

COMMITTEE PRINT

[SHOWING THE TEXT OF H.R. 2646 AS FORWARDED BY THE SUBCOMMITTEE
ON HEALTH ON NOVEMBER 5, 2015]

114TH CONGRESS
1ST SESSION

H. R. 2646

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

IN THE HOUSE OF REPRESENTATIVES

JUNE 4, 2015

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

A BILL

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

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

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

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

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

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

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

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

TITLE II—GRANT REFORM AND RESTRUCTURING

- Sec. 201. National mental health policy laboratory.
- Sec. 202. Innovation grants.
- Sec. 203. Demonstration grants.
- Sec. 204. Early childhood intervention and treatment.
- Sec. 205. Extension of assisted outpatient treatment grant program for individuals with serious mental illness or serious emotional disturbance.
- Sec. 206. Block grants.
- Sec. 207. Workforce development.
- Sec. 208. Authorized grants and programs.
- Sec. 209. Sense of Congress on prioritizing Native American youth and suicide prevention programs.

TITLE III—INTERAGENCY SERIOUS MENTAL ILLNESS
COORDINATING COMMITTEE

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

TITLE IV—COMPASSIONATE COMMUNICATION UNDER HIPAA AND
FERPA

- Sec. 401. Promoting appropriate treatment for mentally ill individuals by treating their caregivers as personal representatives for purposes of HIPAA privacy regulations.
- Sec. 402. Caregivers permitted access to certain education records under FERPA.
- Sec. 403. Confidentiality of records.
- Sec. 404. Model program and materials for training health care providers on disclosing protected health information to community-based providers.
- Sec. 405. Clarification of circumstances under which disclosure of protected health information of mental illness patients is permitted; model training programs.

TITLE V—MEDICARE AND MEDICAID REFORMS

- Sec. 501. Enhanced Medicaid coverage relating to certain mental health services.
- Sec. 502. Coverage of prescription drugs used to treat mental health disorders under Medicaid.
- Sec. 503. Modifications to Medicare discharge planning requirements.
- Sec. 504. At-risk youth Medicaid protection.
- Sec. 505. Optional limited coverage of inpatient services furnished in institutions for mental diseases.

TITLE VI—RESEARCH BY THE NATIONAL INSTITUTE OF MENTAL HEALTH

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

TITLE VII—REAUTHORIZATION AND REFORMS

Subtitle A—Organization and General Authorities

- Sec. 701. In general.
- Sec. 702. Advisory councils.
- Sec. 703. Peer review.

Subtitle B—Protection and Advocacy for Individuals With Mental Illness

- Sec. 711. Prohibition against lobbying by systems accepting Federal funds to protect and advocate the rights of individuals with mental illness.
- Sec. 712. Protection and advocacy activities to focus exclusively on safeguarding rights to be free from abuse and neglect.
- Sec. 713. Reporting.
- Sec. 714. Grievance procedure.
- Sec. 715. Evidence-based treatment for individuals with serious mental illness or serious emotional disturbance.
- Sec. 716. Training and curriculum for advocates for individuals with mental illness.

TITLE VIII—REPORTING

- Sec. 801. GAO study on preventing discriminatory coverage limitations for individuals with serious mental illness and substance use disorders.

TITLE IX—MISCELLANEOUS PROVISIONS

- Sec. 901. Sense of Congress encouraging more psychiatrists to accept health insurance.

1 SEC. 2. DEFINITIONS.

2 In this Act:

- 3 (1) Except as inconsistent with the provisions**
- 4 of this Act, the term “Assistant Secretary” means**

1 the Assistant Secretary for Mental Health and Sub-
2 stance Use Disorders.

3 (2) The term “emergency room boarding”
4 means the practice of admitting patients to an emer-
5 gency department and holding them in that depart-
6 ment after a decision to admit that patient to an in-
7 patient unit has been made but an inpatient psy-
8 chiatric bed is unavailable.

