and coverage in ensuring compliance by such plans and coverage with the parity law;
- (2) a description of actions that Federal departments and agencies are taking to ensure that such plans and coverage comply with the parity law; and
- (3) the identification of enforcement, education, and coordination activities within Federal departments and agencies, including educational activities directed to State insurance commissioners, and a description of how such proper activities can be used to ensure full compliance with the parity law.

SEC. 808. CLARIFICATION OF EXISTING PARITY RULES.

If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage for eating disorder benefits, including residential treatment, such group health plan or health insurance issuer shall provide such benefits consistent with the requirements of section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section 9812 of the Internal Revenue Code of 1986.

PURPOSE AND SUMMARY

H.R. 2646, the “Helping Families in Mental Health Crisis Act of 2016,” was introduced on June 4, 2015, by Rep. Tim Murphy (R-PA) and Rep. Eddie Bernice Johnson (D-TX). H.R. 2646 seeks to direct the Substance Abuse and Mental Health Services Administration to utilize evidence-based approaches when awarding grants. The bill also codifies a provision from a recently finalized Medicaid managed care regulation related to payments for short term stays for adults in institutions for mental diseases (IMD) and extends the availability of the full range of early and periodic screening, diagnostic, and treatment (EPSDT) services to Medicaid children receiving services in an IMD. The cost of the EPSDT policy is offset by requiring the use of electronic visit verification systems for Medicaid-provided personal care services and home health services. H.R. 2646 also directs the Secretary of Health and Human Services (HHS) to undertake rulemaking to clarify when disclosure to families and loved ones is allowed under HIPAA. This legislation provides for targeted, fully CUTGO compliant mental health reauthor-

izations and authorizations of select new grant programs. Finally, the proposal provides improvements for mental health payment parity through better compliance guidance and disclosure support. Inter-agency officials must meet with public stakeholders—including patient advocates and third-party groups—to build a strategy for improving mental health parity and addiction equity requirements.

BACKGROUND AND NEED FOR LEGISLATION

The Energy and Commerce Committee, through the Oversight and Investigation Subcommittee led by Congressman Tim Murphy, undertook a yearlong investigation that spanned the 113th and 114th Congress that examined the state of our mental health care system. In particular, the focus was on untreated serious mental illness (SMI). The Committee inquiry focused specifically on three areas of critical public policy interest: the scope of society's problem that is untreated serious mental illness, how privacy laws may interfere with patient care and public safety, including in the mental health context, and how certain federal resources appropriated for services and treatment of mental illness are currently being spent. This investigation included numerous hearings, bipartisan forums, GAO reports, and culminated in a comprehensive committee report. The main finding was that the patients with serious mental illness, such as schizophrenia, bipolar disorder, or major depression, are often the least likely to be engaged in medical care.

In response to this finding in the second session of the 113th Congress, Rep. Murphy introduced H.R. 3717, the "Helping Families in Mental Health Crisis Act." In the first session of the 114th Congress, Rep. Murphy reintroduced the "Helping Families in Mental Health Crisis Act" as H.R. 2646.

HEARINGS

The Subcommittee on Health held a hearing on H.R. 2646 on June 16, 2015. The hearing was entitled, "Examining H.R. 2646, the Helping Families in Mental Health Crisis Act of 2015" and witnesses included the following:

- Creigh Deeds, Senator, Senate of Virginia;
- Patrick J. Kennedy, Former U.S. Representative (RI), Founder, Kennedy Forum;
- Jeffrey A. Lieberman, M.D., Chairman, Department of Psychiatry, Columbia University College of Physicians and Surgeons;
- Paul Gionfriddo, President and CEO; Mental Health America;
- Steve Coe, Chief Executive Officer, Community Access;
- Mary Jean Billingsley, Parent, National Disability Rights Network; and
- Harvey Rosenthal, Executive Director, New York Association of Psychiatric Rehabilitation Services.

COMMITTEE CONSIDERATION

On November 3 and 4, 2015, the Subcommittee on Health met in open markup session and forwarded H.R. 2646, as amended, to the full Committee by a record vote of 18 yeas and 12 nays. On

June 14 and 15, 2016, the full Committee on Energy and Commerce met in open markup session and ordered H.R. 2646, as amended, favorably reported to the House by a record vote of 53 yeas and 0 nays.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. The following reflects the record votes taken during the Committee consideration:

**COMMITTEE ON ENERGY AND COMMERCE -- 114TH CONGRESS
ROLL CALL VOTE # 70**

BILL: H.R. 2646, Helping Families in Mental Health Crisis Act

AMENDMENT: An amendment offered by Mr. Cardenas, No. 11, to amend section 391 of the PHSA to direct the CDC to conduct, and give assistance to public and nonprofit private entities, scientific institutions, and individuals engaged in the conduct of, research, including data collection, relating to (A) the causes, mechanisms, prevention, diagnosis, and treatment of injuries, including with respect to gun violence; and (B) rehabilitation from such injuries, and to clarify that nothing in section 391 authorizes assistance, grants, or cooperative agreements or contracts for the purpose of advocating or promoting gun control or permits a recipient to use such assistance, grants, agreements, or contracts for the purpose of advocating or promoting gun control. The CDC is also directed to improve, particularly through the inclusion of additional States, the National Violent Death Reporting System. With respect to a wellness and health promotion activity implemented under section 2717(a)(1)(D) of the PHSA, the amendment provides that none of the authorities delegated under section 2717(c), the Patient Protection and Affordable Care Act, or an amendment made by such Act shall be construed to prohibit a physician or other health care provider from (A) asking a patient about the ownership, possession, use, or storage of a firearm or ammunition in the home of such patient; (B) speaking to a patient about gun safety; or (C) reporting to the authorities a patient's threat of violence.

DISPOSITION: NOT AGREED TO, by a roll call vote of 23 yeas and 29 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush	X		
Mr. Whitfield				Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Pitts		X		Mr. Green	X		
Mr. Walden		X		Ms. DeGette	X		
Mr. Murphy		X		Ms. Capps	X		
Mr. Burgess		X		Mr. Doyle	X		
Mrs. Blackburn		X		Ms. Schakowsky	X		
Mr. Scalise				Mr. Butterfield	X		
Mr. Latta		X		Ms. Matsui	X		
Mrs. McMorris Rodgers		X		Ms. Castor	X		
Mr. Harper		X		Mr. Sarbanes	X		
Mr. Lance		X		Mr. McNerney	X		
Mr. Guthrie		X		Mr. Welch	X		
Mr. Olson		X		Mr. Lujan	X		
Mr. McKinley		X		Mr. Tonko	X		
Mr. Pompeo		X		Mr. Yarnuth	X		
Mr. Kinzinger		X		Ms. Clarke	X		
Mr. Griffith		X		Mr. Loeb sack	X		
Mr. Bilirakis		X		Mr. Schrader	X		
Mr. Johnson		X		Mr. Kennedy	X		
Mr. Long		X		Mr. Cardenas	X		
Mrs. Ellmers		X					
Mr. Bucshon		X					
Mr. Flores		X					
Mrs. Brooks		X					
Mr. Mullin		X					
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					

06/15/2016

**COMMITTEE ON ENERGY AND COMMERCE -- 114TH CONGRESS
ROLL CALL VOTE # 71**

BILL: H.R. 2646, Helping Families in Mental Health Crisis Act

AMENDMENT: A motion by Mr. Upton to order H.R. 2646 favorably reported to the House, as amended.
(Final Passage)

DISPOSITION: **AGREED TO**, by a roll call vote of 53 yeas and 0 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton	X			Mr. Pallone	X		
Mr. Barton	X			Mr. Rush	X		
Mr. Whitfield				Ms. Eshoo	X		
Mr. Shimkus	X			Mr. Engel	X		
Mr. Pitts	X			Mr. Green	X		
Mr. Walden	X			Ms. DeGette	X		
Mr. Murphy	X			Ms. Capps	X		
Mr. Burgess	X			Mr. Doyle	X		
Mrs. Blackburn	X			Ms. Schakowsky	X		
Mr. Scalise	X			Mr. Butterfield	X		
Mr. Latta	X			Ms. Matsui	X		
Mrs. McMorris Rodgers	X			Ms. Castor	X		
Mr. Harper	X			Mr. Sarbanes	X		
Mr. Lance	X			Mr. McNerney	X		
Mr. Guthrie	X			Mr. Welch	X		
Mr. Olson	X			Mr. Lujan	X		
Mr. McKinley	X			Mr. Tonko	X		
Mr. Pompeo	X			Mr. Yarmuth	X		
Mr. Kinzinger	X			Ms. Clarke	X		
Mr. Griffith	X			Mr. Loeb sack	X		
Mr. Bilirakis	X			Mr. Schrader	X		
Mr. Johnson	X			Mr. Kennedy	X		
Mr. Long	X			Mr. Cardenas	X		
Mrs. Ellmers	X						
Mr. Bucshon	X						
Mr. Flores	X						
Mrs. Brooks	X						
Mr. Mullin	X						
Mr. Hudson	X						
Mr. Collins	X						
Mr. Cramer	X						

06/15/2016

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee held a hearing and made findings that are reflected in this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The legislation aims to improve and increase access to evidence based treatment and services for individuals with mentally illness and SMI and provide greater oversight of the Federal mental health system, specifically focusing on the Substance Abuse and Mental Health Services Administration.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 2646 would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

EARMARK, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

In compliance with clause 9(e), 9(f), and 9(g) of rule XXI of the Rules of the House of Representatives, the Committee finds that H.R. 2646 contains no earmarks, limited tax benefits, or limited tariff benefits.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 5, 2016.

Re Helping Families in Mental Health Crisis Act of 2015

Hon. FRED UPTON,
*Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has estimated the direct spending effects of H.R. 2646, the Helping Families in Mental Health Crisis Act of 2016, as reported by the House Committee on Energy and Commerce on June 15, 2016.

CBO estimates that enacting H.R. 2646 would reduce net direct spending in the Medicaid program by \$5 million over the 2017–2026 period (see enclosed table). Pay-as-you-go procedures apply because enacting the legislation would affect direct spending. H.R. 2646 would not affect revenues.

Implementing the legislation also would affect spending subject to appropriation mostly because it would reauthorize and make changes to several grant programs administered by the Substance Abuse and Mental Health Services Administration. However, CBO has not yet completed an estimate of the effects the bill would have on discretionary spending.

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027.

PROVIDING SERVICES TO CHILDREN IN INSTITUTIONS OF MENTAL DISEASE

Section 206 of the bill would allow federal reimbursement for certain medical services (such as screening, diagnostic, and treatment services) for children and young adults receiving inpatient care in institutions of mental disease (IMDs), beginning in 2019. Under current law, federal reimbursement is limited to inpatient psychiatric services for these individuals. Based on an analysis of administrative data from the Department of Health and Human Services, CBO estimates that enacting this provision would increase federal spending on average each year by about \$250 per child or young adult in an IMD. As a result, CBO estimates that section 206 would cost \$285 million over the 2017–2026 period.

ELECTRONIC VISIT VERIFICATION SYSTEMS

Section 207 of the bill would require state Medicaid programs to implement an electronic visit verification system (EVV) for verifying the arrival and departure time of attendants who provide personal care or home health care services in a beneficiary's home. Federal payments to a state for personal care services would be reduced if a state fails to implement an EVV for those services by January 1, 2019. Similarly, federal payments for home health care services would be reduced if a state fails to implement an EVV for those services by January 1, 2023.

Based on information from states and other stakeholders, CBO estimates that EVV programs would reduce spending for personal care services and home health services by less than 1 percent, on average, over the 2017–2026 period. Because of the flexibility that H.R. 2646 would provide to states to establish such programs, CBO expects that some states would generate significantly higher savings than the average and others would generate little to no savings. CBO does not expect that any states would have their federal payments reduced as a result of the provision.

Under current law, about two thirds of spending for personal care services and less than a third of spending for home health services are estimated to be subject to EVV over the next ten years because of programs initiated voluntarily by some states. After adjusting for EVV programs that will be in place under current law, CBO estimates that enacting section 207 would reduce direct spending by \$290 million over the 2017–2026 period.

OTHER PROVISIONS

Section 201 of H.R. 2646 would allow states to continue to provide separate Medicaid payments for mental health services and

primary care services that are furnished on the same day. Section 202 of the bill would allow states to receive Medicaid reimbursement for payments made to managed care organizations for treatment in IMDs for adult beneficiaries in certain limited circumstances. That section codifies a provision in a final rule published in the *Federal Register* on May 6, 2016. Because sections 201 and 202 would codify current policies, CBO estimates that they would have no effect on the federal budget.

LONG-TERM BUDGETARY EFFECTS

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027.

INTERGOVERNMENTAL AND PRIVATE-SECTOR MANDATES

H.R. 2646 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act. CBO estimates that provisions in the bill that would decrease federal spending in Medicaid would similarly result in a reduction in state spending for Medicaid over the 2017–2026 period.

If you wish further details on this estimate, we would be pleased to provide them. The CBO staff contact is Lisa Ramirez-Branum. Sincerely,

KEITH HALL,
Director.

Enclosure.

CBO ESTIMATE OF THE DIRECT SPENDING EFFECTS FOR H.R. 2646, THE HELPING FAMILIES IN MENTAL HEALTH CRISIS ACT OF 2016, AS ORDERED REPORTED BY THE COMMITTEE ON ENERGY AND COMMERCE ON JUNE 15, 2016

		Millions of dollars, by fiscal year—											
		2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2021	2017–2026
CHANGES IN DIRECT SPENDING													
Providing Services to Children in Institutions of Mental Disease:													
Estimated Budget Authority													
		0	0	23	33	34	35	37	39	41	43	90	285
Estimated Outlays													
		0	0	23	33	34	35	37	39	41	43	90	285
Electronic Visit Verification Systems:													
Estimated Budget Authority													
		0	0	–11	–21	–30	–39	–43	–46	–48	–52	–61	–290
Estimated Outlays													
		0	0	–11	–21	–30	–39	–43	–46	–48	–52	–61	–290
Total:													
Estimated Budget Authority													
		0	0	13	12	4	–4	–6	–7	–7	–9	29	–5
Estimated Outlays													
		0	0	13	12	4	–4	–6	–7	–7	–9	29	–5

Source: Congressional Budget Office.
Notes: Components may not add to totals because of rounding.
Other provisions of H.R. 2464 would affect spending subject to appropriation. Those provisions would authorize grant programs administered by the Substance Abuse and Mental Health Services Administration and would direct the Administrator of the Centers for Medicare and Medicaid Services to conduct studies, issue guidance, and issue reports. However, CBO has not yet completed an estimate of the discretionary costs of implementing the bill.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

DUPLICATION OF FEDERAL PROGRAMS

No provision of H.R. 2646 establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

DISCLOSURE OF DIRECTED RULE MAKINGS

The Committee estimates that enacting H.R. 2646 specifically directs to be completed 1 rule making within the meaning of 5 U.S.C. 551.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

TITLE I—ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE

Section 101. Assistant Secretary for Mental Health and Substance Use

This section would create an Assistant Secretary for Mental Health and Substance Use (ASMHSU). The Assistant Secretary would replace the Administrator of SAMSHA. The Assistant Secretary would be appointed by the President and confirmed by the Senate, like the current SAMSHA Administrator. Preference for hiring an Assistant Secretary will be given to individuals with a doctoral degree in medicine, osteopathic medicine, or psychology with clinical and research experience.

The Assistant Secretary will be responsible for improving the standards used to evaluate grants, grantees, and the programs being administered by SAMSHA in consultation the National Mental Health and Substance Use Policy Lab (NMHSUPL). The Assistant Secretary will have a Deputy Assistant Secretary that will replace the Deputy Administrator of SAMSHA. The ASMHSU will serve as a voting member on the Council on Graduate Medical Education.

Section 102. Improving Oversight of Mental Health and Substance Use Programs

This section directs the Assistant Secretary for Planning and Evaluation (ASPE) to improve oversight of mental health and substance use programs. The ASPE will collect and organize relevant data, evaluate programs across Federal departments and agencies, and consult with other relevant agencies. The ASPE shall make recommendations on the evaluation of relevant programs across the department.

Section 103. National Mental Health and Substance Use Policy Laboratory

This section creates National Mental Health and Substance Use Policy Laboratory within SAMSHA. It will be responsible for identifying, coordinating, and facilitating the implementation of policy changes likely to have a significant effect on mental health, mental illness, and substance use disorder services while promoting evidence based practices. The NMHSUPL will build off of the existing Office of Policy Planning and Innovation within SAMSHA.

Section 104. Peer Support Specialists Programs

This section directs the Comptroller General of the United States to conduct a study on best practices for peer-support specialist programs in a selection of ten states.

Section 105. Prohibition against Using Federal Funds by Systems Accepting Federal Funds to Protect and Advocate the Rights of Individuals with Mental Illness

This section reiterates current appropriations law and restates the prohibition on Protection and Advocacy organizations against using Federal funds for lobbying.

Section 106. Increased Reporting for Protection and Advocacy Organizations

This section leverages existing reporting that the state-based Protection and Advocacy organizations currently submit to SAMSHA. This section requires Protection and Advocacy organizations to make their yearly Program Performance Request publicly available. In releasing these reports, Protection and Advocacy organizations should ensure the protection of personally identifiable information from public disclosure. This section also requires Protection and Advocacy organizations to provide a more detailed and disaggregated accounting for how each system spends funds and what the source of those funds are. The Committee intends this to build upon the existing data and reporting requirements of current law and not require new data collection or additional reporting.

Section 107. Grievance Procedures

This section directs the Secretary of HHS to establish a grievance procedure within SAMSHA for the state based Protection and Advocacy organizations. The Committee believes that the use of this grievance procedure should come after the exhaustion of the internal grievance procedure established by existing law. The Committee intends the Secretary to ensure compliance with the re-

quirements of the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act through this grievance procedure.

Section 108. Center for Behavioral Health Statistics and Quality

This section authorizes the already existing Center for Behavioral Health Statistics and Quality.

Section 109. Strategic Plan

This section directs the ASMHSU to develop and carry out a strategic plan that is to be updated every five years. The plan should among other initiatives include and help identify strategic priorities, goals and measurable objectives for SAMSHA activities, identify ways to improve services for individuals with SMI and serious emotional disturbance (SED), and ensure programs provide access to evidence based care.

Section 11. Authorities of Centers for Mental Health Services and Substance Abuse Treatment

This section ensures that the Center for Mental Health Services within SAMSHA collaborates with the Director of the National Institute on Mental Health. This section will also increase the oversight of grants administered by SAMSHA.

Section 111. Advisory Councils

This section adds the Director of the National Institute of Mental Health, the Director of the National Institute on Alcohol Abuse and Alcoholism and the Director of the National Institute on Drug Abuse onto relevant advisory committees within SAMSHA.

Section 112. Peer Review

This section requires not less than half of all members of peer review groups related to mental health treatment at SAMSHA to be licensed and experienced professionals with relevant medical, doctoral or advanced degrees in the prevention, diagnosis, or treatment of, or recovery from mental and substance use disorders.

TITLE II—MEDICAID AND MENTAL HEALTH COVERAGE

Section 201. Rule of Construction Related to Medicaid Coverage of Mental Health Services and Primary Care Services Furnished on the Same Day

This section clarifies that nothing in the Medicaid statute should be construed as prohibiting separate payment for the provision of mental health and primary care services provided to an individual on the same day.

Section 202. Optional Limited Coverage of Inpatient Services Furnished in Institutions for Mental Diseases

This section codifies the provision in the recently-finalized Medicaid managed care regulation allowing for capitation payments to be made under certain circumstances for adults receiving treatment in an IMD. Payment can only be made for adults staying no more than 15 days in any given month in an IMD to receive services that, at beneficiary election, are in lieu of other services covered by the state plan.

Section 203. Study and Report Related to Medicaid Managed Care Regulation

This section directs the Secretary acting through the Administrator of the Centers for Medicare & Medicaid Services to conduct a study on the provision of care to adults who were enrolled in Medicaid managed care and received treatment in an IMD. Among other things, the study, due within three years after enactment, is to include information on the number of individuals receiving treatment in IMDs, their length of stay, and how managed care plans determine when to provide services in an IMD in lieu of other benefits, such as community-based mental health services.

Section 204. Guidance on Opportunities for Innovation

This section directs the Administrator of the Centers for Medicare & Medicaid Services to issue a State Medicaid Director letter, within one year of enactment, on opportunities to design innovative service delivery systems to improve care for individuals with serious mental illness or serious emotional disturbance.

Section 205. Study and Report on Medicaid Emergency Psychiatric Demonstration Project

This section directs the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, to collect, analyze, and report on additional data from states that participated in the Medicaid Emergency Psychiatric Demonstration Project under section 2707 of the Patient Protection and Affordable Care Act. The report is due no later than two years after enactment.

Section 206. Providing Full-Range of EPSDT Services to Children in IMDS

While Medicaid coverage is available for children and young adults under age 21 receiving inpatient psychiatric services, under current law, these individuals are statutorily excluded from coverage of early and periodic screening, diagnostic and treatment services (EPSDT). The EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. This benefit ensures that all children in Medicaid receive appropriate preventive, dental, mental health, and developmental, and specialty services. This section specifies that, effective January 1, 2019, children receiving Medicaid-covered inpatient psychiatric hospital services are also entitled to early and periodic screening, diagnostic, and treatment services, from their choice of provider.

Section 207. Electronic Visit Verification System Required for Personal Care Services and Home Health Care Services Under Medicaid

The Office of the Inspector General at HHS has found that personal care services provided in Medicaid are often at risk for fraud, waste, and abuse. To ensure needed services are provided to vulnerable and frail Medicaid beneficiaries, this section directs States to require the use of an electronic visit verification system for Medicaid-provided personal care services and home health services (but this policy does not require States to adopt a single system for providers within their State.) This policy provides enhanced federal

matching for state efforts to implement this policy. The enhanced federal matching percentage outlined in the provision is current law. States that do not require a system for personal care services by January 1, 2019 and home health services by January 1, 2023 will face a modest, incremental reduction in their federal matching percentage for that service. The reduction in the federal matching percentage can be delayed up to one year if the State demonstrates a good faith effort to comply with the requirement. Based on conversations with the Congressional Budget Office, this policy offsets the cost of section 206.

TITLE III—INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE

Section 301. Interdepartmental Serious Mental Illness Coordinating Committee

This section establishes a committee known as the Interdepartmental Serious Mental Illness Coordinating Committee (SMICC). The committee shall report on a summary of advances in serious mental illness SMI and serious emotional disturbance (SED) research, evaluate Federal programs related to SMI and SED, a plan to improve outcomes for those with SMI and SED, and specific recommendations on action relevant agencies can take. The SMICC shall terminate six years after the date it is established.

TITLE IV—COMPASSIONATE COMMUNICATION ON HIPAA

Section 401. Sense of Congress

This section states that it is the Sense of Congress that more clarity is needed surrounding existing HIPAA privacy rules to reduce confusion that may hinder communication with responsible caregivers for a patient with SMI.

Section 402. Confidentiality of Records

This section directs the Secretary to convene stakeholders one year after the regulations updating part 2 of title 42, Code of Federal Regulations are finalized. Stakeholders will determine the effect of the regulation on patient care, health outcomes, and patient privacy.

Section 403. Clarification of Circumstances Under Which Disclosure of Protected Health Information is Permitted

This section directs the Secretary to promulgate rulemaking to clarify circumstances under which disclosure of protected health information is permitted for a patient with mental illness. The Secretary already has the authority to undertake a rule making here, so this does not represent any sort of expansion of Secretary's authority.

Section 404. Development and Dissemination of Model Training Programs

This section would require the Secretary to develop and disseminate model program and materials for training health care providers, lawyers, patients and their families regarding the cir-

cumstances under which patient with mental illness' protected health information can be disclosed without patient consent.

TITLE V—INCREASING ACCESS TO TREATMENT FOR SERIOUS MENTAL ILLNESS

Section 501. Assertive Community Treatment Grant Program for Individuals with Serious Mental Illness

This section directs the ASMHSU to award grants to establish assertive community treatment programs for individuals with SMI. This section has an authorization of \$5 million total for the period of FY18–FY22.

Section 502. Strengthening Community Crisis Response Systems

This section directs the Secretary of Health and Human Services to award grants to states to enhance community-based crisis response systems or to develop, maintain or enhance databases of psychiatric, crisis stabilization units, and residential substance use disorder and community mental health treatment facility beds for individuals with SMI, SED, or substance use disorder. This section has an authorization of \$5 million total for the period of FY18–FY22.

Section 503. Increased and Extended Funding for Assisted Outpatient Grant Program Individuals with Serious Mental Illness

This section extends the authorization of the existing assisted outpatient treatment grant program to 2020. The authorization would be increased to \$20 million for 2018, \$19 million for 2019 and 2020, and \$18 million for 2021 and 2022.

Section 504. Liability for Health Professional Volunteers at Community Health Centers

This section extends liability protections for health professional volunteers at community health centers. This section has no authorization of appropriations.

TITLE VI—SUPPORTING INNOVATIVE AND EVIDENCE-BASED PROGRAMS

SUBTITLE A—ENCOURAGING THE ADVANCEMENT, INCORPORATION AND DEVELOPMENT OF EVIDENCE-BASED PRACTICES

Section 601. Encouraging Innovation and Evidence Based Programs

This section promotes innovation in awarding grants in the mental health space with a focus on advancing evidence-based models. The grants will go towards evaluating models that show promise, integrating care, and expanding and scaling up successful programs.

Section 602. Promoting Access to Information on Evidence-Based Programs and Practices

This section directs the Assistant Secretary to improve access to reliable and valid information on evidence-based programs and practices through the National Registry of Evidence-Based Programs and Practices.

Section 603. Sense of Congress

This sense of Congress states that the National Institute of Mental Health should conduct or support research on the determinants of self-directed and other violence and the connection to mental illness.

SUBTITLE B—SUPPORTING THE STATE RESPONSE TO MENTAL HEALTH NEEDS

Section 611. Community Mental Health Services Block Grant

This section directs states receiving the mental health block grant to submit a plan to SAMSHA on a variety of measures and activities. States will outline their goals and objectives for the period of the plan and identify targets and milestones to be met.

Additional provisions include empowering SAMSHA to hold states that are found materially incompliant on their maintenance of effort within their block grant program accountable.

SUBTITLE C—STRENGTHENING MENTAL HEALTH CARE FOR CHILDREN AND ADOLESCENTS

Section 621. Telehealth Child Psychiatry Access Grants

This section awards grants to support the development of statewide child psychiatry access programs and the improvement of already existing statewide programs. This section has an authorization of \$9 million total for the period of FY18–FY20.

Section 622. Infant and Early Childhood Mental Health Promotion, Intervention and Treatment

This section provides grants to programs for infants and children at significant risk of developing, exhibiting early signs of, or having been diagnosed with mental disorders including SED. This section has an authorization of \$20 million total for the period of FY18–FY22.

Section 623. National Child Traumatic Stress Network

This section reauthorizes the National Child Traumatic Stress Network at its last appropriated level of \$46,887,000 for each of FY17–FY21.

TITLE VII—GRANT PROGRAMS AND PROGRAM REAUTHORIZATIONS

SUBTITLE A—GARRETT LEE SMITH MEMORIAL ACT REAUTHORIZATION

Section 701, 702, and 703. Garrett Lee Smith Memorial Act Reauthorization

This section reauthorizes the Garrett Lee Smith Memorial Act at its last appropriated levels of \$5,988,000 for the Suicide Prevention Technical Assistance Center, \$35,427,000 for Youth Suicide Early Intervention and Prevention Strategies, and \$6,488,000 for Mental Health and Substance Use Disorder Services on Campus. Each section is reauthorized at the levels in the last sentence for each of FY17–FY21.

SUBTITLE B—OTHER PROVISIONS

Section 711. National Suicide Prevention Lifeline Program

This section authorizes the National Suicide Prevention Lifeline at its last appropriated level of \$7,198,000 for each of FY17–FY21.

Section 712. Workforce Development Studies and Reports

This section directs the ASMHSU to report on national and state level workforce projections, the workforce capacity and other relevant information.

Section 713. Minority Fellowship Program

This section authorizes the Minority Fellowship Program at \$12,669,000 a year for FY17–19 and \$13,669,000 a year for FY20–21.

Section 714. Center and Program Repeals

The repeals in this section are for programs that have expired authorizations and have never been appropriated.

Section 715. National Violent Death Reporting System

This section encourages the Centers for Disease Control and Prevention to improve the National Violent Death Reporting System.

Section 716. Sense of Congress on Prioritizing Native American Youth Suicide Prevention Programs

This Sense of Congress urges the Secretary to prioritize programs and activities for individuals who have a high risk or disproportional burden of suicide, such as Native Americans.

Section 717. Peer Professional Workforce Development Grant Program

This section authorizes the Secretary to award grants to develop and sustain behavioral health paraprofessional training and education programs at \$10 million for the period of FY18–FY22.

Section 718. National Health Service Corps

This section clarifies that child and adolescent psychiatrists can participate in the National Health Service Corps.

Section 719. Adult Suicide Prevention

This section authorizes grants for adult suicide prevention at \$30 million total for the period of FY18–FY22.

Section 720. Crisis Intervention Grants for Police and First Responders

This section authorizes crisis intervention training grants for police officers and first responders at \$9 million total for the period of FY18–FY20.

Section 721. Demonstration Grant Program to Train Health Service Psychologists in Community-Based Mental Health

This section authorizes a grant program to increase the psychologist work force at \$12 million total for the period of FY18–FY22.

Section 722. Investment in Tomorrow's Pediatric Health Care Workforce

This section reauthorizes Section 774(f) of the Public Health Service Act which provides for a pediatric specialty loan repayment program. The authorization is for \$12 million total for the period of FY18–FY22.

Section 723. Cut-Go Compliance

This section brings this bill into cut-go compliance.

TITLE VIII—MENTAL HEALTH PARITY

Section 801. Enhanced Compliance with Mental Health and Substance Use Disorder Coverage Requirements

This section aims to improve mental health payment parity through better compliance guidance and disclosure support. Among other items, the section develops inter-agency agreements for information sharing and creates new standards for updating program compliance documents. Agency officials must hold stakeholder meetings with plan issuers to improve public-private coordination and take into consideration public feedback.

Section 802. Action Plan for Enhanced Enforcement of Mental Health and Substance Use Disorder Coverage

Under this section, federal agency officials must hold a public stakeholders meeting with state governments and nationwide stakeholders, including third-party groups and patient advocates, to produce an action plan for improving mental health parity and addiction equity requirements.

Section 803. Report on Investigations Regarding Parity in Mental Health and Substance Use Disorder Benefits

One year following enactment, and annually for five years, an inter-agency analysis on any serious violations of mental health parity compliance standards would be published, summarizing the results of all closed federal investigations finalized in the 12 months preceding the report.

Section 804. GAO Study on Parity in Mental Health and Substance Use Disorder Benefits

Within three years, the Comptroller General of the United States, through consultation with inter-agency leaders, must provide an independent report on treatment limitations, among other items, concerning plan issuers—including state- and federally-funded programs—that treat patients for medical and surgical benefits as well as and mental health or substance use disorder services.

Section 805. Information and Awareness on Eating Disorders

In an effort to improve education and awareness of eating disorders, this section updates and modernizes public outreach efforts through the Office of Women's Health. Among other items, the public awareness should include revised findings on the comorbidities and physician and mental health consequences of serious eating disorders.

Section 806. Education and Training on Eating Disorders

Similar to the provision on eating disorder awareness, this section provides support to educate and train health professionals and school personnel in effective strategies to identify individuals with eating disorders and facilitate early intervention programs. Further, this section helps with early intervention and prevention efforts for avoiding eating disorders.

Section 807. GAO Study on Preventing Discriminatory Coverage Limitations for Individuals with Serious Mental Illness and Substance Use Disorders

Two years after the bill takes effect, the Comptroller General of the United States must submit a public report to Congress detailing the effectiveness of compliance guidelines and the shortfalls of meeting enforcement, education, and coordination of parity requirements.

Section 808. Clarification of Existing Parity Rules

This section clarifies that plan issuers offering coverage for eating disorder benefits must do so in alignment with current mental health parity standards.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * *

TITLE II—ADMINISTRATION AND MISCELLANEOUS PROVISIONS

PART A—ADMINISTRATION

* * * * *

DEFENSE OF CERTAIN MALPRACTICE AND NEGLIGENCE SUITS

SEC. 224. (a) The remedy against the United States provided by sections 1346(b) and 2672 of title 28, or by alternative benefits provided by the United States where the availability of such benefits precludes a remedy under section 1346(b) of title 28, for damage for personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions, including the conduct of clinical studies or investigation, by any commissioned officer or employee of the Public Health Service while acting within the scope of his office or employment, shall be exclusive of any other civil action or proceeding by reason of the same subject-matter against the officer or employee (or his estate) whose act or omission gave rise to the claim.

(b) The Attorney General shall defend any civil action or proceeding brought in any court against any person referred to in subsection (a) of this section (or his estate) for any such damage or injury. Any such person against whom such civil action or proceeding is brought shall deliver within such time after date of service or knowledge of service as determined by the Attorney General, all process served upon him or an attested true copy thereof to his immediate superior or to whomever was designated by the Secretary to receive such papers and such persons shall promptly furnish copies of the pleading and process therein to the United States attorney for the district embracing the place wherein the proceeding is brought, to the Attorney General, and to the Secretary.

(c) Upon a certification by the Attorney General that the defendant was acting in the scope of his employment at the time of the incident out of which the suit arose, any such civil action or proceeding commenced in a State court shall be removed without bond at any time before trial by the Attorney General to the district court of the United States of the district and division embracing the place wherein it is pending and the proceeding deemed a tort action brought against the United States under the provisions of title 28 and all references thereto. Should a United States district court determine on a hearing on a motion to remand held before a trial on the merit that the case so removed is one in which a remedy by suit within the meaning of subsection (a) of this section is not available against the United States, the case shall be remanded to the State Court: *Provided*, That where such a remedy is precluded because of the availability of a remedy through proceedings for compensation or other benefits from the United States as provided by any other law, the case shall be dismissed, but in the event the running of any limitation of time for commencing, or filing an application or claim in, such proceedings for compensation or other benefits shall be deemed to have been suspended during the pendency of the civil action or proceeding under this section.

(d) The Attorney General may compromise or settle any claim asserted in such civil action or proceeding in the manner provided in section 2677 of title 28 and with the same effect.

(e) For purposes of this section, the provisions of section 2680(h) of title 28 shall not apply to assault or battery arising out of negligence in the performance of medical, surgical, dental, or related functions, including the conduct of clinical studies or investigations.

(f) The Secretary or his designee may, to the extent that he deems appropriate, hold harmless or provide liability insurance for any officer or employee of the Public Health Service for damage for personal injury, including death, negligently caused by such officer or employee while acting within the scope of his office or employment and as a result of the performance of medical, surgical, dental, or related functions, including the conduct of clinical studies or investigations, if such employee is assigned to a foreign country or detailed to a State or political subdivision thereof or to a non-profit institution, and if the circumstances are such as are likely to preclude the remedies of third persons against the United States described in section 2679(b) of title 28, for such damage or injury.

(g)(1)(A) For purposes of this section and subject to the approval by the Secretary of an application under subparagraph (D), an entity described in paragraph (4), and any officer, governing board

member, or employee of such an entity, and any contractor of such an entity who is a physician or other licensed or certified health care practitioner (subject to paragraph (5)), shall 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 subsection (k)(3) (subject to paragraph (3)). The remedy against the United States for an entity described in paragraph (4) and any officer, governing board member, employee, or contractor (subject to paragraph (5)) of such an entity who is deemed to be an employee of the Public Health Service pursuant to this paragraph shall be exclusive of any other civil action or proceeding to the same extent as the remedy against the United States is exclusive pursuant to subsection (a).

(B) The deeming of any entity or officer, governing board member, employee, or contractor of the entity to be an employee of the Public Health Service for purposes of this section shall apply with respect to services provided—

(i) to all patients of the entity, and

(ii) subject to subparagraph (C), to individuals who are not patients of the entity.

(C) Subparagraph (B)(ii) applies to services provided to individuals who are not patients of an entity if the Secretary determines, after reviewing an application submitted under subparagraph (D), that the provision of the services to such individuals—

(i) benefits patients of the entity and general populations that could be served by the entity through community-wide intervention efforts within the communities served by such entity;

(ii) facilitates the provision of services to patients of the entity; or

(iii) are otherwise required under an employment contract (or similar arrangement) between the entity and an officer, governing board member, employee, or contractor of the entity.

(D) The Secretary may not under subparagraph (A) deem an entity or an officer, governing board member, employee, or contractor of the entity to be an employee of the Public Health Service for purposes of this section, and may not apply such deeming to services described in subparagraph (B)(ii), unless the entity has submitted an application for such deeming to the Secretary in such form and such manner as the Secretary shall prescribe. The application shall contain detailed information, along with supporting documentation, to verify that the entity, and the officer, governing board member, employee, or contractor of the entity, as the case may be, meets the requirements of subparagraphs (B) and (C) of this paragraph and that the entity meets the requirements of paragraphs (1) through (4) of subsection (h).

(E) The Secretary shall make a determination of whether an entity or an officer, governing board member, employee, or contractor of the entity is deemed to be an employee of the Public Health Service for purposes of this section within 30 days after the receipt of an application under subparagraph (D). The determination of the Secretary that an entity or an officer, governing board member, employee, or contractor of the entity is deemed to be an employee of the Public Health Service for purposes of this section shall apply for the period specified by the Secretary under subparagraph (A).

(F) Once the Secretary makes a determination that an entity or an officer, governing board member, employee, or contractor of an entity is deemed to be an employee of the Public Health Service for purposes of this section, the determination shall be final and binding upon the Secretary and the Attorney General and other parties to any civil action or proceeding. Except as provided in subsection (i), the Secretary and the Attorney General may not determine that the provision of services which are the subject of such a determination are not covered under this section.

(G) In the case of an entity described in paragraph (4) that has not submitted an application under subparagraph (D):

(i) The Secretary may not consider the entity in making estimates under subsection (k)(1).

(ii) This section does not affect any authority of the entity to purchase medical malpractice liability insurance coverage with Federal funds provided to the entity under section 329, 330, or 340A.

(H) In the case of an entity described in paragraph (4) for which an application under subparagraph (D) is in effect, the entity may, through notifying the Secretary in writing, elect to terminate the applicability of this subsection to the entity. With respect to such election by the entity:

(i) The election is effective upon the expiration of the 30-day period beginning on the date on which the entity submits such notification.

(ii) Upon taking effect, the election terminates the applicability of this subsection to the entity and each officer, governing board member, employee, and contractor of the entity.

(iii) Upon the effective date for the election, clauses (i) and (ii) of subparagraph (G) apply to the entity to the same extent and in the same manner as such clauses apply to an entity that has not submitted an application under subparagraph (D).

(iv) If after making the election the entity submits an application under subparagraph (D), the election does not preclude the Secretary from approving the application (and thereby restoring the applicability of this subsection to the entity and each officer, governing board member, employee, and contractor of the entity, subject to the provisions of this subsection and the subsequent provisions of this section.

(2) If, with respect to an entity or person deemed to be an employee for purposes of paragraph (1), a cause of action is instituted against the United States pursuant to this section, any claim of the entity or person for benefits under an insurance policy with respect to medical malpractice relating to such cause of action shall be subrogated to the United States.

(3) This subsection shall apply with respect to a cause of action arising from an act or omission which occurs on or after January 1, 1993.

(4) An entity described in this paragraph is a public or non-profit private entity receiving Federal funds under section 330.

(5) For purposes of paragraph (1), an individual may be considered a contractor of an entity described in paragraph (4) only if—

(A) the individual normally performs on average at least 32½ hours of service per week for the entity for the period of the contract; or

(B) in the case of an individual who normally performs an average of less than 32½ hours of services per week for the entity for the period of the contract, the individual is a licensed or certified provider of services in the fields of family practice, general internal medicine, general pediatrics, or obstetrics and gynecology.

(h) The Secretary may not approve an application under subsection (g)(1)(D) unless the Secretary determines that the entity—

(1) has implemented appropriate policies and procedures to reduce the risk of malpractice and the risk of lawsuits arising out of any health or health-related functions performed by the entity;

(2) has reviewed and verified the professional credentials, references, claims history, fitness, professional review organization findings, and license status of its physicians and other licensed or certified health care practitioners, and, where necessary, has obtained the permission from these individuals to gain access to this information;

(3) has no history of claims having been filed against the United States as a result of the application of this section to the entity or its officers, employees, or contractors as provided for under this section, or, if such a history exists, has fully cooperated with the Attorney General in defending against any such claims and either has taken, or will take, any necessary corrective steps to assure against such claims in the future; and

(4) will fully cooperate with the Attorney General in providing information relating to an estimate described under subsection (k).

(i)(1) Notwithstanding subsection (g)(1), the Attorney General, in consultation with the Secretary, may on the record determine, after notice and opportunity for a full and fair hearing, that an individual physician or other licensed or certified health care practitioner who is an officer, employee, or contractor of an entity described in subsection (g)(4) shall not be deemed to be an employee of the Public Health Service for purposes of this section, if treating such individual as such an employee would expose the Government to an unreasonably high degree of risk of loss because such individual—

(A) does not comply with the policies and procedures that the entity has implemented pursuant to subsection (h)(1);

(B) has a history of claims filed against him or her as provided for under this section that is outside the norm for licensed or certified health care practitioners within the same specialty;

(C) refused to reasonably cooperate with the Attorney General in defending against any such claim;

(D) provided false information relevant to the individual's performance of his or her duties to the Secretary, the Attorney General, or an applicant for or recipient of funds under this Act; or

(E) was the subject of disciplinary action taken by a State medical licensing authority or a State or national professional society.

(2) A final determination by the Attorney General under this subsection that an individual physician or other licensed or certified health care professional shall not be deemed to be an employee of the Public Health Service shall be effective upon receipt by the entity employing such individual of notice of such determination, and shall apply only to acts or omissions occurring after the date such notice is received.

(j) In the case of a health care provider who is an officer, employee, or contractor of an entity described in subsection (g)(4), section 335(e) shall apply with respect to the provider to the same extent and in the same manner as such section applies to any member of the National Health Service Corps.

(k)(1)(A) For each fiscal year, the Attorney General, in consultation with the Secretary, shall estimate by the beginning of the year the amount of all claims which are expected to arise under this section (together with related fees and expenses of witnesses) for which payment is expected to be made in accordance with section 1346 and chapter 171 of title 28, United States Code, from the acts or omissions, during the calendar year that begins during that fiscal year, of entities described in subsection (g)(4) and of officers, employees, or contractors (subject to subsection (g)(5)) of such entities.

(B) The estimate under subparagraph (A) shall take into account—

(i) the value and frequency of all claims for damage for personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by entities described in subsection (g)(4) or by officers, employees, or contractors (subject to subsection (g)(5)) of such entities who are deemed to be employees of the Public Health Service under subsection (g)(1) that, during the preceding 5-year period, are filed under this section or, with respect to years occurring before this subsection takes effect, are filed against persons other than the United States,

(ii) the amounts paid during that 5-year period on all claims described in clause (i), regardless of when such claims were filed, adjusted to reflect payments which would not be permitted under section 1346 and chapter 171 of title 28, United States Code, and

(iii) amounts in the fund established under paragraph (2) but unspent from prior fiscal years.

(2) Subject to appropriations, for each fiscal year, the Secretary shall establish a fund of an amount equal to the amount estimated under paragraph (1) that is attributable to entities receiving funds under each of the grant programs described in paragraph (4) of subsection (g), but not to exceed a total of \$10,000,000 for each such fiscal year. Appropriations for purposes of this paragraph shall be made separate from appropriations made for purposes of sections 329, 330 and 340A.

(3) In order for payments to be made for judgments against the United States (together with related fees and expenses of witnesses) pursuant to this section arising from the acts or omissions of entities described in subsection (g)(4) and of officers, employees, or contractors (subject to subsection (g)(5)) of such entities, the total amount contained within the fund established by the Sec-

retary under paragraph (2) for a fiscal year shall be transferred not later than the December 31 that occurs during the fiscal year to the appropriate accounts in the Treasury.

(1)(1) If a civil action or proceeding is filed in a State court against any entity described in subsection (g)(4) or any officer, governing board member, employee, or any contractor of such an entity for damages described in subsection (a), the Attorney General, within 15 days after being notified of such filing, shall make an appearance in such court and advise such court as to whether the Secretary has determined under subsections (g) and (h), that such entity, officer, governing board member, employee, or contractor of the entity is deemed to be an employee of the Public Health Service for purposes of this section with respect to the actions or omissions that are the subject of such civil action or proceeding. Such advice shall be deemed to satisfy the provisions of subsection (c) that the Attorney General certify that an entity, officer, governing board member, employee, or contractor of the entity was acting within the scope of their employment or responsibility.

(2) If the Attorney General fails to appear in State court within the time period prescribed under paragraph (1), upon petition of any entity or officer, governing board member, employee, or contractor of the entity named, the civil action or proceeding shall be removed to the appropriate United States district court. The civil action or proceeding shall be stayed in such court until such court conducts a hearing, and makes a determination, as to the appropriate forum or procedure for the assertion of the claim for damages described in subsection (a) and issues an order consistent with such determination.

(m)(1) An entity or officer, governing board member, employee, or contractor of an entity described in subsection (g)(1) shall, for purposes of this section, be deemed to be an employee of the Public Health Service with respect to services provided to individuals who are enrollees of a managed care plan if the entity contracts with such managed care plan for the provision of services.

(2) Each managed care plan which enters into a contract with an entity described in subsection (g)(4) shall deem the entity and any officer, governing board member, employee, or contractor of the entity as meeting whatever malpractice coverage requirements such plan may require of contracting providers for a calendar year if such entity or officer, governing board member, employee, or contractor of the entity has been deemed to be an employee of the Public Health Service for purposes of this section for such calendar year. Any plan which is found by the Secretary on the record, after notice and an opportunity for a full and fair hearing, to have violated this subsection shall upon such finding cease, for a period to be determined by the Secretary, to receive and to be eligible to receive any Federal funds under titles XVIII or XIX of the Social Security Act.

(3) For purposes of this subsection, the term "managed care plan" shall mean health maintenance organizations and similar entities that contract at-risk with payors for the provision of health services or plan enrollees and which contract with providers (such as entities described in subsection (g)(4)) for the delivery of such services to plan enrollees.

(n)(1) Not later than one year after the date of the enactment of the Federally Supported Health Centers Assistance Act of 1995, the Comptroller General of the United States shall submit to the Congress a report on the following:

(A) The medical malpractice liability claims experience of entities that have been deemed to be employees for purposes of this section.

(B) The risk exposure of such entities.

(C) The value of private sector risk-management services, and the value of risk-management services and procedures required as a condition of receiving a grant under section 329, 330, or 340A.

(D) A comparison of the costs and the benefits to taxpayers of maintaining medical malpractice liability coverage for such entities pursuant to this section, taking into account—

(i) a comparison of the costs of premiums paid by such entities for private medical malpractice liability insurance with the cost of coverage pursuant to this section; and

(ii) an analysis of whether the cost of premiums for private medical malpractice liability insurance coverage is consistent with the liability claims experience of such entities.

(2) The report under paragraph (1) shall include the following:

(A) A comparison of—

(i) an estimate of the aggregate amounts that such entities (together with the officers, governing board members, employees, and contractors of such entities who have been deemed to be employees for purposes of this section) would have directly or indirectly paid in premiums to obtain medical malpractice liability insurance coverage if this section were not in effect; with

(ii) the aggregate amounts by which the grants received by such entities under this Act were reduced pursuant to subsection (k)(2).

(B) A comparison of—

(i) an estimate of the amount of privately offered such insurance that such entities (together with the officers, governing board members, employees, and contractors of such entities who have been deemed to be employees for purposes of this section) purchased during the three-year period beginning on January 1, 1993; with

(ii) an estimate of the amount of such insurance that such entities (together with the officers, governing board members, employees, and contractors of such entities who have been deemed to be employees for purposes of this section) will purchase after the date of the enactment of the Federally Supported Health Centers Assistance Act of 1995.

(C) An estimate of the medical malpractice liability loss history of such entities for the 10-year period preceding October 1, 1996, including but not limited to the following:

(i) Claims that have been paid and that are estimated to be paid, and legal expenses to handle such claims that have been paid and that are estimated to be paid, by the

Federal Government pursuant to deeming entities as employees for purposes of this section.

(ii) Claims that have been paid and that are estimated to be paid, and legal expenses to handle such claims that have been paid and that are estimated to be paid, by private medical malpractice liability insurance.

(D) An analysis of whether the cost of premiums for private medical malpractice liability insurance coverage is consistent with the liability claims experience of entities that have been deemed as employees for purposes of this section.

(3) In preparing the report under paragraph (1), the Comptroller General of the United States shall consult with public and private entities with expertise on the matters with which the report is concerned.

(o)(1) For purposes of this section, a free clinic health professional shall in providing a qualifying health service to an individual, or an officer, governing board member, employee, or contractor of a free clinic shall in providing services for the free clinic, 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 (6)(D). The preceding sentence is subject to the provisions of this subsection.

(2) In providing a health service to an individual, a health care practitioner shall for purposes of this subsection be considered to be a free clinic health professional if the following conditions are met:

(A) The service is provided to the individual at a free clinic, or through offsite programs or events carried out by the free clinic.

(B) The free clinic is sponsoring the health care practitioner pursuant to paragraph (5)(C).

(C) The service is a qualifying health service (as defined in paragraph (4)).

(D) Neither the health care practitioner nor the free clinic receives any compensation for the service from the individual or from any third-party payor (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program). With respect to compliance with such condition:

(i) The health care practitioner may receive repayment from the free clinic for reasonable expenses incurred by the health care practitioner in the provision of the service to the individual.

(ii) The free clinic may accept voluntary donations for the provision of the service by the health care practitioner to the individual.

(E) Before the service is provided, the health care practitioner or the free clinic provides written notice to the individual of the extent to which the legal liability of the health care practitioner is limited pursuant to this subsection (or in the case of an emergency, the written notice is provided to the individual as soon after the emergency as is practicable). If the individual is a minor or is otherwise legally incompetent, the condition under this subparagraph is that the written notice be

provided to a legal guardian or other person with legal responsibility for the care of the individual.

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

(3)(A) For purposes of this subsection, the term “free clinic” means a health care facility operated by a nonprofit private entity meeting the following requirements:

(i) The entity does not, in providing health services through the facility, accept reimbursement from any third-party payor (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program).

(ii) The entity, in providing health services through the facility, either does not impose charges on the individuals to whom the services are provided, or imposes a charge according to the ability of the individual involved to pay the charge.

(iii) The entity is licensed or certified in accordance with applicable law regarding the provision of health services.

(B) With respect to compliance with the conditions under subparagraph (A), the entity involved may accept voluntary donations for the provision of services.

(4) For purposes of this subsection, the term “qualifying health service” means any medical assistance required or authorized to be provided in the program under title XIX of the Social Security Act, without regard to whether the medical assistance is included in the plan submitted under such program by the State in which the health care practitioner involved provides the medical assistance. References in the preceding sentence to such program shall as applicable be considered to be references to any successor to such program.

(5) Subsection (g) (other than paragraphs (3) through (5)) and subsections (h), (i), and (l) apply to a health care practitioner 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 (6) and subject to the following:

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

(B) This subsection may not be construed as deeming any free clinic to be an employee of the Public Health Service for purposes of this section.

(C) With respect to a free clinic, a health care practitioner is not a free clinic health professional unless the free clinic sponsors the health care practitioner. For purposes of this subsection, the free clinic shall be considered to be sponsoring the health care practitioner if—

(i) with respect to the health care practitioner, the free clinic 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 practitioner is deemed to be an employee of the Public Health Service.

(D) In the case of a health care practitioner who is determined by the Secretary pursuant to subsection (g)(1)(E) to be a free clinic health professional, this subsection applies to the

health care practitioner (with respect to the free clinic sponsoring the health care practitioner pursuant to subparagraph (C)) for any cause of action arising from an act or omission of the health care practitioner occurring on or after the date on which the Secretary makes such determination.

(E) Subsection (g)(1)(F) applies to a health care practitioner for purposes of this subsection only to the extent that, in providing health services to an individual, each of the conditions specified in paragraph (2) is met.

(6)(A) For purposes of making payments for judgments against the United States (together with related fees and expenses of witnesses) pursuant to this section arising from the acts or omissions of free clinic health professionals, there is authorized to be appropriated \$10,000,000 for each fiscal year.

(B) The Secretary shall establish a fund for purposes of this subsection. Each fiscal year amounts appropriated under subparagraph (A) shall be deposited in such fund.

(C) 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 free clinic health professionals, will be paid pursuant to this section during the calendar year that begins in the following fiscal year. Subsection (k)(1)(B) applies to the estimate under the preceding sentence regarding free clinic health professionals 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).

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

(7)(A) This subsection takes effect on the date of the enactment of the first appropriations Act that makes an appropriation under paragraph (6)(A), except as provided in subparagraph (B)(i).

(B)(i) Effective on the date of the enactment of the Health Insurance Portability and Accountability Act of 1996—

(I) the Secretary may issue regulations for carrying out this subsection, and the Secretary may accept and consider applications submitted pursuant to paragraph (5)(C); and

(II) reports under paragraph (6)(C) may be submitted to the Congress.

(ii) For the first fiscal year for which an appropriation is made under subparagraph (A) of paragraph (6), if an estimate under subparagraph (C) of such paragraph has not been made for the calendar year beginning in such fiscal year, the transfer under subparagraph (D) of such paragraph shall be made notwithstanding the lack of the estimate, and the transfer shall be made in an amount equal to the amount of such appropriation.

(p) ADMINISTRATION OF SMALLPOX COUNTERMEASURES BY HEALTH PROFESSIONALS.—

(1) IN GENERAL.—For purposes of this section, and subject to other provisions of this subsection, a covered person shall be

deemed to be an employee of the Public Health Service with respect to liability arising out of administration of a covered countermeasure against smallpox to an individual during the effective period of a declaration by the Secretary under paragraph (2)(A).

(2) DECLARATION BY SECRETARY CONCERNING COUNTERMEASURE AGAINST SMALLPOX.—

(A) AUTHORITY TO ISSUE DECLARATION.—

(i) IN GENERAL.—The Secretary may issue a declaration, pursuant to this paragraph, concluding that an actual or potential bioterrorist incident or other actual or potential public health emergency makes advisable the administration of a covered countermeasure to a category or categories of individuals.

(ii) COVERED COUNTERMEASURE.—The Secretary shall specify in such declaration the substance or substances that shall be considered covered countermeasures (as defined in paragraph (7)(A)) for purposes of administration to individuals during the effective period of the declaration.

(iii) EFFECTIVE PERIOD.—The Secretary shall specify in such declaration the beginning and ending dates of the effective period of the declaration, and may subsequently amend such declaration to shorten or extend such effective period, provided that the new closing date is after the date when the declaration is amended.

(iv) PUBLICATION.—The Secretary shall promptly publish each such declaration and amendment in the Federal Register.

(B) LIABILITY OF UNITED STATES ONLY FOR ADMINISTRATIONS WITHIN SCOPE OF DECLARATION.—Except as provided in paragraph (5)(B)(ii), the United States shall be liable under this subsection with respect to a claim arising out of the administration of a covered countermeasure to an individual only if—

(i) the countermeasure was administered by a qualified person, for a purpose stated in paragraph (7)(A)(i), and during the effective period of a declaration by the Secretary under subparagraph (A) with respect to such countermeasure; and

(ii)(I) the individual was within a category of individuals covered by the declaration; or

(II) the qualified person administering the countermeasure had reasonable grounds to believe that such individual was within such category.

(C) PRESUMPTION OF ADMINISTRATION WITHIN SCOPE OF DECLARATION IN CASE OF ACCIDENTAL VACCINIA INOCULATION.—

(i) IN GENERAL.—If vaccinia vaccine is a covered countermeasure specified in a declaration under subparagraph (A), and an individual to whom the vaccinia vaccine is not administered contracts vaccinia, then, under the circumstances specified in clause (ii), the individual—

(I) shall be rebuttably presumed to have contracted vaccinia from an individual to whom such vaccine was administered as provided by clauses (i) and (ii) of subparagraph (B); and

(II) shall (unless such presumption is rebutted) be deemed for purposes of this subsection to be an individual to whom a covered countermeasure was administered by a qualified person in accordance with the terms of such declaration and as described by subparagraph (B).

(ii) CIRCUMSTANCES IN WHICH PRESUMPTION APPLIES.—The presumption and deeming stated in clause (i) shall apply if—

(I) the individual contracts vaccinia during the effective period of a declaration under subparagraph (A) or by the date 30 days after the close of such period; or

(II) the individual has resided with, or has had contact with, an individual to whom such vaccine was administered as provided by clauses (i) and (ii) of subparagraph (B) and contracts vaccinia after such date.

(D) ACTS AND OMISSIONS DEEMED TO BE WITHIN SCOPE OF EMPLOYMENT.—

(i) IN GENERAL.—In the case of a claim arising out of alleged transmission of vaccinia from an individual described in clause (ii), acts or omissions by such individual shall be deemed to have been taken within the scope of such individual's office or employment for purposes of—

(I) subsection (a); and

(II) section 1346(b) and chapter 171 of title 28, United States Code.

(ii) INDIVIDUALS TO WHOM DEEMING APPLIES.—An individual is described by this clause if—

(I) vaccinia vaccine was administered to such individual as provided by subparagraph (B); and

(II) such individual was within a category of individuals covered by a declaration under subparagraph (A)(i).

(3) EXHAUSTION; EXCLUSIVITY; OFFSET.—

(A) EXHAUSTION.—

(i) IN GENERAL.—A person may not bring a claim under this subsection unless such person has exhausted such remedies as are available under part C of this title, except that if the Secretary fails to make a final determination on a request for benefits or compensation filed in accordance with the requirements of such part within 240 days after such request was filed, the individual may seek any remedy that may be available under this section.

(ii) TOLLING OF STATUTE OF LIMITATIONS.—The time limit for filing a claim under this subsection, or for filing an action based on such claim, shall be tolled dur-

ing the pendency of a request for benefits or compensation under part C of this title.

(iii) CONSTRUCTION.—This subsection shall not be construed as superseding or otherwise affecting the application of a requirement, under chapter 171 of title 28, United States Code, to exhaust administrative remedies.

(B) EXCLUSIVITY.—The remedy provided by subsection (a) shall be exclusive of any other civil action or proceeding for any claim or suit this subsection encompasses, except for a proceeding under part C of this title.

(C) OFFSET.—The value of all compensation and benefits provided under part C of this title for an incident or series of incidents shall be offset against the amount of an award, compromise, or settlement of money damages in a claim or suit under this subsection based on the same incident or series of incidents.

(4) CERTIFICATION OF ACTION BY ATTORNEY GENERAL.—Subsection (c) applies to actions under this subsection, subject to the following provisions:

(A) NATURE OF CERTIFICATION.—The certification by the Attorney General that is the basis for deeming an action or proceeding to be against the United States, and for removing an action or proceeding from a State court, is a certification that the action or proceeding is against a covered person and is based upon a claim alleging personal injury or death arising out of the administration of a covered countermeasure.

(B) CERTIFICATION OF ATTORNEY GENERAL CONCLUSIVE.—The certification of the Attorney General of the facts specified in subparagraph (A) shall conclusively establish such facts for purposes of jurisdiction pursuant to this subsection.

(5) COVERED PERSON TO COOPERATE WITH UNITED STATES.—

(A) IN GENERAL.—A covered person shall cooperate with the United States in the processing and defense of a claim or action under this subsection based upon alleged acts or omissions of such person.

(B) CONSEQUENCES OF FAILURE TO COOPERATE.—Upon the motion of the United States or any other party and upon finding that such person has failed to so cooperate—

(i) the court shall substitute such person as the party defendant in place of the United States and, upon motion, shall remand any such suit to the court in which it was instituted if it appears that the court lacks subject matter jurisdiction;

(ii) the United States shall not be liable based on the acts or omissions of such person; and

(iii) the Attorney General shall not be obligated to defend such action.

(6) RECOURSE AGAINST COVERED PERSON IN CASE OF GROSS MISCONDUCT OR CONTRACT VIOLATION.—

(A) IN GENERAL.—Should payment be made by the United States to any claimant bringing a claim under this subsection, either by way of administrative determination,

settlement, or court judgment, the United States shall have, notwithstanding any provision of State law, the right to recover for that portion of the damages so awarded or paid, as well as interest and any costs of litigation, resulting from the failure of any covered person to carry out any obligation or responsibility assumed by such person under a contract with the United States or from any grossly negligent, reckless, or illegal conduct or willful misconduct on the part of such person.

(B) VENUE.—The United States may maintain an action under this paragraph against such person in the district court of the United States in which such person resides or has its principal place of business.

(7) DEFINITIONS.—As used in this subsection, terms have the following meanings:

(A) COVERED COUNTERMEASURE.—The term “covered countermeasure” or “covered countermeasure against smallpox”, means a substance that is—

(i)(I) used to prevent or treat smallpox (including the vaccinia or another vaccine); or

(II) used to control or treat the adverse effects of vaccinia inoculation or of administration of another covered countermeasure; and

(ii) specified in a declaration under paragraph (2).

(B) COVERED PERSON.—The term “covered person”, when used with respect to the administration of a covered countermeasure, means a person who is—

(i) a manufacturer or distributor of such countermeasure;

(ii) a health care entity under whose auspices—

(I) such countermeasure was administered;

(II) a determination was made as to whether, or under what circumstances, an individual should receive a covered countermeasure;

(III) the immediate site of administration on the body of a covered countermeasure was monitored, managed, or cared for; or

(IV) an evaluation was made of whether the administration of a countermeasure was effective;

(iii) a qualified person who administered such countermeasure;

(iv) a State, a political subdivision of a State, or an agency or official of a State or of such a political subdivision, if such State, subdivision, agency, or official has established requirements, provided policy guidance, supplied technical or scientific advice or assistance, or otherwise supervised or administered a program with respect to administration of such countermeasures;

(v) in the case of a claim arising out of alleged transmission of vaccinia from an individual—

(I) the individual who allegedly transmitted the vaccinia, if vaccinia vaccine was administered to such individual as provided by paragraph (2)(B) and such individual was within a category of indi-

viduals covered by a declaration under paragraph (2)(A)(i); or

(II) an entity that employs an individual described by clause (I) or where such individual has privileges or is otherwise authorized to provide health care;

(vi) an official, agent, or employee of a person described in clause (i), (ii), (iii), or (iv);

(vii) a contractor of, or a volunteer working for, a person described in clause (i), (ii), or (iv), if the contractor or volunteer performs a function for which a person described in clause (i), (ii), or (iv) is a covered person; or

(viii) an individual who has privileges or is otherwise authorized to provide health care under the auspices of an entity described in clause (ii) or (v)(II).

(C) QUALIFIED PERSON.—The term “qualified person”, when used with respect to the administration of a covered countermeasure, means a licensed health professional or other individual who—

(i) is authorized to administer such countermeasure under the law of the State in which the countermeasure was administered; or

(ii) is otherwise authorized by the Secretary to administer such countermeasure.

(D) ARISING OUT OF ADMINISTRATION OF A COVERED COUNTERMEASURE.—The term “arising out of administration of a covered countermeasure”, when used with respect to a claim or liability, includes a claim or liability arising out of—

(i) determining whether, or under what conditions, an individual should receive a covered countermeasure;

(ii) obtaining informed consent of an individual to the administration of a covered countermeasure;

(iii) monitoring, management, or care of an immediate site of administration on the body of a covered countermeasure, or evaluation of whether the administration of the countermeasure has been effective; or

(iv) transmission of vaccinia virus by an individual to whom vaccinia vaccine was administered as provided by paragraph (2)(B).

(q)(1) For purposes of this section, a health professional volunteer at an entity described in subsection (g)(4) shall, in providing a health professional service eligible for funding under section 330 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 (4)(C). The preceding sentence is subject to the provisions of this subsection.

(2) In providing a health service to an individual, a health care practitioner shall for purposes of this subsection be considered to be a health professional volunteer at an entity described in subsection (g)(4) 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), or through offsite programs or events carried out by the entity.*

(B) *The entity is sponsoring the health care practitioner pursuant to paragraph (3)(B).*

(C) *The health care practitioner 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 practitioner may receive repayment from the entity described in subsection (g)(4) for reasonable expenses incurred by the health care practitioner in the provision of the service to the individual.*

(D) *Before the service is provided, the health care practitioner or the 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 practitioner is limited pursuant to this subsection.*

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

(3) *Subsection (g) (other than paragraphs (3) and (5)) and subsections (h), (i), and (l) apply to a health care practitioner 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 (4) and subject to the following:*

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

(B) *With respect to an entity described in subsection (g)(4), a health care practitioner is not a health professional volunteer at such entity unless the entity sponsors the health care practitioner. For purposes of this subsection, the entity shall be considered to be sponsoring the health care practitioner if—*

(i) with respect to the health care practitioner, the entity 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 practitioner is deemed to be an employee of the Public Health Service.

(C) *In the case of a health care practitioner who is determined by the Secretary pursuant to subsection (g)(1)(E) to be a health professional volunteer at such entity, this subsection applies to the health care practitioner (with respect to services performed on behalf of the entity sponsoring the health care practitioner pursuant to subparagraph (B)) for any cause of action arising from an act or omission of the health care practitioner occurring on or after the date on which the Secretary makes such determination.*

(D) *Subsection (g)(1)(F) applies to a health care practitioner for purposes of this subsection only to the extent that, in providing health services to an individual, each of the conditions specified in paragraph (2) is met.*

(4)(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.

(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 professional volunteers, will be paid pursuant to this section 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 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.

(5)(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 (3)(B); and

(ii) reports under paragraph (4)(B) may be submitted to the Congress.

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TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

* * * * *

PART B—FEDERAL-STATE COOPERATION

* * * * *

SEC. 319D. REVITALIZING THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

(a) FACILITIES; CAPACITIES.—

(1) FINDINGS.—Congress finds that the Centers for Disease Control and Prevention has an essential role in defending against and combatting public health threats domestically and abroad and requires secure and modern facilities, and expanded and improved capabilities related to bioterrorism and other public health emergencies, sufficient to enable such Centers to conduct this important mission.

(2) FACILITIES.—

(A) IN GENERAL.—The Director of the Centers for Disease Control and Prevention may design, construct, and equip new facilities, renovate existing facilities (including laboratories, laboratory support buildings, scientific communication facilities, transshipment complexes, secured and isolated parking structures, office buildings, and other facilities and infrastructure), and upgrade security of such

facilities, in order to better conduct the capacities described in section 319A, and for supporting public health activities.

(B) MULTIYEAR CONTRACTING AUTHORITY.—For any project of designing, constructing, equipping, or renovating any facility under subparagraph (A), the Director of the Centers for Disease Control and Prevention may enter into a single contract or related contracts that collectively include the full scope of the project, and the solicitation and contract shall contain the clause “availability of funds” found at section 52.232–18 of title 48, Code of Federal Regulations.

(3) IMPROVING THE CAPACITIES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.—The Secretary shall expand, enhance, and improve the capabilities of the Centers for Disease Control and Prevention relating to preparedness for and responding effectively to bioterrorism and other public health emergencies. Activities that may be carried out under the preceding sentence include—

(A) expanding or enhancing the training of personnel;

(B) improving communications facilities and networks, including delivery of necessary information to rural areas;

(C) improving capabilities for public health surveillance and reporting activities, taking into account the integrated system or systems of public health alert communications and surveillance networks under subsection (b); and

(D) improving laboratory facilities related to bioterrorism and other public health emergencies, including increasing the security of such facilities.

(b) NATIONAL COMMUNICATIONS AND SURVEILLANCE NETWORKS.—

(1) IN GENERAL.—The Secretary, directly or through awards of grants, contracts, or cooperative agreements, shall provide for the establishment of an integrated system or systems of public health alert communications and surveillance networks between and among—

(A) Federal, State, and local public health officials;

(B) public and private health-related laboratories, hospitals, poison control centers, and other health care facilities; and

(C) any other entities determined appropriate by the Secretary.

(2) REQUIREMENTS.—The Secretary shall ensure that networks under paragraph (1) allow for the timely sharing and discussion, in a secure manner, of essential information concerning bioterrorism or another public health emergency, or recommended methods for responding to such an attack or emergency, allowing for coordination to maximize all-hazards medical and public health preparedness and response and to minimize duplication of effort.

(3) STANDARDS.—Not later than one year after the date of the enactment of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, the Secretary, in cooperation with health care providers and State and local public health officials, shall establish any additional technical and reporting standards (including standards for interoperability) for

networks under paragraph (1) and update such standards as necessary.

(c) MODERNIZING PUBLIC HEALTH SITUATIONAL AWARENESS AND BIOSURVEILLANCE.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013, the Secretary, in collaboration with State, local, and tribal public health officials, shall establish a near real-time electronic nationwide public health situational awareness capability through an interoperable network of systems to share data and information to enhance early detection of rapid response to, and management of, potentially catastrophic infectious disease outbreaks, novel emerging threats, and other public health emergencies that originate domestically or abroad. Such network shall be built on existing State situational awareness systems or enhanced systems that enable such connectivity.

(2) STRATEGY AND IMPLEMENTATION PLAN.—Not later than 180 days after the date of enactment of the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013, the Secretary shall submit to the appropriate committees of Congress a coordinated strategy and an accompanying implementation plan that identifies and demonstrates the measurable steps the Secretary will carry out to—

(A) develop, implement, and evaluate the network described in paragraph (1), utilizing the elements described in paragraph (3);

(B) modernize and enhance biosurveillance activities; and

(C) improve information sharing, coordination, and communication among disparate biosurveillance systems supported by the Department of Health and Human Services.

(3) ELEMENTS.—The network described in paragraph (1) shall include data and information transmitted in a standardized format from—

(A) State, local, and tribal public health entities, including public health laboratories;

(B) Federal health agencies;

(C) zoonotic disease monitoring systems;

(D) public and private sector health care entities, hospitals, pharmacies, poison control centers or professional organizations in the field of poison control, community health centers, health centers and clinical laboratories, to the extent practicable and provided that such data are voluntarily provided simultaneously to the Secretary and appropriate State, local, and tribal public health agencies; and

(E) such other sources as the Secretary may deem appropriate.

(4) RULE OF CONSTRUCTION.—Paragraph (3) shall not be construed as requiring separate reporting of data and information from each source listed.

(5) REQUIRED ACTIVITIES.—In establishing and operating the network described in paragraph (1), the Secretary shall—

(A) utilize applicable interoperability standards as determined by the Secretary, and in consultation with the Office of the National Coordinator for Health Information Technology, through a joint public and private sector process;

(B) define minimal data elements for such network;

(C) in collaboration with State, local, and tribal public health officials, integrate and build upon existing State, local, and tribal capabilities, ensuring simultaneous sharing of data, information, and analyses from the network described in paragraph (1) with State, local, and tribal public health agencies; and

(D) in collaboration with State, local, and tribal public health officials, develop procedures and standards for the collection, analysis, and interpretation of data that States, regions, or other entities collect and report to the network described in paragraph (1).

(6) CONSULTATION WITH THE NATIONAL BIODEFENSE SCIENCE BOARD.—In carrying out this section and consistent with section 319M, the National Biodefense Science Board shall provide expert advice and guidance, including recommendations, regarding the measurable steps the Secretary should take to modernize and enhance biosurveillance activities pursuant to the efforts of the Department of Health and Human Services to ensure comprehensive, real-time, all-hazards biosurveillance capabilities. In complying with the preceding sentence, the National Biodefense Science Board shall—

(A) identify the steps necessary to achieve a national biosurveillance system for human health, with international connectivity, where appropriate, that is predicated on State, regional, and community level capabilities and creates a networked system to allow for two-way information flow between and among Federal, State, and local government public health authorities and clinical health care providers;

(B) identify any duplicative surveillance programs under the authority of the Secretary, or changes that are necessary to existing programs, in order to enhance and modernize such activities, minimize duplication, strengthen and streamline such activities under the authority of the Secretary, and achieve real-time and appropriate data that relate to disease activity, both human and zoonotic; and

(C) coordinate with applicable existing advisory committees of the Director of the Centers for Disease Control and Prevention, including such advisory committees consisting of representatives from State, local, and tribal public health authorities and appropriate public and private sector health care entities and academic institutions, in order to provide guidance on public health surveillance activities.

(d) STATE AND REGIONAL SYSTEMS TO ENHANCE SITUATIONAL AWARENESS IN PUBLIC HEALTH EMERGENCIES.—

(1) IN GENERAL.—To implement the network described in subsection (c), the Secretary may award grants to States or consortia of States to enhance the ability of such States or con-

sortia of States to establish or operate a coordinated public health situational awareness system for regional or Statewide early detection of, rapid response to, and management of potentially catastrophic infectious disease outbreaks and public health emergencies, in collaboration with appropriate public health agencies, sentinel hospitals, clinical laboratories, pharmacies, poison control centers, other health care organizations, and animal health organizations within such States.

(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), the State or consortium of States shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including an assurance that the State or consortium of States will submit to the Secretary—

(A) reports of such data, information, and metrics as the Secretary may require;

(B) a report on the effectiveness of the systems funded under the grant; and

(C) a description of the manner in which grant funds will be used to enhance the timelines and comprehensiveness of efforts to detect, respond to, and manage potentially catastrophic infectious disease outbreaks and public health emergencies.

(3) USE OF FUNDS.—A State or consortium of States that receives an award under this subsection—

(A) shall establish, enhance, or operate a coordinated public health situational awareness system for regional or Statewide early detection of, rapid response to, and management of potentially catastrophic infectious disease outbreaks and public health emergencies;

(B) may award grants or contracts to entities described in paragraph (1) within or serving such State to assist such entities in improving the operation of information technology systems, facilitating the secure exchange of data and information, and training personnel to enhance the operation of the system described in subparagraph (A); and

(C) may conduct a pilot program for the development of multi-State telehealth network test beds that build on, enhance, and securely link existing State and local telehealth programs to prepare for, monitor, respond to, and manage the events of public health emergencies, facilitate coordination and communication among medical, public health, and emergency response agencies, and provide medical services through telehealth initiatives within the States that are involved in such a multi-State telehealth network test bed.

(4) LIMITATION.—Information technology systems acquired or implemented using grants awarded under this section must be compliant with—

(A) interoperability and other technological standards, as determined by the Secretary; and

(B) data collection and reporting requirements for the network described in subsection (c).

(5) INDEPENDENT EVALUATION.—Not later than 3 years after the date of enactment of the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013, the Government Accountability Office shall conduct an independent evaluation, and submit to the Secretary and the appropriate committees of Congress a report concerning the activities conducted under this subsection and subsection (c).

(e) TELEHEALTH ENHANCEMENTS FOR EMERGENCY RESPONSE.—

(1) EVALUATION.—The Secretary, in consultation with the Federal Communications Commission and other relevant Federal agencies, shall—

(A) conduct an inventory of telehealth initiatives in existence on the date of enactment of the Pandemic and All-Hazards Preparedness Act, including—

- (i) the specific location of network components;
- (ii) the medical, technological, and communications capabilities of such components;
- (iii) the functionality of such components; and
- (iv) the capacity and ability of such components to handle increased volume during the response to a public health emergency;

(B) identify methods to expand and interconnect the regional health information networks funded by the Secretary, the State and regional broadband networks funded through the rural health care support mechanism pilot program funded by the Federal Communications Commission, and other telehealth networks;

(C) evaluate ways to prepare for, monitor, respond rapidly to, or manage the events of, a public health emergency through the enhanced use of telehealth technologies, including mechanisms for payment or reimbursement for use of such technologies and personnel during public health emergencies;

(D) identify methods for reducing legal barriers that deter health care professionals from providing telemedicine services, such as by utilizing State emergency health care professional credentialing verification systems, encouraging States to establish and implement mechanisms to improve interstate medical licensure cooperation, facilitating the exchange of information among States regarding investigations and adverse actions, and encouraging States to waive the application of licensing requirements during a public health emergency;

(E) evaluate ways to integrate the practice of telemedicine within the National Disaster Medical System; and

(F) promote greater coordination among existing Federal interagency telemedicine and health information technology initiatives.

(2) REPORT.—Not later than 12 months after the date of enactment of the Pandemic and All-Hazards Preparedness Act, the Secretary shall prepare and submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives regarding the findings and recommenda-

tions pursuant to subparagraphs (A) through (F) of paragraph (1).

(f) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out this section, ~~【\$138,300,000 for each of fiscal years 2014 through 2018】~~ *\$138,300,000 for each of fiscal years 2014 through 2016 and \$58,000,000 for each of fiscal years 2017 and 2018.*

(g) **DEFINITION.**—For purposes of this section the term “bio-surveillance” means the process of gathering near real-time biological data that relates to human and zoonotic disease activity and threats to human or animal health, in order to achieve early warning and identification of such health threats, early detection and prompt ongoing tracking of health events, and overall situational awareness of disease activity.

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PART D—PRIMARY HEALTH CARE

Subpart I—Health Centers

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SEC. 330M. TELEHEALTH CHILD PSYCHIATRY ACCESS GRANTS.

(a) **IN GENERAL.**—*The Secretary, acting through the Administrator of the Health Resources and Services Administration and in coordination with other relevant Federal agencies, shall award grants to States, political subdivisions of States, Indian tribes, and tribal organizations (for purposes of this section, as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)) to promote behavioral health integration in pediatric primary care by—*

- (1) *supporting the development of statewide child psychiatry access programs; and*
- (2) *supporting the improvement of existing statewide child psychiatry access programs.*

(b) **PROGRAM REQUIREMENTS.**—

(1) **IN GENERAL.**—*A child psychiatry access program referred to in subsection (a), with respect to which a grant under such subsection may be used, shall—*

(A) *be a statewide network of pediatric mental health teams that provide support to pediatric primary care sites as an integrated team;*

(B) *support and further develop organized State networks of child and adolescent psychiatrists to provide consultative support to pediatric primary care sites;*

(C) *conduct an assessment of critical behavioral consultation needs among pediatric providers and such providers’ preferred mechanisms for receiving consultation and training and technical assistance;*

(D) *develop an online database and communication mechanisms, including telehealth, to facilitate consultation support to pediatric practices;*

(E) *provide rapid statewide clinical telephone or telehealth consultations when requested between the pediatric mental health teams and pediatric primary care providers;*

(F) conduct training and provide technical assistance to pediatric primary care providers to support the early identification, diagnosis, treatment, and referral of children with behavioral health conditions or co-occurring intellectual and other developmental disabilities;

(G) inform and assist pediatric providers in accessing child psychiatry consultations and in scheduling and conducting technical assistance;

(H) assist with referrals to specialty care and community or behavioral health resources; and

(I) establish mechanisms for measuring and monitoring increased access to child and adolescent psychiatric services by pediatric primary care providers and expanded capacity of pediatric primary care providers to identify, treat, and refer children with mental health problems.

(2) PEDIATRIC MENTAL HEALTH TEAMS.—In this subsection, the term “pediatric mental health team” means a team of case coordinators, child and adolescent psychiatrists, and licensed clinical mental health professionals, such as a psychologist, social worker, or mental health counselor.

(c) APPLICATION.—A State, political subdivision of a State, Indian tribe, or tribal organization seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a plan for the rigorous evaluation of activities that are carried out with funds received under such grant.

(d) EVALUATION.—A State, political subdivision of a State, Indian tribe, or tribal organization that receives a grant under this section shall prepare and submit an evaluation of activities carried out with funds received under such grant to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require, including a process and outcome evaluation.

(e) MATCHING REQUIREMENT.—The Secretary may not award a grant under this section unless the State, political subdivision of a State, Indian tribe, or tribal organization involved agrees, with respect to the costs to be incurred by the State, political subdivision of a State, Indian tribe, or tribal organization in carrying out the purpose described in this section, to make available non-Federal contributions (in cash or in kind) toward such costs in an amount that is not less than 20 percent of Federal funds provided in the grant.

(f) AUTHORIZATION OF APPROPRIATIONS.—To carry this section, there are authorized to be appropriated \$9,000,000 for the period of fiscal years 2018 through 2020.

Subpart II—National Health Service Corps Program

NATIONAL HEALTH SERVICE CORPS

SEC. 331. (a)(1) For the purpose of eliminating health manpower shortages in health professional shortage areas, there is established, within the Service, the National Health Service Corps, which shall consist of—

(A) such officers of the Regular and Reserve Corps of the Service as the Secretary may designate,

(B) such civilian employees of the United States as the Secretary may appoint, and

(C) such other individuals who are not employees of the United States.

(2) The Corps shall be utilized by the Secretary to provide primary health services in health professional shortage areas.

(3) For purposes of this subpart and subpart III:

(A) The term "Corps" means the National Health Service Corps.

(B) The term "Corps member" means each of the officers, employees, and individuals of which the Corps consists pursuant to paragraph (1).

(C) The term "health professional shortage area" has the meaning given such term in section 332(a).

(D) The term "primary health services" means health services regarding family medicine, internal medicine, pediatrics (*including pediatric mental health subspecialty services*), obstetrics and gynecology, dentistry, or mental health, that are provided by physicians or other health professionals.

(E)(i) The term "behavioral and mental health professionals" means health service psychologists, licensed clinical social workers, licensed professional counselors, marriage and family therapists, psychiatric nurse specialists, and psychiatrists (*and pediatric subspecialists thereof*).

(ii) The term "graduate program of behavioral and mental health" means a program that trains behavioral and mental health professionals.

(b)(1) The Secretary may conduct at schools of medicine, osteopathic medicine, dentistry, and, as appropriate, nursing and other schools of the health professions, including schools at which graduate programs of behavioral and mental health are offered, and at entities which train allied health personnel, recruiting programs for the Corps, the Scholarship Program, and the Loan Repayment Program. Such recruiting programs shall include efforts to recruit individuals who will serve in the Corps other than pursuant to obligated service under the Scholarship or Loan Repayment Program.

(2) In the case of physicians, dentists, behavioral and mental health professionals, certified nurse midwives, certified nurse practitioners, and physician assistants who have an interest and a commitment to providing primary health care, the Secretary may establish fellowship programs to enable such health professionals to gain exposure to and expertise in the delivery of primary health services in health professional shortage areas. To the maximum extent practicable, the Secretary shall ensure that any such programs are established in conjunction with accredited residency programs, and other training programs, regarding such health professions.

(c)(1) The Secretary may reimburse an applicant for a position in the Corps (including an individual considering entering into a written agreement pursuant to section 338D) for the actual and reasonable expenses incurred in traveling to and from the applicant's place of residence to an eligible site to which the applicant may be assigned under section 333 for the purpose of evaluating such site with regard to being assigned at such site. The Secretary may establish a maximum total amount that may be paid to an individual as reimbursement for such expenses.

(2) The Secretary may also reimburse the applicant for the actual and reasonable expenses incurred for the travel of 1 family member to accompany the applicant to such site. The Secretary may establish a maximum total amount that may be paid to an individual as reimbursement for such expenses.

(3) In the case of an individual who has entered into a contract for obligated service under the Scholarship Program or under the Loan Repayment Program, the Secretary may reimburse such individual for all or part of the actual and reasonable expenses incurred in transporting the individual, the individual's family, and the family's possessions to the site of the individual's assignment under section 333. The Secretary may establish a maximum total amount that may be paid to an individual as reimbursement for such expenses.

(d)(1) The Secretary may, under regulations promulgated by the Secretary, adjust the monthly pay of each member of the Corps (other than a member described in subsection (a)(1)(C)) who is directly engaged in the delivery of health services in a health professional shortage area as follows:

(A) During the first 36 months in which such a member is so engaged in the delivery of health services, his monthly pay may be increased by an amount which when added to the member's monthly pay and allowances will provide a monthly income competitive with the average monthly income from a practice of an individual who is a member of the profession of the Corps member, who has equivalent training, and who has been in practice for a period equivalent to the period during which the Corps member has been in practice.

(B) During the period beginning upon the expiration of the 36 months referred to in subparagraph (A) and ending with the month in which the member's monthly pay and allowances are equal to or exceed the monthly income he received for the last of such 36 months, the member may receive in addition to his monthly pay and allowances an amount which when added to such monthly pay and allowances equals the monthly income he received for such last month.

(C) For each month in which a member is directly engaged in the delivery of health services in a health professional shortage area in accordance with an agreement with the Secretary entered into under section 741(f)(1)(C), under which the Secretary is obligated to make payments in accordance with section 741(f)(2), the amount of any monthly increase under subparagraph (A) or (B) with respect to such member shall be decreased by an amount equal to one-twelfth of the amount which the Secretary is obligated to pay upon the completion of the year of practice in which such month occurs.

For purposes of subparagraphs (A) and (B), the term "monthly pay" includes special pay received under chapter 5 of title 37 of the United States Code.

(2) In the case of a member of the Corps who is directly engaged in the delivery of health services in a health professional shortage area in accordance with a service obligation incurred under the Scholarship Program or the Loan Repayment Program, the adjustment in pay authorized by paragraph (1) may be made for such a member only upon satisfactory completion of such service obliga-

tion, and the first 36 months of such member's being so engaged in the delivery of health services shall, for purposes of paragraph (1)(A), be deemed to begin upon such satisfactory completion.

(3) A member of the Corps described in subparagraph (C) of subsection (a)(1) shall when assigned to an entity under section 333 be subject to the personnel system of such entity, except that such member shall receive during the period of assignment the income that the member would receive if the member was a member of the Corps described in subparagraph (B) of such subsection.

(e) Corps members assigned under section 333 to provide health services in health professional shortage areas shall not be counted against any employment ceiling affecting the Department.

(f) Sections 214 and 216 shall not apply to members of the National Health Service Corps during their period of obligated service under the Scholarship Program or the Loan Repayment Program, except when such members are Commissioned Corps officers who entered into a contract with Secretary under section 338A or 338B after December 31, 2006 and when the Secretary determines that exercising the authority provided under section 214 or 216 with respect to any such officer would not cause unreasonable disruption to health care services provided in the community in which such officer is providing health care services.

(g)(1) The Secretary shall, by rule, prescribe conversion provisions applicable to any individual who, within a year after completion of service as a member of the Corps described in subsection (a)(1)(C), becomes a commissioned officer in the Regular or Reserve Corps of the Service.

(2) The rules prescribed under paragraph (1) shall provide that in applying the appropriate provisions of this Act which relate to retirement, any individual who becomes such an officer shall be entitled to have credit for any period of service as a member of the Corps described in subsection (a)(1)(C).

(h) The Secretary shall ensure that adequate staff is provided to the Service with respect to effectively administering the program for the Corps.

(i)(1) In carrying out subpart III, the Secretary may, in accordance with this subsection, issue waivers to individuals who have entered into a contract for obligated service under the Scholarship Program or the Loan Repayment Program under which the individuals are authorized to satisfy the requirement of obligated service through providing clinical practice that is half time.

(2) A waiver described in paragraph (1) may be provided by the Secretary only if—

(A) the entity for which the service is to be performed—

(i) has been approved under section 333A for assignment of a Corps member; and

(ii) has requested in writing assignment of a health professional who would serve half time;

(B) the Secretary has determined that assignment of a health professional who would serve half time would be appropriate for the area where the entity is located;

(C) a Corps member who is required to perform obligated service has agreed in writing to be assigned for half-time service to an entity described in subparagraph (A);

(D) the entity and the Corps member agree in writing that the Corps member will perform half-time clinical practice;

(E) the Corps member agrees in writing to fulfill all of the service obligations under section 338C through half-time clinical practice and either—

(i) double the period of obligated service that would otherwise be required; or

(ii) in the case of contracts entered into under section 338B, accept a minimum service obligation of 2 years with an award amount equal to 50 percent of the amount that would otherwise be payable for full-time service; and

(F) the Corps member agrees in writing that if the Corps member begins providing half-time service but fails to begin or complete the period of obligated service, the method stated in 338E(c) for determining the damages for breach of the individual's written contract will be used after converting periods of obligated service or of service performed into their full-time equivalents.

(3) In evaluating waivers issued under paragraph (1), the Secretary shall examine the effect of multidisciplinary teams.

(j) For the purposes of this subpart and subpart III:

(1) The term "Department" means the Department of Health and Human Services.

(2) The term "Loan Repayment Program" means the National Health Service Corps Loan Repayment Program established under section 338B.

(3) The term "Scholarship Program" means the National Health Service Corps Scholarship Program established under section 338A.

(4) The term "State" includes, in addition to the several States, only the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, the Virgin Islands, Guam, American Samoa, and the Trust Territory of the Pacific Islands.

(5) The terms "full time" and "full-time" mean a minimum of 40 hours per week in a clinical practice, for a minimum of 45 weeks per year.

(6) The terms "half time" and "half-time" mean a minimum of 20 hours per week (not to exceed 39 hours per week) in a clinical practice, for a minimum of 45 weeks per year.

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Subpart III—Scholarship Program and Loan Repayment Program

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SEC. 338B. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM.

(a) ESTABLISHMENT.—The Secretary shall establish a program to be known as the National Health Service Corps Loan Repayment Program to assure, with respect to the provision of primary health services pursuant to section 331(a)(2)—

- (1) an adequate supply of physicians, dentists, behavioral and mental health professionals, certified nurse midwives, certified nurse practitioners, and physician assistants; and
- (2) if needed by the Corps, an adequate supply of other health professionals.
- (b) ELIGIBILITY.—To be eligible to participate in the Loan Repayment Program, an individual must—
- (1)(A) have a degree in medicine, osteopathic medicine, dentistry, or another health profession, or an appropriate degree from a graduate program of behavioral and mental health, or be certified as a nurse midwife, nurse practitioner, or physician assistant;
- (B) be enrolled in an approved graduate training program in medicine, osteopathic medicine, dentistry, behavioral and mental health, or other health profession, *including any physician child and adolescent psychiatry residency or fellowship training program*; or
- (C) be enrolled as a full-time student—
- (i) in an accredited (as determined by the Secretary) educational institution in a State; and
- (ii) in the final year of a course of a study or program, offered by such institution and approved by the Secretary, leading to a degree in medicine, osteopathic medicine, dentistry, or other health profession;
- (2) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Service or be eligible for selection for civilian service in the Corps; and
- (3) submit to the Secretary an application for a contract described in subsection (f) (relating to the payment by the Secretary of the educational loans of the individual in consideration of the individual serving for a period of obligated service).
- (c) APPLICATION, CONTRACT, AND INFORMATION REQUIREMENTS.—
- (1) SUMMARY AND INFORMATION.—In disseminating application forms and contract forms to individuals desiring to participate in the Loan Repayment Program, the Secretary shall include with such forms—
- (A) a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under section 338E in the case of the individual's breach of the contract; and
- (B) information respecting meeting a service obligation through private practice under an agreement under section 338D and such other information as may be necessary for the individual to understand the individual's prospective participation in the Loan Repayment Program and service in the Corps.
- (2) UNDERSTANDABILITY.—The application form, contract form, and all other information furnished by the Secretary under this subpart shall be written in a manner calculated to be understood by the average individual applying to participate in the Loan Repayment Program.
- (3) AVAILABILITY.—The Secretary shall make such application forms, contract forms, and other information available to

individuals desiring to participate in the Loan Repayment Program on a date sufficiently early to ensure that such individuals have adequate time to carefully review and evaluate such forms and information.

(4) RECRUITMENT AND RETENTION.—

(A) The Secretary shall distribute to health professions schools materials providing information on the Loan Repayment Program and shall encourage the schools to disseminate the materials to the students of the schools.

(B)(i) In the case of any health professional whose period of obligated service under the Loan Repayment Program is nearing completion, the Secretary shall encourage the individual to remain in a health professional shortage area and to continue providing primary health services.