9 (3) The term “evidence-based” means the con-
10 scientious, systematic, explicit, and judicious ap-
11 praisal and use of external, current, reliable, and
12 valid research findings as the basis for making deci-
13 sions about the effectiveness and efficacy of a pro-
14 gram, intervention, or treatment in improving out-
15 come measures for those with serious mental illness,
16 serious emotional disturbances, and substance use
17 disorders including—

18 (A) rates of suicide, suicide attempts, sub-
19 stance abuse, overdose, overdose deaths, emer-
20 gency psychiatric hospitalizations, and emer-
21 gency room boarding;

22 (B) arrests, incarcerations, victimization,
23 homelessness, joblessness, employment, and en-
24 rollment in educational or vocational programs;

1 (C) rates of keeping treatment appoint-
2 ments and compliance with prescribed medica-
3 tions;

4 (D) participants' perceived effectiveness of
5 the program, intervention, or treatment;

6 (E) rates of the programs, interventions,
7 or treatments helping those with serious mental
8 illness or serious emotional disturbance gain
9 control over their lives;

10 (F) violence against persons or property;
11 and

12 (G) homelessness.

13 **TITLE I—ASSISTANT SECRETARY**
14 **FOR MENTAL HEALTH AND**
15 **SUBSTANCE USE DISORDERS**

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

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

22 (1) report directly to the Secretary;

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

1 (3) be selected from among individuals who—

2 (A)(i) have a doctoral degree in medicine
3 or osteopathic medicine and clinical and re-
4 search experience in psychiatry;

5 (ii) graduated from an Accreditation Coun-
6 cil for Graduate Medical Education-accredited
7 psychiatric residency program; and

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

11 (B) have a doctoral degree in psychology
12 with—

13 (i) clinical and research experience re-
14 garding mental illness and substance use
15 disorders; and

16 (ii) an understanding of biological,
17 psychosocial, and pharmaceutical treat-
18 ments of mental illness and substance use
19 disorders.

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

21 (1) coordinate across departments and agencies
22 with respect to the problems of individuals suffering
23 from substance use disorders or a mental illness;

24 (2) coordinate any functions within the Depart-
25 ment of Health and Human Services, other than

1 functions of the National Institutes of Health and
2 the Centers for Medicare & Medicaid Services—

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

6 (B) to improve selective prevention or indi-
7 cated prevention services for such individuals;

8 (C) to ensure access to effective, evidence-
9 based treatment for individuals with mental ill-
10 nesses and individuals with a substance use dis-
11 order;

12 (D) to ensure that grant programs of the
13 Department adhere to scientific standards with
14 an emphasis on selective prevention and indi-
15 cated prevention for individuals with a serious
16 mental illness, serious emotional disturbance, or
17 substance use disorder; and

18 (E) to develop and implement initiatives to
19 encourage individuals to pursue careers (espe-
20 cially in underserved areas and populations) as
21 psychiatrists, psychologists, psychiatric nurse
22 practitioners, clinical social workers, and other
23 licensed mental health professionals specializing
24 in the diagnosis, evaluation, and treatment of

1 individuals with serious mental illness or serious
2 emotional disturbance, including individuals—

3 (i) who are vulnerable to crises, psy-
4 chotic episodes, or suicidal ideation;

5 (ii) whose condition may deteriorate
6 rapidly; or

7 (iii) who require more frequent con-
8 tact or integration of a variety of services
9 by the treating mental health professional;

10 (3) consult with the National Institutes of
11 Health and the Centers for Medicare & Medicaid
12 Services on the functions of such agencies that are
13 described in any of subparagraphs (A) through (E)
14 of paragraph (2);

15 (4) coordinate the administrative and financial
16 management, policy development and planning, eval-
17 uation, knowledge dissemination, and public infor-
18 mation functions that are required for the implemen-
19 tation of mental health and substance use disorder
20 programs, including block grants, treatments, and
21 data collection;

22 (5) conduct and coordinate demonstration
23 projects, evaluations, and service system assessments
24 and other activities necessary to improve the avail-
25 ability and quality of treatment, prevention, and re-

1 lated services related to substance use disorders and
2 mental illness;

3 (6) provide for technical assistance and train-
4 ing, consistent with Federal and State privacy pro-
5 tections, on how patients' protected health informa-
6 tion from providers of mental health and substance
7 use disorder services can be shared with other com-
8 munity-based providers of these services—

9 (A) to facilitate care coordination and
10 medication adherence; and

11 (B) to better manage patients' care during
12 transitions from one care setting to another;

13 (7) within the Department of Health and
14 Human Services, oversee and coordinate all pro-
15 grams and activities relating to—

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

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

22 (C) the reduction of homelessness and in-
23 carceration among individuals with mental ill-
24 ness;

1 (8) across the Federal Government, in conjunc-
2 tion with the Interagency Serious Mental Illness Co-
3 ordinating Committee under section 301A—