(ii) During the period in which a health professional is planning and making the transition to private practice from obligated service under the Loan Repayment Program, the Secretary may provide assistance to the professional regarding such transition if the professional is remaining in a health professional shortage area and is continuing to provide primary health services.

(C) In the case of entities to which participants in the Loan Repayment Program are assigned under section 333, the Secretary shall encourage the entities to provide options with respect to assisting the participants in remaining in the health professional shortage areas involved, and in continuing to provide primary health services, after the period of obligated service under the Loan Repayment Program is completed. The options with respect to which the Secretary provides such encouragement may include options regarding the sharing of a single employment position in the health professions by 2 or more health professionals, and options regarding the recruitment of couples where both of the individuals are health professionals.

(d)(1) Subject to section 333A, in providing contracts under the Loan Repayment Program—

(A) the Secretary shall consider the extent of the demonstrated interest of the applicants for the contracts in providing primary health services; and

(B) may consider such other factors regarding the applicants as the Secretary determines to be relevant to selecting qualified individuals to participate in such Program.

(2) In providing contracts under the Loan Repayment Program, the Secretary shall give priority—

(A) to any application for such a contract submitted by an individual whose training is in a health profession or specialty determined by the Secretary to be needed by the Corps;

(B) to any application for such a contract submitted by an individual who has (and whose spouse, if any, has) characteristics that increase the probability that the individual will continue to serve in a health professional shortage area after the period of obligated service pursuant to subsection (f) is completed; and

(C) subject to subparagraph (B), to any application for such a contract submitted by an individual who is from a disadvantaged background.

(e) APPROVAL REQUIRED FOR PARTICIPATION.—An individual becomes a participant in the Loan Repayment Program only upon the Secretary and the individual entering into a written contract described in subsection (f).

(f) CONTENTS OF CONTRACTS.—The written contract (referred to in this subpart) between the Secretary and an individual shall contain—

(1) an agreement that—

(A) subject to paragraph (3), the Secretary agrees—

(i) to pay on behalf of the individual loans in accordance with subsection (g); and

(ii) to accept (subject to the availability of appropriated funds for carrying out sections 331 through 335 and section 337) the individual into the Corps (or for equivalent service as otherwise provided in this subpart); and

(B) subject to paragraph (3), the individual agrees—

(i) to accept loan payments on behalf of the individual;

(ii) in the case of an individual described in subsection (b)(1)(C), to maintain enrollment in a course of study or training described in such subsection until the individual completes the course of study or training;

(iii) in the case of an individual described in subsection (b)(1)(C), while enrolled in such course of study or training, to maintain an acceptable level of academic standing (as determined under regulations of the Secretary by the educational institution offering such course of study or training); and

(iv) to serve for a time period (hereinafter in this subpart referred to as the “period of obligated service”) equal to 2 years or such longer period as the individual may agree to, as a provider of primary health services in a health professional shortage area (designated under section 332) to which such individual is assigned by the Secretary as a member of the Corps or released under section 338D;

(2) a provision permitting the Secretary to extend for such longer additional periods, as the individual may agree to, the period of obligated service agreed to by the individual under paragraph (1)(B)(iv), including extensions resulting in an aggregate period of obligated service in excess of 4 years;

(3) a provision that any financial obligation of the United States arising out of a contract entered into under this subpart and any obligation of the individual that is conditioned thereon, is contingent on funds being appropriated for loan repayments under this subpart and to carry out the purposes of sections 331 through 335 and sections 337 and 338;

(4) a statement of the damages to which the United States is entitled, under section 338E for the individual’s breach of the contract; and

(5) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this subpart.

(g) PAYMENTS.—

(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Loan Repayment Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for—

(A) tuition expenses;

(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual; or

(C) reasonable living expenses as determined by the Secretary.

(2) PAYMENTS FOR YEARS SERVED.—

(A) IN GENERAL.—For each year of obligated service that an individual contracts to serve under subsection (f) the Secretary may pay up to \$50,000, plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation, on behalf of the individual for loans described in paragraph (1). In making a determination of the amount to pay for a year of such service by an individual, the Secretary shall consider the extent to which each such determination—

(i) affects the ability of the Secretary to maximize the number of contracts that can be provided under the Loan Repayment Program from the amounts appropriated for such contracts;

(ii) provides an incentive to serve in health professional shortage areas with the greatest such shortages; and

(iii) provides an incentive with respect to the health professional involved remaining in a health professional shortage area, and continuing to provide primary health services, after the completion of the period of obligated service under the Loan Repayment Program.

(B) REPAYMENT SCHEDULE.—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

(3) TAX LIABILITY.—For the purpose of providing reimbursements for tax liability resulting from payments under paragraph (2) on behalf of an individual—

(A) the Secretary shall, in addition to such payments, make payments to the individual in an amount equal to 39 percent of the total amount of loan repayments made for the taxable year involved; and

(B) may make such additional payments as the Secretary determines to be appropriate with respect to such purpose.

(4) PAYMENT SCHEDULE.—The Secretary may enter into an agreement with the holder of any loan for which payments are made under the Loan Repayment Program to establish a schedule for the making of such payments.

(h) EMPLOYMENT CEILING.—Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section, while undergoing academic or other training, shall not be counted against any employment ceiling affecting the Department.

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PART Q—PROGRAMS TO IMPROVE THE HEALTH OF CHILDREN

* * * * *

SEC. 399Z-2. INFANT AND EARLY CHILDHOOD MENTAL HEALTH PROMOTION, INTERVENTION, AND TREATMENT.

(a) GRANTS.—The Secretary shall—

(1) award grants to eligible entities, including human services agencies, to develop, maintain, or enhance infant and early childhood mental health promotion, intervention, and treatment programs, including—

(A) programs for infants and children at significant risk of developing, showing early signs of, or having been diagnosed with mental disorders including serious emotional disturbance; and

(B) multigenerational therapy and other services that support the caregiving relationship; and

(2) ensure that programs funded through grants under this section are evidence-informed or evidence-based models, practices, and methods that are, as appropriate, culturally and linguistically appropriate, and can be replicated in other appropriate settings.

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

(1) ELIGIBLE CHILD.—The term “eligible child” means a child from birth to not more than 5 years of age who—

(A) is at risk for, shows early signs of, or has been diagnosed with a mental disorder, including serious emotional disturbance; and

(B) may benefit from infant and early childhood intervention or treatment programs or specialized preschool or elementary school programs that are evidence-based or that have been scientifically demonstrated to show promise but would benefit from further applied development.

(2) ELIGIBLE ENTITY.—The term “eligible entity” means a non-profit institution that—

(A) is accredited or approved by a State mental health or education agency, as applicable, to provide for children from infancy to 5 years of age mental health promotion, intervention, or treatment services that are evidence-based or that have been scientifically demonstrated to show prom-

ise but would benefit from further applied development;
and

(B) provides programs described in subsection (a) that are evidence-based or that have been scientifically demonstrated to show promise but would benefit from further applied development.

(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 INTERVENTION AND TREATMENT PROGRAMS.—An eligible entity may use amounts awarded under a grant under subsection (a)(1) to carry out the following:

(1) Provide age-appropriate mental health promotion and early intervention services or mental disorder treatment services, which may include specialized programs, for eligible children at significant risk of developing, showing early signs of, or having been diagnosed with a mental disorder, including serious emotional disturbance. Such services may include social and behavioral services as well as multigenerational therapy and other services that support the caregiving relationship.

(2) Provide training for health care professionals with expertise in infant and early childhood mental health care with respect to appropriate and relevant integration with other disciplines such as primary care clinicians, early intervention specialists, child welfare staff, home visitors, early care and education providers, and others who work with young children and families.

(3) Provide mental health consultation to personnel of early care and education programs (including licensed or regulated center-based and home-based child care, home visiting, preschool special education, and early intervention programs) who work with children and families.

(4) Provide training for mental health clinicians in infant and early childhood promising and evidence-based practices and models for mental health treatment and early intervention, including with regard to practices for identifying and treating mental and behavioral disorders of infants and children resulting from exposure or repeated exposure to adverse childhood experiences or childhood trauma.

(5) Provide age-appropriate assessment, diagnostic, and intervention services for eligible children, including early mental health promotion, intervention, and treatment services.

(e) MATCHING FUNDS.—The Secretary 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 subsection (d), to make available non-Federal contributions (in cash or in kind) toward such costs in an amount that is not less than 10 percent of the total amount of Federal funds provided in the grant.

(f) AUTHORIZATION OF APPROPRIATIONS.—To carry this section, there are authorized to be appropriated \$20,000,000 for the period of fiscal years 2018 through 2022.

* * * * *

TITLE V—SUBSTANCE ABUSE AND MENTAL HEALTH
SERVICES ADMINISTRATION

PART A—ORGANIZATION AND GENERAL AUTHORITIES

SEC. 501. SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION.

(a) **ESTABLISHMENT.**—The Substance Abuse and Mental Health Services Administration (hereafter referred to in this title as the “Administration”) is an agency of the Service.

(b) **AGENCIES.**—The following entities are agencies of the Administration:

- (1) The Center for Substance Abuse Treatment.
- (2) The Center for Substance Abuse Prevention.
- (3) The Center for Mental Health Services.
- (4) *The Center for Behavioral Health Statistics and Quality.*

[(c) **ADMINISTRATOR AND DEPUTY ADMINISTRATOR.**—

[(1) ADMINISTRATOR.—The Administration shall be headed by an Administrator (hereinafter in this title referred to as the “Administrator”) who shall be appointed by the President, by and with the advice and consent of the Senate.

[(2) DEPUTY ADMINISTRATOR.—The Administrator, with the approval of the Secretary, may appoint a Deputy Administrator and may employ and prescribe the functions of such officers and employees, including attorneys, as are necessary to administer the activities to be carried out through the Administration.]

(c) **ASSISTANT SECRETARY AND DEPUTY ASSISTANT SECRETARY.**—

(1) ASSISTANT SECRETARY.—

(A) APPOINTMENT.—*The Administration shall be headed by an official to be known as the Assistant Secretary for Mental Health and Substance Use (hereinafter in this title referred to as the “Assistant Secretary”) who shall be appointed by the President, by and with the advice and consent of the Senate.*

(B) QUALIFICATIONS.—*In selecting the Assistant Secretary, the President shall give preference to individuals who have—*

- (i) a doctoral degree in medicine, osteopathic medicine, or psychology;*
- (ii) clinical and research experience regarding mental health and substance use disorders; and*
- (iii) an understanding of biological, psychosocial, and pharmaceutical treatments of mental illness and substance use disorders.*

(2) 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, including attorneys, as are necessary to administer the activities to be carried out through the Administration.*

(d) **AUTHORITIES.**—The Secretary, acting through the [Administrator] Assistant Secretary, shall—

- (1) supervise the functions of the agencies of the Administration in order to assure that the programs carried out through each such agency receive appropriate and equitable support

and that there is cooperation among the agencies in the implementation of such programs;

(2) establish and implement, through the respective agencies, a comprehensive program to improve the provision of treatment and related services to individuals with respect to substance abuse and mental illness and to improve prevention services, promote mental health and protect the legal rights of individuals with mental illnesses and individuals who are substance abusers;

(3) carry out the administrative and financial management, policy development and planning, evaluation, knowledge dissemination, and public information functions that are required for the implementation of this title;

(4) assure that the Administration 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;

(5) support activities that will improve the provision of treatment, prevention and related services, including the development of national mental health and substance abuse goals and model programs;

(6) in cooperation with the National Institutes of Health, the Centers for Disease Control and the Health Resources and Services Administration develop educational materials and intervention strategies to reduce the risks of HIV or tuberculosis among substance abusers and individuals with mental illness and to develop appropriate mental health services for individuals with such illnesses;

(7) coordinate Federal policy with respect to the provision of treatment services for substance abuse utilizing anti-addiction medications, including methadone;

(8) conduct programs, and assure the coordination of such programs with activities of the National Institutes of Health and the Agency for Health Care Policy Research, as appropriate, to evaluate the process, outcomes and community impact of treatment and prevention services and systems of care in order to identify the manner in which such services can most effectively be provided;

(9) collaborate with the Director of the National Institutes of Health in the development of a system by which the relevant research findings of the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the National Institute of Mental Health, and, as appropriate, the Agency for Health Care Policy Research are disseminated to service providers in a manner designed to improve the delivery and effectiveness of treatment and prevention services;

(10) encourage public and private entities that provide health insurance to provide benefits for substance abuse and mental health services;

(11) promote the integration of substance abuse and mental health services into the mainstream of the health care delivery system of the United States;

(12) monitor compliance by hospitals and other facilities with the requirements of sections 542 and 543;

(13) with respect to grant programs authorized under this title, assure that—

(A) all grants that are awarded for the provision of services are subject to performance and outcome evaluations; and

(B) all grants that are awarded to entities other than States are awarded only after the State in which the entity intends to provide services—

(i) is notified of the pendency of the grant application; and

(ii) is afforded an opportunity to comment on the merits of the application;

(14) assure that services provided with amounts appropriated under this title are provided bilingually, if appropriate;

(15) improve coordination among prevention programs, treatment facilities and nonhealth care systems such as employers, labor unions, and schools, and encourage the adoption of employee assistance programs and student assistance programs;

(16) maintain a clearinghouse for substance abuse and mental health information to assure the widespread dissemination of such information to States, political subdivisions, educational agencies and institutions, treatment providers, and the general public;

(17) in collaboration with the National Institute on Aging, and in consultation with the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism and the National Institute of Mental Health, as appropriate, promote and evaluate substance abuse services for older Americans in need of such services, and mental health services for older Americans who are seriously mentally ill; **[and]**

(18) promote the coordination of service programs conducted by other departments, agencies, organizations and individuals that are or may be related to the problems of individuals suffering from mental illness or substance abuse, including liaisons with the Social Security Administration, Centers for Medicare & Medicaid Services, and other programs of the Department, as well as liaisons with the Department of Education, Department of Justice, and other Federal Departments and offices, as appropriate**[.]**;

(19) evaluate, in consultation with the Assistant Secretary for Financial Resources, the information used for oversight of grants under programs related to mental and substance use disorders, including co-occurring disorders, administered by the Center for Mental Health Services;

(20) periodically review Federal programs and activities relating to the diagnosis or prevention of, or treatment or rehabilitation for, mental illness and substance use disorders to identify any such programs or activities that have proven to be effective or efficient in improving outcomes or increasing access to evidence-based programs;

(21) establish standards for the appointment of peer-review panels to evaluate grant applications and recommend standards for mental health grant programs; and

(22) in consultation with the National Mental Health and Substance Use Policy Laboratory, and after providing an oppor-

tunity for public input, set standards for grant programs under this title for mental health and substance use services, which may address—

(A) the capacity of the grantee to implement the award;

(B) requirements for the description of the program implementation approach;

(C) the extent to which the grant plan submitted by the grantee as part of its application must explain how the grantee will reach the population of focus and provide a statement of need, including to what extent the grantee will increase the number of clients served and the estimated percentage of clients receiving services who report positive functioning after 6 months or no past-month substance use, as applicable;

(D) the extent to which the grantee must collect and report on required performance measures; and

(E) the extent to which the grantee is proposing evidence-based practices and the extent to which—

(i) 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; or

(ii) if no evidence-based practice exists for a population of focus, the way in which the grantee will implement adaptations of evidence-based practices, promising practices, or cultural practices.

(e) ASSOCIATE ADMINISTRATOR FOR ALCOHOL PREVENTION AND TREATMENT POLICY.—

(1) IN GENERAL.—There may be in the Administration an Associate Administrator for Alcohol Prevention and Treatment Policy to whom the [Administrator] *Assistant Secretary* may delegate the functions of promoting, monitoring, and evaluating service programs for the prevention and treatment of alcoholism and alcohol abuse within the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment and the Center for Mental Health Services, and coordinating such programs among the Centers, and among the Centers and other public and private entities. The Associate Administrator also may ensure that alcohol prevention, education, and policy strategies are integrated into all programs of the Centers that address substance abuse prevention, education, and policy, and that the Center for Substance Abuse Prevention addresses the Healthy People 2010 goals and the National Dietary Guidelines of the Department of Health and Human Services and the Department of Agriculture related to alcohol consumption.

(2) PLAN.—

(A) The [Administrator] *Assistant Secretary*, acting through the Associate Administrator for Alcohol Prevention and Treatment Policy, shall develop, and periodically review and as appropriate revise, a plan for programs and policies to treat and prevent alcoholism and alcohol abuse. The plan shall be developed (and reviewed and revised) in collaboration with the Directors of the Centers of the Administration and in consultation with members of other Federal agencies and public and private entities.

(B) Not later than 1 year after the date of the enactment of the ADAMHA Reorganization Act, the [Administrator] *Assistant Secretary* shall submit to the Congress the first plan developed under subparagraph (A).

(3) REPORT.—

(A) Not less than once during each 2 years, the [Administrator] *Assistant Secretary*, acting through the Associate Administrator for Alcohol Prevention and Treatment Policy, shall prepare a report describing the alcoholism and alcohol abuse prevention and treatment programs undertaken by the Administration and its agencies, and the report shall include a detailed statement of the expenditures made for the activities reported on and the personnel used in connection with such activities.

(B) Each report under subparagraph (A) shall include a description of any revisions in the plan under paragraph (2) made during the preceding 2 years.

(C) Each report under subparagraph (A) shall be submitted to the [Administrator] *Assistant Secretary* for inclusion in the biennial report under subsection (k).

(f) ASSOCIATE ADMINISTRATOR FOR WOMEN'S SERVICES.—

(1) APPOINTMENT.—The [Administrator] *Assistant Secretary*, with the approval of the Secretary, shall appoint an Associate Administrator for Women's Services who shall report directly to the [Administrator] *Assistant Secretary*.

(2) DUTIES.—The Associate Administrator appointed under paragraph (1) shall—

(A) establish a committee to be known as the Coordinating Committee for Women's Services (hereafter in this subparagraph referred to as the "Coordinating Committee"), which shall be composed of the Directors of the agencies of the Administration (or the designees of the Directors);

(B) acting through the Coordinating Committee, with respect to women's substance abuse and mental health services—

(i) identify the need for such services, and make an estimate each fiscal year of the funds needed to adequately support the services;

(ii) identify needs regarding the coordination of services;

(iii) encourage the agencies of the Administration to support such services; and

(iv) assure that the unique needs of minority women, including Native American, Hispanic, African-American and Asian women, are recognized and addressed within the activities of the Administration; and

(C) establish an advisory committee to be known as the Advisory Committee for Women's Services, which shall be composed of not more than 10 individuals, a majority of whom shall be women, who are not officers or employees of the Federal Government, to be appointed by the [Administrator] *Assistant Secretary* from among physicians, practitioners, treatment providers, and other health pro-

professionals, whose clinical practice, specialization, or professional expertise includes a significant focus on women's substance abuse and mental health conditions, that shall—

(i) advise the Associate Administrator on appropriate activities to be undertaken by the agencies of the Administration with respect to women's substance abuse and mental health services, including services which require a multidisciplinary approach;

(ii) collect and review data, including information provided by the Secretary (including the material referred to in paragraph (3)), and report biannually to the [Administrator] *Assistant Secretary* regarding the extent to which women are represented among senior personnel, and make recommendations regarding improvement in the participation of women in the workforce of the Administration; and

(iii) prepare, for inclusion in the biennial report required pursuant to subsection (k), a description of activities of the Committee, including findings made by the Committee regarding—

(I) the extent of expenditures made for women's substance abuse and mental health services by the agencies of the Administration; and

(II) the estimated level of funding needed for substance abuse and mental health services to meet the needs of women;

(D) improve the collection of data on women's health by—

(i) reviewing the current data at the Administration to determine its uniformity and applicability;

(ii) developing standards for all programs funded by the Administration so that data are, to the extent practicable, collected and reported using common reporting formats, linkages and definitions; and

(iii) reporting to the [Administrator] *Assistant Secretary* a plan for incorporating the standards developed under clause (ii) in all Administration programs and a plan to assure that the data so collected are accessible to health professionals, providers, researchers, and members of the public; and

(E) shall establish, maintain, and operate a program to provide information on women's substance abuse and mental health services.

(3) STUDY.—

(A) The Secretary, acting through the Assistant Secretary for Personnel, shall conduct a study to evaluate the extent to which women are represented among senior personnel at the Administration.

(B) Not later than 90 days after the date of the enactment of the ADAMHA Reorganization Act, the Assistant Secretary for Personnel shall provide the Advisory Committee for Women's Services with a study plan, including the methodology of the study and any sampling frames. Not later than 180 days after such date of enactment, the Assistant Secretary shall prepare and submit directly to

the Advisory Committee a report concerning the results of the study conducted under subparagraph (A).

(C) The Secretary shall prepare and provide to the Advisory Committee for Women's Services any additional data as requested.

(4) OFFICE.—Nothing in this subsection shall be construed to preclude the Secretary from establishing within the Substance Abuse and Mental Health Administration an Office of Women's Health.

(5) DEFINITION.—For purposes of this subsection, the term “women's substance abuse and mental health conditions”, with respect to women of all age, ethnic, and racial groups, means all aspects of substance abuse and mental illness—

(A) unique to or more prevalent among women; or

(B) with respect to which there have been insufficient services involving women or insufficient data.

(g) SERVICES OF EXPERTS.—

(1) IN GENERAL.—The [Administrator] *Assistant Secretary* may obtain (in accordance with section 3109 of title 5, United States Code, but without regard to the limitation in such section on the number of days or the period of service) the services of not more than 20 experts or consultants who have professional qualifications. Such experts and consultants shall be obtained for the Administration and for each of its agencies.

(2) COMPENSATION AND EXPENSES.—

(A) Experts and consultants whose services are obtained under paragraph (1) shall be paid or reimbursed for their expenses associated with traveling to and from their assignment location in accordance with sections 5724, 5724a(a), 5724a(c), and 5726(c) of title 5, United States Code.

(B) Expenses specified in subparagraph (A) may not be allowed in connection with the assignment of an expert or consultant whose services are obtained under paragraph (1), unless and until the expert or consultant agrees in writing to complete the entire period of assignment or one year, whichever is shorter, unless separated or reassigned for reasons beyond the control of the expert or consultant that are acceptable to the Secretary. If the expert or consultant violates the agreement, the money spent by the United States for the expenses specified in subparagraph (A) is recoverable from the expert or consultant as a debt of the United States. The Secretary may waive in whole or in part a right of recovery under this subparagraph.

(h) PEER REVIEW GROUPS.—The [Administrator] *Assistant Secretary* shall, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates, establish such peer review groups and program advisory committees as are needed to carry out the requirements of this title and appoint and pay members of such groups, except that officers and employees of the United States shall not receive additional compensation for services as members of such groups.

The Federal Advisory Committee Act shall not apply to the duration of a peer review group appointed under this subsection.

(i) VOLUNTARY SERVICES.—The [Administrator] Assistant Secretary may accept voluntary and uncompensated services.

(j) ADMINISTRATION.—The [Administrator] Assistant Secretary shall ensure that programs and activities assigned under this title to the Administration are fully administered by the respective Centers to which such programs and activities are assigned.

(k) REPORT CONCERNING ACTIVITIES AND PROGRESS.—Not later than February 10, 1994, and once every 2 years thereafter, the [Administrator] Assistant Secretary shall prepare and submit to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, the report containing—

(1) a description of the activities carried out by the Administration;

(2) a description of any measurable progress made in improving the availability and quality of substance abuse and mental health services;

(3) a description of the mechanisms by which relevant research findings of the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute of Mental Health have been disseminated to service providers or otherwise utilized by the Administration to further the purposes of this title; and

(4) any report required in this title to be submitted to the Administrator for inclusion in the report under this subsection.

(l) STRATEGIC PLAN.—

(1) IN GENERAL.—Not later than December 1, 2017, and every 5 years thereafter, the Assistant Secretary shall develop and carry out a strategic plan in accordance with this subsection for the planning and operation of evidence-based programs and grants carried out by the Administration.

(2) COORDINATION.—In developing and carrying out the strategic plan under this section, the Assistant Secretary shall take into consideration the report of the Interdepartmental Serious Mental Illness Coordinating Committee under section 301 of the Helping Families in Mental Health Crisis Act of 2016.

(3) PUBLICATION OF PLAN.—Not later than December 1, 2017, and every 5 years thereafter, the Assistant Secretary shall—

(A) submit the strategic plan developed under paragraph

(1) to the appropriate committees of Congress; and

(B) post such plan on the Internet website of the Administration.

(4) CONTENTS.—The strategic plan developed under paragraph (1) shall—

(A) identify strategic priorities, goals, and measurable objectives for mental and substance use disorder activities and programs operated and supported by the Administration, including priorities to prevent or eliminate the burden of mental illness and substance use disorders;

(B) identify ways to improve services for individuals with a mental or substance use disorder, including services related to the prevention of, diagnosis of, intervention in, treatment of, and recovery from, mental or substance use

disorders, including serious mental illness or serious emotional disturbance, and access to services and supports for individuals with a serious mental illness or serious emotional disturbance;

(C) ensure that programs provide, as appropriate, access to effective and evidence-based prevention, diagnosis, intervention, treatment, and recovery services, including culturally and linguistically appropriate services, as appropriate, for individuals with a mental or substance use disorder;

(D) identify opportunities to collaborate with the Health Resources and Services Administration to develop or improve—

(i) initiatives to encourage individuals to pursue careers (especially in rural and underserved areas and populations) as psychiatrists, psychologists, psychiatric nurse practitioners, physician assistants, occupational therapists, clinical social workers, certified peer support specialists, licensed professional counselors, or other licensed or certified mental health professionals, including such professionals specializing in the diagnosis, evaluation, or treatment of individuals with a serious mental illness or serious emotional disturbance; and

(ii) a strategy to improve the recruitment, training, and retention of a workforce for the treatment of individuals with mental or substance use disorders, or co-occurring disorders;

(E) identify opportunities to improve collaboration with States, local governments, communities, and Indian tribes and tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)); and

(F) specify a strategy to disseminate evidenced-based and promising best practices related to prevention, diagnosis, early intervention, treatment, and recovery services related to mental illness, particularly for individuals with a serious mental illness and children and adolescents with a serious emotional disturbance, and substance use disorders.

[(1)] *(m) APPLICATIONS FOR GRANTS AND CONTRACTS.—With respect to awards of grants, cooperative agreements, and contracts under this title, the [Administrator] Assistant Secretary, or the Director of the Center involved, as the case may be, may not make such an award unless—*

(1) an application for the award is submitted to the official involved;

(2) with respect to carrying out the purpose for which the award is to be provided, the application provides assurances of compliance satisfactory to such official; and

(3) the application is otherwise in such form, is made in such manner, and contains such agreements, assurances, and information as the official determines to be necessary to carry out the purpose for which the award is to be provided.

[(m)] *(n) EMERGENCY RESPONSE.—*

(1) **IN GENERAL.**—Notwithstanding section 504 and except as provided in paragraph (2), the Secretary may use not to exceed 2.5 percent of all amounts appropriated under this title for a fiscal year to make noncompetitive grants, contracts or cooperative agreements to public entities to enable such entities to address emergency substance abuse or mental health needs in local communities.

(2) **EXCEPTIONS.**—Amounts appropriated under part C shall not be subject to paragraph (1).

(3) **EMERGENCIES.**—The Secretary shall establish criteria for determining that a substance abuse or mental health emergency exists and publish such criteria in the Federal Register prior to providing funds under this subsection.

[(n)] (o) LIMITATION ON THE USE OF CERTAIN INFORMATION.—No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under section 505 may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose. Such information may not be published or released in other form if the person who supplied the information or who is described in it is identifiable unless such person has consented (as determined under regulations of the Secretary) to its publication or release in other form.

[(o)] (p) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of providing grants, cooperative agreements, and contracts under this section, there are authorized to be appropriated \$25,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003.

SEC. 501A. IMPROVING OVERSIGHT OF MENTAL HEALTH AND SUBSTANCE USE PROGRAMS.

(a) ACTIVITIES.—*For the purpose of ensuring efficient and effective planning and evaluation of mental and substance use disorder programs and related activities, the Assistant Secretary for Planning and Evaluation, in consultation with the Assistant Secretary for Mental Health and Substance Use, shall—*

(1) collect and organize relevant data on homelessness, involvement with the criminal justice system, hospitalizations, mortality outcomes, and other measures the Secretary deems appropriate from across Federal departments and agencies;

(2) evaluate programs related to mental and substance use disorders, including co-occurring disorders, across Federal departments and agencies, as appropriate, including programs related to—

(A) prevention, intervention, treatment, and recovery support services, including such services for individuals with a serious mental illness or serious emotional disturbance;

(B) the reduction of homelessness and involvement with the criminal justice system among individuals with a mental or substance use disorder; and

(C) public health and health services; and

(3) consult, as appropriate, with the Assistant Secretary, the Behavioral Health Coordinating Council of the Department of Health and Human Services, other agencies within the Depart-

ment of Health and Human Services, and other relevant Federal departments.

(b) *RECOMMENDATIONS.*—The Assistant Secretary for Planning and Evaluation shall develop an evaluation strategy that identifies priority programs to be evaluated by the Assistant Secretary and priority programs to be evaluated by other relevant agencies within the Department of Health and Human Services. The Assistant Secretary for Planning and Evaluation shall provide recommendations on improving programs and activities based on the evaluation described in subsection (a)(2) as needing improvement.

SEC. 501B. NATIONAL MENTAL HEALTH AND SUBSTANCE USE POLICY LABORATORY.

(a) *IN GENERAL.*—There shall be established within the Administration a National Mental Health and Substance Use Policy Laboratory (referred to in this section as the “Laboratory”).

(b) *RESPONSIBILITIES.*—The Laboratory shall—

(1) continue to carry out the authorities and activities that were in effect for the Office of Policy, Planning, and Innovation as such Office existed prior to the date of enactment of the Helping Families in Mental Health Crisis Act of 2016;

(2) identify, coordinate, and facilitate the implementation of policy changes likely to have a significant effect on mental health, mental illness, and the prevention and treatment of substance use disorder services;

(3) collect, as appropriate, information from grantees under programs operated by the Administration in order to evaluate and disseminate information on evidence-based practices, including culturally and linguistically appropriate services, as appropriate, and service delivery models;

(4) provide leadership in identifying and coordinating policies and programs, including evidence-based programs, related to mental and substance use disorders;

(5) recommend ways in which payers may implement program and policy findings of the Administration and the Laboratory to improve outcomes and reduce per capita program costs;

(6) in consultation with the Assistant Secretary for Planning and Evaluation, as appropriate, periodically review Federal programs and activities relating to the diagnosis or prevention of, or treatment or rehabilitation for, mental illness and substance use disorders, including by—

(A) identifying any such programs or activities that are duplicative;

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

(C) formulating recommendations for coordinating, eliminating, or improving programs or activities identified under subparagraph (A) or (B) and merging such programs or activities into other successful programs or activities; and

(7) carry out other activities as deemed necessary to continue to encourage innovation and disseminate evidence-based programs and practices, including programs and practices with scientific merit.

(c) *EVIDENCE-BASED PRACTICES AND SERVICE DELIVERY MODELS.*—

(1) *IN GENERAL.*—*In selecting evidence-based best practices and service delivery models for evaluation and dissemination, the Laboratory—*

(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 or serious emotional disturbance, 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.*

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

(3) *CONSULTATION.*—*In carrying out the duties under this subsection, the Laboratory shall consult with—*

(A) *representatives of the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism, on an ongoing basis;*

(B) *other appropriate Federal agencies;*

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

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

(d) *PROMOTING INNOVATION.*—

(1) *IN GENERAL.*—*The Assistant Secretary, in coordination with the Laboratory, may award grants to States, local governments, Indian tribes or tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act), educational institutions, and nonprofit organizations to develop evidence-based interventions, including culturally and linguistically appropriate services, as appropriate, for—*

(A) *evaluating a model that has been scientifically demonstrated to show promise, but would benefit from further applied development, for—*

(i) *enhancing the prevention, diagnosis, intervention, treatment, and recovery of mental illness, serious emotional disturbance, substance use disorders, and co-occurring disorders; or*

(ii) *integrating or coordinating physical health services and mental and substance use disorder services; and*

(B) *expanding, replicating, or scaling evidence-based programs across a wider area to enhance effective screening, early diagnosis, intervention, and treatment with respect to mental illness, serious mental illness, and serious emotional disturbance, primarily by—*

(i) *applying delivery of care, including training staff in effective evidence-based treatment; or*

(ii) *integrating models of care across specialties and jurisdictions.*

(2) *CONSULTATION.—In awarding grants under this paragraph, the Assistant Secretary shall, as appropriate, consult with the advisory councils described in section 502, the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism, as appropriate.*

(3) *AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated—*

(A) *to carry out paragraph (1)(A), \$7,000,000 for the period of fiscal years 2018 through 2020; and*

(B) *to carry out paragraph (1)(B), \$7,000,000 for the period of fiscal years 2018 through 2020.*

ADVISORY COUNCILS

SEC. 502. (a) **APPOINTMENT.**—

(1) **IN GENERAL.**—The Secretary shall appoint an advisory council for—

(A) the Substance Abuse and Mental Health Services Administration;

(B) the Center for Substance Abuse Treatment;

(C) the Center for Substance Abuse Prevention; **[and]**

(D) the Center for Mental Health Services**【.】**; and

(E) *the Center for Behavioral Health Statistics and Quality.*

Each such advisory council shall advise, consult with, and make recommendations to the Secretary and the **【Administrator】** Assistant Secretary or Director of the Administration or Center for which the advisory council is established concerning matters relating to the activities carried out by and through the Administration or Center and the policies respecting such activities.

(2) **FUNCTION AND ACTIVITIES.**—An advisory council—

(A)(i) may on the basis of the materials provided by the organization respecting activities conducted at the organization, make recommendations to the **【Administrator】** Assistant Secretary or Director of the Administration or Center for which it was established respecting such activities;

(ii) shall review applications submitted for grants and cooperative agreements for activities for which advisory council approval is required under section 504(d)(2) and recommend for approval applications for projects that show promise of making valuable contributions to the Administration's mission; and

(iii) may review any grant, contract, or cooperative agreement proposed to be made or entered into by the organization;

(B) may collect, by correspondence or by personal investigation, information as to studies and services that are being carried on in the United States or any other country as to the diseases, disorders, or other aspects of human health with respect to which the organization was established and with the approval of the **[Administrator]** *Assistant Secretary* or Director, whichever is appropriate, make such information available through appropriate publications for the benefit of public and private health entities and health professions personnel and for the information of the general public; and

(C) may appoint subcommittees and convene workshops and conferences.

(b) MEMBERSHIP.—

(1) IN GENERAL.—Each advisory council shall consist of non-voting ex officio members and not more than 12 members to be appointed by the Secretary under paragraph (3).

(2) EX OFFICIO MEMBERS.—The ex officio members of an advisory council shall consist of—

(A) the Secretary;

(B) the **[Administrator]** *Assistant Secretary*;

(C) the Director of the Center for which the council is established;

(D) the Under Secretary for Health of the Department of Veterans Affairs;

(E) the Assistant Secretary for Defense for Health Affairs (or the designates of such officers); **[and]**

(F) for the advisory councils appointed under subsections (a)(1)(A) and (a)(1)(D), the Director of the National Institute of Mental Health;

(G) for the advisory councils appointed under subsections (a)(1)(A), (a)(1)(B), and (a)(1)(C), the Director of the National Institute on Drug Abuse;

(H) for the advisory councils appointed under subsections (a)(1)(A), (a)(1)(B), and (a)(1)(C), the Director of the National Institute on Alcohol Abuse and Alcoholism; and

[(F)] (I) such additional officers or employees of the United States as the Secretary determines necessary for the advisory council to effectively carry out its functions.

(3) APPOINTED MEMBERS.—Individuals shall be appointed to an advisory council under paragraph (1) as follows:

(A) Nine of the members shall be appointed by the Secretary from among the leading representatives of the health disciplines (including public health and behavioral and social sciences) relevant to the activities of the Administration or Center for which the advisory council is established.

(B) Three of the members shall be appointed by the Secretary from the general public and shall include leaders in fields of public policy, public relations, law, health policy economics, or management.

(C) *Not less than half of the members of the advisory council appointed under subsection (a)(1)(D)—*

(i) shall have—

(I) a medical degree;

- (II) a doctoral degree in psychology; or
 (III) an advanced degree in nursing or social work from an accredited graduate school or be a certified physician assistant; and
 (ii) shall specialize in the mental health field.

(4) COMPENSATION.—Members of an advisory council who are officers or employees of the United States shall not receive any compensation for service on the advisory council. The remaining members of an advisory council shall receive, for each day (including travel time) they are engaged in the performance of the functions of the advisory council, compensation at rates not to exceed the daily equivalent to the annual rate in effect for grade GS-18 of the General Schedule.

(c) TERMS OF OFFICE.—

(1) IN GENERAL.—The term of office of a member of an advisory council appointed under subsection (b) shall be 4 years, except that any member appointed to fill a vacancy for an unexpired term shall serve for the remainder of such term. The Secretary shall make appointments to an advisory council in such a manner as to ensure that the terms of the members not all expire in the same year. A member of an advisory council may serve after the expiration of such member's term until a successor has been appointed and taken office.

(2) REAPPOINTMENTS.—A member who has been appointed to an advisory council for a term of 4 years may not be reappointed to an advisory council during the 2-year period beginning on the date on which such 4-year term expired.

(3) TIME FOR APPOINTMENT.—If a vacancy occurs in an advisory council among the members under subsection (b), the Secretary shall make an appointment to fill such vacancy within 90 days from the date the vacancy occurs.

(d) CHAIR.—The Secretary shall select a member of an advisory council to serve as the chair of the council. The Secretary may so select an individual from among the appointed members, or may select the **[Administrator]** *Assistant Secretary* or the Director of the Center involved. The term of office of the chair shall be 2 years.

(e) MEETINGS.—An advisory council shall meet at the call of the chairperson or upon the request of the **[Administrator]** *Assistant Secretary* or Director of the Administration or Center for which the advisory council is established, but in no event less than 2 times during each fiscal year. The location of the meetings of each advisory council shall be subject to the approval of the **[Administrator]** *Assistant Secretary* or Director of Administration or Center for which the council was established.

(f) EXECUTIVE SECRETARY AND STAFF.—The **[Administrator]** *Assistant Secretary* or Director of the Administration or Center for which the advisory council is established shall designate a member of the staff of the Administration or Center for which the advisory council is established to serve as the Executive Secretary of the advisory council. The **[Administrator]** *Assistant Secretary* or Director shall make available to the advisory council such staff, information, and other assistance as it may require to carry out its functions. The **[Administrator]** *Assistant Secretary* or Director shall provide orientation and training for new members of the advisory council

to provide for their effective participation in the functions of the advisory council.

* * * * *

SEC. 504. PEER REVIEW.

(a) **IN GENERAL.**—The Secretary, after consultation with the [Administrator] *Assistant Secretary*, shall require appropriate peer review of grants, cooperative agreements, and contracts to be administered through the agency which exceed the simple acquisition threshold as defined in section 4(11) of the Office of Federal Procurement Policy Act.

(b) **MEMBERS.**—The members of any peer review group established under subsection (a) shall be individuals who by virtue of their training or experience are eminently qualified to perform the review functions of the group. Not more than one-fourth of the members of any such peer review group shall be officers or employees of the United States. *In the case of any such peer review group that is reviewing a grant, cooperative agreement, or contract related to mental illness treatment, not less than half of the members of such peer review group shall be licensed and experienced professionals in the prevention, diagnosis, or treatment of, or recovery from, mental or substance use disorders and have a medical degree, a doctoral degree in psychology, or an advanced degree in nursing or social work from an accredited program.*

(c) **ADVISORY COUNCIL REVIEW.**—If the direct cost of a grant or cooperative agreement (described in subsection (a)) exceeds the simple acquisition threshold as defined by section 4(11) of the Office of Federal Procurement Policy Act, the Secretary may make such a grant or cooperative agreement only if such grant or cooperative agreement is recommended—

- (1) after peer review required under subsection (a); and
- (2) by the appropriate advisory council.

(d) **CONDITIONS.**—The Secretary may establish limited exceptions to the limitations contained in this section regarding participation of Federal employees and advisory council approval. The circumstances under which the Secretary may make such an exception shall be made public.

DATA COLLECTION

SEC. 505. (a) The Secretary, acting through the [Administrator] *Assistant Secretary*, shall collect data each year on—

- (1) the national incidence and prevalence of the various forms of mental illness and substance abuse; and
- (2) the incidence and prevalence of such various forms in major metropolitan areas selected by the [Administrator] *Assistant Secretary*.

(b) With respect to the activities of the [Administrator] *Assistant Secretary* under subsection (a) relating to mental health, the [Administrator] *Assistant Secretary* shall ensure that such activities include, at a minimum, the collection of data on—

- (1) the number and variety of public and nonprofit private treatment programs;
- (2) the number and demographic characteristics of individuals receiving treatment through such programs;
- (3) the type of care received by such individuals; and

(4) such other data as may be appropriate.

(c)(1) With respect to the activities of the **[Administrator]** *Assistant Secretary* under subsection (a) relating to substance abuse, the **[Administrator]** *Assistant Secretary* shall ensure that such activities include, at a minimum, the collection of data on—

(A) the number of individuals admitted to the emergency rooms of hospitals as a result of the abuse of alcohol or other drugs;

(B) the number of deaths occurring as a result of substance abuse, as indicated in reports by coroners;

(C) the number and variety of public and private nonprofit treatment programs, including the number and type of patient slots available;

(D) the number of individuals seeking treatment through such programs, the number and demographic characteristics of individuals receiving such treatment, the percentage of individuals who complete such programs, and, with respect to individuals receiving such treatment, the length of time between an individual's request for treatment and the commencement of treatment;

(E) the number of such individuals who return for treatment after the completion of a prior treatment in such programs and the method of treatment utilized during the prior treatment;

(F) the number of individuals receiving public assistance for such treatment programs;

(G) the costs of the different types of treatment modalities for drug and alcohol abuse and the aggregate relative costs of each such treatment modality provided within a State in each fiscal year;

(H) to the extent of available information, the number of individuals receiving treatment for alcohol or drug abuse who have private insurance coverage for the costs of such treatment;

(I) the extent of alcohol and drug abuse among high school students and among the general population; and

(J) the number of alcohol and drug abuse counselors and other substance abuse treatment personnel employed in public and private treatment facilities.

(2) Annual surveys shall be carried out in the collection of data under this subsection. Summaries and analyses of the data collected shall be made available to the public.

(d) After consultation with the States and with appropriate national organizations, the **[Administrator]** *Assistant Secretary* shall develop uniform criteria for the collection of data, using the best available technology, pursuant to this section.

* * * * *

SEC. 506B. GRANTS FOR ECSTASY AND OTHER CLUB DRUGS ABUSE PREVENTION.

(a) **AUTHORITY.**—The **[Administrator]** *Assistant Secretary* may make grants to, and enter into contracts and cooperative agreements with, public and nonprofit private entities to enable such entities—

(1) to carry out school-based programs concerning the dangers of the abuse of and addiction to 3,4-methylenedioxy meth-

amphetamine, related drugs, and other drugs commonly referred to as “club drugs” using methods that are effective and science-based, including initiatives that give students the responsibility to create their own anti-drug abuse education programs for their schools; and

(2) to carry out community-based abuse and addiction prevention programs relating to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs that are effective and science-based.

(b) USE OF FUNDS.—Amounts made available under a grant, contract or cooperative agreement under subsection (a) shall be used for planning, establishing, or administering prevention programs relating to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs.

(c) USE OF FUNDS.—

(1) DISCRETIONARY FUNCTIONS.—Amounts provided to an entity under this section may be used—

(A) to carry out school-based programs that are focused on those districts with high or increasing rates of abuse and addiction to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs and targeted at populations that are most at risk to start abusing these drugs;

(B) to carry out community-based prevention programs that are focused on those populations within the community that are most at-risk for abuse of and addiction to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs;

(C) to assist local government entities to conduct appropriate prevention activities relating to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs;

(D) to train and educate State and local law enforcement officials, prevention and education officials, health professionals, members of community anti-drug coalitions and parents on the signs of abuse of and addiction to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs and the options for treatment and prevention;

(E) for planning, administration, and educational activities related to the prevention of abuse of and addiction to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs;

(F) for the monitoring and evaluation of prevention activities relating to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs and reporting and disseminating resulting information to the public; and

(G) for targeted pilot programs with evaluation components to encourage innovation and experimentation with new methodologies.

(2) PRIORITY.—The **Administrator** *Assistant Secretary* shall give priority in awarding grants under this section to rural and urban areas that are experiencing a high rate or rapid increases in abuse and addiction to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs.

(d) ALLOCATION AND REPORT.—

(1) PREVENTION PROGRAM ALLOCATION.—Not less than \$500,000 of the amount appropriated in each fiscal year to carry out this section shall be made available to the [Administrator] *Assistant Secretary*, acting in consultation with other Federal agencies, to support and conduct periodic analyses and evaluations of effective prevention programs for abuse of and addiction to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs and the development of appropriate strategies for disseminating information about and implementing such programs.

(2) REPORT.—The [Administrator] *Assistant Secretary* shall annually prepare and submit to the Committee on Health, Education, Labor, and Pensions, the Committee on the Judiciary, and the Committee on Appropriations of the Senate, and the Committee on Commerce, the Committee on the Judiciary, and the Committee on Appropriations of the House of Representatives, a report containing the results of the analyses and evaluations conducted under paragraph (1).

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section—

(1) \$10,000,000 for fiscal year 2001; and

(2) such sums as may be necessary for each succeeding fiscal year.

PART B—CENTERS AND PROGRAMS

Subpart 1—Center for Substance Abuse Treatment

CENTER FOR SUBSTANCE ABUSE TREATMENT

SEC. 507. (a) ESTABLISHMENT.—There is established in the Administration a Center for Substance Abuse Treatment (hereafter in this section referred to as the “Center”). The Center shall be headed by a Director (hereafter in this section referred to as the “Director”) appointed by the Secretary from among individuals with extensive experience or academic qualifications in the [treatment of substance abuse] *treatment of substance use disorders* or in the evaluation of substance [abuse treatment systems] *use disorder treatment systems*.