4 (A) review all programs and activities re-
5 lating to the prevention of, or treatment or re-
6 habilitation for, mental illness or substance use
7 disorders;

8 (B) identify any such programs and activi-
9 ties that are duplicative;

10 (C) identify any such programs and activi-
11 ties that—

12 (i) are not evidence-based, effective, or
13 efficient; or

14 (ii) fail to improve a meaningful out-
15 come; and

16 (D) formulate recommendations for ex-
17 panding, coordinating, eliminating, and improv-
18 ing programs and activities identified pursuant
19 to subparagraph (B) or (C) and merging any
20 such programs and activities into other, suc-
21 cessful programs and activities;

22 (9) identify evidence-based best practices across
23 the Federal Government for treatment and services
24 for those with mental health and substance use dis-

1 orders by reviewing practices for efficiency, effective-
2 ness, quality, coordination, and cost effectiveness;

3 (10) supervise the National Mental Health Pol-
4 icy Laboratory; and

5 (11) not later than one year after the date of
6 enactment of the Helping Families in Mental Health
7 Crisis Act of 2015 and every two years after, submit
8 to the Congress and make publicly available a report
9 containing a nationwide strategy to increase the psy-
10 chiatric workforce and recruit medical professionals
11 for the treatment of individuals with a serious men-
12 tal illness, serious emotional disturbance, or sub-
13 stance use disorder.

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

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

20 (2) to promote greater research-oriented psy-
21 chiatrist residency training on evidence-based service
22 delivery models for individuals with serious mental
23 illness, serious emotional disturbance, or substance
24 use disorders;

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

3 (A) evidence-based coordinated care mod-
4 els; and

5 (B) the necessary psychiatric workforce ca-
6 pacity for these models, including psychiatrists
7 (including child and adolescent psychiatrists),
8 psychologists, psychiatric nurse practitioners,
9 clinical social workers, and mental health, peer-
10 support specialists;

11 (4) to increase access to child and adolescent
12 psychiatric services in order to promote early inter-
13 vention for prevention and mitigation of mental ill-
14 ness; and

15 (5) to identify populations and locations that
16 are the most underserved by mental health profes-
17 sionals and the most in need of psychiatrists (includ-
18 ing child and adolescent psychiatrists), psychologists,
19 psychiatric nurse practitioners, clinical social work-
20 ers, and mental health, peer-support specialists.

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

1 (1) the integration of mental health, substance
2 use, and physical health services for the purpose of
3 diagnosing, preventing, treating, or providing reha-
4 bilitation for mental illness or substance use dis-
5 orders, including any such services provided through
6 the justice system (including departments of correc-
7 tion), the education system, or other entities other
8 than the Department of Health and Human Serv-
9 ices;

10 (2) crisis intervention for, early diagnosis and
11 intervention services for the prevention of, and treat-
12 ment and rehabilitation for, serious mental illness,
13 serious emotional disturbance, or substance use dis-
14 orders;

15 (3) workforce development for—

16 (A) appropriate treatment of serious men-
17 tal illness, serious emotional disturbance, or
18 substance use disorders; and

19 (B) research activities that advance sci-
20 entific and clinical understandings of these dis-
21 orders, including the development and imple-
22 mentation of a continuing nationwide strategy
23 to increase the psychiatric workforce with psy-
24 chiatrists, child and adolescent psychiatrists,
25 psychologists, psychiatric nurse practitioners,

1 clinical social workers, and mental health peer
2 support specialists; and

3 (4) grants that improve a meaningful outcome
4 in people with mental illness, serious mental illness,
5 or serious emotional disturbance such as reducing
6 homelessness, arrest, incarceration, hospitalization,
7 and suicide.

8 (e) REQUIREMENTS AND RESTRICTIONS ON AUTHOR-
9 ITY TO AWARD GRANTS.—In awarding any mental health
10 grant or financial assistance, the Assistant Secretary, and
11 any agency or official within the Office of the Assistant
12 Secretary, shall comply with the following:

13 (1) The grant or financial assistance shall be
14 for activities consisting of, or based upon—

15 (A) applied scientific research;

16 (B) demonstrated scientific work; or

17 (C) in exceptional circumstances at the dis-
18 cretion of the Director of the National Mental
19 Health Policy Lab.