(b) DUTIES.—The Director of the Center shall—

(1) administer the substance abuse treatment block grant program authorized in section 1921;

(2) ensure that emphasis is placed on children and adolescents in the development of treatment programs;

(3) collaborate with the Attorney General to develop programs to provide substance [abuse] *use disorder* treatment services to individuals who have had contact with the Justice system, especially adolescents;

(4) collaborate with the Director of the Center for Substance Abuse Prevention in order to provide outreach services to identify individuals in need of treatment services, with emphasis on the provision of such services to pregnant and postpartum women and their infants and to [individuals who abuse drugs] *individuals who use drugs* intravenously;

(5) collaborate with the Director of the National Institute on Drug Abuse, with the Director of the National Institute on Al-

cohol Abuse and Alcoholism, and with the States to promote the study, dissemination, and implementation of research findings that will improve the delivery and effectiveness of treatment services;

(6) collaborate with the Administrator of the Health Resources and Services Administration and the Administrator of the Centers for Medicare & Medicaid Services to promote the increased integration into the mainstream of the health care system of the United States of programs for providing treatment services;

(7) evaluate plans submitted by the States pursuant to section 1932(a)(6) in order to determine whether the plans adequately provide for the availability, allocation, and effectiveness of treatment services;

(8) sponsor regional workshops on improving the quality and availability of treatment services;

(9) provide technical assistance to public and nonprofit private entities that provide treatment services, including technical assistance with respect to the process of submitting to the Director applications for any program of grants or contracts [carried out by the Director];

[(10) encourage the States to expand the availability (relative to fiscal year 1992) of programs providing treatment services through self-run, self-supported recovery based on the programs of housing operated pursuant to section 1925;]

[(11)] (10) carry out activities to educate individuals on the need for establishing treatment facilities within their communities;

[(12)] (11) encourage public and private entities that provide health insurance to provide benefits for outpatient treatment services and other nonhospital-based treatment services;

[(13)] (12) evaluate treatment programs to determine the quality and appropriateness of various forms of treatment, which shall be carried out through grants, contracts, or cooperative agreements provided to public or nonprofit private entities[; and];

[(14) in carrying out paragraph (13), assess the quality, appropriateness, and costs of various treatment forms for specific patient groups.]

(13) *ensure the consistent documentation of the application of criteria when awarding grants and the ongoing oversight of grantees after such grants are awarded; and*

(14) *work with States, providers, and individuals in recovery, and their families, to promote the expansion of recovery support services and systems of care oriented towards recovery.*

(c) GRANTS AND CONTRACTS.—In carrying out the duties established in subsection (b), the Director may make grants to and enter into contracts and cooperative agreements with public and nonprofit private entities.

RESIDENTIAL TREATMENT PROGRAMS FOR PREGNANT AND
POSTPARTUM WOMEN

SEC. 508. (a) IN GENERAL.—The Director of the Center for Substance Abuse Treatment shall provide awards of grants, cooperative agreement, or contracts to public and nonprofit private entities

for the purpose of providing to pregnant and postpartum women treatment for substance abuse through programs in which, during the course of receiving treatment—

- (1) the women reside in facilities provided by the programs;
- (2) the minor children of the women reside with the women in such facilities, if the women so request; and
- (3) the services described in subsection (d) are available to or on behalf of the women.

(b) AVAILABILITY OF SERVICES FOR EACH PARTICIPANT.—A funding agreement for an award under subsection (a) for an applicant is that, in the program operated pursuant to such subsection—

- (1) treatment services and each supplemental service will be available through the applicant, either directly or through agreements with other public or nonprofit private entities; and
- (2) the services will be made available to each woman admitted to the program.

(c) INDIVIDUALIZED PLAN OF SERVICES.—A funding agreement for an award under subsection (a) for an applicant is that—

- (1) in providing authorized services for an eligible woman pursuant to such subsection, the applicant will, in consultation with the woman, prepare an individualized plan for the provision to the woman of the services; and
- (2) treatment services under the plan will include—
 - (A) individual, group, and family counseling, as appropriate, regarding substance abuse; and
 - (B) follow-up services to assist the woman in preventing a relapse into such abuse.

(d) REQUIRED SUPPLEMENTAL SERVICES.—In the case of an eligible woman, the services referred to in subsection (a)(3) are as follows:

- (1) Prenatal and postpartum health care.
- (2) Referrals for necessary hospital services.
- (3) For the infants and children of the woman—
 - (A) pediatric health care, including treatment for any perinatal effects of maternal substance abuse and including screenings regarding the physical and mental development of the infants and children;
 - (B) counseling and other mental health services, in the case of children; and
 - (C) comprehensive social services.
- (4) Providing supervision of children during periods in which the woman is engaged in therapy or in other necessary health or rehabilitative activities.
- (5) Training in parenting.
- (6) Counseling on the human immunodeficiency virus and on acquired immune deficiency syndrome.
- (7) Counseling on domestic violence and sexual abuse.
- (8) Counseling on obtaining employment, including the importance of graduating from a secondary school.
- (9) Reasonable efforts to preserve and support the family units of the women, including promoting the appropriate involvement of parents and others, and counseling the children of the women.
- (10) Planning for and counseling to assist reentry into society, both before and after discharge, including referrals to any

public or nonprofit private entities in the community involved that provide services appropriate for the women and the children of the women.

(11) Case management services, including—

(A) assessing the extent to which authorized services are appropriate for the women and their children;

(B) in the case of the services that are appropriate, ensuring that the services are provided in a coordinated manner; and

(C) assistance in establishing eligibility for assistance under Federal, State, and local programs providing health services, mental health services, housing services, employment services, educational services, or social services.

(e) MINIMUM QUALIFICATIONS FOR RECEIPT OF AWARD.—

(1) CERTIFICATION BY RELEVANT STATE AGENCY.—With respect to the principal agency of the State involved that administers programs relating to substance abuse, the Director may make an award under subsection (a) to an applicant only if the agency has certified to the Director that—

(A) the applicant has the capacity to carry out a program described in subsection (a);

(B) the plans of the applicant for such a program are consistent with the policies of such agency regarding the treatment of substance abuse; and

(C) the applicant, or any entity through which the applicant will provide authorized services, meets all applicable State licensure or certification requirements regarding the provision of the services involved.

(2) STATUS AS MEDICAID PROVIDER.—

(A) Subject to subparagraphs (B) and (C), the Director may make an award under subsection (a) only if, in the case of any authorized service that is available pursuant to the State plan approved under title XIX of the Social Security Act for the State involved—

(i) the applicant for the award will provide the service directly, and the applicant has entered into a participation agreement under the State plan and is qualified to receive payments under such plan; or

(ii) the applicant will enter into an agreement with a public or nonprofit private entity under which the entity will provide the service, and the entity has entered into such a participation agreement plan and is qualified to receive such payments.

(B)(i) In the case of an entity making an agreement pursuant to subparagraph (A)(ii) regarding the provision of services, the requirement established in such subparagraph regarding a participation agreement shall be waived by the Director if the entity does not, in providing health care services, impose a charge or accept reimbursement available from any third-party payor, including reimbursement under any insurance policy or under any Federal or State health benefits plan.

(ii) A determination by the Director of whether an entity referred to in clause (i) meets the criteria for a waiver under such clause shall be made without regard to wheth-

er the entity accepts voluntary donations regarding the provision of services to the public.

(C) With respect to any authorized service that is available pursuant to the State plan described in subparagraph (A), the requirements established in such subparagraph shall not apply to the provision of any such service by an institution for mental diseases to an individual who has attained 21 years of age and who has not attained 65 years of age. For purposes of the preceding sentence, the term "institution for mental diseases" has the meaning given such term in section 1905(i) of the Social Security Act.

(f) REQUIREMENT OF MATCHING FUNDS.—

(1) IN GENERAL.—With respect to the costs of the program to be carried out by an applicant pursuant to subsection (a), a funding agreement for an award under such subsection is that the applicant will make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that—

(A) for the first fiscal year for which the applicant receives payments under an award under such subsection, is not less than \$1 for each \$9 of Federal funds provided in the award;

(B) for any second such fiscal year, is not less than \$1 for each \$9 of Federal funds provided in the award; and

(C) for any subsequent such fiscal year, is not less than \$1 for each \$3 of Federal funds provided in the award.

(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. 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.

(g) OUTREACH.—A funding agreement for an award under subsection (a) for an applicant is that the applicant will provide outreach services in the community involved to identify women who are engaging in substance abuse and to encourage the women to undergo treatment for such abuse.

(h) ACCESSIBILITY OF PROGRAM; CULTURAL CONTEXT OF SERVICES.—A funding agreement for an award under subsection (a) for an applicant is that—

(1) the program operated pursuant to such subsection will be operated at a location that is accessible to low-income pregnant and postpartum women; and

(2) authorized services will be provided in the language and the cultural context that is most appropriate.

(i) CONTINUING EDUCATION.—A funding agreement for an award under subsection (a) is that the applicant involved will provide for continuing education in treatment services for the individuals who will provide treatment in the program to be operated by the applicant pursuant to such subsection.

(j) IMPOSITION OF CHARGES.—A funding agreement for an award under subsection (a) for an applicant is that, if a charge is imposed

for the provision of authorized services to on behalf of an eligible woman, such charge—

(1) will be made according to a schedule of charges that is made available to the public;

(2) will be adjusted to reflect the income of the woman involved; and

(3) will not be imposed on any such woman with an income of less than 185 percent of the official poverty line, as established by the Director of the Office for Management and Budget and revised by the Secretary in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

(k) REPORTS TO DIRECTOR.—A funding agreement for an award under subsection (a) is that the applicant involved will submit to the Director a report—

(1) describing the utilization and costs of services provided under the award;

(2) specifying the number of women served, the number of infants served, and the type and costs of services provided; and

(3) providing such other information as the Director determines to be appropriate.

(l) REQUIREMENT OF APPLICATION.—The Director may make an award under subsection (a) only if an application for the award is submitted to the Director containing such agreements, and the application is in such form, is made in such manner, and contains such other agreements and such assurances and information as the Director determines to be necessary to carry out this section.

(m) EQUITABLE ALLOCATION OF AWARDS.—In making awards under subsection (a), the Director shall ensure that the awards are equitably allocated among the principal geographic regions of the United States, subject to the availability of qualified applicants for the awards.

(n) DURATION OF AWARD.—The period during which payments are made to an entity from an award under subsection (a) may not exceed 5 years. The provision of such payments shall be subject to annual approval by the Director of the payments and subject to the availability of appropriations for the fiscal year involved to make the payments. This subsection may not be construed to establish a limitation on the number of awards under such subsection that may be made to an entity.

(o) EVALUATIONS; DISSEMINATION OF FINDINGS.—The Director shall, directly or through contract, provide for the conduct of evaluations of programs carried out pursuant to subsection (a). The Director shall disseminate to the States the findings made as a result of the evaluations.

(p) REPORTS TO CONGRESS.—Not later than October 1, 1994, the Director shall submit to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, a report describing programs carried out pursuant to this section. Every 2 years thereafter, the Director shall prepare a report describing such programs carried out during the preceding 2 years, and shall submit the report to the [Administrator] *Assistant Secretary* for inclusion in the biennial report under section 501(k). Each report under this subsection shall include a summary of any evaluations conducted under sub-

section (m) during the period with respect to which the report is prepared.

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

(1) The term “authorized services” means treatment services and supplemental services.

(2) The term “eligible woman” means a woman who has been admitted to a program operated pursuant to subsection (a).

(3) The term “funding agreement under subsection (a)”, with respect to an award under subsection (a), means that the Director may make the award only if the applicant makes the agreement involved.

(4) The term “treatment services” means treatment for substance abuse, including the counseling and services described in subsection (c)(2).

(5) The term “supplemental services” means the services described in subsection (d).

(r) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary to fiscal years 2001 through 2003.

* * * * *

[METHAMPHETAMINE AND AMPHETAMINE TREATMENT INITIATIVE

[SEC. 514. (a) GRANTS.—

[(1) AUTHORITY TO MAKE GRANTS.—The Director of the Center for Substance Abuse Treatment may make grants to States and Indian tribes recognized by the United States that have a high rate, or have had a rapid increase, in methamphetamine or amphetamine abuse or addiction in order to permit such States and Indian tribes to expand activities in connection with the treatment of methamphetamine or amphetamine abuser or addiction in the specific geographical areas of such States or Indian tribes, as the case may be, where there is such a rate or has been such an increase.

[(2) RECIPIENTS.—Any grants under paragraph (1) shall be directed to the substance abuse directors of the States, and of the appropriate tribal government authorities of the Indian tribes, selected by the Director to receive such grants.

[(3) NATURE OF ACTIVITIES.—Any activities under a grant under paragraph (1) shall be based on reliable scientific evidence of their efficacy in the treatment of methamphetamine or amphetamine abuse or addiction.

[(b) GEOGRAPHIC DISTRIBUTION.—The Director shall ensure that grants under subsection (a) are distributed equitably among the various regions of the country and among rural, urban, and suburban areas that are affected by methamphetamine or amphetamine abuse or addiction.

[(c) ADDITIONAL ACTIVITIES.—The Director shall—

[(1) evaluate the activities supported by grants under subsection (a);

[(2) disseminate widely such significant information derived from the evaluation as the Director considers appropriate to assist States, Indian tribes, and private providers of treatment services for methamphetamine or amphetamine abuser or ad-

diction in the treatment of methamphetamine or amphetamine abuse or addiction; and

[(3) provide States, Indian tribes, and such providers with technical assistance in connection with the provision of such treatment.

[(d) AUTHORIZATION OF APPROPRIATIONS.—

[(1) IN GENERAL.—There are authorized to be appropriated to carry out this section \$10,000,000 for fiscal year 2000 and such sums as may be necessary for each of fiscal years 2001 and 2002.

[(2) USE OF CERTAIN FUNDS.—Of the funds appropriated to carry out this section in any fiscal year, the lesser of 5 percent of such funds or \$1,000,000 shall be available to the Director for purposes of carrying out subsection (c).

[(SEC. 514A. EARLY INTERVENTION SERVICES FOR CHILDREN AND ADOLESCENTS.

[(a) IN GENERAL.—The Secretary shall award grants, contracts, or cooperative agreements to public and private nonprofit entities, including local educational agencies (as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)), for the purpose of providing early intervention substance abuse services for children and adolescents.

[(b) PRIORITY.—In awarding grants, contracts, or cooperative agreements under subsection (a), the Secretary shall give priority to applicants who demonstrate an ability to—

[(1) screen for and assess substance use and abuse by children and adolescents;

[(2) make appropriate referrals for children and adolescents who are in need of treatment for substance abuse;

[(3) provide early intervention services, including counseling and ancillary services, that are designed to meet the developmental needs of children and adolescents who are at risk for substance abuse; and

[(4) develop networks with the educational, juvenile justice, social services, and other agencies and organizations in the State or local community involved that will work to identify children and adolescents who are in need of substance abuse treatment services.

[(c) CONDITION.—In awarding grants, contracts, or cooperative agreements under subsection (a), the Secretary shall ensure that such grants, contracts, or cooperative agreements are allocated, subject to the availability of qualified applicants, among the principal geographic regions of the United States, to Indian tribes and tribal organizations, and to urban and rural areas.

[(d) DURATION OF GRANTS.—The Secretary shall award grants, contracts, or cooperative agreements under subsection (a) for periods not to exceed 5 fiscal years.

[(e) APPLICATION.—An entity desiring a grant, contract, or cooperative agreement under subsection (a) shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

[(f) EVALUATION.—An entity that receives a grant, contract, or cooperative agreement under subsection (a) shall submit, in the application for such grant, contract, or cooperative agreement, a plan for the evaluation of any project undertaken with funds provided

under this section. Such entity shall provide the Secretary with periodic evaluations of the progress of such project and such evaluation at the completion of such project as the Secretary determines to be appropriate.

[(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, \$20,000,000 for fiscal year 2001, and such sums as may be necessary for fiscal years 2002 and 2003.]

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Subpart 2—Center for Substance Abuse Prevention

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[PREVENTION, TREATMENT, AND REHABILITATION MODEL PROJECTS FOR HIGH RISK YOUTH

[SEC. 517. (a) The Secretary, through the Director of the Prevention Center, shall make grants to public and nonprofit private entities for projects to demonstrate effective models for the prevention, treatment, and rehabilitation of drug abuse and alcohol abuse among high risk youth.

[(b)(1) In making grants for drug abuse and alcohol abuse prevention projects under this section, the Secretary shall give priority to applications for projects directed at children of substance abusers, latchkey children, children at risk of abuse or neglect, preschool children eligible for services under the Head Start Act, children at risk of dropping out of school, children at risk of becoming adolescent parents, and children who do not attend school and who are at risk of being unemployed.

[(2) In making grants for drug abuse and alcohol abuse treatment and rehabilitation projects under this section, the Secretary shall give priority to projects which address the relationship between drug abuse or alcohol abuse and physical child abuse, sexual child abuse, emotional child abuse, dropping out of school, unemployment, delinquency, pregnancy, violence, suicide, or mental health problems.

[(3) In making grants under this section, the Secretary shall give priority to applications from community based organizations for projects to develop innovative models with multiple, coordinated services for the prevention or for the treatment and rehabilitation of drug abuse or alcohol abuse by high risk youth.

[(4) In making grants under this section, the Secretary shall give priority to applications for projects to demonstrate effective models with multiple, coordinated services which may be replicated and which are for the prevention or for the treatment and rehabilitation of drug abuse or alcohol abuse by high risk youth.

[(5) In making grants under this section, the Secretary shall give priority to applications that employ research designs adequate for evaluating the effectiveness of the program.

[(c) The Secretary shall ensure that projects under subsection (a) include strategies for reducing the use of alcoholic beverages and tobacco products by individuals to whom it is unlawful to sell or distribute such beverages or products.

[(d) To the extent feasible, the Secretary shall make grants under this section in all regions of the United States, and shall en-

sure the distribution of grants under this section among urban and rural areas.

[(e) In order to receive a grant for a project under this section for a fiscal year, a public or nonprofit private entity shall submit an application to the Secretary, acting through the Office. The Secretary may provide to the Governor of the State the opportunity to review and comment on such application. Such application shall be in such form, shall contain such information, and shall be submitted at such time as the Secretary may by regulation prescribe.

[(f) The Director of the Office shall evaluate projects conducted with grants under this section.

[(g) For purposes of this section, the term “high risk youth” means an individual who has not attained the age of 21 years, who is at high risk of becoming, or who has become, a drug abuser or an alcohol abuser, and who—

- [(1) is identified as a child of a substance abuser;
- [(2) is a victim of physical, sexual, or psychological abuse;
- [(3) has dropped out of school;
- [(4) has become pregnant;
- [(5) is economically disadvantaged;
- [(6) has committed a violent or delinquent act;
- [(7) has experienced mental health problems;
- [(8) has attempted suicide;
- [(9) has experienced long-term physical pain due to injury;

or

- [(10) has experienced chronic failure in school.

[(h) For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2003.]

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[SEC. 519A. GRANTS FOR STRENGTHENING FAMILIES.

[(a) PROGRAM AUTHORIZED.—The Secretary, acting through the Director of the Prevention Center, may make grants to public and nonprofit private entities to develop and implement model substance abuse prevention programs to provide early intervention and substance abuse prevention services for individuals of high-risk families and the communities in which such individuals reside.

[(b) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants that—

- [(1) have proven experience in preventing substance abuse by individuals of high-risk families and reducing substance abuse in communities of such individuals;
- [(2) have demonstrated the capacity to implement community-based partnership initiatives that are sensitive to the diverse backgrounds of individuals of high-risk families and the communities of such individuals;
- [(3) have experience in providing technical assistance to support substance abuse prevention programs that are community-based;
- [(4) have demonstrated the capacity to implement research-based substance abuse prevention strategies; and
- [(5) have implemented programs that involve families, residents, community agencies, and institutions in the implementation and design of such programs.

[(c) DURATION OF GRANTS.—The Secretary shall award grants under subsection (a) for a period not to exceed 5 years.

[(d) USE OF FUNDS.—An applicant that is awarded a grant under subsection (a) shall—

[(1) in the first fiscal year that such funds are received under the grant, use such funds to develop a model substance abuse prevention program; and

[(2) in the fiscal year following the first fiscal year that such funds are received, use such funds to implement the program developed under paragraph (1) to provide early intervention and substance abuse prevention services to—

[(A) strengthen the environment of children of high risk families by targeting interventions at the families of such children and the communities in which such children reside;

[(B) strengthen protective factors, such as—

[(i) positive adult role models;

[(ii) messages that oppose substance abuse;

[(iii) community actions designed to reduce accessibility to and use of illegal substances; and

[(iv) willingness of individuals of families in which substance abuse occurs to seek treatment for substance abuse;

[(C) reduce family and community risks, such as family violence, alcohol or drug abuse, crime, and other behaviors that may effect healthy child development and increase the likelihood of substance abuse; and

[(D) build collaborative and formal partnerships between community agencies, institutions, and businesses to ensure that comprehensive high quality services are provided, such as early childhood education, health care, family support programs, parent education programs, and home visits for infants.

[(e) APPLICATION.—To be eligible to receive a grant under subsection (a), an applicant shall prepare and submit to the Secretary an application that—

[(1) describes a model substance abuse prevention program that such applicant will establish;

[(2) describes the manner in which the services described in subsection (d)(2) will be provided; and

[(3) describe in as much detail as possible the results that the entity expects to achieve in implementing such a program.

[(f) MATCHING FUNDING.—The Secretary may not make a grant to a entity under subsection (a) unless that entity agrees that, with respect to the costs to be incurred by the entity in carrying out the program for which the grant was awarded, the entity will make available non-Federal contributions in an amount that is not less than 40 percent of the amount provided under the grant.

[(g) REPORT TO SECRETARY.—An applicant that is awarded a grant under subsection (a) shall prepare and submit to the Secretary a report in such form and containing such information as the Secretary may require, including an assessment of the efficacy of the model substance abuse prevention program implemented by the applicant and the short, intermediate, and long term results of such program.

【(h) EVALUATIONS.—The Secretary shall conduct evaluations, based in part on the reports submitted under subsection (g), to determine the effectiveness of the programs funded under subsection (a) in reducing substance use in high-risk families and in making communities in which such families reside in stronger. The Secretary shall submit such evaluations to the appropriate committees of Congress.

【(i) HIGH-RISK FAMILIES.—In this section, the term “high-risk family” means a family in which the individuals of such family are at a significant risk of using or abusing alcohol or any illegal substance.

【(j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, \$3,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003.】

SEC. 519B. PROGRAMS TO REDUCE UNDERAGE DRINKING.

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

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

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

(3) The term “youth” means persons under the age of 21.

(4) The term “IOM report” means the report released in September 2003 by the National Research Council, Institute of Medicine, and entitled “Reducing Underage Drinking: A Collective Responsibility”.

(b) SENSE OF CONGRESS.—It is the sense of the Congress that:

(1) A multi-faceted effort is needed to more successfully address the problem of underage drinking in the United States. A coordinated approach to prevention, intervention, treatment, enforcement, and research is key to making progress. This Act recognizes the need for a focused national effort, and addresses particulars of the Federal portion of that effort, as well as Federal support for State activities.

(2) The Secretary of Health and Human Services shall continue to conduct research and collect data on the short and long-range impact of alcohol use and abuse upon adolescent brain development and other organ systems.

(3) States and communities, including colleges and universities, are encouraged to adopt comprehensive prevention approaches, including—

(A) evidence-based screening, programs and curricula;

(B) brief intervention strategies;

(C) consistent policy enforcement; and

(D) environmental changes that limit underage access to alcohol.

(4) Public health groups, consumer groups, and the alcohol beverage industry should continue and expand evidence-based efforts to prevent and reduce underage drinking.

(5) The entertainment industries have a powerful impact on youth, and they should use rating systems and marketing codes to reduce the likelihood that underage audiences will be

exposed to movies, recordings, or television programs with unsuitable alcohol content.

(6) The National Collegiate Athletic Association, its member colleges and universities, and athletic conferences should affirm a commitment to a policy of discouraging alcohol use among underage students and other young fans.

(7) Alcohol is a unique product and should be regulated differently than other products by the States and Federal Government. States have primary authority to regulate alcohol distribution and sale, and the Federal Government should support and supplement these State efforts. States also have a responsibility to fight youth access to alcohol and reduce underage drinking. Continued State regulation and licensing of the manufacture, importation, sale, distribution, transportation and storage of alcoholic beverages are clearly in the public interest and are critical to promoting responsible consumption, preventing illegal access to alcohol by persons under 21 years of age from commercial and non-commercial sources, maintaining industry integrity and an orderly marketplace, and furthering effective State tax collection.

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

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

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

(B) OTHER AGENCIES.—The officials referred to in paragraph (1) are the Secretary of Education, the Attorney General, the Secretary of Transportation, the Secretary of the Treasury, the Secretary of Defense, the Surgeon General, the Director of the Centers for Disease Control and Prevention, the Director of the National Institute on Alcohol Abuse and Alcoholism, the [Administrator of the Substance Abuse and Mental Health Services Administration] *Assistant Secretary for Mental Health and Substance Use*, the Director of the National Institute on Drug Abuse, the Assistant Secretary for Children and Families, the Director of the Office of National Drug Control Policy, the Administrator of the National Highway Traffic Safety Administration, the Administrator of the Office of Juvenile Justice and Delinquency Prevention, the Chairman of the Federal Trade Commission, and such other Federal officials as the Secretary of Health and Human Services determines to be appropriate.

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

(D) DUTIES.—The Committee shall guide policy and program development across the Federal Government with respect to underage drinking, provided, however, that nothing in this section shall be construed as transferring regu-

latory or program authority from an Agency to the Coordinating Committee.

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

(F) ANNUAL REPORT.—

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

(I) all programs and policies of Federal agencies designed to prevent and reduce underage drinking;

(II) the extent of progress in preventing and reducing underage drinking nationally;

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

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

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

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

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

(III) Measures of the exposure of underage populations to messages regarding alcohol in advertising and the entertainment media as reported by the Federal Trade Commission.

(IV) Surveillance data, including information on the onset and prevalence of underage drinking, consumption patterns and the means of underage access. The Secretary shall develop a plan to improve the collection, measurement and consistency of reporting Federal underage alcohol data.

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

(VI) Evidence-based best practices to prevent and reduce underage drinking and provide treatment services to those youth who need them.

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

(A) IN GENERAL.—The Secretary shall, with input and collaboration from other appropriate Federal agencies, States, Indian tribes, territories, and public health, consumer, and alcohol beverage industry groups, annually

issue a report on each State's performance in enacting, enforcing, and creating laws, regulations, and programs to prevent or reduce underage drinking.

(B) STATE PERFORMANCE MEASURES.—

(i) IN GENERAL.—The Secretary shall develop, in consultation with the Committee, a set of measures to be used in preparing the report on best practices.

(ii) CATEGORIES.—In developing these measures, the Secretary shall consider categories including, but not limited to:

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

(II) Whether or not the State has comprehensive liability statutes pertaining to underage access to alcohol such as dram shop, social host, and house party laws, and the prevalence of enforcement of each of these laws.

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

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

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

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

(VII) Whether or not the State has programs targeted to youths, parents, and caregivers to deter underage drinking; and the number of individuals served by these programs.

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

(IX) The amount that the State invests, per youth capita, on the prevention of underage drinking, further broken down by the amount spent on—

(aa) compliance check programs in retail outlets, including providing technology to prevent and detect the use of false identification by minors to make alcohol purchases;

(bb) checkpoints and saturation patrols that include the goal of reducing and deterring underage drinking;

(cc) community-based, school-based, and higher-education-based programs to prevent underage drinking;

(dd) underage drinking prevention programs that target youth within the juvenile justice and child welfare systems; and

(ee) other State efforts or programs as deemed appropriate.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection \$1,000,000 for fiscal year 2007, and \$1,000,000 for each of the fiscal years 2008 through 2010.

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

(1) SCOPE OF THE CAMPAIGN.—The Secretary shall continue to fund and oversee the production, broadcasting, and evaluation of the national adult-oriented media public service campaign if the Secretary determines that such campaign is effective in achieving the media campaign's measurable objectives.

(2) REPORT.—The Secretary shall provide a report to the Congress annually detailing the production, broadcasting, and evaluation of the campaign referred to in paragraph (1), and to detail in the report the effectiveness of the campaign in reducing underage drinking, the need for and likely effectiveness of an expanded adult-oriented media campaign, and the feasibility and the likely effectiveness of a national youth-focused media campaign to combat underage drinking.

(3) CONSULTATION REQUIREMENT.—In carrying out the media campaign, the Secretary shall direct the entity carrying out the national adult-oriented media public service campaign to consult with interested parties including both the alcohol beverage industry and public health and consumer groups. The progress of this consultative process is to be covered in the report under paragraph (2).

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, \$1,000,000 for fiscal year 2007 and \$1,000,000 for each of the fiscal years 2008 through 2010.

(e) INTERVENTIONS.—

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

(A) AUTHORIZATION OF PROGRAM.—The [Administrator of the Substance Abuse and Mental Health Services Administration] *Assistant Secretary for Mental Health and Substance Use*, in consultation with the Director of the Office of National Drug Control Policy, shall award, if the [Administrator] *Assistant Secretary* determines that the Department of Health and Human Services is not cur-

rently conducting activities that duplicate activities of the type described in this subsection, “enhancement grants” to eligible entities to design, test, evaluate and disseminate effective strategies to maximize the effectiveness of community-wide approaches to preventing and reducing underage drinking. This subsection is subject to the availability of appropriations.

(B) PURPOSES.—The purposes of this paragraph are to—

- (i) prevent and reduce alcohol use among youth in communities throughout the United States;
- (ii) strengthen collaboration among communities, the Federal Government, and State, local, and tribal governments;
- (iii) enhance intergovernmental cooperation and coordination on the issue of alcohol use among youth;
- (iv) serve as a catalyst for increased citizen participation and greater collaboration among all sectors and organizations of a community that first demonstrates a long-term commitment to reducing alcohol use among youth;
- (v) disseminate to communities timely information regarding state-of-the-art practices and initiatives that have proven to be effective in preventing and reducing alcohol use among youth; and
- (vi) enhance, not supplant, effective local community initiatives for preventing and reducing alcohol use among youth.

(C) APPLICATION.—An eligible entity desiring an enhancement grant under this paragraph shall submit an application to the [Administrator] *Assistant Secretary* at such time, and in such manner, and accompanied by such information as the [Administrator] *Assistant Secretary* may require. Each application shall include—

- (i) a complete description of the entity’s current underage alcohol use prevention initiatives and how the grant will appropriately enhance the focus on underage drinking issues; or
- (ii) a complete description of the entity’s current initiatives, and how it will use this grant to enhance those initiatives by adding a focus on underage drinking prevention.

(D) USES OF FUNDS.—Each eligible entity that receives a grant under this paragraph shall use the grant funds to carry out the activities described in such entity’s application submitted pursuant to subparagraph (C). Grants under this paragraph shall not exceed \$50,000 per year and may not exceed four years.

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

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

(G) DEFINITIONS.—For purposes of this paragraph, the term “eligible entity” means an organization that is currently receiving or has received grant funds under the Drug-Free Communities Act of 1997 (21 U.S.C. 1521 et seq.).

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

(I) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this paragraph \$5,000,000 for fiscal year 2007, and \$5,000,000 for each of the fiscal years 2008 through 2010.

(2) GRANTS DIRECTED AT PREVENTING AND REDUCING ALCOHOL ABUSE AT INSTITUTIONS OF HIGHER EDUCATION.—

(A) AUTHORIZATION OF PROGRAM.—The Secretary shall award grants to eligible entities to enable the entities to prevent and reduce the rate of underage alcohol consumption including binge drinking among students at institutions of higher education.

(B) APPLICATIONS.—An eligible entity that desires to receive a grant under this paragraph shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require. Each application shall include—

(i) a description of how the eligible entity will work to enhance an existing, or where none exists to build a, statewide coalition;

(ii) a description of how the eligible entity will target underage students in the State;

(iii) a description of how the eligible entity intends to ensure that the statewide coalition is actually implementing the purpose of this section and moving toward indicators described in subparagraph (D);

(iv) a list of the members of the statewide coalition or interested parties involved in the work of the eligible entity;

(v) a description of how the eligible entity intends to work with State agencies on substance abuse prevention and education;

(vi) the anticipated impact of funds provided under this paragraph in preventing and reducing the rates of underage alcohol use;

(vii) outreach strategies, including ways in which the eligible entity proposes to—

(I) reach out to students and community stakeholders;

(II) promote the purpose of this paragraph;

(III) address the range of needs of the students and the surrounding communities; and

(IV) address community norms for underage students regarding alcohol use; and

(viii) such additional information as required by the Secretary.

(C) USES OF FUNDS.—Each eligible entity that receives a grant under this paragraph shall use the grant funds to

carry out the activities described in such entity's application submitted pursuant to subparagraph (B).

(D) ACCOUNTABILITY.—On the date on which the Secretary first publishes a notice in the Federal Register soliciting applications for grants under this paragraph, the Secretary shall include in the notice achievement indicators for the program authorized under this paragraph. The achievement indicators shall be designed—

(i) to measure the impact that the statewide coalitions assisted under this paragraph are having on the institutions of higher education and the surrounding communities, including changes in the number of incidents of any kind in which students have abused alcohol or consumed alcohol while under the age of 21 (including violations, physical assaults, sexual assaults, reports of intimidation, disruptions of school functions, disruptions of student studies, mental health referrals, illnesses, or deaths);

(ii) to measure the quality and accessibility of the programs or information offered by the eligible entity; and

(iii) to provide such other measures of program impact as the Secretary determines appropriate.

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

(F) DEFINITIONS.—For purposes of this paragraph:

(i) ELIGIBLE ENTITY.—The term “eligible entity” means a State, institution of higher education, or non-profit entity.

(ii) INSTITUTION OF HIGHER EDUCATION.—The term “institution of higher education” has the meaning given the term in section 101(a) of the Higher Education Act of 1965 (20 U.S.C. 1001(a)).

(iii) SECRETARY.—The term “Secretary” means the Secretary of Education.

(iv) STATE.—The term “State” means each of the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico.

(v) STATEWIDE COALITION.—The term “statewide coalition” means a coalition that—

(I) includes, but is not limited to—

(aa) institutions of higher education within a State; and

(bb) a nonprofit group, a community underage drinking prevention coalition, or another substance abuse prevention group within a State; and

(II) works toward lowering the alcohol abuse rate by targeting underage students at institutions of higher education throughout the State and in the surrounding communities.

(vi) SURROUNDING COMMUNITY.—The term “surrounding community” means the community—

(I) that surrounds an institution of higher education participating in a statewide coalition;

(II) where the students from the institution of higher education take part in the community; and

(III) where students from the institution of higher education live in off-campus housing.

(G) ADMINISTRATIVE EXPENSES.—Not more than 5 percent of a grant under this paragraph may be expended for administrative expenses.

(H) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this paragraph \$5,000,000 for fiscal year 2007, and \$5,000,000 for each of the fiscal years 2008 through 2010.

(f) ADDITIONAL RESEARCH.—

(1) ADDITIONAL RESEARCH ON UNDERAGE DRINKING.—

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

(i) Comprehensive community-based programs or strategies and statewide systems to prevent and reduce underage drinking, across the underage years from early childhood to age 21, including programs funded and implemented by government entities, public health interest groups and foundations, and alcohol beverage companies and trade associations.

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

(iii) Compiling information on the involvement of alcohol in unnatural deaths of persons ages 12 to 20 in the United States, including suicides, homicides, and unintentional injuries such as falls, drownings, burns, poisonings, and motor vehicle crash deaths.

(B) CERTAIN MATTERS.—The Secretary shall carry out activities toward the following objectives with respect to underage drinking:

(i) Obtaining new epidemiological data within the national or targeted surveys that identify alcohol use and attitudes about alcohol use during pre- and early adolescence, including harm caused to self or others as a result of adolescent alcohol use such as violence, date rape, risky sexual behavior, and prenatal alcohol exposure.

(ii) Developing or identifying successful clinical treatments for youth with alcohol problems.

(C) PEER REVIEW.—Research under subparagraph (A) shall meet current Federal standards for scientific peer review.

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection \$6,000,000 for fiscal year 2007, and \$6,000,000 for each of the fiscal years 2008 through 2010.

[SEC. 519C. SERVICES FOR INDIVIDUALS WITH FETAL ALCOHOL SYNDROME.

[(a) IN GENERAL.—The Secretary shall make awards of grants, cooperative agreements, or contracts to public and nonprofit private entities, including Indian tribes and tribal organizations, to provide services to individuals diagnosed with fetal alcohol syndrome or alcohol-related birth defects.

[(b) USE OF FUNDS.—An award under subsection (a) may, subject to subsection (d), be used to—

[(1) screen and test individuals to determine the type and level of services needed;

[(2) develop a comprehensive plan for providing services to the individual;

[(3) provide mental health counseling;

[(4) provide substance abuse prevention services and treatment, if needed;

[(5) coordinate services with other social programs including social services, justice system, educational services, health services, mental health and substance abuse services, financial assistance programs, vocational services and housing assistance programs;

[(6) provide vocational services;

[(7) provide health counseling;

[(8) provide housing assistance;

[(9) parenting skills training;

[(10) overall case management;

[(11) supportive services for families of individuals with Fetal Alcohol Syndrome; and

[(12) provide other services and programs, to the extent authorized by the Secretary after consideration of recommendations made by the National Task Force on Fetal Alcohol Syndrome.

[(c) REQUIREMENTS.—To be eligible to receive an award under subsection (a), an applicant shall—

[(1) demonstrate that the program will be part of a coordinated, comprehensive system of care for such individuals;

[(2) demonstrate an established communication with other social programs in the community including social services, justice system, financial assistance programs, health services, educational services, mental health and substance abuse services, vocational services and housing assistance services;

[(3) show a history of working with individuals with fetal alcohol syndrome or alcohol-related birth defects;

[(4) provide assurance that the services will be provided in a culturally and linguistically appropriate manner; and

[(5) provide assurance that at the end of the 5-year award period, other mechanisms will be identified to meet the needs of the individuals and families served under such award.

[(d) RELATIONSHIP TO PAYMENTS UNDER OTHER PROGRAMS.—An award may be made under subsection (a) only if the applicant involved agrees that the award will not be expended to pay the expenses of providing any service under this section to an individual to the extent that payment has been made, or can reasonably be expected to be made, with respect to such expenses—

[(1) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

[(2) by an entity that provides health services on a prepaid basis.

[(e) DURATION OF AWARDS.—With respect to an award under subsection (a), the period during which payments under such award are made to the recipient may not exceed 5 years.

[(f) EVALUATION.—The Secretary shall evaluate each project carried out under subsection (a) and shall disseminate the findings with respect to each such evaluation to appropriate public and private entities.

[(g) FUNDING.—

[(1) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated \$25,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003.

[(2) ALLOCATION.—Of the amounts appropriated under paragraph (1) for a fiscal year, not less than \$300,000 shall, for purposes relating to fetal alcohol syndrome and alcohol-related birth defects, be made available for collaborative, coordinated interagency efforts with the National Institute on Alcohol Abuse and Alcoholism, the Eunice Kennedy Shriver National Institute of Child Health and Human Development, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Department of Education, and the Department of Justice.]

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[SEC. 519E. PREVENTION OF METHAMPHETAMINE AND INHALANT ABUSE AND ADDICTION.

[(a) GRANTS.—The Director of the Center for Substance Abuse Prevention (referred to in this section as the “Director”) may make grants to and enter into contracts and cooperative agreements with public and nonprofit private entities to enable such entities—

[(1) to carry out school-based programs concerning the dangers of methamphetamine or inhalant abuse and addiction, using methods that are effective and evidence-based, including initiatives that give students the responsibility to create their own anti-drug abuse education programs for their schools; and

[(2) to carry out community-based methamphetamine or inhalant abuse and addiction prevention programs that are effective and evidence-based.

[(b) USE OF FUNDS.—Amounts made available under a grant, contract or cooperative agreement under subsection (a) shall be used for planning, establishing, or administering methamphetamine or inhalant prevention programs in accordance with subsection (c).

[(c) PREVENTION PROGRAMS AND ACTIVITIES.—

[(1) IN GENERAL.—Amounts provided under this section may be used—

[(A) to carry out school-based programs that are focused on those districts with high or increasing rates of methamphetamine or inhalant abuse and addiction and targeted at populations which are most at risk to start methamphetamine or inhalant abuse;

[(B) to carry out community-based prevention programs that are focused on those populations within the community that are most at-risk for methamphetamine or inhalant abuse and addiction;

[(C) to assist local government entities to conduct appropriate methamphetamine or inhalant prevention activities;

[(D) to train and educate State and local law enforcement officials, prevention and education officials, members of community anti-drug coalitions and parents on the signs of methamphetamine or inhalant abuse and addiction and the options for treatment and prevention;

[(E) for planning, administration, and educational activities related to the prevention of methamphetamine or inhalant abuse and addiction;

[(F) for the monitoring and evaluation of methamphetamine or inhalant prevention activities, and reporting and disseminating resulting information to the public; and

[(G) for targeted pilot programs with evaluation components to encourage innovation and experimentation with new methodologies.

[(2) PRIORITY.—The Director shall give priority in making grants under this section to rural and urban areas that are experiencing a high rate or rapid increases in methamphetamine or inhalant abuse and addiction.

[(d) ANALYSES AND EVALUATION.—

[(1) IN GENERAL.—Up to \$500,000 of the amount available in each fiscal year to carry out this section shall be made available to the Director, acting in consultation with other Federal agencies, to support and conduct periodic analyses and evaluations of effective prevention programs for methamphetamine or inhalant abuse and addiction and the development of appropriate strategies for disseminating information about and implementing these programs.

[(2) ANNUAL REPORTS.—The Director shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Appropriations of the Senate and the Committee on Commerce and Committee on Appropriations of the House of Representatives, an annual report with the results of the analyses and evaluation under paragraph (1).

[(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out subsection (a), \$10,000,000 for fiscal year 2001, and such sums as may be necessary for each of fiscal years 2002 and 2003.]

Subpart 3—Center for Mental Health Services

CENTER FOR MENTAL HEALTH SERVICES

SEC. 520. (a) ESTABLISHMENT.—There is established in the Administration a Center for Mental Health Services (hereafter in this section referred to as the “Center”). The Center shall be headed by a Director (hereafter in this section referred to as the “Director”) appointed by the Secretary from among individuals with extensive experience or academic qualifications in the provision of mental health services or in the evaluation of mental health service systems.

(b) DUTIES.—The Director of the Center shall—

(1) design national goals and establish national priorities for—

(A) the prevention of mental illness; and

(B) the promotion of mental health;

(2) encourage and assist local entities and State agencies to achieve the goals and priorities described in paragraph (1);

(3) *collaborate with the Director of the National Institute of Mental Health to ensure that, as appropriate, programs related to the prevention and treatment of mental illness and the promotion of mental health are carried out in a manner that reflects the best available science and evidence-based practices, including culturally and linguistically appropriate services;*

[(3)] (4) collaborate with the Department of Education and the Department of Justice to develop programs to assist local communities in addressing violence among children and adolescents;

[(4)] (5) develop and coordinate Federal prevention policies and programs and to assure increased focus on the prevention of mental illness and the promotion of mental health *through policies and programs that reduce risk and promote resiliency;*

[(5)] (6) *in collaboration with the Director of the National Institute of Mental Health, develop improved methods of treating individuals with mental health problems and improved methods of assisting the families of such individuals;*

[(6)] (7) administer the mental health services block grant program authorized in section 1911;

[(7)] (8) promote policies and programs at Federal, State, and local levels and in the private sector that foster independence, *increase meaningful participation of individuals with mental illness in programs and activities of the Administration,* and protect the legal rights of persons with mental illness, including carrying out the provisions of the Protection and Advocacy of Mentally Ill Individuals Act;

[(8)] (9) carry out the programs under part C;

[(9)] (10) carry out responsibilities for the Human Resource Development program, and programs of clinical training for [professional and paraprofessional personnel pursuant to section 303] *paraprofessional personnel and health professionals;*

[(10)] (11) conduct services-related assessments, including evaluations of the organization and financing of care, self-help and consumer-run programs, mental health economics, mental health service systems, rural mental health, and *telemental*

health, and improve the capacity of State to conduct evaluations of publicly funded mental health programs;

[(11)] establish a clearinghouse for mental health information to assure the widespread dissemination of such information] (12) *disseminate mental health information, including evidenced-based practices*, to States, political subdivisions, educational agencies and institutions, treatment and prevention service providers, and the general public, including information concerning the practical application of research supported by the National Institute of Mental Health that is applicable to improving the delivery of services;

[(12)] (13) provide technical assistance to public and private entities that are providers of mental health services;

[(13)] (14) monitor and enforce obligations incurred by community mental health centers pursuant to the Community Mental Health Centers Act (as in effect prior to the repeal of such Act on August 13, 1981, by section 902(e)(2)(B) of Public Law 97–35 (95 Stat. 560));

[(14)] (15) conduct surveys with respect to mental health, such as the National Reporting Program; [and]

[(15)] (16) assist States in improving their mental health data collection[.]; and

(17) *consult with other agencies and offices of the Department of Health and Human Services to ensure, with respect to each grant awarded by the Center for Mental Health Services, the consistent documentation of the application of criteria when awarding grants and the ongoing oversight of grantees after such grants are awarded.*

(c) GRANTS AND CONTRACTS.—In carrying out the duties established in subsection (b), the Director may make grants to and enter into contracts and cooperative agreements with public and non-profit private entities.

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SEC. 520B. NATIONAL CENTERS OF EXCELLENCE FOR DEPRESSION.

(a) DEPRESSIVE DISORDER DEFINED.—In this section, the term “depressive disorder” means a mental or brain disorder relating to depression, including major depression, bipolar disorder, and related mood disorders.