20 (2) Any program to be funded shall be dem-
21 onstrated—

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

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

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

7 (4) An application for the grant or financial as-
8 sistance shall include, as applicable—

9 (A) a scientific justification based on pre-
10 viously demonstrated models, the number of in-
11 dividuals to be served, the population to be tar-
12 geted, what objective outcomes measures will be
13 used, and details on how the program or activ-
14 ity to be funded can be replicated and by whom;
15 and

16 (B) a description of the studies, meth-
17 odologies and mathematical models to be used
18 and relied upon and pre-registered, including
19 any such anonymized data sets published, and
20 all results, including null results reported.

21 (5) Applicants shall be evaluated and selected
22 through a blind, peer-review process by expert men-
23 tal health care or substance use disorder treatment
24 providers with professional experience in—

25 (A) mental health research or treatment;

1 (B) substance abuse research or treatment;

2 or

3 (C) other areas of expertise appropriate to
4 the grant or other financial assistance.

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

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

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

20 (B) Federal funds are being used as re-
21 quired by the conditions of the award and by
22 applicable guidelines of the National Mental
23 Health Policy Laboratory.

24 (8) Award recipients that fail an audit or fail
25 to provide information pursuant to an audit shall

1 have their awards terminated or shall be placed on
2 a corrective action plan to address the issues raised
3 in the audit findings.

4 (f) DEFINITIONS.—In this section:

5 (1) The term “selective prevention” means pre-
6 vention that is designed to detect or prevent a dis-
7 ease or condition among individuals or a subpopula-
8 tion determined to be at risk for the disease or con-
9 dition.

10 (2) The term “indicated prevention” means pre-
11 vention that is designed to reduce or minimize the
12 consequences of a disease or condition among indi-
13 viduals who have the disease or condition.

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

15 (a) IN GENERAL.—Effective on the date that is 1
16 year after the date of enactment of this Act of the first
17 full fiscal year following such date of enactment, the Sec-
18 retary of Health and Human Services shall delegate to the
19 Assistant Secretary all duties and authorities that—

20 (1) as of the day before the date of enactment
21 of this Act, were vested in the Administrator of the
22 Substance Abuse and Mental Health Services Ad-
23 ministration; and

24 (2) are not terminated by this Act.

1 (b) TRANSITION.—This section and the amendments
2 made by this section apply beginning on the day that is
3 6 months after the date of enactment of this Act. As of
4 such day, the Secretary of Health and Human Services
5 shall provide for the transfer of the personnel, assets, and
6 obligations of the Substance Abuse and Mental Health
7 Services Administration to the Office of the Assistant Sec-
8 retary.

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

12 (1) in the title heading, by striking “**SUB-**
13 **STANCE ABUSE AND MENTAL HEALTH**
14 **SERVICES ADMINISTRATION**” and insert-
15 ing “**MENTAL HEALTH AND SUBSTANCE**
16 **USE DISORDERS**”;

17 (2) by amending section 501(a) to read as fol-
18 lows:

19 “(a) ASSISTANT SECRETARY.—The Assistant Sec-
20 retary for Mental Health and Substance Use Disorders
21 shall have the duties and authorities vested in the Assist-
22 ant Secretary by this title in addition to the duties and
23 authorities vested in the Assistant Secretary by section
24 501 of the Helping Families in Mental Health Crisis Act
25 of 2015 and other provisions of law.”;

1 (3) by amending section 501(c) to read as fol-
2 lows:

3 “(c) DEPUTY ASSISTANT SECRETARY.—The Assist-
4 ant Secretary, with the approval of the Secretary, may ap-
5 point a Deputy Assistant Secretary and may employ and
6 prescribe the functions of such officers and employees, in-
7 cluding attorneys, as are necessary to administer the ac-
8 tivities to be carried out under this title.”;

9 (4) by striking “Administrator of the Substance
10 Abuse and Mental Health Services Administration”
11 each place it appears and inserting “Assistant Sec-
12 retary for Mental Health and Substance Use Dis-
13 orders”;

14 (5) by striking “Administrator” each place it
15 appears and inserting “Assistant Secretary”, except
16 where the term “Administrator” appears within the
17 term—

18 (A) Associate Administrator;

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

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

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

1 (6) by striking “Substance Abuse and Mental
2 Health Services Administration” each place it ap-
3 pears and inserting “Office of the Assistant Sec-
4 retary”;

5 (7) in section 502, by striking “Administration
6 or Center” each place it appears and inserting “Of-
7 fice or Center”;

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

11 (9) by striking the term “Administration” each
12 place it appears and inserting “Office of the Assist-
13 ant Secretary”, except in the heading of section
14 520G(b) and where the term “Administration” ap-
15 pears with the term—

16 (A) Health Resources and Services Admin-
17 istration; or

18 (B) National Highway Traffic Safety Ad-
19 ministration.