(b) GRANT PROGRAM.—

(1) IN GENERAL.—The Secretary, acting through the [Administrator] *Assistant Secretary*, shall award grants on a competitive basis to eligible entities to establish national centers of excellence for depression (referred to in this section as “Centers”), which shall engage in activities related to the treatment of depressive disorders.

(2) ALLOCATION OF AWARDS.—If the funds authorized under subsection (f) are appropriated in the amounts provided for under such subsection, the Secretary shall allocate such amounts so that—

(A) not later than 1 year after the date of enactment of the ENHANCED Act of 2009, not more than 20 Centers may be established; and

(B) not later than September 30, 2016, not more than 30 Centers may be established.

(3) GRANT PERIOD.—

(A) IN GENERAL.—A grant awarded under this section shall be for a period of 5 years.

(B) RENEWAL.—A grant awarded under subparagraph (A) may be renewed, on a competitive basis, for 1 additional 5-year period, at the discretion of the Secretary. In determining whether to renew a grant, the Secretary shall consider the report cards issued under subsection (e)(2).

(4) USE OF FUNDS.—Grant funds awarded under this subsection shall be used for the establishment and ongoing activities of the recipient of such funds.

(5) ELIGIBLE ENTITIES.—

(A) REQUIREMENTS.—To be eligible to receive a grant under this section, an entity shall—

(i) be an institution of higher education or a public or private nonprofit research institution; and

(ii) submit an application to the Secretary at such time and in such manner as the Secretary may require, as described in subparagraph (B).

(B) APPLICATION.—An application described in subparagraph (A)(ii) shall include—

(i) evidence that such entity—

(I) provides, or is capable of coordinating with other entities to provide, comprehensive health services with a focus on mental health services and subspecialty expertise for depressive disorders;

(II) collaborates with other mental health providers, as necessary, to address co-occurring mental illnesses;

(III) is capable of training health professionals about mental health; and

(ii) such other information, as the Secretary may require.

(C) PRIORITIES.—In awarding grants under this section, the Secretary shall give priority to eligible entities that meet 1 or more of the following criteria:

(i) Demonstrated capacity and expertise to serve the targeted population.

(ii) Existing infrastructure or expertise to provide appropriate, evidence-based and culturally and linguistically competent services.

(iii) A location in a geographic area with disproportionate numbers of underserved and at-risk populations in medically underserved areas and health professional shortage areas.

(iv) Proposed innovative approaches for outreach to initiate or expand services.

(v) Use of the most up-to-date science, practices, and interventions available.

(vi) Demonstrated capacity to establish cooperative and collaborative agreements with community mental health centers and other community entities to provide mental health, social, and human services to individuals with depressive disorders.

(6) NATIONAL COORDINATING CENTER.—

(A) IN GENERAL.—The Secretary, acting through the [Administrator] *Assistant Secretary*, shall designate 1 recipient of a grant under this section to be the coordinating center of excellence for depression (referred to in this section as the “coordinating center”). The Secretary shall select such coordinating center on a competitive basis, based upon the demonstrated capacity of such center to perform the duties described in subparagraph (C).

(B) APPLICATION.—A Center that has been awarded a grant under paragraph (1) may apply for designation as the coordinating center by submitting an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(C) DUTIES.—The coordinating center shall—

- (i) develop, administer, and coordinate the network of Centers under this section;
- (ii) oversee and coordinate the national database described in subsection (d);
- (iii) lead a strategy to disseminate the findings and activities of the Centers through such database; and
- (iv) serve as a liaison with the Administration, the National Registry of Evidence-based Programs and Practices of the Administration, and any Federal interagency or interagency forum on mental health.

(7) MATCHING FUNDS.—The Secretary may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to \$1 for each \$5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

(c) ACTIVITIES OF THE CENTERS.—Each Center shall carry out the following activities:

(1) GENERAL ACTIVITIES.—Each Center shall—

(A) integrate basic, clinical, or health services interdisciplinary research and practice in the development, implementation, and dissemination of evidence-based interventions;

(B) involve a broad cross-section of stakeholders, such as researchers, clinicians, consumers, families of consumers, and voluntary health organizations, to develop a research agenda and disseminate findings, and to provide support in the implementation of evidence-based practices;

(C) provide training and technical assistance to mental health professionals, and engage in and disseminate translational research with a focus on meeting the needs of individuals with depressive disorders; and

(D) educate policy makers, employers, community leaders, and the public about depressive disorders to reduce stigma and raise awareness of treatments.

(2) IMPROVED TREATMENT STANDARDS, CLINICAL GUIDELINES, DIAGNOSTIC PROTOCOLS, AND CARE COORDINATION PRACTICE.—Each Center shall collaborate with other Centers in the network to—

(A) develop and implement treatment standards, clinical guidelines, and protocols that emphasize primary prevention, early intervention, treatment for, and recovery from, depressive disorders;

(B) foster communication with other providers attending to co-occurring physical health conditions such as cardiovascular, diabetes, cancer, and substance abuse disorders;

(C) leverage available community resources, develop and implement improved self-management programs, and, when appropriate, involve family and other providers of social support in the development and implementation of care plans; and

(D) use electronic health records and telehealth technology to better coordinate and manage, and improve access to, care, as determined by the coordinating center.

(3) TRANSLATIONAL RESEARCH THROUGH COLLABORATION OF CENTERS AND COMMUNITY-BASED ORGANIZATIONS.—Each Center shall—

(A) demonstrate effective use of a public-private partnership to foster collaborations among members of the network and community-based organizations such as community mental health centers and other social and human services providers;

(B) expand interdisciplinary, translational, and patient-oriented research and treatment; and

(C) coordinate with accredited academic programs to provide ongoing opportunities for the professional and continuing education of mental health providers.

(d) NATIONAL DATABASE.—

(1) IN GENERAL.—The coordinating center shall establish and maintain a national, publicly available database to improve prevention programs, evidence-based interventions, and disease management programs for depressive disorders, using data collected from the Centers, as described in paragraph (2).

(2) DATA COLLECTION.—Each Center shall submit data gathered at such center, as appropriate, to the coordinating center regarding—

(A) the prevalence and incidence of depressive disorders;

(B) the health and social outcomes of individuals with depressive disorders;

(C) the effectiveness of interventions designed, tested, and evaluated;

(D) other information, as the Secretary may require.

(3) SUBMISSION OF DATA TO THE [ADMINISTRATOR] ASSISTANT SECRETARY.—The coordinating center shall submit to the [Administrator] Assistant Secretary the data and financial information gathered under paragraph (2).

(4) PUBLICATION USING DATA FROM THE DATABASE.—A Center, or an individual affiliated with a Center, may publish findings using the data described in paragraph (2) only if such cen-

ter submits such data to the coordinating center, as required under such paragraph.

(e) ESTABLISHMENT OF STANDARDS; REPORT CARDS AND RECOMMENDATIONS; THIRD PARTY REVIEW.—

(1) ESTABLISHMENT OF STANDARDS.—The Secretary, acting through the [Administrator] *Assistant Secretary*, shall establish performance standards for—

(A) each Center; and

(B) the network of Centers as a whole.

(2) REPORT CARDS.—The Secretary, acting through the [Administrator] *Assistant Secretary*, shall—

(A) for each Center, not later than 3 years after the date on which such center of excellence is established and annually thereafter, issue a report card to the coordinating center to rate the performance of such Center; and

(B) not later than 3 years after the date on which the first grant is awarded under subsection (b)(1) and annually thereafter, issue a report card to Congress to rate the performance of the network of centers of excellence as a whole.

(3) RECOMMENDATIONS.—Based upon the report cards described in paragraph (2), the Secretary shall, not later than September 30, 2015—

(A) make recommendations to the Centers regarding improvements such centers shall make; and

(B) make recommendations to Congress for expanding the Centers to serve individuals with other types of mental disorders.

(4) THIRD PARTY REVIEW.—Not later than 3 years after the date on which the first grant is awarded under subsection (b)(1) and annually thereafter, the Secretary shall arrange for an independent third party to conduct an evaluation of the network of Centers to ensure that such centers are meeting the goals of this section.

(f) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—To carry out this section, there are authorized to be appropriated—

(A) \$100,000,000 for each of the fiscal years 2011 through 2015; and

(B) \$150,000,000 for each of the fiscal years 2016 through 2020.

(2) ALLOCATION OF FUNDS AUTHORIZED.—Of the amount appropriated under paragraph (1) for a fiscal year, the Secretary shall determine the allocation of each Center receiving a grant under this section, but in no case may the allocation be more than \$5,000,000, except that the Secretary may allocate not more than \$10,000,000 to the coordinating center.

SEC. 520C. [YOUTH INTERAGENCY RESEARCH, TRAINING, AND TECHNICAL ASSISTANCE CENTERS.] SUICIDE PREVENTION TECHNICAL ASSISTANCE CENTER.

(a) PROGRAM AUTHORIZED.—The Secretary, acting through the [Administrator of the Substance Abuse and Mental Health Services Administration] *Assistant Secretary for Mental Health and Substance Use*, [and in consultation with the Administrator of the Office of Juvenile Justice and Delinquency Prevention, the Director

of the Bureau of Justice Assistance and the Director of the National Institutes of Health—]

[(1) shall award grants or contracts to public or nonprofit private entities to establish not more than four research, training, and technical assistance centers to carry out the activities described in subsection (c); and

[(2) shall award a competitive grant to 1 additional research, training, and technical assistance center to carry out the activities described in subsection (d).] *shall establish 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 regarding the prevention of suicide among all ages, particularly among groups that are at high risk for suicide.*

[(b) APPLICATION.—A public or private nonprofit entity desiring a grant or contract under subsection (a) shall prepare and submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

[(c) AUTHORIZED ACTIVITIES.—A center established under a grant or contract under subsection (a)(1) shall—

[(1) provide training with respect to state-of-the-art mental health and justice-related services and successful mental health and substance abuse-justice collaborations that focus on children and adolescents, to public policymakers, law enforcement administrators, public defenders, police, probation officers, judges, parole officials, jail administrators and mental health and substance abuse providers and administrators;

[(2) engage in research and evaluations concerning State and local justice and mental health systems, including system redesign initiatives, and disseminate information concerning the results of such evaluations;

[(3) provide direct technical assistance, including assistance provided through toll-free telephone numbers, concerning issues such as how to accommodate individuals who are being processed through the courts under the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), what types of mental health or substance abuse service approaches are effective within the judicial system, and how community-based mental health or substance abuse services can be more effective, including relevant regional, ethnic, and gender-related considerations; and

[(4) provide information, training, and technical assistance to State and local governmental officials to enhance the capacity of such officials to provide appropriate services relating to mental health or substance abuse.

[(d) ADDITIONAL CENTER.—] *(b) RESPONSIBILITIES OF THE CENTER.—[The additional research, training, and technical assistance center established under subsection (a)(2) shall provide appropriate information, training, and technical assistance to States, political subdivisions of a State, Federally recognized Indian tribes, tribal organizations, institutions of higher education, public organizations, or private nonprofit organizations for] The center established under subsection (a) shall conduct activities for the purpose of—*

(1) [the development or continuation of] *developing and continuing* statewide or tribal [youth suicide] *suicide* early intervention and prevention strategies for all ages, particularly among groups that are at high risk for suicide;

(2) ensuring the surveillance of [youth suicide] *suicide* early intervention and prevention strategies for all ages, particularly among groups that are at high risk for suicide;

(3) studying the costs and effectiveness of statewide *and tribal* [youth suicide] *suicide* early intervention and prevention strategies in order to provide information concerning relevant issues of importance to State, tribal, and national policy-makers;

(4) further identifying and understanding causes and associated risk factors for [youth suicide] *suicide*;

(5) analyzing the efficacy of new and existing [youth suicide] *suicide* early intervention *and prevention* techniques and technology;

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

(7) studying the effectiveness of State-sponsored statewide and tribal [youth suicide] *suicide* early intervention and prevention strategies on the overall wellness and health promotion strategies related to suicide attempts;

(8) promoting the sharing of data regarding [youth suicide] *suicide* with Federal agencies involved with [youth suicide] *suicide* early intervention and prevention, and State-sponsored statewide or tribal [youth suicide] *suicide* early intervention and prevention strategies for the purpose of identifying previously unknown mental health causes and associated risk factors for suicide [in youth];

(9) evaluating and disseminating outcomes and best practices of mental [and behavioral health] *health and substance use disorder* services at institutions of higher education; and

(10) *conducting* other activities determined appropriate by the Secretary.

[(e) AUTHORIZATION OF APPROPRIATIONS.—

[(1) For the purpose of awarding grants or contracts under subsection (a)(1), there is authorized to be appropriated \$4,000,000 for fiscal year 2001, and such sums as may be necessary for fiscal years 2002 and 2003.

[(2) For the purpose of awarding a grant under subsection (a)(2), there are authorized to be appropriated \$3,000,000 for fiscal year 2005, \$4,000,000 for fiscal year 2006, and \$5,000,000 for fiscal year 2007.]

(c) AUTHORIZATION OF APPROPRIATIONS.—*For the purpose of carrying out this section, there are authorized to be appropriated \$5,988,000 for each of fiscal years 2017 through 2021.*

(d) REPORT.—*Not later than 2 years after the date of enactment of the Helping Families in Mental Health Crisis Act of 2016, the Secretary shall submit to Congress a report on the activities carried out by the center established under subsection (a) during the year involved, including the potential effects of such activities, and the States, organizations, and institutions that have worked with the center.*

§ 520D. SERVICES FOR YOUTH OFFENDERS.

[(a) IN GENERAL.—The Secretary, acting through the Director of the Center for Mental Health Services, and in consultation with the Director of the Center for Substance Abuse Treatment, the Administrator of the Office of Juvenile Justice and Delinquency Prevention, and the Director of the Special Education Programs, shall award grants on a competitive basis to State or local juvenile justice agencies to enable such agencies to provide aftercare services for youth offenders who have been discharged from facilities in the juvenile or criminal justice system and have serious emotional disturbances or are at risk of developing such disturbances.

[(b) USE OF FUNDS.—A State or local juvenile justice agency receiving a grant under subsection (a) shall use the amounts provided under the grant—

[(1) to develop a plan describing the manner in which the agency will provide services for each youth offender who has a serious emotional disturbance and has been detained or incarcerated in facilities within the juvenile or criminal justice system;

[(2) to provide a network of core or aftercare services or access to such services for each youth offender, including diagnostic and evaluation services, substance abuse treatment services, outpatient mental health care services, medication management services, intensive home-based therapy, intensive day treatment services, respite care, and therapeutic foster care;

[(3) to establish a program that coordinates with other State and local agencies providing recreational, social, educational, vocational, or operational services for youth, to enable the agency receiving a grant under this section to provide community-based system of care services for each youth offender that addresses the special needs of the youth and helps the youth access all of the aforementioned services; and

[(4) using not more than 20 percent of funds received, to provide planning and transition services as described in paragraph (3) for youth offenders while such youth are incarcerated or detained.

[(c) APPLICATION.—A State or local juvenile justice agency that desires a grant under subsection (a) shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

[(d) REPORT.—Not later than 3 years after the date of the enactment of this section and annually thereafter, the Secretary shall prepare and submit, to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Commerce of the House of Representatives, a report that describes the services provided pursuant to this section.

[(e) DEFINITIONS.—In this section:

[(1) SERIOUS EMOTIONAL DISTURBANCE.—The term “serious emotional disturbance” with respect to a youth offender means an offender who currently, or at any time within the 1-year period ending on the day on which services are sought under this section, has a diagnosable mental, behavioral, or emotional disorder that functionally impairs the offender’s life by substantially limiting the offender’s role in family, school, or commu-

nity activities, and interfering with the offender's ability to achieve or maintain one or more developmentally-appropriate social, behavior, cognitive, communicative, or adaptive skills.

[(2) COMMUNITY-BASED SYSTEM OF CARE.—The term “community-based system of care” means the provision of services for the youth offender by various State or local agencies that in an interagency fashion or operating as a network addresses the recreational, social, educational, vocational, mental health, substance abuse, and operational needs of the youth offender.

[(3) YOUTH OFFENDER.—The term “youth offender” means an individual who is 21 years of age or younger who has been discharged from a State or local juvenile or criminal justice system, except that if the individual is between the ages of 18 and 21 years, such individual has had contact with the State or local juvenile or criminal justice system prior to attaining 18 years of age and is under the jurisdiction of such a system at the time services are sought.

[(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section \$40,000,000 for fiscal year 2001, and such sums as may be necessary for each of fiscal years 2002 and 2003.]

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

(a) IN GENERAL.—The Secretary, acting through the [Administrator of the Substance Abuse and Mental Health Services Administration] *Assistant Secretary for Mental Health and Substance Use*, 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 abuse] *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 statewide 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 [each State is awarded only 1 grant or cooperative agreement under this section] *a State does not receive more than 1 grant or cooperative agreement under this section at any 1 time.* For purposes of the preceding sentence, a State shall be considered to have [been awarded] *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 abuse] *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 abuse 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 intervention 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) COORDINATION AND COLLABORATION.—

(1) IN GENERAL.—In carrying out this section, the Secretary shall collaborate with 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 or section 520E-1 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 520C, section 520E-1, or section 520E-2 shall not be used to pay for or refer for abortion.

(j) PARENTAL CONSENT.—States and entities receiving funding under this section and section 520E-1 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 or section 520E–1 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 or section 520E–1 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 school or secondary school (as such terms are defined in section 8101 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 24 years of age.

[(m) AUTHORIZATION OF APPROPRIATIONS.—

[(1) IN GENERAL.—For the purpose of carrying out this section, there are authorized to be appropriated \$7,000,000 for fiscal year 2005, \$18,000,000 for fiscal year 2006, and \$30,000,000 for fiscal year 2007.

[(2) PREFERENCE.—If less than \$3,500,000 is appropriated for any fiscal year to carry out this section, in awarding grants and cooperative agreements under this section during the fiscal year, the Secretary shall give preference to States that have rates of suicide that significantly exceed the national average as determined by the Centers for Disease Control and Prevention.]

(m) AUTHORIZATION OF APPROPRIATIONS.—*For the purpose of carrying out this section, there are authorized to be appropriated \$35,427,000 for each of fiscal years 2017 through 2021.*

* * * * *

SEC. 520E-2. MENTAL [AND BEHAVIORAL HEALTH] HEALTH AND SUBSTANCE USE DISORDER SERVICES ON CAMPUS.

(a) IN GENERAL.—The Secretary, acting through the Director of the Center for Mental Health [Services,] *Services and* in consultation with the Secretary of Education, may award grants on a competitive basis to institutions of higher education to enhance services for students with mental [and behavioral health problems] *health or substance use disorders* that can lead to school failure, such as depression, [substance abuse] *substance use disorders*, and suicide attempts, so that students will successfully complete their studies.

(b) USE OF FUNDS.—The Secretary may not make a grant to an institution of higher education under this section unless the institution agrees to use the grant only [for—] *for one or more of the following:*

- [(1) educational seminars;
- [(2) the operation of hot lines;
- [(3) preparation of informational material;
- [(4) preparation of educational materials for families of students to increase awareness of potential mental and behavioral health issues of students enrolled at the institution of higher education;
- [(5) training programs for students and campus personnel to respond effectively to students with mental and behavioral health problems that can lead to school failure, such as depression, substance abuse, and suicide attempts; or
- [(6) the creation of a networking infrastructure to link colleges and universities that do not have mental health services with health care providers who can treat mental and behavioral health problems.]

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

(2) The operation of hotlines.

(3) Preparing informational material.

(4) Providing outreach services to notify students about available mental health and substance use disorder services.

(5) Administering voluntary mental health and substance use disorder screenings and assessments.

(6) Supporting the training of students, faculty, and staff to respond effectively to students with mental health and substance use disorders.

(7) Creating a network infrastructure to link colleges and universities with health care providers who treat mental health and substance use disorders.

(c) ELIGIBLE GRANT RECIPIENTS.—Any institution of higher education receiving 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; or
- (5) institution of higher education supported, evidence-based, mental health and [substance abuse] *substance use disorder* programs.

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

(1) A description of identified mental ~~【and behavioral health】~~ *health and substance use disorder* needs of students, *including veterans whenever possible and appropriate*, 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, *which may include, as appropriate and in accordance with subsection (b)(7), a plan to seek input from relevant stakeholders in the community, including appropriate public and private entities, in order to carry out the program under the grant.*

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

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

(e) 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 in 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 ~~【and behavioral health problems】~~ *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 requirement established in paragraph (1) with respect to an institution of higher education if the Secretary determines that extraordinary need at the institution justifies the waiver.

(f) 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 [and behavioral health] *health and substance use disorder* services at institutions of higher education, including efforts to reduce the incidence of [suicide and substance abuse] *suicide and substance use disorders*.

(g) DEFINITION.—In this section, the term “institution of higher education” has the meaning given such term in section 101 of the Higher Education Act of 1965.

(h) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated [\$5,000,000 for fiscal year 2005, \$5,000,000 for fiscal year 2006, and \$5,000,000 for fiscal year 2007.] *\$6,488,000 for each of fiscal years 2017 through 2021.*

SEC. 520E-3. NATIONAL SUICIDE PREVENTION LIFELINE PROGRAM.

(a) *IN GENERAL.*—*The Secretary, acting through the Assistant Secretary, shall maintain the National Suicide Prevention Lifeline Program (referred to in this section as the “Program”), authorized under section 520A and in effect prior to the date of enactment of the Helping Families in Mental Health Crisis Act of 2016.*

(b) *ACTIVITIES.*—*In maintaining the Program, the activities of the Secretary shall include—*

(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.*

(c) AUTHORIZATION OF APPROPRIATIONS.—*To carry out this section, there are authorized to be appropriated \$7,198,000 for each of fiscal years 2017 through 2021.*

[SEC. 520F. GRANTS FOR EMERGENCY MENTAL HEALTH CENTERS.

[(a) PROGRAM AUTHORIZED.—The Secretary shall award grants to States, political subdivisions of States, Indian tribes, and tribal organizations to support the designation of hospitals and health centers as Emergency Mental Health Centers.

[(b) HEALTH CENTER.—In this section, the term “health center” has the meaning given such term in section 330, and includes community health centers and community mental health centers.

[(c) DISTRIBUTION OF AWARDS.—The Secretary shall ensure that such grants awarded under subsection (a) are equitably distributed among the geographical regions of the United States, between urban and rural populations, and between different settings of care including health centers, mental health centers, hospitals, and other psychiatric units or facilities.

[(d) APPLICATION.—A State, political subdivision of a State, Indian tribe, or tribal organization that desires a grant under subsection (a) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a plan for the rigorous evaluation of activities carried out with funds received under this section.

[(e) USE OF FUNDS.—

[(1) IN GENERAL.—A State, political subdivision of a State, Indian tribe, or tribal organization receiving a grant under subsection (a) shall use funds from such grant to establish or designate hospitals and health centers as Emergency Mental Health Centers.

[(2) EMERGENCY MENTAL HEALTH CENTERS.—Such Emergency Mental Health Centers described in paragraph (1)—

[(A) shall—

[(i) serve as a central receiving point in the community for individuals who may be in need of emergency mental health services;

[(ii) purchase, if needed, any equipment necessary to evaluate, diagnose and stabilize an individual with a mental illness;

[(iii) provide training, if needed, to the medical personnel staffing the Emergency Mental Health Center to evaluate, diagnose, stabilize, and treat an individual with a mental illness; and

[(iv) provide any treatment that is necessary for an individual with a mental illness or a referral for such individual to another facility where such treatment may be received; and

[(B) may establish and train a mobile crisis intervention team to respond to mental health emergencies within the community.

[(f) EVALUATION.—A State, political subdivision of a State, Indian tribe, or tribal organization that receives a grant under subsection (a) shall prepare and submit an evaluation to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require, including an evaluation of activities carried out with funds received under this section and a process and outcomes evaluation.

[(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, \$25,000,000 for fiscal year 2001 and such sums as may be necessary for each of the fiscal years 2002 through 2003.]

SEC. 520F. STRENGTHENING COMMUNITY CRISIS RESPONSE SYSTEMS.

(a) *IN GENERAL.*—*The Secretary shall award competitive grants—*

(1) to State and local governments and Indian tribes and tribal organizations to enhance community-based crisis response systems; or

(2) to States to develop, maintain, or enhance a database of beds at inpatient psychiatric facilities, crisis stabilization units, and residential community mental health and residential substance use disorder treatment facilities, for individuals with serious mental illness, serious emotional disturbance, or substance use disorders.

(b) *APPLICATION.*—

(1) IN GENERAL.—*To receive a grant or cooperative agreement under subsection (a), an entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.*

(2) COMMUNITY-BASED CRISIS RESPONSE PLAN.—*An application for a grant under subsection (a)(1) shall include a plan for—*

(A) promoting integration and coordination between local public and private entities engaged in crisis response, including first responders, emergency health care providers, primary care providers, law enforcement, court systems, health care payers, social service providers, and behavioral health providers;

(B) developing a plan for entering into memoranda of understanding with public and private entities to implement crisis response services;

(C) expanding the continuum of community-based services to address crisis intervention and prevention; and

(D) developing models for minimizing hospital readmissions, including through appropriate discharge planning.

(3) *BEDS DATABASE PLAN.*—An application for a grant under subsection (a)(2) shall include a plan for developing, maintaining, or enhancing a real-time Internet-based bed database to collect, aggregate, and display information about beds in inpatient psychiatric facilities and crisis stabilization units, and residential community mental health and residential substance use disorder treatment facilities, to facilitate the identification and designation of facilities for the temporary treatment of individuals in mental or substance use disorder crisis.

(c) *DATABASE REQUIREMENTS.*—A bed database described in this section is a database that—

(1) includes information on inpatient psychiatric facilities, crisis stabilization units, and residential community mental health and residential substance use disorder facilities in the State involved, including contact information for the facility or unit;

(2) provides real-time information about the number of beds available at each facility or unit and, for each available bed, the type of patient that may be admitted, the level of security provided, and any other information that may be necessary to allow for the proper identification of appropriate facilities for treatment of individuals in mental or substance use disorder crisis; and

(3) enables searches of the database to identify available beds that are appropriate for the treatment of individuals in mental or substance use disorder crisis.

(d) *EVALUATION.*—An entity receiving a grant under subsection (a)(1) shall submit to the Secretary, at such time, in such manner, and containing such information as the Secretary may reasonably require, a report, including an evaluation of the effect of such grant on—

(1) local crisis response services and measures of individuals receiving crisis planning and early intervention supports;

(2) individuals reporting improved functional outcomes; and

(3) individuals receiving regular followup care following a crisis.

(e) *AUTHORIZATION OF APPROPRIATIONS.*—There is authorized to be appropriated to carry out this section, \$5,000,000 for the period of fiscal years 2018 through 2022.

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[SEC. 520H. IMPROVING OUTCOMES FOR CHILDREN AND ADOLESCENTS THROUGH SERVICES INTEGRATION BETWEEN CHILD WELFARE AND MENTAL HEALTH SERVICES.

[(a) IN GENERAL.—The Secretary shall award grants, contracts or cooperative agreements to States, political subdivisions of States, Indian tribes, and tribal organizations to provide integrated child welfare and mental health services for children and adolescents under 19 years of age in the child welfare system or at risk for becoming part of the system, and parents or caregivers with a mental illness or a mental illness and a co-occurring substance abuse disorder.

[(b) DURATION.—With respect to a grant, contract or cooperative agreement awarded under this section, the period during which payments under such award are made to the recipient may not exceed 5 years.

[(c) APPLICATION.—

[(1) IN GENERAL.—To be eligible to receive an award under subsection (a), a State, political subdivision of a State, Indian tribe, or tribal organization shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

[(2) CONTENT.—An application submitted under paragraph (1) shall—

[(A) describe the program to be funded under the grant, contract or cooperative agreement;

[(B) explain how such program reflects best practices in the provision of child welfare and mental health services; and

[(C) provide assurances that—

[(i) persons providing services under the grant, contract or cooperative agreement are adequately trained to provide such services; and

[(ii) the services will be provided in accordance with subsection (d).

[(d) USE OF FUNDS.—A State, political subdivision of a State, Indian tribe, or tribal organization that receives a grant, contract, or cooperative agreement under subsection (a) shall use amounts made available through such grant, contract or cooperative agreement to—

[(1) provide family-centered, comprehensive, and coordinated child welfare and mental health services, including prevention, early intervention and treatment services for children and adolescents, and for their parents or caregivers;

[(2) ensure a single point of access for such coordinated services;

[(3) provide integrated mental health and substance abuse treatment for children, adolescents, and parents or caregivers with a mental illness and a co-occurring substance abuse disorder;

[(4) provide training for the child welfare, mental health and substance abuse professionals who will participate in the program carried out under this section;

[(5) provide technical assistance to child welfare and mental health agencies;

[(6) develop cooperative efforts with other service entities in the community, including education, social services, juvenile justice, and primary health care agencies;

[(7) coordinate services with services provided under the Medicaid program and the State Children’s Health Insurance Program under titles XIX and XXI of the Social Security Act;

[(8) provide linguistically appropriate and culturally competent services; and

[(9) evaluate the effectiveness and cost-efficiency of the integrated services that measure the level of coordination, outcome measures for parents or caregivers with a mental illness or a mental illness and a co-occurring substance abuse disorder, and outcome measures for children.

[(e) DISTRIBUTION OF AWARDS.—The Secretary shall ensure that grants, contracts, and cooperative agreements awarded under subsection (a) are equitably distributed among the geographical regions of the United States and between urban and rural populations.

[(f) EVALUATION.—The Secretary shall evaluate each program carried out by a State, political subdivision of a State, Indian tribe, or tribal organization under subsection (a) and shall disseminate the findings with respect to each such evaluation to appropriate public and private entities.

[(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, \$10,000,000 for fiscal year 2001, and such sums as may be necessary for each of fiscal years 2002 and 2003.]

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SEC. 520K. AWARDS FOR CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

(a) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—The term “eligible entity” means a qualified community mental health program defined under section 1913(b)(1).

(2) SPECIAL POPULATIONS.—The term “special populations” means adults with mental illnesses who have co-occurring primary care conditions and chronic diseases.

(b) PROGRAM AUTHORIZED.—The Secretary, acting through the [Administrator] Assistant Secretary shall award grants and cooperative agreements to eligible entities to establish demonstration projects for the provision of coordinated and integrated services to special populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings.

(c) APPLICATION.—To be eligible to receive a grant or cooperative agreement under this section, an eligible entity shall submit an application to the [Administrator] Assistant Secretary at such time, in such manner, and accompanied by such information as the [Administrator] Assistant Secretary may require, including a description of partnerships, or other arrangements with local primary care providers, including community health centers, to provide services to special populations.

(d) USE OF FUNDS.—

(1) **IN GENERAL.**—For the benefit of special populations, an eligible entity shall use funds awarded under this section for—

(A) the provision, by qualified primary care professionals, of on site primary care services;

(B) reasonable costs associated with medically necessary referrals to qualified specialty care professionals, other coordinators of care or, if permitted by the terms of the grant or cooperative agreement, by qualified specialty care professionals on a reasonable cost basis on site at the eligible entity;

(C) information technology required to accommodate the clinical needs of primary and specialty care professionals;

or

(D) facility modifications needed to bring primary and specialty care professionals on site at the eligible entity.

(2) **LIMITATION.**—Not to exceed 15 percent of grant or cooperative agreement funds may be used for activities described in subparagraphs (C) and (D) of paragraph (1).

(e) **EVALUATION.**—Not later than 90 days after a grant or cooperative agreement awarded under this section expires, 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.

(f) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out this section, \$50,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2014.

Subpart 4—Center for Behavioral Health Statistics and Quality

SEC. 520L. CENTER FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY.

(a) **ESTABLISHMENT.**—*There is established in the Administration a Center for Behavioral Health Statistics and Quality (in this section referred to as the “Center”). The Center shall be headed by a Director (in this section referred to as the “Director”) appointed by the Secretary from among individuals with extensive experience and academic qualifications in research and analysis in behavioral health care or related fields.*

(b) **DUTIES.**—*The Director of the Center shall—*

(1) *coordinate the Administration’s integrated data strategy by coordinating—*

(A) *surveillance and data collection (including that authorized by section 505);*

(B) *evaluation;*

(C) *statistical and analytic support;*

(D) *service systems research; and*

(E) *performance and quality information systems;*

(2) *recommend a core set of measurement standards for grant programs administered by the Administration; and*

(3) *coordinate evaluation efforts for the grant programs, contracts, and collaborative agreements of the Administration.*

(c) **BIANNUAL REPORT TO CONGRESS.**—*Not later than 2 years after the date of enactment of this section, and every 2 years thereafter,*

the Director of the Center shall submit to Congress a report on the quality of services furnished through grant programs of the Administration, including applicable measures of outcomes for individuals and public outcomes such as—

(1) the number of patients screened positive for unhealthy alcohol use who receive brief counseling as appropriate; the number of patients screened positive for tobacco use and receiving smoking cessation interventions; the number of patients with a new diagnosis of major depressive episode who are assessed for suicide risk; the number of patients screened positive for clinical depression with a documented followup plan; and the number of patients with a documented pain assessment that have a followup treatment plan when pain is present; and satisfaction with care;

(2) the incidence and prevalence of substance use and mental disorders; the number of suicide attempts and suicide completions; overdoses seen in emergency rooms resulting from alcohol and drug use; emergency room boarding; overdose deaths; emergency psychiatric hospitalizations; new criminal justice involvement while in treatment; stable housing; and rates of involvement in employment, education, and training; and

(3) such other measures for outcomes of services as the Director may determine.

(d) **STAFFING COMPOSITION.**—The staff of the Center may include individuals with advanced degrees and field expertise as well as clinical and research experience in mental and substance use disorders such as—

(1) professionals with clinical and research expertise in the prevention and treatment of, and recovery from, substance use and mental disorders;

(2) professionals with training and expertise in statistics or research and survey design and methodologies; and

(3) other related fields in the social and behavioral sciences, as specified by relevant position descriptions.

(e) **GRANTS AND CONTRACTS.**—In carrying out the duties established in subsection (b), the Director may make grants to and enter into contracts and cooperative agreements with public and nonprofit private entities.

(f) **DEFINITION.**—In this section, the term “emergency room boarding” means the practice of admitting patients to an emergency department and holding such patients in the department until inpatient psychiatric beds become available.

SEC. 520M. ASSERTIVE COMMUNITY TREATMENT GRANT PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

(a) **IN GENERAL.**—The Assistant Secretary shall award grants to eligible entities—

(1) to establish assertive community treatment programs for individuals with serious mental illness; or

(2) to maintain or expand such programs.

(b) **ELIGIBLE ENTITIES.**—To be eligible to receive a grant under this section, an entity shall be a State, county, city, tribe, tribal organization, mental health system, health care facility, or any other entity the Assistant Secretary deems appropriate.

(c) **SPECIAL CONSIDERATION.**—In selecting among applicants for a grant under this section, the Assistant Secretary may give special

consideration to the potential of the applicant's program to reduce hospitalization, homelessness, and involvement with the criminal justice system while improving the health and social outcomes of the patient.

(d) **ADDITIONAL ACTIVITIES.**—*The Assistant Secretary shall—*

(1) *not later than the end of fiscal year 2021, submit a report to the appropriate congressional committees on the grant program under this section, including an evaluation of—*

(A) *cost savings and public health outcomes such as mortality, suicide, substance abuse, hospitalization, and use of services;*

(B) *rates of involvement with the criminal justice system of patients;*

(C) *rates of homelessness among patients; and*

(D) *patient and family satisfaction with program participation; and*

(2) *provide appropriate information, training, and technical assistance to grant recipients under this section to help such recipients to establish, maintain, or expand their assertive community treatment programs.*

(e) **AUTHORIZATION OF APPROPRIATIONS.**—

(1) **IN GENERAL.**—*To carry out this section, there is authorized to be appropriated \$5,000,000 for the period of fiscal years 2018 through 2022.*

(2) **USE OF CERTAIN FUNDS.**—*Of the funds appropriated to carry out this section in any fiscal year, no more than 5 percent shall be available to the Assistant Secretary for carrying out subsection (d).*

PART C—PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS

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SEC. 528. REQUIREMENT OF REPORTS BY STATES.

(a) **IN GENERAL.**—*The Secretary may not make payments under section 521 unless the State involved agrees that, by not later than January 31 of each fiscal year, the State will prepare and submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the [Administrator of the Substance Abuse and Mental Health Services Administration] Assistant Secretary for Mental Health and Substance Use) to be necessary for—*

(1) *securing a record and a description of the purposes for which amounts received under section 521 were expended during the preceding fiscal year and of the recipients of such amounts; and*

(2) *determining whether such amounts were expended in accordance with the provisions of this part.*

(b) **AVAILABILITY TO PUBLIC OF REPORTS.**—*The Secretary may not make payments under section 521 unless the State involved agrees to make copies of the reports described in subsection (a) available for public inspection.*

(c) **EVALUATIONS BY COMPTROLLER GENERAL.**—*The [Administrator of the Substance Abuse and Mental Health Services Administration] Assistant Secretary for Mental Health and Substance Use*

shall evaluate at least once every 3 years the expenditures of grants under this part by eligible entities in order to ensure that expenditures are consistent with the provisions of this part, and shall include in such evaluation recommendations regarding changes needed in program design or operations.

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PART D—MISCELLANEOUS PROVISIONS RELATING TO SUBSTANCE ABUSE AND MENTAL HEALTH

SEC. 541. SUBSTANCE ABUSE AMONG GOVERNMENT AND OTHER EMPLOYEES.

(a) PROGRAMS AND SERVICES.—

(1) DEVELOPMENT.—The Secretary, acting through the [Administrator of the Substance Abuse and Mental Health Services Administration] *Assistant Secretary for Mental Health and Substance Use*, shall be responsible for fostering substance abuse prevention and treatment programs and services in State and local governments and in private industry.

(2) MODEL PROGRAMS.—

(A) IN GENERAL.—Consistent with the responsibilities described in paragraph (1), the Secretary, acting through the [Administrator of the Substance Abuse and Mental Health Services Administration] *Assistant Secretary for Mental Health and Substance Use*, shall develop a variety of model programs suitable for replication on a cost-effective basis in different types of business concerns and State and local governmental entities.

(B) DISSEMINATION OF INFORMATION.—The Secretary, acting through the [Administrator of the Substance Abuse and Mental Health Services Administration] *Assistant Secretary for Mental Health and Substance Use*, shall disseminate information and materials relative to such model programs to the State agencies responsible for the administration of substance abuse prevention, treatment, and rehabilitation activities and shall, to the extent feasible provide technical assistance to such agencies as requested.

(b) DEPRIVATION OF EMPLOYMENT.—

(1) PROHIBITION.—No person may be denied or deprived of Federal civilian employment or a Federal professional or other license or right solely on the grounds of prior substance abuse.

(2) APPLICATION.—This subsection shall not apply to employment in—

- (A) the Central Intelligence Agency;
- (B) the Federal Bureau of Investigation;
- (C) the National Security Agency;
- (D) any other department or agency of the Federal Government designated for purposes of national security by the President; or

(E) in any position in any department or agency of the Federal Government, not referred to in subparagraphs (A) through (D), which position is determined pursuant to regulations prescribed by the head of such agency or department to be a sensitive position.

(3) REHABILITATION ACT.—The inapplicability of the prohibition described in paragraph (1) to the employment described in paragraph (2) shall not be construed to reflect on the applicability of the Rehabilitation Act of 1973 or other anti-discrimination laws to such employment.

(c) CONSTRUCTION.—This section shall not be construed to prohibit the dismissal from employment of a Federal civilian employee who cannot properly function in his employment.

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SEC. 544. PROMOTING ACCESS TO INFORMATION ON EVIDENCE-BASED PROGRAMS AND PRACTICES.

(a) *IN GENERAL.*—The Assistant Secretary shall improve access to reliable and valid information on evidence-based programs and practices, including information on the strength of evidence associated with such programs and practices, related to mental and substance use disorders for States, local communities, nonprofit entities, and other stakeholders by posting on the website of the National Registry of Evidence-Based Programs and Practices evidence-based programs and practices that have been reviewed by the Assistant Secretary pursuant to the requirements of this section.

(b) *NOTICE.*—

(1) *PERIODS.*—In carrying out subsection (a), the Assistant Secretary may establish an initial period for the submission of applications for evidence-based programs and practices to be posted publicly in accordance with subsection (a) (and may establish subsequent such periods). The Assistant Secretary shall publish notice of such application periods in the Federal Register.

(2) *ADDRESSING GAPS.*—Such notice may solicit applications for evidence-based practices and programs to address gaps in information identified by the Assistant Secretary, the Assistant Secretary for Planning and Evaluation, the Assistant Secretary for Financial Resources, or the National Mental Health and Substance Use Policy Laboratory, including pursuant to priorities identified in the strategic plan established under section 501(l).

(c) *REQUIREMENTS.*—The Assistant Secretary shall establish minimum requirements for applications referred to in this section, including applications related to the submission of research and evaluation.

(d) *REVIEW AND RATING.*—The Assistant Secretary shall review applications prior to public posting, and may prioritize the review of applications for evidence-based practices and programs that are related to topics included in the notice established under subsection (b). The Assistant Secretary shall utilize a rating and review system, which shall include information on the strength of evidence associated with such programs and practices and a rating of the methodological rigor of the research supporting the application. The Assistant Secretary shall make the metrics used to evaluate applications and the resulting ratings publicly available.

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PART G—PROJECTS FOR CHILDREN AND VIOLENCE

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SEC. 582. GRANTS TO ADDRESS THE PROBLEMS OF PERSONS WHO EXPERIENCE VIOLENCE RELATED STRESS.

(a) **IN GENERAL.**—The Secretary shall award grants, contracts or cooperative agreements to public and nonprofit private entities, as well as to Indian tribes and tribal organizations, for the purpose of **developing programs focusing on the behavioral and biological aspects of psychological trauma response and for developing knowledge with regard to evidence-based practices for treating psychiatric disorders of children and youth resulting from witnessing or experiencing a traumatic event.** *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 practices for identifying and treating mental disorders, behavioral disorders, and physical health conditions of children and youth resulting from witnessing or experiencing a traumatic event.*

(b) **PRIORITIES.**—In awarding grants, contracts or cooperative agreements under **subsection (a) related** *subsection (a)(2) (related to the development of knowledge on evidence-based practices for treating disorders associated with psychological trauma* **treating mental, behavioral, and biological disorders associated with psychological trauma**), the Secretary shall give priority to **mental health agencies and programs that have established clinical and basic research** *universities, hospitals, mental health agencies, and other programs that have established clinical expertise and research experience in the field of trauma-related mental disorders.*

(c) **CHILD OUTCOME DATA.**—*The NCTSI coordinating center shall collect, analyze, report, and make publicly available NCTSI-wide child treatment process and outcome data regarding the early identification and delivery of evidence-based 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 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 practices.*

[(c)] (g) GEOGRAPHICAL DISTRIBUTION.—The Secretary shall ensure that grants, contracts or cooperative agreements under subsection (a) **with respect to centers of excellence are distributed eq-**

uitably among the regions of the country] *are distributed equitably among the regions of the United States* and among urban and rural areas.

[(d)] (h) EVALUATION.—The Secretary, as part of the application process, shall require that each applicant for a grant, contract or cooperative agreement under subsection (a) submit a plan for the rigorous evaluation of the activities funded under the grant, contract or agreement, including both process and outcomes evaluation, and the submission of an evaluation at the end of the project period.

[(e)] (i) DURATION OF AWARDS.—With respect to a grant, contract or cooperative agreement under subsection (a), the period during which payments under such an award will be made to the [recipient may not exceed 5 years] *recipient shall not be less than 4 years, but shall not exceed 5 years*. Such grants, contracts or agreements may be renewed.

[(f)] (j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, [\\$50,000,000 for fiscal year 2001, and such sums as may be necessary for each of fiscal years 2003 through 2006] *\\$46,887,000 for each of fiscal years 2017 through 2021*.

[(g)] (k) SHORT TITLE.—This section may be cited as the “Donald J. Cohen National Child Traumatic Stress Initiative”.

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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 racial and ethnic minorities; and*
- (3) *increasing the number of culturally competent behavioral health professionals and school personnel who teach, administer, conduct services research, and provide direct mental health or substance use services to racial and ethnic minority populations.*

(b) *TRAINING COVERED.*—The fellowships under subsection (a) shall be for *postbaccalaureate training (including for master’s and doctoral degrees) for mental health professionals, including in the fields of psychiatry, nursing, social work, psychology, marriage and family therapy, mental health counseling, and substance use and addiction counseling.*

(c) *AUTHORIZATION OF APPROPRIATIONS.*—To carry out this section, there are authorized to be appropriated *\\$12,669,000 for each*

of fiscal years 2017, 2018, and 2019 and \$13,669,000 for each of fiscal years 2020 and 2021.

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TITLE VII—HEALTH PROFESSIONS EDUCATION

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PART E—HEALTH PROFESSIONS AND PUBLIC HEALTH WORKFORCE

Subpart 1—Health Professions Workforce Information and Analysis

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SEC. 762. ADVISORY COUNCIL ON GRADUATE MEDICAL EDUCATION.

(a) **ESTABLISHMENT; DUTIES.**—There is established the Council on Graduate Medical Education (in this section referred to as the “Council”). The Council shall—

(1) make recommendations to the Secretary of Health and Human Services (in this section referred to as the “Secretary”), and to the Committee on Labor and Human Resources of the Senate, and the Committee on Energy and Commerce of the House of Representatives, with respect to—

(A) the supply and distribution of physicians in the United States;

(B) current and future shortages or excesses of physicians in medical and surgical specialties and subspecialties;

(C) issues relating to foreign medical school graduates;

(D) appropriate Federal policies with respect to the matters specified in subparagraphs (A), (B), and (C), including policies concerning changes in the financing of undergraduate and graduate medical education programs and changes in the types of medical education training in graduate medical education programs;

(E) appropriate efforts to be carried out by hospitals, schools of medicine, schools of osteopathic medicine, and accrediting bodies with respect to the matters specified in subparagraphs (A), (B), and (C), including efforts for changes in undergraduate and graduate medical education programs; and

(F) deficiencies in, and needs for improvements in, existing data bases concerning the supply and distribution of, and postgraduate training programs for, physicians in the United States and steps that should be taken to eliminate those deficiencies;

(2) encourage entities providing graduate medical education to conduct activities to voluntarily achieve the recommendations of the Council under paragraph (1)(E);

(3) develop, publish, and implement performance measures for programs under this title, except for programs under part C or D;

(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this title, except for programs under part C or D; and

(5) recommend appropriation levels for programs under this title, except for programs under part C or D.

(b) COMPOSITION.—The Council shall be composed of—

(1) the Assistant Secretary for Health or the designee of the Assistant Secretary;

(2) the Administrator of the Health Care Financing Administration;

(3) the Chief Medical Director of the Department of Veterans Affairs;

(4) *the Assistant Secretary for Mental Health and Substance Use;*

[(4)] (5) 6 members appointed by the Secretary to include representatives of practicing primary care physicians, national and specialty physician organizations, foreign medical graduates, and medical student and house staff associations;

[(5)] (6) 4 members appointed by the Secretary to include representatives of schools of medicine and osteopathic medicine and public and private teaching hospitals; and

[(6)] (7) 4 members appointed by the Secretary to include representatives of health insurers, business, and labor.

(c) TERMS OF APPOINTED MEMBERS.—

(1) IN GENERAL; STAGGERED ROTATION.—Members of the Council appointed under paragraphs [(4), (5), and (6)] (5), (6), and (7) of subsection (b) shall be appointed for a term of 4 years, except that the term of office of the members first appointed shall expire, as designated by the Secretary at the time of appointment, 4 at the end of 1 year, 4 at the end of 2 years, 3 at the end of 3 years, and 3 at the end of 4 years.

(2) DATE CERTAIN FOR APPOINTMENT.—The Secretary shall appoint the first members to the Council under paragraphs [(4), (5), and (6)] (5), (6), and (7) of subsection (b) within 60 days after the date of enactment of this section.

(d) CHAIR.—The Council shall elect one of its members as Chairman of the Council.

(e) QUORUM.—Nine members of the Council shall constitute a quorum, but a lesser number may hold hearings.

(f) VACANCIES.—Any vacancy in the Council shall not affect its power to function.

(g) COMPENSATION.—Each member of the Council who is not otherwise employed by the United States Government shall receive compensation at a rate equal to the daily rate prescribed for GS-18 under the General Schedule under section 5332 of title 5, United States Code, for each day, including traveltime, such member is engaged in the actual performance of duties as a member of the Council. A member of the Council who is an officer or employee of the United States Government shall serve without additional compensation. All members of the Council shall be reimbursed for travel, subsistence, and other necessary expenses incurred by them in the performance of their duties.

(h) CERTAIN AUTHORITIES AND DUTIES.—

(1) AUTHORITIES.—In order to carry out the provisions of this section, the Council is authorized to—

(A) collect such information, hold such hearings, and sit and act at such times and places, either as a whole or by subcommittee, and request the attendance and testimony of such witnesses and the production of such books, records, correspondence, memoranda, papers, and documents as the Council or such subcommittee may consider available; and

(B) request the cooperation and assistance of Federal departments, agencies, and instrumentalities, and such departments, agencies, and instrumentalities are authorized to provide such cooperation and assistance.

(2) COORDINATION OF ACTIVITIES.—The Council shall coordinate its activities with the activities of the Secretary under section 792 of the Public Health Service Act. The Secretary shall, in cooperation with the Council and pursuant to the recommendations of the Council, take such steps as are practicable to eliminate deficiencies in the data base established under such section 792 and shall make available in its reports such comprehensive data sets as are developed pursuant to this section.

(i) REQUIREMENT REGARDING REPORTS.—In the reports required under subsection (a), the Council shall specify its activities during the period for which the report is made.

(j) FINAL REPORT.—Not later than April 1, 2002, the Council shall submit a final report under subsection (a).

(k) TERMINATION.—The Council shall terminate September 30, 2003.

(l) FUNDING.—Amounts otherwise appropriated under this title may be utilized by the Secretary to support the activities of the Council.

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Subpart 3—Recruitment and Retention Programs

SEC. 775. INVESTMENT IN TOMORROW'S PEDIATRIC HEALTH CARE WORKFORCE.

(a) ESTABLISHMENT.—The Secretary shall establish and carry out a pediatric specialty loan repayment program under which the eligible individual agrees to be employed full-time for a specified period (which shall not be less than 2 years) in providing pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care, including substance abuse prevention and treatment services.

(b) PROGRAM ADMINISTRATION.—Through the program established under this section, the Secretary shall enter into contracts with qualified health professionals under which—

(1) such qualified health professionals will agree to provide pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care in an area with a shortage of the specified pediatric subspecialty that

has a sufficient pediatric population to support such pediatric subspecialty, as determined by the Secretary; and

(2) the Secretary agrees to make payments on the principal and interest of undergraduate, graduate, or graduate medical education loans of professionals described in paragraph (1) of not more than \$35,000 a year for each year of agreed upon service under such paragraph for a period of not more than 3 years during the qualified health professional's—

(A) participation in an accredited pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental health subspecialty residency or fellowship; or

(B) employment as a pediatric medical subspecialist, pediatric surgical specialist, or child and adolescent mental health professional serving an area or population described in such paragraph.

(c) IN GENERAL.—

(1) ELIGIBLE INDIVIDUALS.—

(A) PEDIATRIC MEDICAL SPECIALISTS AND PEDIATRIC SURGICAL SPECIALISTS.—For purposes of contracts with respect to pediatric medical specialists and pediatric surgical specialists, the term “qualified health professional” means a licensed physician who—

(i) is entering or receiving training in an accredited pediatric medical subspecialty or pediatric surgical specialty residency or fellowship; or

(ii) has completed (but not prior to the end of the calendar year in which this section is enacted) the training described in subparagraph (B).

(B) CHILD AND ADOLESCENT MENTAL AND BEHAVIORAL HEALTH.—For purposes of contracts with respect to child and adolescent mental and behavioral health care, the term “qualified health professional” means a health care professional who—

(i) has received specialized training or clinical experience in child and adolescent mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family therapy, school counseling, or professional counseling;

(ii) has a license or certification in a State to practice allopathic medicine, osteopathic medicine, psychology, school psychology, psychiatric nursing, social work, school social work, marriage and family therapy, school counseling, or professional counseling; or

(iii) is a mental health service professional who completed (but not before the end of the calendar year in which this section is enacted) specialized training or clinical experience in child and adolescent mental health described in clause (i).

(2) ADDITIONAL ELIGIBILITY REQUIREMENTS.—The Secretary may not enter into a contract under this subsection with an eligible individual unless—

(A) the individual agrees to work in, or for a provider serving, a health professional shortage area or medically

underserved area, or to serve a medically underserved population;

(B) the individual is a United States citizen or a permanent legal United States resident; and

(C) if the individual is enrolled in a graduate program, the program is accredited, and the individual has an acceptable level of academic standing (as determined by the Secretary).

(d) PRIORITY.—In entering into contracts under this subsection, the Secretary shall give priority to applicants who—

(1) are or will be working in a school or other pre-kindergarten, elementary, or secondary education setting;

(2) have familiarity with evidence-based methods and cultural and linguistic competence health care services; and

(3) demonstrate financial need.

[(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated \$30,000,000 for each of fiscal years 2010 through 2014 to carry out subsection (c)(1)(A) and \$20,000,000 for each of fiscal years 2010 through 2013 to carry out subsection (c)(1)(B).]

(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated \$12,000,000 for the period of fiscal years 2018 through 2022.

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TITLE XIX—BLOCK GRANTS

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PART B—BLOCK GRANTS REGARDING MENTAL HEALTH AND SUBSTANCE ABUSE

Subpart I—Block Grants for Community Mental Health Services

SEC. 1911. FORMULA GRANTS TO STATES.

(a) IN GENERAL.—For the purpose described in subsection (b), the Secretary, acting through the Director of the Center for Mental Health Services, shall make an allotment each fiscal year for each State in an amount determined in accordance with section 1918. The Secretary shall make a grant to the State of the allotment made for the State for the fiscal year if the State submits to the Secretary an application in accordance with section 1917.

(b) PURPOSE OF GRANTS.—A funding agreement for a grant under subsection (a) is that, subject to section 1916, the State involved will expend the grant only for the purpose of—

(1) providing community mental health services for adults with a serious mental illness and children with a serious emotional disturbance as defined in accordance with section 1912(c);

[(1)] (2) carrying out the plan submitted under section 1912(a) by the State for the fiscal year involved;

[(2)] (3) evaluating programs and services carried out under the plan; and

[(3)] (4) planning, administration, and educational activities related to providing services under the plan.

SEC. 1912. STATE PLAN FOR COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CERTAIN INDIVIDUALS.

(a) IN GENERAL.—The Secretary may make a grant under section 1911 only if—

(1) the State involved submits to the Secretary a plan for providing comprehensive community mental health services to adults with a serious mental illness and to children with a serious emotional disturbance;

(2) the plan meets the criteria specified in subsection (b); and

(3) the plan is approved by the Secretary.

[(b) CRITERIA FOR PLAN.—With respect to the provision of comprehensive community mental health services to individuals who are either adults with a serious mental illness or children with a serious emotional disturbance, the criteria referred to in subsection (a) regarding a plan are as follows:

[(1) COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH SYSTEMS.—The plan provides for an organized community-based system of care for individuals with mental illness and describes available services and resources in a comprehensive system of care, including services for dually diagnosed individuals. The description of the system of care shall include health and mental health services, rehabilitation services, employment services, housing services, educational services, substance abuse services, medical and dental care, and other support services to be provided to individuals with Federal, State and local public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities, including services to be provided by local school systems under the Individuals with Disabilities Education Act. The plan shall include a separate description of case management services and provide for activities leading to reduction of hospitalization.

[(2) MENTAL HEALTH SYSTEM DATA AND EPIDEMIOLOGY.—The plan contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children and presents quantitative targets to be achieved in the implementation of the system described in paragraph (1).

[(3) CHILDREN'S SERVICES.—In the case of children with serious emotional disturbance, the plan—

[(A) subject to subparagraph (B), provides for a system of integrated social services, educational services, juvenile services, and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (such system to include services provided under the Individuals with Disabilities Education Act);

[(B) provides that the grant under section 1911 for the fiscal year involved will not be expended to provide any service under such system other than comprehensive community mental health services; and

[(C) provides for the establishment of a defined geographic area for the provision of the services of such system.

【(4) TARGETED SERVICES TO RURAL AND HOMELESS POPULATIONS.—The plan describes the State’s outreach to and services for individuals who are homeless and how community-based services will be provided to individuals residing in rural areas.

【(5) MANAGEMENT SYSTEMS.—The plan describes the financial resources, staffing and training for mental health providers that is necessary to implement the plan, and provides for the training of providers of emergency health services regarding mental health. The plan further describes the manner in which the State intends to expend the grant under section 1911 for the fiscal year involved.

Except as provided for in paragraph (3), the State plan shall contain the information required under this subsection with respect to both adults with serious mental illness and children with serious emotional disturbance.】

(b) CRITERIA FOR PLAN.—*In accordance with subsection (a), a State shall submit to the Secretary a plan that, at a minimum, satisfies the following criteria:*

(1) SYSTEM OF CARE.—*The plan provides a description of the system of care of the State, including as follows:*

(A) COMPREHENSIVE COMMUNITY-BASED HEALTH SYSTEMS.—*The plan shall—*

(i) *identify the single State agency to be responsible for the administration of the program under the grant, including any third party who administers mental health services and is responsible for complying with the requirements of this part with respect to the grant;*

(ii) *provide for an organized community-based system of care for individuals with mental illness, and describe available services and resources in a comprehensive system of care, including services for individuals with mental health and behavioral health co-occurring disorders;*

(iii) *include a description of the manner in which the State and local entities will coordinate services to maximize the efficiency, effectiveness, quality, and cost effectiveness of services and programs to produce the best possible outcomes (including health services, rehabilitation services, employment services, housing services, educational services, substance use disorder services, legal services, law enforcement services, social services, child welfare services, medical and dental care services, and other support services to be provided with Federal, State, and local public and private resources) with other agencies to enable individuals receiving services to function outside of inpatient or residential institutions, to the maximum extent of their capabilities, including services to be provided by local school systems under the Individuals with Disabilities Education Act;*

(iv) *include a description of how the State—*

(I) *promotes evidence-based practices, including those evidence-based programs that address the needs of individuals with early serious mental ill-*

ness regardless of the age of the individual at onset;

(II) provides comprehensive individualized treatment; or

(III) integrates mental and physical health services;

(v) include a description of case management services;

(vi) include a description of activities that seek to engage individuals with serious mental illness or serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication between individuals, families, caregivers, and treatment providers; and

(vii) as appropriate to and reflective of the uses the State proposes for the block grant monies—

(I) a description of the activities intended to reduce hospitalizations and hospital stays using the block grant monies;

(II) a description of the activities intended to reduce incidents of suicide using the block grant monies; and

(III) a description of how the State integrates mental health and primary care using the block grant monies.

(B) MENTAL HEALTH SYSTEM DATA AND EPIDEMIOLOGY.—

The plan shall contain an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children and presents quantitative targets and outcome measures for programs and services provided under this subpart.

(C) CHILDREN'S SERVICES.—In the case of children with serious emotional disturbance (as defined in accordance with subsection (c)), the plan shall provide for a system of integrated social services, educational services, child welfare services, juvenile justice services, law enforcement services, and substance use disorder services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (such system to include services provided under the Individuals with Disabilities Education Act).

(D) TARGETED SERVICES TO RURAL AND HOMELESS POPULATIONS.—The plan shall describe the State's outreach to and services for individuals who are homeless and how community-based services will be provided to individuals residing in rural areas.

(E) MANAGEMENT SERVICES.—The plan shall—

(i) describe the financial resources available, the existing mental health workforce, and the workforce trained in treating individuals with co-occurring mental and substance use disorders;

(ii) provide for the training of providers of emergency health services regarding mental health;

(iii) describe the manner in which the State intends to expend the grant under section 1911 for the fiscal year involved; and

(iv) describe the manner in which the State intends to comply with each of the funding agreements in this subpart and subpart III.

(2) GOALS AND OBJECTIVES.—The plan establishes goals and objectives for the period of the plan, including targets and milestones that are intended to be met, and the activities that will be undertaken to achieve those targets.

(c) DEFINITIONS REGARDING MENTAL ILLNESS AND EMOTIONAL DISTURBANCE; METHODS FOR ESTIMATE OF INCIDENCE AND PREVALENCE.—

(1) ESTABLISHMENT BY SECRETARY OF DEFINITIONS; DISSEMINATION.—For purposes of this subpart, the Secretary shall establish definitions for the terms “adults with a serious mental illness” and “children with a serious emotional disturbance”. The Secretary shall disseminate the definitions to the States.

(2) STANDARDIZED METHODS.—The Secretary shall establish standardized methods for making the estimates required in subsection (b)(11) with respect to a State. A funding agreement for a grant under section 1911 for the State is that the State will utilize such methods in making the estimates.

(3) DATE CERTAIN FOR COMPLIANCE BY SECRETARY.—Not later than 90 days after the date of the enactment of the ADAMHA Reorganization Act, the Secretary shall establish the definitions described in paragraph (1), shall begin dissemination of the definitions to the States, and shall establish the standardized methods described in paragraph (2).

(d) REQUIREMENT OF IMPLEMENTATION OF PLAN.—

(1) COMPLETE IMPLEMENTATION.—Except as provided in paragraph (2), in making a grant under section 1911 to a State for a fiscal year, the Secretary shall make a determination of the extent to which the State has implemented the plan required in subsection (a). If the Secretary determines that a State has not completely implemented the plan, the Secretary shall reduce the amount of the allotment under section 1911 for the State for the fiscal year involved by an amount equal to 10 percent of the amount determined under section 1918 for the State for the fiscal year.

(2) SUBSTANTIAL IMPLEMENTATION AND GOOD FAITH EFFORT REGARDING FISCAL YEAR 1993.—

(A) In making a grant under section 1911 to a State for fiscal year 1993, the Secretary shall make a determination of the extent to which the State has implemented the plan required in subsection (a). If the Secretary determines that the State has not substantially implemented the plan, the Secretary shall, subject to subparagraph (B), reduce the amount of the allotment under section 1911 for the State for such fiscal year by an amount equal to 10 percent of the amount determined under section 1918 for the State for the fiscal year.

(B) In carrying out subparagraph (A), if the Secretary determines that the State is making a good faith effort to implement the plan required in subsection (a), the Sec-

retary may make a reduction under such subparagraph in an amount that is less than the amount specified in such subparagraph, except that the reduction may not be made in an amount that is less than 5 percent of the amount determined under section 1918 for the State for fiscal year 1993.

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SEC. 1915. ADDITIONAL PROVISIONS.

(a) **REVIEW OF STATE PLAN BY MENTAL HEALTH PLANNING COUNCIL.**—The Secretary may make a grant under section 1911 to a State only if—

- (1) the plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year has been reviewed by the State mental health planning council under section 1914; and
- (2) the State submits to the Secretary any recommendations received by the State from such council for modifications to the plan (without regard to whether the State has made the recommended modifications) and any comments concerning the annual report.

(b) **MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES FOR MENTAL HEALTH.**—

【(1) **IN GENERAL.**—A funding agreement for a grant under section 1911 is that the State involved will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.】

(1) IN GENERAL.—A funding agreement for a grant under section 1911 is that the State involved will maintain State expenditures for community mental health services at a level that is not less than the average of the amounts prescribed by this paragraph (prior to any waiver under paragraph (3)) for such expenditures by such State for each of the two fiscal years immediately preceding the fiscal year for which the State is applying for the grant.

(2) **EXCLUSION OF CERTAIN FUNDS.**—The Secretary may exclude from the aggregate State expenditures under [subsection (a)] *paragraph (1)*, funds appropriated to the [principle] *principal* agency for authorized activities which are of a non-recurring nature and for a specific purpose.

【(3) **WAIVER.**—The Secretary may, upon the request of a State, waive the requirement established in paragraph (1) if the Secretary determines that extraordinary economic conditions in the State justify the waiver.】

(3) **WAIVER.**—

(A) IN GENERAL.—The Secretary may, upon the request of a State, waive the requirement established in paragraph (1) in whole or in part, if the Secretary determines that extraordinary economic conditions in the State in the fiscal year involved or in the previous fiscal year justify the waiver.

(B) DATE CERTAIN FOR ACTION UPON REQUEST.—The Secretary shall approve or deny a request for a waiver under

this paragraph not later than 120 days after the date on which the request is made.

(C) APPLICABILITY OF WAIVER.—A waiver provided by the Secretary under this paragraph shall be applicable only to the fiscal year involved.

(4) NONCOMPLIANCE BY STATE.—

[(A) In making a grant under section 1911 to a State for a fiscal year, the Secretary shall make a determination of whether, for the previous fiscal year, the State maintained material compliance with the agreement made under paragraph (1). If the Secretary determines that a State has failed to maintain such compliance, the Secretary shall reduce the amount of the allotment under section 1911 for the State for the fiscal year for which the grant is being made by an amount equal to the amount constituting such failure for the previous fiscal year.]

(A) IN GENERAL.—

(i) DETERMINATION AND REDUCTION.—The Secretary shall determine, in the case of each State, and for each fiscal year, whether the State maintained material compliance with the agreement made under paragraph (1). If the Secretary determines that a State has failed to maintain such compliance for a fiscal year, the Secretary shall reduce the amount of the allotment under section 1911 for the State, for the first fiscal year beginning after such determination is final, by an amount equal to the amount constituting such failure for the previous fiscal year about which the determination was made.

(ii) ALTERNATIVE SANCTION.—The Secretary may by regulation provide for an alternative method of imposing a sanction for a failure by a State to maintain material compliance with the agreement under paragraph (1) if the Secretary determines that such alternative method would be more equitable and would be a more effective incentive for States to maintain such material compliance.

(B) SUBMISSION OF INFORMATION TO THE SECRETARY.—

The Secretary may make a grant under section 1911 for a fiscal year only if the State involved submits to the Secretary information sufficient for the Secretary to make the determination required in **[subparagraph (A)] subparagraph (A)(i)**.

* * * * *

SEC. 1917. APPLICATION FOR GRANT.

(a) IN GENERAL.—For purposes of section 1911, an application for a grant under such section for a fiscal year in accordance with this section if, subject to subsection (b)—

(1) the plan is received by the Secretary not later than September 1 of the fiscal year prior to the fiscal year for which a State is seeking funds, and the report from the previous fiscal year as required under section **[1941] 1942(a)** is received by December 1 of the fiscal year of the grant;

(2) the application contains each funding agreement that is described in this subpart or subpart III for such a grant (other than any such agreement that is not applicable to the State);

(3) the agreements are made through certification from the chief executive officer of the State;

(4) with respect to such agreements, the application provides assurances of compliance satisfactory to the Secretary;

(5) the application contains the plan required in section 1912(a), the information required in section **1915(b)(3)(B)** *1915(b)*, and the report required in section 1942(a);

(6) the application contains recommendations in compliance with section 1915(a), or if no such recommendations are received by the State, the application otherwise demonstrates compliance with such section; and

(7) the application (including the plan under section 1912(a)) is otherwise in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart.

(b) **WAIVERS REGARDING CERTAIN TERRITORIES.**—In the case of any territory of the United States except Puerto Rico, the Secretary may waive such provisions of this subpart and subpart III as the Secretary determines to be appropriate, other than the provisions of section 1916.

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SEC. 1920. FUNDING.

(a) **AUTHORIZATION OF APPROPRIATIONS.**—For the purpose of carrying out this subpart, and subpart III and section 505 with respect to mental health, there are authorized to be appropriated \$450,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003.

(b) **ALLOCATIONS FOR TECHNICAL ASSISTANCE, DATA COLLECTION, AND PROGRAM EVALUATION.**—

(1) **IN GENERAL.**—For the purpose of carrying out section 1948(a) with respect to mental health and the purposes specified in paragraphs (2) and (3), the Secretary shall obligate 5 percent of the amounts appropriated under subsection (a) for a fiscal year.

(2) **DATA COLLECTION.**—The purpose specified in this paragraph is carrying out sections 505 and 1971 with respect to mental health.

(3) **PROGRAM EVALUATION.**—The purpose specified in this paragraph is the conduct of evaluations of prevention and treatment programs and services with respect to mental health to determine methods for improving the availability and quality of such programs and services.

(c) **BEST PRACTICES IN CLINICAL CARE MODELS.**—*A State shall expend not less than 10 percent of the amount the State receives for carrying out this subpart in each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset.*

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TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

PART A—INDIVIDUAL AND GROUP MARKET REFORMS

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Subpart II—Improving Coverage

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SEC. 2726. PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

(a) IN GENERAL.—

(1) AGGREGATE LIFETIME LIMITS.—In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) NO LIFETIME LIMIT.—If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.

(B) LIFETIME LIMIT.—If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the “applicable lifetime limit”), the plan or coverage shall either—

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any aggregate lifetime limit on mental health or substance use disorder benefits that is less than the applicable lifetime limit.

(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) ANNUAL LIMITS.—In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) NO ANNUAL LIMIT.—If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health or substance use disorder benefits.

(B) ANNUAL LIMIT.—If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the “applicable annual limit”), the plan or coverage shall either—

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any annual limit on mental health or substance use disorder benefits that is less than the applicable annual limit.

(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(3) FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS.—

(A) IN GENERAL.—In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(B) DEFINITIONS.—In this paragraph:

(i) FINANCIAL REQUIREMENT.—The term “financial requirement” includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an

aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2).

(ii) **PREDOMINANT.**—A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) **TREATMENT LIMITATION.**—The term “treatment limitation” includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(4) **AVAILABILITY OF PLAN INFORMATION.**—The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

(5) **OUT-OF-NETWORK PROVIDERS.**—In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

(6) **COMPLIANCE PROGRAM GUIDANCE DOCUMENT.**—

(A) **IN GENERAL.**—*Not later than 6 months after the date of enactment of the Helping Families in Mental Health Crisis Act of 2016, the Inspector General of the Department of Health and Human Services, in coordination with the Secretary, the Secretary of Labor, or the Secretary of the Treasury, shall issue a compliance program guidance document to help improve compliance with this section.*

(B) **EXAMPLES ILLUSTRATING COMPLIANCE AND NON-COMPLIANCE.**—

(i) **IN GENERAL.**—*The compliance program guidance document required under this paragraph shall provide illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986 based on investigations of violations of such sections, including—*

(I) examples illustrating requirements for information disclosures and nonquantitative treatment limitations; and

(II) descriptions of the violations uncovered during the course of such investigations.

(ii) **NONQUANTITATIVE TREATMENT LIMITATIONS.**—To the extent that any example described in clause (i) involves a finding of compliance or noncompliance with regard to any requirement for nonquantitative treatment limitations, the example shall provide sufficient detail to fully explain such finding, including a full description of the criteria involved for medical and surgical benefits and the criteria involved for mental health and substance use disorder benefits.

(iii) **ACCESS TO ADDITIONAL INFORMATION REGARDING COMPLIANCE.**—In developing and issuing the compliance program guidance document required under this paragraph, the Inspector General of the Department of Health and Human Services may—

(I) enter into interagency agreements with the Inspector General of the Department of Labor and the Inspector General of the Department of the Treasury to share findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986; and

(II) enter into an agreement with a State to share information on findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986.

(C) **RECOMMENDATIONS.**—The compliance program guidance document shall include recommendations to avoid violations of this section and encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. Such internal controls may include a compliance checklist with illustrative examples of nonquantitative treatment limitations on mental health and substance use disorder benefits, which may fail to comply with this section in relation to nonquantitative treatment limitations on medical and surgical benefits.

(D) **UPDATING THE COMPLIANCE PROGRAM GUIDANCE DOCUMENT.**—The compliance program guidance document shall be updated every 2 years to include illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986.

(7) **ADDITIONAL GUIDANCE.**—

(A) *IN GENERAL.*—Not later than 6 months after the date of enactment of the *Helping Families in Mental Health Crisis Act of 2016*, the Secretary, in coordination with the Secretary of Labor and the Secretary of the Treasury, shall issue guidance to group health plans and health insurance issuers offering group or individual health insurance coverage to assist such plans and issuers in satisfying the requirements of this section.

(B) *DISCLOSURE.*—

(i) *GUIDANCE FOR PLANS AND ISSUERS.*—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use for disclosing information to ensure compliance with the requirements under this section (and any regulations promulgated pursuant to this section).

(ii) *DOCUMENTS FOR PARTICIPANTS, BENEFICIARIES, CONTRACTING PROVIDERS, OR AUTHORIZED REPRESENTATIVES.*—The guidance issued under this paragraph may include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use to provide any participant, beneficiary, contracting provider, or authorized representative, as applicable, with documents containing information that the health plans or issuers are required to disclose to participants, beneficiaries, contracting providers, or authorized representatives to ensure compliance with this section, any regulation issued pursuant to this section, or any other applicable law or regulation, including information that is comparative in nature with respect to—

(I) nonquantitative treatment limitations for both medical and surgical benefits and mental health and substance use disorder benefits;

(II) the processes, strategies, evidentiary standards, and other factors used to apply the limitations described in subclause (I); and

(III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and mental health and substance use disorder benefits.

(C) *NONQUANTITATIVE TREATMENT LIMITATIONS.*—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that group health plans and health insurance issuers offering group or individual health insurance coverage may use regarding the development and application of nonquantitative treatment limitations to ensure compliance with this section (and any regulations promulgated pursuant to this section), including—

(i) examples of methods of determining appropriate types of nonquantitative treatment limitations with respect to both medical and surgical benefits and mental health and substance use disorder benefits, including nonquantitative treatment limitations pertaining to—

(I) medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;

(II) limitations with respect to prescription drug formulary design; and

(III) use of fail-first or step therapy protocols;

(ii) examples of methods of determining—

(I) network admission standards (such as credentialing); and

(II) factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;

(iii) examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of nonquantitative treatment limitations;

(iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans or issuers in performing a nonquantitative treatment limitation analysis;

(v) examples of how specific evidentiary standards may be used to determine whether treatments are considered experimental or investigative;

(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;

(vii) examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for individuals with a serious mental illness and types of medical management techniques;

(viii) examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship between the covered mental health or substance use disorder benefit and a traditional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment; and

(ix) additional illustrative examples of methods, processes, strategies, evidentiary standards, and other factors for which the Secretary determines that additional guidance is necessary to improve compliance with this section.

(D) PUBLIC COMMENT.—Prior to issuing any final guidance under this paragraph, the Secretary shall provide a public comment period of not less than 60 days during

which any member of the public may provide comments on a draft of the guidance.

(b) CONSTRUCTION.—Nothing in this section shall be construed—

(1) as requiring a group health plan or a health insurance issuer offering group or individual health insurance coverage to provide any mental health or substance use disorder benefits; or

(2) in the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).

(c) EXEMPTIONS.—

(1) SMALL EMPLOYER EXEMPTION.—This section shall not apply to any group health plan and a health insurance issuer offering group or individual health insurance coverage for any plan year of a small employer (as defined in section 2791(e)(4), except that for purposes of this paragraph such term shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual).

(2) COST EXEMPTION.—

(A) IN GENERAL.—With respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

(B) APPLICABLE PERCENTAGE.—With respect to a plan (or coverage), the applicable percentage described in this subparagraph shall be—

(i) 2 percent in the case of the first plan year in which this section is applied; and

(ii) 1 percent in the case of each subsequent plan year.

(C) DETERMINATIONS BY ACTUARIES.—Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation

relied upon by the actuary, shall be maintained by the group health plan or health insurance issuer for a period of 6 years following the notification made under subparagraph (E).

(D) 6-MONTH DETERMINATIONS.—If a group health plan (or a health insurance issuer offering coverage in connection with a group health plan) seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

(E) NOTIFICATION.—

(i) IN GENERAL.—A group health plan (or a health insurance issuer offering coverage in connection with a group health plan) that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

(ii) REQUIREMENT.—A notification to the Secretary under clause (i) shall include—

(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and

(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

(iii) CONFIDENTIALITY.—A notification to the Secretary under clause (i) shall be confidential. The Secretary shall make available, upon request and on not more than an annual basis, an anonymous itemization of such notifications, that includes—

(I) a breakdown of States by the size and type of employers submitting such notification; and

(II) a summary of the data received under clause (ii).

(F) AUDITS BY APPROPRIATE AGENCIES.—To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan or health insurance issuer relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also con-

duct such an audit with respect to an exemption covered by such notification.

(d) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

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

(1) AGGREGATE LIFETIME LIMIT.—The term “aggregate lifetime limit” means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

(2) ANNUAL LIMIT.—The term “annual limit” means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

(3) MEDICAL OR SURGICAL BENEFITS.—The term “medical or surgical benefits” means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health or substance use disorder benefits.

(4) MENTAL HEALTH BENEFITS.—The term “mental health benefits” means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(5) SUBSTANCE USE DISORDER BENEFITS.—The term “substance use disorder benefits” means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.

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PROTECTION AND ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS ACT

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TITLE I—PROTECTION AND ADVOCACY SYSTEMS

PART A—ESTABLISHMENT OF SYSTEMS

* * * * *

SYSTEM REQUIREMENTS

SEC. 105. (a) A system established in a State under section 103 to protect and advocate the rights of individuals with mental illness shall—

(1) have the authority to—

(A) investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the

system or if there is probable cause to believe that the incidents occurred;

(B) pursue administrative, legal, and other appropriate remedies to ensure the protection of individuals with mental illness who are receiving care or treatment in the State; and

(C) pursue administrative, legal, and other remedies on behalf of an individual who—

(i) was a individual with mental illness; and

(ii) is a resident of the State,

but only with respect to matters which occur within 90 days after the date of the discharge of such individual from a facility providing care or treatment;

(2) be independent of any agency in the State which provides treatment or services (other than advocacy services) to individuals with mental illness;

(3) have access to facilities in the State providing care or treatment;

(4) in accordance with section 106, have access to all records of—

(A) any individual who is a client of the system if such individual, or the legal guardian, conservator, or other legal representative of such individual, has authorized the system to have such access;

(B) any individual (including an individual who has died or whose whereabouts are unknown)—

(i) who by reason of the mental or physical condition of such individual is unable to authorize the system to have such access;

(ii) who does not have a legal guardian, conservator, or other legal representative, or for whom the legal guardian is the State; and

(iii) with respect to whom a complaint has been received by the system or with respect to whom as a result of monitoring or other activities (either of which result from a complaint or other evidence) there is probable cause to believe that such individual has been subject to abuse or neglect; and

(C) any individual with a mental illness, who has a legal guardian, conservator, or other legal representative, with respect to whom a complaint has been received by the system or with respect to whom there is probable cause to believe the health or safety of the individual is in serious and immediate jeopardy, whenever—

(i) such representative has been contacted by such system upon receipt of the name and address of such representative;

(ii) such system has offered assistance to such representative to resolve the situation; and

(iii) such representative has failed or refused to act on behalf of the individual;

(5) have an arrangement with the Secretary and the agency of the State which administers the State plan under title XIX of the Social Security Act for the furnishing of the information required by subsection (b);

(6) establish an advisory council—

(A) which will advise the system on policies and priorities to be carried out in protecting and advocating the rights of individuals with mental illness;

(B) which shall include attorneys, mental health professionals, individuals from the public who are knowledgeable about mental illness, a provider of mental health services, individuals who have received or are receiving mental health services, and family members of such individuals, and at least 60 percent the membership of which shall be comprised of individuals who have received or are receiving mental health services or who are family members of such individuals; and

(C) which shall be chaired by an individual who has received or is receiving mental health services or who is a family member of such an individual;

(7) on January 1, 1987, and January 1 of each succeeding year, prepare and transmit to the Secretary and the head of the State mental health agency of the State in which the system **[is located a report]** *is located, and make publicly available, a report* describing the activities, accomplishments, and expenditures of the system during the most recently completed fiscal year, including a section prepared by the advisory council that describes the activities of the council and its assessment of the operations of the system;

(8) on an annual basis, provide the public with an opportunity to comment on the priorities established by, and the activities of, the system;

(9) establish a grievance procedure for clients or prospective clients of the system to assure that individuals with mental illness have full access to the services of the system and for individuals who have received or are receiving mental health services, family members of such individuals with mental illness, or representatives of such individuals or family members to assure that the eligible system is operating in compliance with the provisions of this title and title III; **[and]**

(10) not use allotments provided to a system in a manner inconsistent with section 5 of the Assisted Suicide Funding Restriction Act of 1997**[.]**; and

(11) *agree to refrain, during any period for which funding is provided to the system under this part, from using Federal funds to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local, or tribal government in policymaking and administrative processes within the executive branch of that government.*

(b) The Secretary and the agency of a State which administers its State plan under title XIX of the Social Security Act shall provide the eligible system of the State with a copy of each annual survey report and plan of corrections for cited deficiencies made

pursuant to titles XVIII and XIX of the Social Security Act with respect to any facility rendering care or treatment to individuals with mental illness in the State in which such system is located. A report or plan shall be made available within 30 days after the completion of the report or plan.

(c)(1)(A) Each system established in a State, through allotments received under section 103, to protect and advocate the rights of individuals with mental illness shall have a governing authority.

(B) In States in which the governing authority is organized as a private non-profit entity with a multi-member governing board, or a public system with a multi-member governing board, such governing board shall be selected according to the policies and procedures of the system. The governing board shall be composed of—

(i) members (to be selected no later than October 1, 1990) who broadly represent or are knowledgeable about the needs of the clients served by the system; and

(ii) in the case of a governing authority organized as a private non-profit entity, members who broadly represent or are knowledgeable about the needs of the clients served by the system including the chairperson of the advisory council of such system. As used in this subparagraph, the term “members who broadly represent or are knowledgeable about the needs of the clients served by the system” shall be construed to include individuals who have received or are receiving mental health services and family members of such individuals.

(2) The governing authority established under paragraph (1) shall—

(A) be responsible for the planning, design, implementation, and functioning of the system; and

(B) consistent with subparagraph (A), jointly develop the annual priorities of the system with the advisory council.

(d) *GRIEVANCE PROCEDURE.*—*The Secretary shall establish an independent grievance procedure for persons described in subsection (a)(9).*

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PART B—ADMINISTRATIVE PROVISIONS

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REPORTS BY THE SECRETARY

SEC. 114. (a) The Secretary shall include in each report required under section 105 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 a separate statement which contains—

(1) a description of the activities, accomplishments, and expenditures of systems to protect and advocate the rights of individuals with mental illness supported with payments from allotments under this title, including—

(A) a specification of the total number of individuals with mental illness served by such systems;

(B) a description of the types of activities undertaken by such systems;

(C) a description of the types of facilities providing care or treatment with respect to which such activities are undertaken;

- (D) a description of the manner in which such activities are initiated; and
- (E) a description of the accomplishments resulting from such activities;
- (2) a description of—
 - (A) systems to protect and advocate the rights of individuals with mental illness supported with payments from allotments under this title;
 - (B) activities conducted by States to protect and advocate such rights;
 - (C) mechanisms established by residential facilities for individuals with mental illness to protect and advocate such rights; and
 - (D) the coordination among such systems, activities, and mechanisms;
- (3) a specification of the number of systems established with allotments under this title and of whether each such system was established by a public or nonprofit private entity; **[and]**
- (4) recommendations for activities and services to improve the protection and advocacy of the rights of individuals with mental illness and a description of needs for such activities and services which have not been met by systems established under this title~~].~~; *and*
- (5) *using data from the existing required annual program progress reports submitted by each system funded under this title, a detailed accounting for each such system 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.*

(b) In preparing each statement required by subsection (a), the Secretary shall use and include information submitted to the Secretary in the reports required under section 105(a)(7).

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SOCIAL SECURITY ACT

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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PAYMENT TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

- (1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) and (j) of this section and subsection 1923(f) of the total amount expended during such quarter as medical assistance under the State plan; plus
- (2)(A) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the

Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency or any other public agency; plus

(B) notwithstanding paragraph (1) or subparagraph (A), with respect to amounts expended for nursing aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) (including the costs for nurse aides to complete such competency evaluation programs), regardless of whether the programs are provided in or outside nursing facilities or of the skill of the personnel involved in such programs, an amount equal to 50 percent (or, for calendar quarters beginning on or after July 1, 1988, and before October 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such programs; plus

(C) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to preadmission screening and resident review activities conducted by the State under section 1919(e)(7); plus

(D) for each calendar quarter during—

- (i) fiscal year 1991, an amount equal to 90 percent,
- (ii) fiscal year 1992, an amount equal to 85 percent,
- (iii) fiscal year 1993, an amount equal to 80 percent, and
- (iv) fiscal year 1994 and thereafter, an amount equal to 75 percent,

of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to State activities under section 1919(g); plus

(E) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to translation or interpretation services in connection with the enrollment of, retention of, and use of services under this title by, children of families for whom English is not the primary language; plus

(3) an amount equal to—

(A)(i) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of title XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such

State's plan and the plan of any other State approved under this title,

(ii) 90 per centum of so much of the sums expended during any such quarter in the fiscal year ending June 30, 1972, or the fiscal year ending June 30, 1973, as are attributable to the design, development, or installation of cost determination systems for State-owned general hospitals (except that the total amount paid to all States under this clause for either such fiscal year shall not exceed \$150,000), and

(iii) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b)) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such developments or modifications of systems of the type described in clause (i) as are necessary for the efficient collection and reporting on child health measures; and

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; and

(C)(i) 75 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of medical and utilization review by a utilization and quality control peer review organization or by an entity which meets the requirements of section 1152, as determined by the Secretary, under a contract entered into under section 1902(d); and

(ii) 75 percent of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of independent external reviews conducted under section 1932(c)(2); and

(D) 75 percent of so much of the sums expended by the State plan during a quarter in 1991, 1992, or 1993, as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of section 1927(g);

(E) 50 percent of the sums expended with respect to costs incurred during such quarter as are attributable to providing—

(i) services to identify and educate individuals who are likely to be eligible for medical assistance under this title and who have Sickle Cell Disease or who are carriers of the sickle cell gene, including education regarding how to identify such individuals; or

(ii) education regarding the risks of stroke and other complications, as well as the prevention of stroke and other complications, in individuals who are likely to be eligible for medical assistance under this title and who have Sickle Cell Disease; and

(F)(i) 100 percent of so much of the sums expended during such quarter as are attributable to payments to Medicaid providers described in subsection (t)(1) to encourage the adoption and use of certified EHR technology; and

(ii) 90 percent of so much of the sums expended during such quarter as are attributable to payments for reasonable administrative expenses related to the administration of payments described in clause (i) if the State meets the condition described in subsection (t)(9); plus

(H)(i) 90 percent of the sums expended during the quarter as are attributable to the design, development, or installation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement section 1902(ee) (including a system described in paragraph (2)(B) thereof), and

(ii) 75 percent of the sums expended during the quarter as are attributable to the operation of systems to which clause (i) applies, plus

(4) an amount equal to 100 percent of the sums expended during the quarter which are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus

(5) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the offering, arranging, and furnishing (directly or on a contract basis) of family planning services and supplies;

(6) subject to subsection (b)(3), an amount equal to—

(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and

(B) 75 per centum of the sums expended during each succeeding calendar quarter, with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to the establishment and operation of (including the training of personnel employed by) a State Medicaid fraud control unit (described in subsection (q)); plus

(7) subject to section 1919(g)(3)(B), an amount equal to 50 per centum of the remainder of the amounts expended during

such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b)(1) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter beginning after December 31, 1969, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under title XVIII which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of title XVIII, other than amounts expended under provisions of the plan of such State required by section 1902(a)(34).

(2) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

(3) The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a)(6) may not exceed the higher of—

(A) \$125,000, or

(B) one-quarter of 1 per centum of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this title.

(4) Amounts expended by a State for the use of an enrollment broker in marketing medicaid managed care organizations and other managed care entities to eligible individuals under this title shall be considered, for purposes of subsection (a)(7), to be necessary for the proper and efficient administration of the State plan but only if the following conditions are met with respect to the broker:

(A) The broker is independent of any such entity and of any health care providers (whether or not any such provider participates in the State plan under this title) that provide coverage of services in the same State in which the broker is conducting enrollment activities.

(B) No person who is an owner, employee, consultant, or has a contract with the broker either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program under this title or title XVIII or debarred by any Federal agency, or subject to a civil money penalty under this Act.

(5) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State shall be decreased in a quarter by the amount of any health care related taxes (described in section 1902(w)(3)(A)) that are imposed on a hospital described in subsection (w)(3)(F) in that quarter.

(c) Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part C of such Act.

(d)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2)(A) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(B) Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1902(a)(25).

(C) For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 1 year in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 1-year period, whether or not recovery was made.

(D)(i) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).

(ii) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity due to fraud within 1 year of discovery because there is not a final determination of the amount of the overpayment under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof) before the date that is 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3)(A) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(B)(i) Subparagraph (A) and paragraph (2)(B) shall not apply to any amount recovered or paid to a State as part of the comprehen-

sive settlement of November 1998 between manufacturers of tobacco products, as defined in section 5702(d) of the Internal Revenue Code of 1986, and State Attorneys General, or as part of any individual State settlement or judgment reached in litigation initiated or pursued by a State against one or more such manufacturers.

(ii) Except as provided in subsection (i)(19), a State may use amounts recovered or paid to the State as part of a comprehensive or individual settlement, or a judgment, described in clause (i) for any expenditures determined appropriate by the State.

(4) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(5) In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under section 1116(d), and such State disputes such disallowance, the amount of the Federal payment in controversy shall, at the option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount. If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent payments made to such State under this title, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount was disallowed and ending on the date of such final determination at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day treasury bill auction rates during such period.

(6)(A) Each State (as defined in subsection (w)(7)(D)) shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to—

(i) provider-related donations made to the State or units of local government during such fiscal year, and

(ii) health care related taxes collected by the State or such units during such fiscal year.

(B) Each State shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to the total amount of payment adjustments made, and the amount of payment adjustments made to individual providers (by provider), under section 1923(c) during such fiscal year.

(e) A State plan approved under this title may include, as a cost with respect to hospital services under the plan under this title, periodic expenditures made to reflect transitional allowances established with respect to a hospital closure or conversion under section 1884.

(f)(1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

(B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the

amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133 $\frac{1}{3}$ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of title IV of this Act.

(ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.

(C) The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of \$100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of \$100 or such other amount, as the case may be.

(2)(A) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred by such family for medical care or for any other type of remedial care recognized under State law or, (B) notwithstanding section 1916 at State option, an amount paid by such family, at the family's option, to the State, provided that the amount, when combined with costs incurred in prior months, is sufficient when excluded from the family's income to reduce such family's income below the applicable income limitation described in paragraph (1). The amount of State expenditures for which medical assistance is available under subsection (a)(1) will be reduced by amounts paid to the State pursuant to this subparagraph.

(3) For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of title IV of this Act shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan provided for aid to such a family.

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual described in section 1902(a)(10)(A)(i)(III), 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(V), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), 1902(a)(10)(A)(i)(VIII), 1902(a)(10)(A)(i)(IX), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(A)(ii)(XIII), 1902(a)(10)(A)(ii)(XIV), or 1902(a)(10)(A)(ii)(XV), 1902(a)(10)(A)(ii)(XVI), 1902(a)(10)(A)(ii)(XVII), 1902(a)(10)(A)(ii)(XVIII), 1902(a)(10)(A)(ii)(XIX), 1902(a)(10)(A)(ii)(XX), 1902(a)(10)(A)(ii)(XXI), 1902(a)(10)(A)(ii)(XXII), 1905(p)(1) or for any individual—

(A) who is receiving aid or assistance under any plan of the State approved under title I, X, XIV or XVI, or part A of title

IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or

(B) who is not receiving such aid or assistance, and with respect to whom such benefits are not being paid, but (i) is eligible to receive such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or assistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), or who is a PACE program eligible individual enrolled in a PACE program under section 1934, but only if the income of such individual (as determined under section 1612, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1),

at the time of the provision of the medical assistance giving rise to such expenditure.

(g)(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1876 or which is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act)), the Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services or services in an intermediate care facility for the mentally retarded for 60 days or inpatient mental hospital services for 90 days (whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services or services in an intermediate care facility for the mentally retarded furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals and intermediate care facilities for the mentally retarded pursuant to paragraphs (26) and (31) of section 1902(a) whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams. In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1812.

(2) The Secretary shall, as part of his validation procedures under this subsection, conduct timely sample onsite surveys of pri-

vate and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this title, and his findings with respect to such surveys (as well as the showings of the State agency required under this subsection) shall be made available for public inspection.

(3)(A) No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect—

(i) if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning before January 1, 1977;

(ii) before January 1, 1978;

(iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes effect; or

(iv) due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after September 30, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.

(B) The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State, made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before January 1, 1978, is determined to be either unsatisfactory under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to any calendar quarter ending on or before December 31, 1978, is satisfactory under such paragraph and is valid under paragraph (2).

(4)(A) The Secretary may not find the showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter, unless the State demonstrates to the satisfaction of the Secretary good cause for not meeting such deadline.

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals and intermediate care facilities for the mentally retarded under paragraphs (26) and (31) of section 1902(a), if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—

(i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and

(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

(5) In the case of a State's unsatisfactory or invalid showing made with respect to a type of facility or institutional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1) is equal to $33\frac{1}{3}$ per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the State plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of such patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter.

(6)(A) Recertifications required under section 1902(a)(44) shall be conducted at least every 60 days in the case of inpatient hospital services.

(B) Such recertifications in the case of services in an intermediate care facility for the mentally retarded shall be conducted at least—

- (i) 60 days after the date of the initial certification,
- (ii) 180 days after the date of the initial certification,
- (iii) 12 months after the date of the initial certification,
- (iv) 18 months after the date of the initial certification,
- (v) 24 months after the date of the initial certification, and
- (vi) every 12 months thereafter.

(C) For purposes of determining compliance with the schedule established by this paragraph, a recertification shall be considered to have been done on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required and the State establishes good cause why the physician or other person making such recertification did not meet such schedule.

(i) Payment under the preceding provisions of this section shall not be made—

(1) for organ transplant procedures unless the State plan provides for written standards respecting the coverage of such procedures and unless such standards provide that—

(A) similarly situated individuals are treated alike; and

(B) any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan; or

(2) with respect to any amount expended for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—

(A) under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2),

(B) at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew or had reason to know of the exclusion (after

a reasonable time period after reasonable notice has been furnished to the person); or

(C) by any individual or entity to whom the State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of section 1862(o) and this subparagraph, unless the State determines in accordance with such regulations there is good cause not to suspend such payments; or

(3) with respect to any amount expended for inpatient hospital services furnished under the plan (other than amounts attributable to the special situation of a hospital which serves a disproportionate number of low income patients with special needs) to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for care or services furnished under the plan by a hospital unless such hospital has in effect a utilization review plan which meets the requirements imposed by section 1861(k) for purposes of title XVIII; and if such hospital has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k); or

(5) with respect to any amount expended for any drug product for which payment may not be made under part B of title XVIII because of section 1862(c); or

(6) with respect to any amount expended for inpatient hospital tests (other than in emergency situations) not specifically ordered by the attending physician or other responsible practitioner; or

(7) with respect to any amount expended for clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital, to the extent such amount exceeds the amount that would be recognized under section 1833(h) for such tests performed for an individual enrolled under part B of title XVIII; or

(8) with respect to any amount expended for medical assistance (A) for nursing facility services to reimburse (or otherwise compensate) a nursing facility for payment of a civil money penalty imposed under section 1919(h) or (B) for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty im-

posed under this title or title XI or for legal expenses in defense of an exclusion or civil money penalty under this title or title XI if there is no reasonable legal ground for the provider's case; or

(10)(A) with respect to covered outpatient drugs unless there is a rebate agreement in effect under section 1927 with respect to such drugs or unless section 1927(a)(3) applies,

(B) with respect to any amount expended for an innovator multiple source drug (as defined in section 1927(k)) dispensed on or after July 1, 1991, if, under applicable State law, a less expensive multiple source drug could have been dispensed, but only to the extent that such amount exceeds the upper payment limit for such multiple source drug;

(C) with respect to covered outpatient drugs described in section 1927(a)(7), unless information respecting utilization data and coding on such drugs that is required to be submitted under such section is submitted in accordance with such section, and

(D) with respect to any amount expended for reimbursement to a pharmacy under this title for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment under this title (other than with respect to a reasonable restocking fee for such drug); or

(11) with respect to any amount expended for physicians' services furnished on or after the first day of the first quarter beginning more than 60 days after the date of establishment of the physician identifier system under section 1902(x), unless the claim for the services includes the unique physician identifier provided under such system; or

(13) with respect to any amount expended to reimburse (or otherwise compensate) a nursing facility for payment of legal expenses associated with any action initiated by the facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action; or

(14) with respect to any amount expended on administrative costs to carry out the program under section 1928; or

(15) with respect to any amount expended for a single-antigen vaccine and its administration in any case in which the administration of a combined-antigen vaccine was medically appropriate (as determined by the Secretary); or

(16) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; or

(17) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan under this title; or

(18) with respect to any amount expended for home health care services provided by an agency or organization unless the agency or organization provides the State agency on a continuing basis a surety bond in a form specified by the Secretary under paragraph (7) of section 1861(o) and in an amount that is not less than \$50,000 or such comparable surety bond as the Secretary may permit under the last sentence of such section; or

(19) with respect to any amount expended on administrative costs to initiate or pursue litigation described in subsection (d)(3)(B);

(20) with respect to amounts expended for medical assistance provided to an individual described in subclause (XV) or (XVI) of section 1902(a)(10)(A)(ii) for a fiscal year unless the State demonstrates to the satisfaction of the Secretary that the level of State funds expended for such fiscal year for programs to enable working individuals with disabilities to work (other than for such medical assistance) is not less than the level expended for such programs during the most recent State fiscal year ending before the date of the enactment of this paragraph;

(21) with respect to amounts expended for covered outpatient drugs described in section 1927(d)(2)(K) (relating to drugs when used for treatment of sexual or erectile dysfunction);

(22) with respect to amounts expended for medical assistance for an individual who declares under section 1137(d)(1)(A) to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this title, unless the requirement of section 1902(a)(46)(B) is met;

(23) with respect to amounts expended for medical assistance for covered outpatient drugs (as defined in section 1927(k)(2)) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad;

(24) if a State is required to implement an asset verification program under section 1940 and fails to implement such program in accordance with such section, with respect to amounts expended by such State for medical assistance for individuals subject to asset verification under such section, unless—

(A) the State demonstrates to the Secretary's satisfaction that the State made a good faith effort to comply;

(B) not later than 60 days after the date of a finding that the State is in noncompliance, the State submits to the Secretary (and the Secretary approves) a corrective action plan to remedy such noncompliance; and

(C) not later than 12 months after the date of such submission (and approval), the State fulfills the terms of such corrective action plan;

(25) with respect to any amounts expended for medical assistance for individuals for whom the State does not report enrollee encounter data (as defined by the Secretary) to the Medicaid Statistical Information System (MSIS) in a timely manner (as determined by the Secretary);

(26) with respect to any amounts expended for medical assistance for individuals described in subclause (VIII) of subsection (a)(10)(A)(i) other than medical assistance provided through benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2); or

(27) with respect to any amounts expended by the State on the basis of a fee schedule for items described in section 1861(n) and furnished on or after January 1, 2019, as determined in the aggregate with respect to each class of such items as defined by the Secretary, in excess of the aggregate amount,

if any, that would be paid for such items within such class on a fee-for-service basis under the program under part B of title XVIII, including, as applicable, under a competitive acquisition program under section 1847 in an area of the State.

Nothing in paragraph (1) shall be construed as permitting a State to provide services under its plan under this title that are not reasonable in amount, duration, and scope to achieve their purpose. Paragraphs (1), (2), (16), (17), and (18) shall apply with respect to items or services furnished and amounts expended by or through a managed care entity (as defined in section 1932(a)(1)(B)) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.

(j) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 1914.

(k) The Secretary is authorized to provide at the request of any State (and without cost to such State) such technical and actuarial assistance as may be necessary to assist such State to contract with any medicaid managed care organization which meets the requirements of subsection (m) of this section for the purpose of providing medical care and services to individuals who are entitled to medical assistance under this title.

(l)(1) Subject to paragraphs (3) and (4), with respect to any amount expended for personal care services or home health care services requiring an in-home visit by a provider that are provided under a State plan under this title (or under a waiver of the plan) and furnished in a calendar quarter beginning on or after January 1, 2019 (or, in the case of home health care services, on or after January 1, 2023), unless a State requires the use of an electronic visit verification system for such services furnished in such quarter under the plan or such waiver, the Federal medical assistance percentage shall be reduced—

(A) in the case of personal care services—

(i) for calendar quarters in 2019 and 2020, by .25 percentage points;

(ii) for calendar quarters in 2021, by .5 percentage points;

(iii) for calendar quarters in 2022, by .75 percentage points; and

(iv) for calendar quarters in 2023 and each year thereafter, by 1 percentage point; and

(B) in the case of home health care services—

(i) for calendar quarters in 2023 and 2024, by .25 percentage points;

(ii) for calendar quarters in 2025, by .5 percentage points;

(iii) for calendar quarters in 2026, by .75 percentage points; and

(iv) for calendar quarters in 2027 and each year thereafter, by 1 percentage point.

(2) Subject to paragraphs (3) and (4), in implementing the requirement for the use of an electronic visit verification system under paragraph (1), a State shall—

(A) consult with agencies and entities that provide personal care services, home health care services, or both under the State plan (or under a waiver of the plan) to ensure that such system—

- (i) is minimally burdensome;
 - (ii) takes into account existing best practices and electronic visit verification systems in use in the State; and
 - (iii) is conducted in accordance with the requirements of HIPAA privacy and security law (as defined in section 3009 of the Public Health Service Act);
- (B) take into account a stakeholder process that includes input from beneficiaries, family caregivers, personal care or home health care services workers, and other stakeholders, as determined by the State in accordance with guidance from the Secretary; and
- (C) ensure that individuals who furnish personal care services, home health care services, or both under the State plan (or under a waiver of the plan) are provided the opportunity for training on the use of such system.
- (3) Paragraphs (1) and (2) shall not apply in the case of a State that, as of the date of the enactment of this subsection, requires the use of any system for the electronic verification of visits conducted as part of both personal care services and home health care services.
- (4)(A) In the case of a State described in subparagraph (B), the reduction under paragraph (1) shall not apply—
- (i) in the case of personal care services, for calendar quarters in 2019; and
 - (ii) in the case of home health care services, for calendar quarters in 2023.
- (B) For purposes of subparagraph (A), a State described in this subparagraph is a State that demonstrates to the Secretary that the State—
- (i) has made a good faith effort to comply with the requirements of paragraphs (1) and (2) (including by taking steps to adopt the technology used for an electronic visit verification system); or
 - (ii) in implementing such a system, has encountered unavoidable system delays.
- (5) In this subsection:
- (A) The term “electronic visit verification system” means, with respect to personal care services or home health care services, a system under which visits conducted as part of such services are electronically verified with respect to—
- (i) the type of service performed;
 - (ii) the individual receiving the service;
 - (iii) the date of the service;
 - (iv) the location of service delivery;
 - (v) the individual providing the service; and
 - (vi) the time the service begins and ends.
- (B) The term “home health care services” means services described in section 1905(a)(7) provided under a State plan under this title (or under a waiver of the plan).
- (C) The term “personal care services” means personal care services provided under a State plan under this title (or under a waiver of the plan), including services provided under section 1905(a)(24), 1915(c), 1915(i), 1915(j), or 1915(k) or under a wavier under section 1115.
- (6)(A) In the case in which a State requires personal care service and home health care service providers to utilize an electronic visit

verification system operated by the State or a contractor on behalf of the State, the Secretary shall pay to the State, for each quarter, an amount equal to 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such system, and 75 per centum of so much of the sums for the operation and maintenance of such system.

(B) Subparagraph (A) shall not apply in the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system that is not operated by the State or a contractor on behalf of the State.

(m)(1)(A) The term “medicaid managed care organization” means a health maintenance organization, an eligible organization with a contract under section 1876 or a Medicare+Choice organization with a contract under part C of title XVIII, a provider sponsored organization, or any other public or private organization, which meets the requirement of section 1902(w) and—

(i) makes services it provides to individuals eligible for benefits under this title accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for medical assistance under the State plan) not enrolled with the organization, and

(ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State, meets the requirements of subparagraph (C)(i) (if applicable), and which assures that individuals eligible for benefits under this title are in no case held liable for debts of the organization in case of the organization’s insolvency.

An organization that is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) is deemed to meet the requirements of clauses (i) and (ii).

(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a medicaid managed care organization within the meaning of subparagraph (A), shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

(C)(i) Subject to clause (ii), a provision meets the requirements of this subparagraph for an organization if the organization meets solvency standards established by the State for private health maintenance organizations or is licensed or certified by the State as a risk-bearing entity.

(ii) Clause (i) shall not apply to an organization if—

(I) the organization is not responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and physicians’ services;

(II) the organization is a public entity;

(III) the solvency of the organization is guaranteed by the State; or

(IV) the organization is (or is controlled by) one or more Federally-qualified health centers and meets solvency standards established by the State for such an organization.

For purposes of subclause (IV), the term “control” means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization

through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.

(2)(A) Except as provided in subparagraphs (B), (C), and (G), no payment shall be made under this title to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization) which is responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1905(a) or for the provision of any three or more of the services described in such paragraphs unless—

(i) the Secretary has determined that the entity is a Medicaid managed care organization organization as defined in paragraph (1);

(iii) such services are provided for the benefit of individuals eligible for benefits under this title in accordance with a contract between the State and the entity under which prepaid payments to the entity are made on an actuarially sound basis and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of \$1,000,000 for 1998 and, for a subsequent year, the amount established under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year;

(iv) such contract provides that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain (I) to the ability of the entity to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

(v) such contract provides that in the entity's enrollment, re-enrollment, or disenrollment of individuals who are eligible for benefits under this title and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services;

(vi) such contract (I) permits individuals who have elected under the plan to enroll with the entity for provision of such benefits to terminate such enrollment in accordance with section 1932(a)(4), and (II) provides for notification in accordance with such section of each such individual, at the time of the individual's enrollment, of such right to terminate such enrollment;

(vii) such contract provides that, in the case of medically necessary services which were provided (I) to an individual enrolled with the entity under the contract and entitled to benefits with respect to such services under the State's plan and (II) other than through the organization because the services were immediately required due to an unforeseen illness, injury, or condition, either the entity or the State provides for reimbursement with respect to those services,

(viii) such contract provides for disclosure of information in accordance with section 1124 and paragraph (4) of this subsection;

(ix) such contract provides, in the case of an entity that has entered into a contract for the provision of services with a Federally-qualified health center or a rural health clinic, that the entity shall provide payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not a Federally-qualified health center or a rural health clinic;

(x) any physician incentive plan that it operates meets the requirements described in section 1876(i)(8);

(xi) such contract provides for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary;

(xii) such contract, and the entity complies with the applicable requirements of section 1932; and

(xiii) such contract provides that (I) covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1927 as the State is subject to and that the State shall collect such rebates from manufacturers, (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates, and (III) the entity shall report to the State, on such timely and periodic basis as specified by the Secretary in order to include in the information submitted by the State to a manufacturer and the Secretary under section 1927(b)(2)(A), information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drug under this subsection (other than covered outpatient drugs that under subsection (j)(1) of section 1927 are not subject to the requirements of that section) and such other data as the Secretary determines necessary to carry out this subsection.

(B) Subparagraph (A) except with respect to clause (ix) of subparagraph (A), does not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

(i)(I) received a grant of at least \$100,000 in the fiscal year ending June 30, 1976, under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act, and for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title has been the recipient of a grant under either such section; and

(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section

1905(a) and, to the extent required by section 1902(a)(10)(D) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a); or

(ii) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

(I) which received in the fiscal year ending June 30, 1976, at least \$100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

(II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this title on a prepaid capitation risk basis or on any other risk basis; or

(iii) which has contracted with the single State agency for the provision of services (but not including inpatient hospital services) to persons eligible under this title on a prepaid risk basis prior to 1970.

(G) In the case of an entity which is receiving (and has received during the previous two years) a grant of at least \$100,000 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act or is receiving (and has received during the previous two years) at least \$100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, clause (i) of subparagraph (A) shall not apply.

(H) In the case of an individual who—

(i) in a month is eligible for benefits under this title and enrolled with a medicaid managed care organization with a contract under this paragraph or with a primary care case manager with a contract described in section 1905(t)(3),

(ii) in the next month (or in the next 2 months) is not eligible for such benefits, but

(iii) in the succeeding month is again eligible for such benefits,

the State plan, subject to subparagraph (A)(vi), may enroll the individual for that succeeding month with the organization described in clause (i) if the organization continues to have a contract under this paragraph with the State or with the manager described in such clause if the manager continues to have a contract described in section 1905(t)(3) with the State.

(I)(i) Notwithstanding the limitation specified in the subdivision (B) following paragraph (29) of section 1905(a) and subject to clause (ii), a State may, under a risk contract entered into by the State under this title (or under section 1115) with a medicaid managed care organization or a prepaid inpatient health plan (as defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation)), make a monthly capitation payment to such organization or plan for enrollees with the organization or plan who are over 21 years of age and under 65 years of age and are receiving

inpatient treatment in an institution for mental diseases (as defined in section 1905(i)), so long as each of the following conditions is met:

(I) The institution is a hospital providing inpatient psychiatric or substance use disorder services or a sub-acute facility providing psychiatric or substance use disorder crisis residential services.

(II) The length of stay in such an institution for such treatment is for a short-term stay of no more than 15 days during the period of the monthly capitation payment.

(III) The provision of such treatment meets the following criteria for consideration as services or settings that are in lieu of services or settings covered under the State plan:

(aa) The State determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the State plan.

(bb) The enrollee is not required by the managed care organization or prepaid inpatient health plan to use the alternative service or setting.

(cc) Such treatment is authorized and identified in such contract, and will be offered to such enrollees at the option of the managed care organization or prepaid inpatient health plan.

(ii) For purposes of setting the amount of such a monthly capitation payment, a State may use the utilization of services provided to an individual under this subparagraph when developing the inpatient psychiatric or substance use disorder component of such payment, but the amount of such payment for such services may not exceed the cost of the same services furnished through providers included under the State plan.

(4)(A) Each medicaid managed care organization which is not a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General a description of transactions between the organization and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

(i) Any sale or exchange, or leasing of any property between the organization and such a party.

(ii) Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

(iii) Any lending of money or other extension of credit between the organization and such a party.

The State or Secretary may require that information reported respecting an organization which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(B) Each organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

(5)(A) If the Secretary determines that an entity with a contract under this subsection—

(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(ii) imposes premiums on individuals enrolled under this subsection in excess of the premiums permitted under this title;

(iii) acts to discriminate among individuals in violation of the provision of paragraph (2)(A)(v), including expulsion or refusal to re-enroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this subsection) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(iv) misrepresents or falsifies information that is furnished—

(I) to the Secretary or the State under this subsection,

or

(II) to an individual or to any other entity under this subsection, or

(v) fails to comply with the requirements of section 1876(i)(8),

the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in subparagraph (B).

(B) The remedies described in this subparagraph are—

(i) civil money penalties of not more than \$25,000 for each determination under subparagraph (A), or, with respect to a determination under clause (iii) or (iv)(I) of such subparagraph, of not more than \$100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iii), \$15,000 for each individual not enrolled as a result of a practice described in such subparagraph, or

(ii) denial of payment to the State for medical assistance furnished under the contract under this subsection for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(6)(A) For purposes of this subsection and section 1902(e)(2)(A), in the case of the State of New Jersey, the term “contract” shall be deemed to include an undertaking by the State agency, in the State plan under this title, to operate a program meeting all requirements of this subsection.

(B) The undertaking described in subparagraph (A) must provide—

(i) for the establishment of a separate entity responsible for the operation of a program meeting the requirements of this subsection, which entity may be a subdivision of the State agency administering the State plan under this title;

(ii) for separate accounting for the funds used to operate such program; and

(iii) for setting the capitation rates and any other payment rates for services provided in accordance with this subsection using a methodology satisfactory to the Secretary designed to ensure that total Federal matching payments under this title for such services will be lower than the matching payments that would be made for the same services, if provided under the State plan on a fee for service basis to an actuarially equivalent population.

(C) The undertaking described in subparagraph (A) shall be subject to approval (and annual re-approval) by the Secretary in the same manner as a contract under this subsection.

(D) The undertaking described in subparagraph (A) shall not be eligible for a waiver under section 1915(b).

(o) Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions of this section for expenditures for medical assistance provided for an individual under its State plan approved under this title to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.

(p)(1) When a political subdivision of a State makes, for the State of which it is a political subdivision, or one State makes, for another State, the enforcement and collection of rights of support or payment assigned under section 1912, pursuant to a cooperative arrangement under such section (either within or outside of such State), there shall be paid to such political subdivision or such other State from amounts which would otherwise represent the Federal share of payments for medical assistance provided to the eligible individuals on whose behalf such enforcement and collection was made, an amount equal to 15 percent of any amount collected which is attributable to such rights of support or payment.

(2) Where more than one jurisdiction is involved in such enforcement or collection, the amount of the incentive payment determined under paragraph (1) shall be allocated among the jurisdictions in a manner to be prescribed by the Secretary.

(q) For the purposes of this section, the term “State medicaid fraud control unit” means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

(1) The entity (A) is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for

criminal violations, (B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Secretary, that (i) assure its referral of suspected criminal violations relating to the program under this title to the appropriate authority or authorities in the State for prosecution and (ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions, or (C) has a formal working relationship with the office of the State Attorney General and has formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Secretary and which provide effective coordination of activities between the entity and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the program under this title.

(2) The entity is separate and distinct from the single State agency that administers or supervises the administration of the State plan under this title.

(3) The entity's function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with (A) any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan under this title; and (B) upon the approval of the Inspector General of the relevant Federal agency, any aspect of the provision of health care services and activities of providers of such services under any Federal health care program (as defined in section 1128B(f)(1)), if the suspected fraud or violation of law in such case or investigation is primarily related to the State plan under this title.

(4)(A) The entity has—

(i) procedures for reviewing complaints of abuse or neglect of patients in health care facilities which receive payments under the State plan under this title;

(ii) at the option of the entity, procedures for reviewing complaints of abuse or neglect of patients residing in board and care facilities; and

(iii) procedures for acting upon such complaints under the criminal laws of the State or for referring such complaints to other State agencies for action.

(B) For purposes of this paragraph, the term "board and care facility" means a residential setting which receives payment (regardless of whether such payment is made under the State plan under this title) from or on behalf of two or more unrelated adults who reside in such facility, and for whom one or both of the following is provided:

(i) Nursing care services provided by, or under the supervision of, a registered nurse, licensed practical nurse, or licensed nursing assistant.

(ii) A substantial amount of personal care services that assist residents with the activities of daily living, including personal hygiene, dressing, bathing, eating, toileting, ambulation, transfer, positioning, self-medication, body care,

travel to medical services, essential shopping, meal preparation, laundry, and housework.

(5) The entity provides for the collection, or referral for collection to a single State agency, of overpayments that are made under the State plan or under any Federal health care program (as so defined) to health care facilities and that are discovered by the entity in carrying out its activities. All funds collected in accordance with this paragraph shall be credited exclusively to, and available for expenditure under, the Federal health care program (including the State plan under this title) that was subject to the activity that was the basis for the collection.

(6) The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity's activities.

(7) The entity submits to the Secretary an application and annual reports containing such information as the Secretary determines, by regulation, to be necessary to determine whether the entity meets the other requirements of this subsection.

(r)(1) In order to receive payments under subsection (a) for use of automated data systems in administration of the State plan under this title, a State must, in addition to meeting the requirements of paragraph (3), have in operation mechanized claims processing and information retrieval systems that meet the requirements of this subsection and that the Secretary has found—

(A) are adequate to provide efficient, economical, and effective administration of such State plan;

(B) are compatible with the claims processing and information retrieval systems used in the administration of title XVIII, and for this purpose—

(i) have a uniform identification coding system for providers, other payees, and beneficiaries under this title or title XVIII;

(ii) provide liaison between States and carriers and intermediaries with agreements under title XVIII to facilitate timely exchange of appropriate data;

(iii) provide for exchange of data between the States and the Secretary with respect to persons sanctioned under this title or title XVIII; and

(iv) effective for claims filed on or after October 1, 2010, incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other such methodologies of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with paragraph (4);

(C) are capable of providing accurate and timely data;

(D) are complying with the applicable provisions of part C of title XI;

(E) are designed to receive provider claims in standard formats to the extent specified by the Secretary; and

(F) effective for claims filed on or after January 1, 1999, provide for electronic transmission of claims data in the format

specified by the Secretary and consistent with the Medicaid Statistical Information System (MSIS) (including detailed individual enrollee encounter data and other information that the Secretary may find necessary and including, for data submitted to the Secretary on or after January 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for program integrity, program oversight, and administration, at such frequency as the Secretary shall determine).

(2) In order to meet the requirements of this paragraph, mechanized claims processing and information retrieval systems must meet the following requirements:

(A) The systems must be capable of developing provider, physician, and patient profiles which are sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

(B) The State must provide that information on probable fraud or abuse which is obtained from, or developed by, the systems, is made available to the State's medicaid fraud control unit (if any) certified under subsection (q) of this section.

(C) The systems must meet all performance standards and other requirements for initial approval developed by the Secretary.

(3) In order to meet the requirements of this paragraph, a State must have in operation an eligibility determination system which provides for data matching through the Public Assistance Reporting Information System (PARIS) facilitated by the Secretary (or any successor system), including matching with medical assistance programs operated by other States.

(4) For purposes of paragraph (1)(B)(iv), the Secretary shall do the following:

(A) Not later than September 1, 2010:

(i) Identify those methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under this title.

(ii) Identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under this title with respect to items or services for which States provide medical assistance under this title and no national correct coding methodologies have been established under such Initiative with respect to title XVIII.

(iii) Notify States of—

(I) the methodologies identified under subparagraphs (A) and (B) (and of any other national correct coding methodologies identified under subparagraph (B)); and

(II) how States are to incorporate such methodologies into claims filed under this title.

(B) Not later than March 1, 2011, submit a report to Congress that includes the notice to States under clause (iii) of subparagraph (A) and an analysis supporting the identification

of the methodologies made under clauses (i) and (ii) of subparagraph (A).

(s) Notwithstanding the preceding provisions of this section, no payment shall be made to a State under this section for expenditures for medical assistance under the State plan consisting of a designated health service (as defined in subsection (h)(6) of section 1877) furnished to an individual on the basis of a referral that would result in the denial of payment for the service under title XVIII if such title provided for coverage of such service to the same extent and under the same terms and conditions as under the State plan, and subsections (f) and (g)(5) of such section shall apply to a provider of such a designated health service for which payment may be made under this title in the same manner as such subsections apply to a provider of such a service for which payment may be made under such title.

(t)(1) For purposes of subsection (a)(3)(F), the payments described in this paragraph to encourage the adoption and use of certified EHR technology are payments made by the State in accordance with this subsection —

(A) to Medicaid providers described in paragraph (2)(A) not in excess of 85 percent of net average allowable costs (as defined in paragraph (3)(E)) for certified EHR technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology) with respect to such providers; and

(B) to Medicaid providers described in paragraph (2)(B) not in excess of the maximum amount permitted under paragraph (5) for the provider involved.

(2) In this subsection and subsection (a)(3)(F), the term “Medicaid provider” means—

(A) an eligible professional (as defined in paragraph (3)(B))—

(i) who is not hospital-based and has at least 30 percent of the professional’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this title;

(ii) who is not described in clause (i), who is a pediatrician, who is not hospital-based, and who has at least 20 percent of the professional’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this title; and

(iii) who practices predominantly in a Federally qualified health center or rural health clinic and has at least 30 percent of the professional’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to needy individuals (as defined in paragraph (3)(F)); and

(B)(i) a children’s hospital, or

(ii) an acute-care hospital that is not described in clause (i) and that has at least 10 percent of the hospital’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this title.

An eligible professional shall not qualify as a Medicaid provider under this subsection unless any right to payment under sections 1848(o) and 1853(l) with respect to the eligible professional has been waived in a manner specified by the Secretary. For purposes of calculating patient volume under subparagraph (A)(iii), insofar as it is related to uncompensated care, the Secretary may require the adjustment of such uncompensated care data so that it would be an appropriate proxy for charity care, including a downward adjustment to eliminate bad debt data from uncompensated care. In applying subparagraphs (A) and (B)(ii), the methodology established by the Secretary for patient volume shall include individuals enrolled in a Medicaid managed care plan (under section 1903(m) or section 1932).

(3) In this subsection and subsection (a)(3)(F):

(A) The term “certified EHR technology” means a qualified electronic health record (as defined in 3000(13) of the Public Health Service Act) that is certified pursuant to section 3001(c)(5) of such Act as meeting standards adopted under section 3004 of such Act that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

(B) The term “eligible professional” means a—

- (i) physician;
- (ii) dentist;
- (iii) certified nurse mid-wife;
- (iv) nurse practitioner; and

(v) physician assistant insofar as the assistant is practicing in a rural health clinic that is led by a physician assistant or is practicing in a Federally qualified health center that is so led.

(C) The term “average allowable costs” means, with respect to certified EHR technology of Medicaid providers described in paragraph (2)(A) for—

(i) the first year of payment with respect to such a provider, the average costs for the purchase and initial implementation or upgrade of such technology (and support services including training that is for, or is necessary for the adoption and initial operation of, such technology) for such providers, as determined by the Secretary based upon studies conducted under paragraph (4)(C); and

(ii) a subsequent year of payment with respect to such a provider, the average costs not described in clause (i) relating to the operation, maintenance, and use of such technology for such providers, as determined by the Secretary based upon studies conducted under paragraph (4)(C).

(D) The term “hospital-based” means, with respect to an eligible professional, a professional (such as a pathologist, anesthesiologist, or emergency physician) who furnishes substantially all of the individual’s professional services in a hospital inpatient or emergency room setting and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by

the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.

(E) The term “net average allowable costs” means, with respect to a Medicaid provider described in paragraph (2)(A), average allowable costs reduced by the average payment the Secretary estimates will be made to such Medicaid providers (determined on a percentage or other basis for such classes or types of providers as the Secretary may specify) from other sources (other than under this subsection, or by the Federal government or a State or local government) that is directly attributable to payment for certified EHR technology or support services described in subparagraph (C).

(F) The term “needy individual” means, with respect to a Medicaid provider, an individual—

- (i) who is receiving assistance under this title;
 - (ii) who is receiving assistance under title XXI;
 - (iii) who is furnished uncompensated care by the provider; or
 - (iv) for whom charges are reduced by the provider on a sliding scale basis based on an individual’s ability to pay.
- (4)(A) With respect to a Medicaid provider described in paragraph (2)(A), subject to subparagraph (B), in no case shall—
- (i) the net average allowable costs under this subsection for the first year of payment (which may not be later than 2016), which is intended to cover the costs described in paragraph (3)(C)(i), exceed \$25,000 (or such lesser amount as the Secretary determines based on studies conducted under subparagraph (C));
 - (ii) the net average allowable costs under this subsection for a subsequent year of payment, which is intended to cover costs described in paragraph (3)(C)(ii), exceed \$10,000; and
 - (iii) payments be made for costs described in clause (ii) after 2021 or over a period of longer than 5 years.

(B) In the case of Medicaid provider described in paragraph (2)(A)(ii), the dollar amounts specified in subparagraph (A) shall be $\frac{2}{3}$ of the dollar amounts otherwise specified.

(C) For the purposes of determining average allowable costs under this subsection, the Secretary shall study the average costs to Medicaid providers described in paragraph (2)(A) of purchase and initial implementation and upgrade of certified EHR technology described in paragraph (3)(C)(i) and the average costs to such providers of operations, maintenance, and use of such technology described in paragraph (3)(C)(ii). In determining such costs for such providers, the Secretary may utilize studies of such amounts submitted by States.

(5)(A) In no case shall the payments described in paragraph (1)(B) with respect to a Medicaid provider described in paragraph (2)(B) exceed—

- (i) in the aggregate the product of—
 - (I) the overall hospital EHR amount for the provider computed under subparagraph (B); and
 - (II) the Medicaid share for such provider computed under subparagraph (C);

- (ii) in any year 50 percent of the product described in clause (i); and
- (iii) in any 2-year period 90 percent of such product.

(B) For purposes of this paragraph, the overall hospital EHR amount, with respect to a Medicaid provider, is the sum of the applicable amounts specified in section 1886(n)(2)(A) for such provider for the first 4 payment years (as estimated by the Secretary) determined as if the Medicare share specified in clause (ii) of such section were 1. The Secretary shall establish, in consultation with the State, the overall hospital EHR amount for each such Medicaid provider eligible for payments under paragraph (1)(B). For purposes of this subparagraph in computing the amounts under section 1886(n)(2)(C) for payment years after the first payment year, the Secretary shall assume that in subsequent payment years discharges increase at the average annual rate of growth of the most recent 3 years for which discharge data are available per year.

(C) The Medicaid share computed under this subparagraph, for a Medicaid provider for a period specified by the Secretary, shall be calculated in the same manner as the Medicare share under section 1886(n)(2)(D) for such a hospital and period, except that there shall be substituted for the numerator under clause (i) of such section the amount that is equal to the number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals who are receiving medical assistance under this title and who are not described in section 1886(n)(2)(D)(i). In computing inpatient-bed-days under the previous sentence, the Secretary shall take into account inpatient-bed-days attributable to inpatient-bed-days that are paid for individuals enrolled in a Medicaid managed care plan (under section 1903(m) or section 1932).

(D) In no case may the payments described in paragraph (1)(B) with respect to a Medicaid provider described in paragraph (2)(B) be paid—

- (i) for any year beginning after 2016 unless the provider has been provided payment under paragraph (1)(B) for the previous year; and
- (ii) over a period of more than 6 years of payment.

(6) Payments described in paragraph (1) are not in accordance with this subsection unless the following requirements are met:

(A)(i) The State provides assurances satisfactory to the Secretary that amounts received under subsection (a)(3)(F) with respect to payments to a Medicaid provider are paid, subject to clause (ii), directly to such provider (or to an employer or facility to which such provider has assigned payments) without any deduction or rebate.

(ii) Amounts described in clause (i) may also be paid to an entity promoting the adoption of certified EHR technology, as designated by the State, if participation in such a payment arrangement is voluntary for the eligible professional involved and if such entity does not retain more than 5 percent of such payments for costs not related to certified EHR technology (and support services including maintenance and training) that is for, or is necessary for the operation of, such technology.

(B) A Medicaid provider described in paragraph (2)(A) is responsible for payment of the remaining 15 percent of the net average allowable cost and shall be determined to have met

such responsibility to the extent that the payment to the Medicaid provider is not in excess of 85 percent of the net average allowable cost.

(C)(i) Subject to clause (ii), with respect to payments to a Medicaid provider—

(I) for the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates that it is engaged in efforts to adopt, implement, or upgrade certified EHR technology; and

(II) for a year of payment, other than the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates meaningful use of certified EHR technology through a means that is approved by the State and acceptable to the Secretary, and that may be based upon the methodologies applied under section 1848(o) or 1886(n).

(ii) In the case of a Medicaid provider who has completed adopting, implementing, or upgrading such technology prior to the first year of payment to the Medicaid provider under this subsection, clause (i)(I) shall not apply and clause (i)(II) shall apply to each year of payment to the Medicaid provider under this subsection, including the first year of payment.

(D) To the extent specified by the Secretary, the certified EHR technology is compatible with State or Federal administrative management systems.

For purposes of subparagraph (B), a Medicaid provider described in paragraph (2)(A) may accept payments for the costs described in such subparagraph from a State or local government. For purposes of subparagraph (C), in establishing the means described in such subparagraph, which may include clinical quality reporting to the State, the State shall ensure that populations with unique needs, such as children, are appropriately addressed.

(7) With respect to Medicaid providers described in paragraph (2)(A), the Secretary shall ensure coordination of payment with respect to such providers under sections 1848(o) and 1853(l) and under this subsection to assure no duplication of funding. Such coordination shall include, to the extent practicable, a data matching process between State Medicaid agencies and the Centers for Medicare & Medicaid Services using national provider identifiers. For such purposes, the Secretary may require the submission of such data relating to payments to such Medicaid providers as the Secretary may specify.

(8) In carrying out paragraph (6)(C), the State and Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this title and title XVIII. In doing so, the Secretary may deem satisfaction of requirements for such meaningful use for a payment year under title XVIII to be sufficient to qualify as meaningful use under this subsection. The Secretary may also specify the reporting periods under this subsection in order to carry out this paragraph.

(9) In order to be provided Federal financial participation under subsection (a)(3)(F)(ii), a State must demonstrate to the satisfaction of the Secretary, that the State—

(A) is using the funds provided for the purposes of administering payments under this subsection, including tracking of meaningful use by Medicaid providers;

(B) is conducting adequate oversight of the program under this subsection, including routine tracking of meaningful use attestations and reporting mechanisms; and

(C) is pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information under this title, subject to applicable laws and regulations governing such exchange.

(10) The Secretary shall periodically submit reports to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on status, progress, and oversight of payments described in paragraph (1), including steps taken to carry out paragraph (7). Such reports shall also describe the extent of adoption of certified EHR technology among Medicaid providers resulting from the provisions of this subsection and any improvements in health outcomes, clinical quality, or efficiency resulting from such adoption.

(u)(1)(A) Notwithstanding subsection (a)(1), if the ratio of a State's erroneous excess payments for medical assistance (as defined in subparagraph (D)) to its total expenditures for medical assistance under the State plan approved under this title exceeds 0.03, for the period consisting of the third and fourth quarters of fiscal year 1983, or for any full fiscal year thereafter, then the Secretary shall make no payment for such period or fiscal year with respect to so much of such erroneous excess payments as exceeds such allowable error rate of 0.03.

(B) The Secretary may waive, in certain limited cases, all or part of the reduction required under subparagraph (A) with respect to any State if such State is unable to reach the allowable error rate for a period or fiscal year despite a good faith effort by such State.

(C) In estimating the amount to be paid to a State under subsection (d), the Secretary shall take into consideration the limitation on Federal financial participation imposed by subparagraph (A) and shall reduce the estimate he makes under subsection (d)(1), for purposes of payment to the State under subsection (d)(3), in light of any expected erroneous excess payments for medical assistance (estimated in accordance with such criteria, including sampling procedures, as he may prescribe and subject to subsequent adjustment, if necessary, under subsection (d)(2)).

(D)(i) For purposes of this subsection, the term "erroneous excess payments for medical assistance" means the total of—

(I) payments under the State plan with respect to ineligible individuals and families, and

(II) overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility.

(ii) In determining the amount of erroneous excess payments for medical assistance to an ineligible individual or family under clause (i)(I), if such ineligibility is the result of an error in determining the amount of the resources of such individual or family, the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment with respect to such individual

or family, or (II) the difference between the actual amount of such resources and the allowable resource level established under the State plan.

(iii) In determining the amount of erroneous excess payments for medical assistance to an individual or family under clause (i)(II), the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment on behalf of the individual or family, or (II) the difference between the actual amount incurred for medical care by the individual or family and the amount which should have been incurred in order to establish eligibility for medical assistance.

(iv) In determining the amount of erroneous excess payments, there shall not be included any error resulting from a failure of an individual to cooperate or give correct information with respect to third-party liability as required under section 1912(a)(1)(C) or 402(a)(26)(C) or with respect to payments made in violation of section 1906.

(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1920(b)(1)), for items and services described in subsection (a) of section 1920A provided to a child during a presumptive eligibility period under such section, for medical assistance provided to an individual described in subsection (a) of section 1920B during a presumptive eligibility period under such section, or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section 1902(a)(47)(B) to be a qualified entity for such purpose.

(E) For purposes of subparagraph (D), there shall be excluded, in determining both erroneous excess payments for medical assistance and total expenditures for medical assistance—

(i) payments with respect to any individual whose eligibility therefor was determined exclusively by the Secretary under an agreement pursuant to section 1634 and such other classes of individuals as the Secretary may by regulation prescribe whose eligibility was determined in part under such an agreement; and

(ii) payments made as the result of a technical error.

(2) The State agency administering the plan approved under this title shall, at such times and in such form as the Secretary may specify, provide information on the rates of erroneous excess payments made (or expected, with respect to future periods specified by the Secretary) in connection with its administration of such plan, together with any other data he requests that are reasonably necessary for him to carry out the provisions of this subsection.

(3)(A) If a State fails to cooperate with the Secretary in providing information necessary to carry out this subsection, the Secretary, directly or through contractual or such other arrangements as he may find appropriate, shall establish the error rates for that State on the basis of the best data reasonably available to him and in accordance with such techniques for sampling and estimating as he finds appropriate.

(B) In any case in which it is necessary for the Secretary to exercise his authority under subparagraph (A) to determine a State's

error rates for a fiscal year, the amount that would otherwise be payable to such State under this title for quarters in such year shall be reduced by the costs incurred by the Secretary in making (directly or otherwise) such determination.

(4) This subsection shall not apply with respect to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, or American Samoa.

(v)(1) Notwithstanding the preceding provisions of this section, except as provided in paragraphs (2) and (4), no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

(2) Payment shall be made under this section for care and services that are furnished to an alien described in paragraph (1) only if—

(A) such care and services are necessary for the treatment of an emergency medical condition of the alien,

(B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this title (other than the requirement of the receipt of aid or assistance under title IV, supplemental security income benefits under title XVI, or a State supplementary payment), and

(C) such care and services are not related to an organ transplant procedure.

(3) For purposes of this subsection, the term “emergency medical condition” means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(A) placing the patient’s health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(4)(A) A State may elect (in a plan amendment under this title) to provide medical assistance under this title, notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, to children and pregnant women who are lawfully residing in the United States (including battered individuals described in section 431(c) of such Act) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

(ii) CHILDREN.—Individuals under 21 years of age, including optional targeted low-income children described in section 1905(u)(2)(B).

(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

(C) As part of the State’s ongoing eligibility redetermination requirements and procedures for an individual provided medical as-

sistance as a result of an election by the State under subparagraph (A), a State shall verify that the individual continues to lawfully reside in the United States using the documentation presented to the State by the individual on initial enrollment. If the State cannot successfully verify that the individual is lawfully residing in the United States in this manner, it shall require that the individual provide the State with further documentation or other evidence to verify that the individual is lawfully residing in the United States.

(w)(1)(A) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State (as defined in paragraph (7)(D)) under subsection (a)(1) for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year—

(i) from provider-related donations (as defined in paragraph (2)(A)), other than—

(I) bona fide provider-related donations (as defined in paragraph (2)(B)), and

(II) donations described in paragraph (2)(C);

(ii) from health care related taxes (as defined in paragraph (3)(A)), other than broad-based health care related taxes (as defined in paragraph (3)(B));

(iii) from a broad-based health care related tax, if there is in effect a hold harmless provision (described in paragraph (4)) with respect to the tax; or

(iv) only with respect to State fiscal years (or portions thereof) occurring on or after January 1, 1992, and before October 1, 1995, from broad-based health care related taxes to the extent the amount of such taxes collected exceeds the limit established under paragraph (5).

(B) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State under subsection (a)(7) for all quarters in a Federal fiscal year (beginning with fiscal year 1993), the total amount expended during the fiscal year for administrative expenditures under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during such quarters from donations described in paragraph (2)(C), to the extent the amount of such donations exceeds 10 percent of the amounts expended under the State plan under this title during the fiscal year for purposes described in paragraphs (2), (3), (4), (6), and (7) of subsection (a).

(C)(i) Except as otherwise provided in clause (ii), subparagraph (A)(i) shall apply to donations received on or after January 1, 1992.

(ii) Subject to the limits described in clause (iii) and subparagraph (E), subparagraph (A)(i) shall not apply to donations received before the effective date specified in subparagraph (F) if such donations are received under programs in effect or as described in State plan amendments or related documents submitted to the Secretary by September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements,

State budget documentation, or other documentary evidence in existence on that date.

(iii) In applying clause (ii) in the case of donations received in State fiscal year 1993, the maximum amount of such donations to which such clause may be applied may not exceed the total amount of such donations received in the corresponding period in State fiscal year 1992 (or not later than 5 days after the last day of the corresponding period).

(D)(i) Except as otherwise provided in clause (ii), subparagraphs (A)(ii) and (A)(iii) shall apply to taxes received on or after January 1, 1992.

(ii) Subparagraphs (A)(ii) and (A)(iii) shall not apply to impermissible taxes (as defined in clause (iii)) received before the effective date specified in subparagraph (F) to the extent the taxes (including the tax rate or base) were in effect, or the legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

(iii) In this subparagraph and subparagraph (E), the term “impermissible tax” means a health care related tax for which a reduction may be made under clause (ii) or (iii) of subparagraph (A).

(E)(i) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for the portion of State fiscal year 1992 occurring during calendar year 1992 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in the portion of that fiscal year.

(ii) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for State fiscal year 1993 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in that fiscal year.

(F) In this paragraph in the case of a State—

(i) except as provided in clause (iii), with a State fiscal year beginning on or before July 1, the effective date is October 1, 1992,

(ii) except as provided in clause (iii), with a State fiscal year that begins after July 1, the effective date is January 1, 1993, or

(iii) with a State legislature which is not scheduled to have a regular legislative session in 1992, with a State legislature which is not scheduled to have a regular legislative session in 1993, or with a provider-specific tax enacted on November 4, 1991, the effective date is July 1, 1993.

(2)(A) In this subsection (except as provided in paragraph (6)), the term “provider-related donation” means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by—

(i) a health care provider (as defined in paragraph (7)(B)),

(ii) an entity related to a health care provider (as defined in paragraph (7)(C)), or

(iii) an entity providing goods or services under the State plan for which payment is made to the State under paragraph (2), (3), (4), (6), or (7) of subsection (a).

(B) For purposes of paragraph (1)(A)(i)(I), the term “bona fide provider-related donation” means a provider-related donation that

has no direct or indirect relationship (as determined by the Secretary) to payments made under this title to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

(C) For purposes of paragraph (1)(A)(i)(II), donations described in this subparagraph are funds expended by a hospital, clinic, or similar entity for the direct cost (including costs of training and of preparing and distributing outreach materials) of State or local agency personnel who are stationed at the hospital, clinic, or entity to determine the eligibility of individuals for medical assistance under this title and to provide outreach services to eligible or potentially eligible individuals.

(3)(A) In this subsection (except as provided in paragraph (6)), the term “health care related tax” means a tax (as defined in paragraph (7)(F)) that—

(i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or

(ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities.

In applying clause (i), a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.

(B) In this subsection, the term “broad-based health care related tax” means a health care related tax which is imposed with respect to a class of health care items or services (as described in paragraph (7)(A)) or with respect to providers of such items or services and which, except as provided in subparagraphs (D), (E), and (F)—

(i) is imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers in the State (or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction) or is imposed with respect to all non-Federal, nonpublic providers in the class; and

(ii) is imposed uniformly (in accordance with subparagraph (C)).

(C)(i) Subject to clause (ii), for purposes of subparagraph (B)(ii), a tax is considered to be imposed uniformly if—

(I) in the case of a tax consisting of a licensing fee or similar tax on a class of health care items or services (or providers of such items or services), the amount of the tax imposed is the same for every provider providing items or services within the class;

(II) in the case of a tax consisting of a licensing fee or similar tax imposed on a class of health care items or services (or providers of such services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of such items or services in the class;

(III) in the case of a tax based on revenues or receipts with respect to a class of items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items or services) in the class on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services (or all such providers) in the State (or, in the case of a tax imposed by a unit of local government within the State, in the area over which the unit has jurisdiction); or

(IV) in the case of any other tax, the State establishes to the satisfaction of the Secretary that the tax is imposed uniformly.

(ii) Subject to subparagraphs (D) and (E), a tax imposed with respect to a class of health care items and services is not considered to be imposed uniformly if the tax provides for any credits, exclusions, or deductions which have as their purpose or effect the return to providers of all or a portion of the tax paid in a manner that is inconsistent with subclauses (I) and (II) of subparagraph (E)(ii) or provides for a hold harmless provision described in paragraph (4).

(D) A tax imposed with respect to a class of health care items and services is considered to be imposed uniformly—

(i) notwithstanding that the tax is not imposed with respect to items or services (or the providers thereof) for which payment is made under a State plan under this title or title XVIII, or

(ii) in the case of a tax described in subparagraph (C)(i)(III), notwithstanding that the tax provides for exclusion (in whole or in part) of revenues or receipts from a State plan under this title or title XVIII.

(E)(i) A State may submit an application to the Secretary requesting that the Secretary treat a tax as a broad-based health care related tax, notwithstanding that the tax does not apply to all health care items or services in class (or all providers of such items and services), provides for a credit, deduction, or exclusion, is not applied uniformly, or otherwise does not meet the requirements of subparagraph (B) or (C). Permissible waivers may include exemptions for rural or sole-community providers.

(ii) The Secretary shall approve such an application if the State establishes to the satisfaction of the Secretary that—

(I) the net impact of the tax and associated expenditures under this title as proposed by the State is generally redistributive in nature, and

(II) the amount of the tax is not directly correlated to payments under this title for items or services with respect to which the tax is imposed.

The Secretary shall by regulation specify types of credits, exclusions, and deductions that will be considered to meet the requirements of this subparagraph.

(F) In no case shall a tax not qualify as a broad-based health care related tax under this paragraph because it does not apply to a hospital that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code and that does not accept payment under the State plan under this title or under title XVIII.

(4) For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:

(A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this title) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.

(B) All or any portion of the payment made under this title to the taxpayer varies based only upon the amount of the total tax paid.

(C)(i) The State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.

(ii) For purposes of clause (i), a determination of the existence of an indirect guarantee shall be made under paragraph (3)(i) of section 433.68(f) of title 42, Code of Federal Regulations, as in effect on November 1, 2006, except that for portions of fiscal years beginning on or after January 1, 2008, and before October 1, 2011, "5.5 percent" shall be substituted for "6 percent" each place it appears.

The provisions of this paragraph shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this title nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.

(5)(A) For purposes of this subsection, the limit under this subparagraph with respect to a State is an amount equal to 25 percent (or, if greater, the State base percentage, as defined in subparagraph (B)) of the non-Federal share of the total amount expended under the State plan during a State fiscal year (or portion thereof), as it would be determined pursuant to paragraph (1)(A) without regard to paragraph (1)(A)(iv).

(B)(i) In subparagraph (A), the term "State base percentage" means, with respect to a State, an amount (expressed as a percentage) equal to—

(I) the total of the amount of health care related taxes (whether or not broad-based) and the amount of provider-related donations (whether or not bona fide) projected to be collected (in accordance with clause (ii)) during State fiscal year 1992, divided by

(II) the non-Federal share of the total amount estimated to be expended under the State plan during such State fiscal year.

(ii) For purposes of clause (i)(I), in the case of a tax that is not in effect throughout State fiscal year 1992 or the rate (or base) of which is increased during such fiscal year, the Secretary shall project the amount to be collected during such fiscal year as if the tax (or increase) were in effect during the entire State fiscal year.

(C)(i) The total amount of health care related taxes under subparagraph (B)(i)(I) shall be determined by the Secretary based on only those taxes (including the tax rate or base) which were in ef-

fect, or for which legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

(ii) The amount of provider-related donations under subparagraph (B)(i)(I) shall be determined by the Secretary based on programs in effect on September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

(iii) The amount of expenditures described in subparagraph (B)(i)(II) shall be determined by the Secretary based on the best data available as of the date of the enactment of this subsection.

(6)(A) Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

(B) For purposes of this subsection, funds the use of which the Secretary may not restrict under subparagraph (A) shall not be considered to be a provider-related donation or a health care related tax.

(7) For purposes of this subsection:

(A) Each of the following shall be considered a separate class of health care items and services:

(i) Inpatient hospital services.

(ii) Outpatient hospital services.

(iii) Nursing facility services (other than services of intermediate care facilities for the mentally retarded).

(iv) Services of intermediate care facilities for the mentally retarded.

(v) Physicians' services.

(vi) Home health care services.

(vii) Outpatient prescription drugs.

(viii) Services of managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation).

(ix) Such other classification of health care items and services consistent with this subparagraph as the Secretary may establish by regulation.

(B) The term "health care provider" means an individual or person that receives payments for the provision of health care items or services.

(C) An entity is considered to be "related" to a health care provider if the entity—

(i) is an organization, association, corporation or partnership formed by or on behalf of health care providers;

(ii) is a person with an ownership or control interest (as defined in section 1124(a)(3)) in the provider;

(iii) is the employee, spouse, parent, child, or sibling of the provider (or of a person described in clause (ii)); or

- (iv) has a similar, close relationship (as defined in regulations) to the provider.
- (D) The term “State” means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.
- (E) The “State fiscal year” means, with respect to a specified year, a State fiscal year ending in that specified year.
- (F) The term “tax” includes any licensing fee, assessment, or other mandatory payment, but does not include payment of a criminal or civil fine or penalty (other than a fine or penalty imposed in lieu of or instead of a fee, assessment, or other mandatory payment).
- (G) The term “unit of local government” means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State.
- (x)(1) For purposes of section 1902(a)(46)(B)(i), the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual.
- (2) The requirement of paragraph (1) shall not apply to an individual declaring to be a citizen or national of the United States who is eligible for medical assistance under this title—
- (A) and is entitled to or enrolled for benefits under any part of title XVIII;
- (B) and is receiving—
- (i) disability insurance benefits under section 223 or monthly insurance benefits under section 202 based on such individual’s disability (as defined in section 223(d)); or
- (ii) supplemental security income benefits under title XVI;
- (C) and with respect to whom—
- (i) child welfare services are made available under part B of title IV on the basis of being a child in foster care; or
- (ii) adoption or foster care assistance is made available under part E of title IV;
- (D) pursuant to the application of section 1902(e)(4) (and, in the case of an individual who is eligible for medical assistance on such basis, the individual shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance on such basis); or
- (E) on such basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality has been previously presented.
- (3)(A) For purposes of this subsection, the term “satisfactory documentary evidence of citizenship or nationality” means—
- (i) any document described in subparagraph (B); or

- (ii) a document described in subparagraph (C) and a document described in subparagraph (D).
 - (B) The following are documents described in this subparagraph:
 - (i) A United States passport.
 - (ii) Form N-550 or N-570 (Certificate of Naturalization).
 - (iii) Form N-560 or N-561 (Certificate of United States Citizenship).
 - (iv) A valid State-issued driver's license or other identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act, but only if the State issuing the license or such document requires proof of United States citizenship before issuance of such license or document or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen.
 - (v)(I) Except as provided in subclause (II), a document issued by a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).
 - (II) With respect to those federally recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, the Secretary shall, after consulting with such tribes, issue regulations authorizing the presentation of such other forms of documentation (including tribal documentation, if appropriate) that the Secretary determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subsection.
 - (vi) Such other document as the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.
 - (C) The following are documents described in this subparagraph:
 - (i) A certificate of birth in the United States.
 - (ii) Form FS-545 or Form DS-1350 (Certification of Birth Abroad).
 - (iii) Form I-197 (United States Citizen Identification Card).
 - (iv) Form FS-240 (Report of Birth Abroad of a Citizen of the United States).
 - (v) Such other document (not described in subparagraph (B)(iv)) as the Secretary may specify that provides proof of United States citizenship or nationality.
 - (D) The following are documents described in this subparagraph:
 - (i) Any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act.
 - (ii) Any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.
 - (E) A reference in this paragraph to a form includes a reference to any successor form.
- (4) In the case of an individual declaring to be a citizen or national of the United States with respect to whom a State requires the presentation of satisfactory documentary evidence of citizenship or nationality under section 1902(a)(46)(B)(i), the individual shall be provided at least the reasonable opportunity to present satisfac-

tory documentary evidence of citizenship or nationality under this subsection as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.

(5) Nothing in subparagraph (A) or (B) of section 1902(a)(46), the preceding paragraphs of this subsection, or the Deficit Reduction Act of 2005, including section 6036 of such Act, shall be construed as changing the requirement of section 1902(e)(4) that a child born in the United States to an alien mother for whom medical assistance for the delivery of such child is available as treatment of an emergency medical condition pursuant to subsection (v) shall be deemed eligible for medical assistance during the first year of such child's life.

(y) PAYMENTS FOR ESTABLISHMENT OF ALTERNATE NON-EMERGENCY SERVICES PROVIDERS.—

(1) PAYMENTS.—In addition to the payments otherwise provided under subsection (a), subject to paragraph (2), the Secretary shall provide for payments to States under such subsection for the establishment of alternate non-emergency service providers (as defined in section 1916A(e)(5)(B)), or networks of such providers.

(2) LIMITATION.—The total amount of payments under this subsection shall not exceed \$50,000,000 during the 4-year period beginning with 2006. This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

(3) PREFERENCE.—In providing for payments to States under this subsection, the Secretary shall provide preference to States that establish, or provide for, alternate non-emergency services providers or networks of such providers that—

(A) serve rural or underserved areas where beneficiaries under this title may not have regular access to providers of primary care services; or

(B) are in partnership with local community hospitals.

(4) FORM AND MANNER OF PAYMENT.—Payment to a State under this subsection shall be made only upon the filing of such application in such form and in such manner as the Secretary shall specify. Payment to a State under this subsection shall be made in the same manner as other payments under section 1903(a).

(z) MEDICAID TRANSFORMATION PAYMENTS.—

(1) IN GENERAL.—In addition to the payments provided under subsection (a), subject to paragraph (4), the Secretary shall provide for payments to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under this title.

(2) PERMISSIBLE USES OF FUNDS.—The following are examples of innovative methods for which funds provided under this subsection may be used:

(A) Methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs.

- (B) Methods for improving rates of collection from estates of amounts owed under this title.
- (C) Methods for reducing waste, fraud, and abuse under the program under this title, such as reducing improper payment rates as measured by annual payment error rate measurement (PERM) project rates.
- (D) Implementation of a medication risk management program as part of a drug use review program under section 1927(g).
- (E) Methods in reducing, in clinically appropriate ways, expenditures under this title for covered outpatient drugs, particularly in the categories of greatest drug utilization, by increasing the utilization of generic drugs through the use of education programs and other incentives to promote greater use of generic drugs.
- (F) Methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital and clinic systems.

(3) APPLICATION; TERMS AND CONDITIONS.—

- (A) IN GENERAL.—No payments shall be made to a State under this subsection unless the State applies to the Secretary for such payments in a form, manner, and time specified by the Secretary.
- (B) TERMS AND CONDITIONS.—Such payments are made under such terms and conditions consistent with this subsection as the Secretary prescribes.
- (C) ANNUAL REPORT.—Payment to a State under this subsection is conditioned on the State submitting to the Secretary an annual report on the programs supported by such payment. Such report shall include information on—
 - (i) the specific uses of such payment;
 - (ii) an assessment of quality improvements and clinical outcomes under such programs; and
 - (iii) estimates of cost savings resulting from such programs.

(4) FUNDING.—

- (A) LIMITATION ON FUNDS.—The total amount of payments under this subsection shall be equal to, and shall not exceed—
 - (i) \$75,000,000 for fiscal year 2007; and
 - (ii) \$75,000,000 for fiscal year 2008.

This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

- (B) ALLOCATION OF FUNDS.—The Secretary shall specify a method for allocating the funds made available under this subsection among States. Such method shall provide preference for States that design programs that target health providers that treat significant numbers of Medicaid beneficiaries. Such method shall provide that not less than 25 percent of such funds shall be allocated among States the population of which (as determined according to data collected by the United States Census Bureau) as of July 1, 2004, was more than 105 percent of the population

of the respective State (as so determined) as of April 1, 2000.

(C) FORM AND MANNER OF PAYMENT.—Payment to a State under this subsection shall be made in the same manner as other payments under section 1903(a). There is no requirement for State matching funds to receive payments under this subsection.

(5) MEDICATION RISK MANAGEMENT PROGRAM.—

(A) IN GENERAL.—For purposes of this subsection, the term “medication risk management program” means a program for targeted beneficiaries that ensures that covered outpatient drugs are appropriately used to optimize therapeutic outcomes through improved medication use and to reduce the risk of adverse events.

(B) ELEMENTS.—Such program may include the following elements:

(i) The use of established principles and standards for drug utilization review and best practices to analyze prescription drug claims of targeted beneficiaries and identify outlier physicians.

(ii) On an ongoing basis provide outlier physicians—

(I) a comprehensive pharmacy claims history for each targeted beneficiary under their care;

(II) information regarding the frequency and cost of relapses and hospitalizations of targeted beneficiaries under the physician’s care; and

(III) applicable best practice guidelines and empirical references.

(iii) Monitor outlier physician’s prescribing, such as failure to refill, dosage strengths, and provide incentives and information to encourage the adoption of best clinical practices.

(C) TARGETED BENEFICIARIES.—For purposes of this paragraph, the term “targeted beneficiaries” means Medicaid eligible beneficiaries who are identified as having high prescription drug costs and medical costs, such as individuals with behavioral disorders or multiple chronic diseases who are taking multiple medications.

* * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term “medical assistance” means payment of part or all of the cost of the following care and services or the care and services themselves, or both (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment

and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are—

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

(ii) relatives specified in section 406(b)(1) with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of title IV,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under title XVI,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI,

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title XVI,

(viii) pregnant women,

(ix) individuals provided extended benefits under section 1925,

(x) individuals described in section 1902(u)(1),

(xi) individuals described in section 1902(z)(1),

(xii) employed individuals with a medically improved disability (as defined in subsection (v)),

(xiii) individuals described in section 1902(aa),

(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII) or 1902(a)(10)(A)(i)(IX),

(xv) individuals described in section 1902(a)(10)(A)(ii)(XX),

(xvi) individuals described in section 1902(ii), or

(xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection,

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for mental diseases);

(2)(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (1)(1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (1)(1)) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (1)(2)) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4)(A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for individuals who are eligible under the plan and are under the age of 21; (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies; and (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb));

(5)(A) physicians' services furnished by a physician (as defined in section 1861(r)(1)), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist (described in section 1861(r)(2)) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section 1861(r)(1));

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services, including—

(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force;

(B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and

(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

(14) inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases;

(15) services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with section 1902(a)(31), to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h), and, effective January 1, 2019, the full-range of early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for such individuals whether or not such screening, diagnostic, and treatment services are furnished by the provider of inpatient psychiatric hospital services for individuals under age 21;

(17) services furnished by a nurse-midwife (as defined in section 1861(gg)) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider, and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle;

(18) hospice care (as defined in subsection (o));

(19) case management services (as defined in section 1915(g)(2)) and TB-related services described in section 1902(z)(2)(F);

(20) respiratory care services (as defined in section 1902(e)(9)(C));

(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider;

(22) home and community care (to the extent allowed and as defined in section 1929) for functionally disabled elderly individuals;

(23) community supported living arrangements services (to the extent allowed and as defined in section 1930);

(24) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location;

(25) primary care case management services (as defined in subsection (t));

(26) services furnished under a PACE program under section 1934 to PACE program eligible individuals enrolled under the program under such section;

(27) subject to subsection (x), primary and secondary medical strategies and treatment and services for individuals who have Sickle Cell Disease;

(28) freestanding birth center services (as defined in subsection (1)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (1)(3)(B)) and that are otherwise included in the plan; and

(29) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary, except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under title I, X, XIV, or XVI), and such person is determined, under such a State plan, to be essential to the well-being of such individual. The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of title XVIII for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under title XVIII who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof. No service (including counseling) shall be excluded from the definition of “medical assistance” solely because it is provided as a treatment service for alcoholism or drug dependency.

(b) Subject to subsections (y), (z), and (aa) and section 1933(d), the term “Federal medical assistance percentage” for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam,

the Northern Mariana Islands, and American Samoa shall be 55 percent, (3) for purposes of this title and title XXI, the Federal medical assistance percentage for the District of Columbia shall be 70 percent, (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 2105(b) with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII), and (5) in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of subsection (a)(13), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)(C) of such subsection), shall be increased by 1 percentage point with respect to medical assistance for such services and vaccines and for items and services described in subsection (a)(4)(D). The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act). Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures (other than expenditures under section 1923) described in subsection (u)(2)(A) or subsection (u)(3) for the State for a fiscal year, and that do not exceed the amount of the State's available allotment under section 2104, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 2105(b).

(c) For definition of the term "nursing facility", see section 1919(a).

(d) The term "intermediate care facility for the mentally retarded" means an institution (or distinct part thereof) for the mentally retarded or persons with related conditions if—

(1) the primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and the institution meets such standards as may be prescribed by the Secretary;

(2) the mentally retarded individual with respect to whom a request for payment is made under a plan approved under this title is receiving active treatment under such a program; and

(3) in the case of a public institution, the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institution (or distinct part thereof) in the State will not, because of payments made under this title, be reduced below the average amount expended for such services in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under this title.

(e) In the case of any State the State plan of which (as approved under this title)—

(1) does not provide for the payment of services (other than services covered under section 1902(a)(12)) provided by an optometrist; but

(2) at a prior period did provide for the payment of services referred to in paragraph (1);

the term “physicians’ services” (as used in subsection (a)(5)) shall include services of the type which an optometrist is legally authorized to perform where the State plan specifically provides that the term “physicians’ services”, as employed in such plan, includes services of the type which an optometrist is legally authorized to perform, and shall be reimbursed whether furnished by a physician or an optometrist.

(f) For purposes of this title, the term “nursing facility services” means services which are or were required to be given an individual who needs or needed on a daily basis nursing care (provided directly by or requiring the supervision of nursing personnel) or other rehabilitation services which as a practical matter can only be provided in a nursing facility on an inpatient basis.

(g) If the State plan includes provision of chiropractors’ services, such services include only—

(1) services provided by a chiropractor (A) who is licensed as such by the State and (B) who meets uniform minimum standards promulgated by the Secretary under section 1861(r)(5); and

(2) services which consist of treatment by means of manual manipulation of the spine which the chiropractor is legally authorized to perform by the State.

(h)(1) For purposes of paragraph (16) of subsection (a), the term “inpatient psychiatric hospital services for individuals under age 21” includes only—

(A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1861(f) or in another inpatient setting that the Secretary has specified in regulations;

(B) inpatient services which, in the case of any individual (i) involve active treatment which meets such standards as may be prescribed in regulations by the Secretary, and (ii) a team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary; and

(C) inpatient services which, in the case of any individual, are provided prior to (i) the date such individual attains age 21, or (ii) in the case of an individual who was receiving such services in the period immediately preceding the date on which he attained age 21, (I) the date such individual no longer requires such services, or (II) if earlier, the date such individual attains age 22;

(2) Such term does not include services provided during any calendar quarter under the State plan of any State if the total amount

of the funds expended, during such quarter, by the State (and the political subdivisions thereof) from non-Federal funds for inpatient services included under paragraph (1), and for active psychiatric care and treatment provided on an outpatient basis for eligible mentally ill children, is less than the average quarterly amount of the funds expended, during the 4-quarter period ending December 31, 1971, by the State (and the political subdivisions thereof) from non-Federal funds for such services.

(i) The term "institution for mental diseases" means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

(j) The term "State supplementary payment" means any cash payment made by a State on a regular basis to an individual who is receiving supplemental security income benefits under title XVI or who would but for his income be eligible to receive such benefits, as assistance based on need in supplementation of such benefits (as determined by the Commissioner of Social Security), but only to the extent that such payments are made with respect to an individual with respect to whom supplemental security income benefits are payable under title XVI, or would but for his income be payable under that title.

(k) Increased supplemental security income benefits payable pursuant to section 211 of Public Law 93-66 shall not be considered supplemental security income benefits payable under title XVI.

(1)(1) The terms "rural health clinic services" and "rural health clinic" have the meanings given such terms in section 1861(aa), except that (A) clause (ii) of section 1861(aa)(2) shall not apply to such terms, and (B) the physician arrangement required under section 1861(aa)(2)(B) shall only apply with respect to rural health clinic services and, with respect to other ambulatory care services, the physician arrangement required shall be only such as may be required under the State plan for those services.

(2)(A) The term "Federally-qualified health center services" means services of the type described in subparagraphs (A) through (C) of section 1861(aa)(1) when furnished to an individual as a patient of a Federally-qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in section 1861(aa)(2)(B) is deemed a reference to a Federally-qualified health center or a physician at the center, respectively.

(B) The term "Federally-qualified health center" means an entity which—

(i) is receiving a grant under section 330 of the Public Health Service Act,

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and

(II) meets the requirements to receive a grant under section 330 of such Act,

(iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity, or

(iv) was treated by the Secretary, for purposes of part B of title XVIII, as a comprehensive Federally funded health center as of January 1, 1990; and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services. In applying clause (ii), the Secretary may waive any requirement referred to in such clause for up to 2 years for good cause shown.

(3)(A) The term “freestanding birth center services” means services furnished to an individual at a freestanding birth center (as defined in subparagraph (B)) at such center.

(B) The term “freestanding birth center” means a health facility—

- (i) that is not a hospital;
- (ii) where childbirth is planned to occur away from the pregnant woman’s residence;
- (iii) that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and
- (iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.

(C) A State shall provide separate payments to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center (as defined in subparagraph (B)), such as nurse midwives and other providers of services such as birth attendants recognized under State law, as determined appropriate by the Secretary. For purposes of the preceding sentence, the term “birth attendant” means an individual who is recognized or registered by the State involved to provide health care at childbirth and who provides such care within the scope of practice under which the individual is legally authorized to perform such care under State law (or the State regulatory mechanism provided by State law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a birth attendant.

(m)(1) Subject to paragraph (2), the term “qualified family member” means an individual (other than a qualified pregnant woman or child, as defined in subsection (n)) who is a member of a family that would be receiving aid under the State plan under part A of title IV pursuant to section 407 if the State had not exercised the option under section 407(b)(2)(B)(i).

(2) No individual shall be a qualified family member for any period after September 30, 1998.

(n) The term “qualified pregnant woman or child” means—

- (1) a pregnant woman who—
 - (A) would be eligible for aid to families with dependent children under part A of title IV (or would be eligible for such aid if coverage under the State plan under part A of title IV included aid to families with dependent children of unemployed parents pursuant to section 407) if her child had been born and was living with her in the month such

aid would be paid, and such pregnancy has been medically verified;

(B) is a member of a family which would be eligible for aid under the State plan under part A of title IV pursuant to section 407 if the plan required the payment of aid pursuant to such section; or

(C) otherwise meets the income and resources requirements of a State plan under part A of title IV; and

(2) a child who has not attained the age of 19, who was born after September 30, 1983 (or such earlier date as the State may designate), and who meets the income and resources requirements of the State plan under part A of title IV.

(o)(1)(A) Subject to subparagraphs (B) and (C), the term “hospice care” means the care described in section 1861(dd)(1) furnished by a hospice program (as defined in section 1861(dd)(2)) to a terminally ill individual who has voluntarily elected (in accordance with paragraph (2)) to have payment made for hospice care instead of having payment made for certain benefits described in section 1812(d)(2)(A) and for which payment may otherwise be made under title XVIII and intermediate care facility services under the plan. For purposes of such election, hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care.

(B) For purposes of this title, with respect to the definition of hospice program under section 1861(dd)(2), the Secretary may allow an agency or organization to make the assurance under subparagraph (A)(iii) of such section without taking into account any individual who is afflicted with acquired immune deficiency syndrome (AIDS).

(C) A voluntary election to have payment made for hospice care for a child (as defined by the State) shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under this title for, services that are related to the treatment of the child’s condition for which a diagnosis of terminal illness has been made.

(2) An individual’s voluntary election under this subsection —

(A) shall be made in accordance with procedures that are established by the State and that are consistent with the procedures established under section 1812(d)(2);

(B) shall be for such a period or periods (which need not be the same periods described in section 1812(d)(1)) as the State may establish; and

(C) may be revoked at any time without a showing of cause and may be modified so as to change the hospice program with respect to which a previous election was made.

(3) In the case of an individual—

(A) who is residing in a nursing facility or intermediate care facility for the mentally retarded and is receiving medical assistance for services in such facility under the plan,

(B) who is entitled to benefits under part A of title XVIII and has elected, under section 1812(d), to receive hospice care under such part, and

(C) with respect to whom the hospice program under such title and the nursing facility or intermediate care facility for

the mentally retarded have entered into a written agreement under which the program takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual, instead of any payment otherwise made under the plan with respect to the facility's services, the State shall provide for payment to the hospice program of an amount equal to the additional amount determined in section 1902(a)(13)(B) and, if the individual is an individual described in section 1902(a)(10)(A), shall provide for payment of any coinsurance amounts imposed under section 1813(a)(4).

(p)(1) The term "qualified medicare beneficiary" means an individual—

(A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1818A),

(B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in paragraph (2)(D)) does not exceed an income level established by the State consistent with paragraph (2), and

(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program or, effective beginning with January 1, 2010, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1860D-14(a)(3) (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be).

(2)(A) The income level established under paragraph (1)(B) shall be at least the percent provided under subparagraph (B) (but not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(B) Except as provided in subparagraph (C), the percent provided under this clause, with respect to eligibility for medical assistance on or after—

- (i) January 1, 1989, is 85 percent,
- (ii) January 1, 1990, is 90 percent, and
- (iii) January 1, 1991, is 100 percent.

(C) In the case of a State which has elected treatment under section 1902(f) and which, as of January 1, 1987, used an income standard for individuals age 65 or older which was more restrictive than the income standard established under the supplemental security income program under title XVI, the percent provided under subparagraph (B), with respect to eligibility for medical assistance on or after—

- (i) January 1, 1989, is 80 percent,
- (ii) January 1, 1990, is 85 percent,
- (iii) January 1, 1991, is 95 percent, and

(iv) January 1, 1992, is 100 percent.

(D)(i) In determining under this subsection the income of an individual who is entitled to monthly insurance benefits under title II for a transition month (as defined in clause (ii)) in a year, such income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such title which have occurred pursuant to section 215(i) for benefits payable for months beginning with December of the previous year.

(ii) For purposes of clause (i), the term “transition month” means each month in a year through the month following the month in which the annual revision of the official poverty line, referred to in subparagraph (A), is published.

(3) The term “medicare cost-sharing” means (subject to section 1902(n)(2)) the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1818 or 1818A, and

(ii) premiums under section 1839,

(B) Coinsurance under title XVIII (including coinsurance described in section 1813).

(C) Deductibles established under title XVIII (including those described in section 1813 and section 1833(b)).

(D) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to “80 percent” therein were deemed a reference to “100 percent”.

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1876.

(4) Notwithstanding any other provision of this title, in the case of a State (other than the 50 States and the District of Columbia)—

(A) the requirement stated in section 1902(a)(10)(E) shall be optional, and

(B) for purposes of paragraph (2), the State may substitute for the percent provided under subparagraph (B) of such paragraph or 1902(a)(10)(E)(iii) any percent.

In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirement of section 1902(a)(10)(E) in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

(5)(A) The Secretary shall develop and distribute to States a simplified application form for use by individuals (including both qualified medicare beneficiaries and specified low-income medicare beneficiaries) in applying for medical assistance for medicare cost-sharing under this title in the States which elect to use such form. Such form shall be easily readable by applicants and uniform nationally. The Secretary shall provide for the translation of such application form into at least the 10 languages (other than English) that are most often used by individuals applying for hospital insurance benefits under section 226 or 226A and shall make the translated forms available to the States and to the Commissioner of Social Security.

(B) In developing such form, the Secretary shall consult with beneficiary groups and the States.

(6) For provisions relating to outreach efforts to increase awareness of the availability of medicare cost-sharing, see section 1144.

(q) The term “qualified severely impaired individual” means an individual under age 65—

(1) who for the month preceding the first month to which this subsection applies to such individual—

(A) received (i) a payment of supplemental security income benefits under section 1611(b) on the basis of blindness or disability, (ii) a supplementary payment under section 1616 of this Act or under section 212 of Public Law 93-66 on such basis, (iii) a payment of monthly benefits under section 1619(a), or (iv) a supplementary payment under section 1616(c)(3), and

(B) was eligible for medical assistance under the State plan approved under this title; and

(2) with respect to whom the Commissioner of Social Security determines that—

(A) the individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, continues to meet all non-disability-related requirements for eligibility for benefits under title XVI,

(B) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611(b) (if he were otherwise eligible for such payments),

(C) the lack of eligibility for benefits under this title would seriously inhibit his ability to continue or obtain employment, and

(D) the individual’s earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under title XVI (including any federally administered State supplementary payments), this title, and publicly funded attendant care services (including personal care assistance) that would be available to him in the absence of such earnings.

In the case of an individual who is eligible for medical assistance pursuant to section 1619(b) in June, 1987, the individual shall be a qualified severely impaired individual for so long as such individual meets the requirements of paragraph (2).

(r) The term “early and periodic screening, diagnostic, and treatment services” means the following items and services:

(1) Screening services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines, and

- (ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and
- (B) which shall at a minimum include—
 - (i) a comprehensive health and developmental history (including assessment of both physical and mental health development),
 - (ii) a comprehensive unclothed physical exam,
 - (iii) appropriate immunizations (according to the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines) according to age and health history,
 - (iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and
 - (v) health education (including anticipatory guidance).
- (2) Vision services—
 - (A) which are provided—
 - (i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
 - (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
 - (B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.
- (3) Dental services—
 - (A) which are provided—
 - (i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and
 - (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
 - (B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.
- (4) Hearing services—
 - (A) which are provided—
 - (i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
 - (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
 - (B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.
- (5) Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this title shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this title in early and periodic screening, diagnostic, and treatment services.

(s) The term “qualified disabled and working individual” means an individual—

(1) who is entitled to enroll for hospital insurance benefits under part A of title XVIII under section 1818A (as added by 6012 of the Omnibus Budget Reconciliation Act of 1989);

(2) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed 200 percent of the official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;

(3) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual or a couple (in the case of an individual with a spouse) may have and obtain benefits for supplemental security income benefits under title XVI; and

(4) who is not otherwise eligible for medical assistance under this title.

(t)(1) The term “primary care case management services” means case-management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.

(2) The term “primary care case manager” means any of the following that provides services of the type described in paragraph (1) under a contract referred to in such paragraph:

(A) A physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services.

(B) At State option—

(i) a nurse practitioner (as described in section 1905(a)(21));

(ii) a certified nurse-midwife (as defined in section 1861(gg)); or

(iii) a physician assistant (as defined in section 1861(aa)(5)).

(3) The term “primary care case management contract” means a contract between a primary care case manager and a State under which the manager undertakes to locate, coordinate, and monitor covered primary care (and such other covered services as may be specified under the contract) to all individuals enrolled with the manager, and which—

(A) provides for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies;

(B) restricts enrollment to individuals residing sufficiently near a service delivery site of the manager to be able to reach that site within a reasonable time using available and affordable modes of transportation;

(C) provides for arrangements with, or referrals to, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

(D) prohibits discrimination on the basis of health status or requirements for health care services in enrollment, disenrollment, or reenrollment of individuals eligible for medical assistance under this title;

(E) provides for a right for an enrollee to terminate enrollment in accordance with section 1932(a)(4); and

(F) complies with the other applicable provisions of section 1932.

(4) For purposes of this subsection, the term “primary care” includes all health care services customarily provided in accordance with State licensure and certification laws and regulations, and all laboratory services customarily provided by or through, a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

(u)(1) The conditions described in this paragraph for a State plan are as follows:

(A) The State is complying with the requirement of section 2105(d)(1).

(B) The plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out the fourth sentence of subsection (b).

(2)(A) For purposes of subsection (b), the expenditures described in this subparagraph are expenditures for medical assistance for optional targeted low-income children described in subparagraph (B).

(B) For purposes of this paragraph, the term “optional targeted low-income child” means a targeted low-income child as defined in section 2110(b)(1) (determined without regard to that portion of subparagraph (C) of such section concerning eligibility for medical assistance under this title) who would not qualify for medical assistance under the State plan under this title as in effect on March 31, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1902(l)(1)(D)). Such term excludes any child eligible for medical assistance only by reason of section 1902(a)(10)(A)(ii)(XIX).

(3) For purposes of subsection (b), the expenditures described in this paragraph are expenditures for medical assistance for children who are born before October 1, 1983, and who would be described in section 1902(l)(1)(D) if they had been born on or after such date, and who are not eligible for such assistance under the State plan under this title based on such State plan as in effect as of March 31, 1997.

(4) The limitations on payment under subsections (f) and (g) of section 1108 shall not apply to Federal payments made under section 1903(a)(1) based on an enhanced FMAP described in section 2105(b).

(v)(1) The term “employed individual with a medically improved disability” means an individual who—

(A) is at least 16, but less than 65, years of age;

(B) is employed (as defined in paragraph (2));

(C) ceases to be eligible for medical assistance under section 1902(a)(10)(A)(ii)(XV) because the individual, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be eligible for benefits under section 223(d) or 1614(a)(3); and

(D) continues to have a severe medically determinable impairment, as determined under regulations of the Secretary.

(2) For purposes of paragraph (1), an individual is considered to be “employed” if the individual—

(A) is earning at least the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act (29 U.S.C. 206) and working at least 40 hours per month; or

(B) is engaged in a work effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, as defined by the State and approved by the Secretary.’

(w)(1) For purposes of this title, the term “independent foster care adolescent” means an individual—

(A) who is under 21 years of age;

(B) who, on the individual’s 18th birthday, was in foster care under the responsibility of a State; and

(C) whose assets, resources, and income do not exceed such levels (if any) as the State may establish consistent with paragraph (2).

(2) The levels established by a State under paragraph (1)(C) may not be less than the corresponding levels applied by the State under section 1931(b).

(3) A State may limit the eligibility of independent foster care adolescents under section 1902(a)(10)(A)(ii)(XVII) to those individuals with respect to whom foster care maintenance payments or independent living services were furnished under a program funded under part E of title IV before the date the individuals attained 18 years of age.

(x) For purposes of subsection (a)(27), the strategies, treatment, and services described in that subsection include the following:

(1) Chronic blood transfusion (with deferoxamine chelation) to prevent stroke in individuals with Sickle Cell Disease who have been identified as being at high risk for stroke.

(2) Genetic counseling and testing for individuals with Sickle Cell Disease or the sickle cell trait to allow health care professionals to treat such individuals and to prevent symptoms of Sickle Cell Disease.

(3) Other treatment and services to prevent individuals who have Sickle Cell Disease and who have had a stroke from having another stroke.

(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

(1) AMOUNT OF INCREASE.—Notwithstanding subsection (b), the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, with respect to amounts expended by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be equal to—

- (A) 100 percent for calendar quarters in 2014, 2015, and 2016;
- (B) 95 percent for calendar quarters in 2017;
- (C) 94 percent for calendar quarters in 2018;
- (D) 93 percent for calendar quarters in 2019; and
- (E) 90 percent for calendar quarters in 2020 and each year thereafter.

(2) DEFINITIONS.—In this subsection:

(A) NEWLY ELIGIBLE.—The term “newly eligible” means, with respect to an individual described in subclause (VIII) of section 1902(a)(10)(A)(i), an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, as of December 1, 2009, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

(B) FULL BENEFITS.—The term “full benefits” means, with respect to an individual, medical assistance for all services covered under the State plan under this title that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i).

(z) EQUITABLE SUPPORT FOR CERTAIN STATES.—

(1)(A) During the period that begins on January 1, 2014, and ends on December 31, 2015, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to a fiscal year occurring during that period shall be increased by 2.2 percentage points for any State described in subparagraph (B) for amounts expended for medical assistance for individuals who are not newly eligible (as defined in subsection (y)(2)) individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).

(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—

- (i) is an expansion State described in paragraph (3);
- (ii) the Secretary determines will not receive any payments under this title on the basis of an increased Federal medical assistance percentage under subsection (y) for expenditures for medical assistance for newly eligible individuals (as so defined); and

(iii) has not been approved by the Secretary to divert a portion of the DSH allotment for a State to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.

(2)(A) For calendar quarters in 2014 and each year thereafter, the Federal medical assistance percentage otherwise determined under subsection (b) for an expansion State described in paragraph (3) with respect to medical assistance for individuals described in section 1902(a)(10)(A)(i)(VIII) who are nonpregnant childless adults with respect to whom the State may require enrollment in benchmark coverage under section 1937 shall be equal to the percent specified in subparagraph (B)(i) for such year.

(B)(i) The percent specified in this subparagraph for a State for a year is equal to the Federal medical assistance percentage (as defined in the first sentence of subsection (b)) for the State increased by a number of percentage points equal to the transition percentage (specified in clause (ii) for the year) of the number of percentage points by which—

(I) such Federal medical assistance percentage for the State, is less than

(II) the percent specified in subsection (y)(1) for the year.

(ii) The transition percentage specified in this clause for—

(I) 2014 is 50 percent;

(II) 2015 is 60 percent;

(III) 2016 is 70 percent;

(IV) 2017 is 80 percent;

(V) 2018 is 90 percent; and

(VI) 2019 and each subsequent year is 100 percent.

(3) A State is an expansion State if, on the date of the enactment of the Patient Protection and Affordable Care Act, the State offers health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, that includes inpatient hospital services, is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1938. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence shall not be considered to be an expansion State.

(aa)(1) Notwithstanding subsection (b), beginning January 1, 2011, the Federal medical assistance percentage for a fiscal year for a disaster-recovery FMAP adjustment State shall be equal to the following:

(A) In the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the State's regular FMAP shall be increased by 50 percent of the number of percentage points by which the State's regular FMAP for such fiscal year is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111-5 (if applicable to the preceding fiscal year) and with-

out regard to this subsection, subsections (y) and (z), and subsections (b) and (c) of section 5001 of Public Law 111-5.

(B) In the case of the second or any succeeding fiscal year for which this subsection applies to the State, the State's regular FMAP for such fiscal year shall be increased by 25 percent (or 50 percent in the case of fiscal year 2013) of the number of percentage points by which the State's regular FMAP for such fiscal year is less than the Federal medical assistance percentage received by the State during the preceding fiscal year.

(2) In this subsection, the term "disaster-recovery FMAP adjustment State" means a State that is one of the 50 States or the District of Columbia, for which, at any time during the preceding 7 fiscal years, the President has declared a major disaster under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act and determined as a result of such disaster that every county or parish in the State warrant individual and public assistance or public assistance from the Federal Government under such Act and for which—

(A) in the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the State's regular FMAP for the fiscal year is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111-5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsections (y) and (z), and subsections (b) and (c) of section 5001 of Public Law 111-5, by at least 3 percentage points; and

(B) in the case of the second or any succeeding fiscal year for which this subsection applies to the State, the State's regular FMAP for the fiscal year is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection by at least 3 percentage points.

(3) In this subsection, the term "regular FMAP" means, for each fiscal year for which this subsection applies to a State, the Federal medical assistance percentage that would otherwise apply to the State for the fiscal year, as determined under subsection (b) and without regard to this subsection, subsections (y) and (z), and section 10202 of the Patient Protection and Affordable Care Act.

(4) The Federal medical assistance percentage determined for a disaster-recovery FMAP adjustment State under paragraph (1) shall apply for purposes of this title (other than with respect to disproportionate share hospital payments described in section 1923 and payments under this title that are based on the enhanced FMAP described in 2105(b)) and shall not apply with respect to payments under title IV (other than under part E of title IV) or payments under title XXI.

(bb)(1) For purposes of this title, the term "counseling and pharmacotherapy for cessation of tobacco use by pregnant women" means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and non-prescription tobacco cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by pregnant

women who use tobacco products or who are being treated for tobacco use that is furnished—

(A) by or under the supervision of a physician; or

(B) by any other health care professional who—

(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

(ii) is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose.

(2) Subject to paragraph (3), such term is limited to—

(A) services recommended with respect to pregnant women in “Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline”, published by the Public Health Service in May 2008, or any subsequent modification of such Guideline; and

(B) such other services that the Secretary recognizes to be effective for cessation of tobacco use by pregnant women.

(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this title.

(cc) REQUIREMENT FOR CERTAIN STATES.—Notwithstanding subsections (y), (z), and (aa), in the case of a State that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures required under the State plan under section 1902(a)(2), the State shall not be eligible for an increase in its Federal medical assistance percentage under such subsections if it requires that political subdivisions pay a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1923, than the respective percentages that would have been required by the State under the State plan under this title, State law, or both, as in effect on December 31, 2009, and without regard to any such increase. Voluntary contributions by a political subdivision to the non-Federal share of expenditures under the State plan under this title or to the non-Federal share of payments under section 1923, shall not be considered to be required contributions for purposes of this subsection. The treatment of voluntary contributions, and the treatment of contributions required by a State under the State plan under this title, or State law, as provided by this subsection, shall also apply to the increases in the Federal medical assistance percentage under section 5001 of the American Recovery and Reinvestment Act of 2009.

(dd) INCREASED FMAP FOR ADDITIONAL EXPENDITURES FOR PRIMARY CARE SERVICES.—Notwithstanding subsection (b), with respect to the portion of the amounts expended for medical assistance for services described in section 1902(a)(13)(C) furnished on or after January 1, 2013, and before January 1, 2015, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1932(f)) exceeds the payment rate applicable to such services under the State plan as of July 1, 2009, the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia shall be equal to 100 percent. The preceding sentence does not prohibit the payment of Federal financial participation based on the Federal

medical assistance percentage for amounts in excess of those specified in such sentence.

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PROTECTING ACCESS TO MEDICARE ACT OF 2014

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TITLE II—OTHER HEALTH PROVISIONS

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

(a) **IN GENERAL.**—The Secretary shall establish a 4-year pilot program to award not more than 50 grants each year to eligible entities for assisted outpatient treatment programs for individuals with serious mental illness.

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

(c) **SELECTING AMONG APPLICANTS.**—The Secretary—

(1) may only award grants under this section to applicants that have not previously implemented an assisted outpatient treatment program; and

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

(d) **USE OF GRANT.**—An assisted outpatient treatment program funded with a grant awarded under this section shall include—

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

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

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

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

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

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

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

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

(e) **REPORT.**—Not later than the end of each of fiscal years 2016, 2017, and 2018, the Secretary shall submit a report to the appro-

priate congressional committees on the grant program under this section. Each such report shall include an evaluation of the following:

- (1) Cost savings and public health outcomes such as mortality, suicide, substance abuse, hospitalization, and use of services.
- (2) Rates of incarceration by patients.
- (3) Rates of homelessness among patients.
- (4) Patient and family satisfaction with program participation.

(f) DEFINITIONS.—In this section:

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

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

(3) The term “Secretary” means the Secretary of Health and Human Services.

(g) FUNDING.—

(1) AMOUNT OF GRANTS.—A grant under this section shall be in an amount that is not more than \$1,000,000 for each of fiscal years 2015 through ~~2018~~ 2022. Subject to the preceding sentence, the Secretary shall determine the amount of each grant based on the population of the area, including estimated patients, to be served under the grant.

(2) AUTHORIZATION OF APPROPRIATIONS.—There ~~is authorized to be appropriated to carry out this section \$15,000,000 for each of fiscal years 2015 through 2018~~ *are authorized to be appropriated to carry out this section \$15,000,000 for each of fiscal years 2015 through 2017, \$20,000,000 for fiscal year 2018, \$19,000,000 for each of fiscal years 2019 and 2020, and \$18,000,000 for each of fiscal years 2021 and 2022.*

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