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

23 (1) any reference in statute, regulation, or guid-
24 ance to the Administrator of the Substance Abuse
25 and Mental Health Services Administration shall be

1 construed to be a reference to the Assistant Sec-
2 retary for Mental Health and Substance Use Dis-
3 orders; and

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

8 **SEC. 103. REPORTS.**

9 (a) REPORT ON INVESTIGATIONS REGARDING PAR-
10 ITY IN MENTAL HEALTH AND SUBSTANCE USE DIS-
11 ORDER BENEFITS.—

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

22 (A) identifying Federal investigations con-
23 ducted or completed during the preceding 12-
24 month period regarding compliance with parity
25 in mental health and substance use disorder

1 benefits, including benefits provided to persons
2 with serious mental illness, serious emotional
3 disturbance, and substance use disorders, under
4 the Paul Wellstone and Pete Domenici Mental
5 Health Parity and Addiction Equity Act of
6 2008 (subtitle B of title V of division C of Pub-
7 lic Law 110–343); and

8 (B) summarizing the results of such inves-
9 tigations.

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

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

15 (B) The benefit classification or classifica-
16 tions examined by each investigation.

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

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

22 (3) LIMITATION.—Individually identifiable in-
23 formation shall be excluded from reports under
24 paragraph (1) consistent with Federal privacy pro-
25 tections.

1 (b) REPORT ON BEST PRACTICES FOR PEER-SUP-
2 PORT SPECIALIST PROGRAMS, TRAINING, AND CERTIFI-
3 CATION.—

4 (1) IN GENERAL.—Not later than 1 year after
5 the date of enactment of this Act, and biannually
6 thereafter, the Assistant Secretary shall submit to
7 the Congress and make publicly available a report on
8 innovations, best practices, and professional stand-
9 ards in States for—

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

12 (B) training and certifying peer-support
13 specialists.

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

17 (A) uses his or her lived experience of re-
18 covery from mental illness or substance abuse,
19 plus skills learned in formal training, to facili-
20 tate support groups, and to work on a one-on-
21 one basis, with individuals with a serious men-
22 tal illness, serious emotional disturbance, or a
23 substance use disorder, in consultation with and
24 under the supervision of a licensed mental
25 health or substance use treatment professional;

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

4 (C) does not provide direct medical serv-
5 ices; and

6 (D) does not perform services outside of
7 his or her area of training, expertise, com-
8 petence, or scope of practice.

9 In defining the term “peer-support specialist” for
10 purposes of this section, the Assistant Secretary
11 shall take into consideration the competencies of a
12 peer-support specialist applied by the Department of
13 Veterans Affairs.

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

17 (A) Hours of formal work or volunteer ex-
18 perience related to mental health and substance
19 use issues.

20 (B) Types of peer specialist exams re-
21 quired.

22 (C) Code of ethics.

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

25 (i) psychopharmacology;

- 1 (ii) integrating physical medicine and
2 mental health supportive services;
- 3 (iii) ethics;
- 4 (iv) scope of practice;
- 5 (v) crisis intervention;
- 6 (vi) identification and treatment of
7 mental health disorders;
- 8 (vii) State confidentiality laws;
- 9 (viii) Federal privacy protections, in-
10 cluding under the Health Insurance Port-
11 ability and Accountability Act of 1996; and
- 12 (ix) other areas as determined by the
13 Assistant Secretary.
- 14 (E) Requirements to explain what, where,
15 when, and how to accurately complete all re-
16 quired documentation activities.
- 17 (F) Required or recommended skill sets,
18 including—
- 19 (i) identifying consumer risk indica-
20 tors, including individual stressors, trig-
21 gers, and indicators of pre-crisis symp-
22 toms;
- 23 (ii) explaining basic crisis avoidance
24 techniques;

1 (iii) explaining basic suicide preven-
2 tion concepts and techniques;

3 (iv) identifying indicators that the
4 consumer may be experiencing abuse or ne-
5 glect;

6 (v) identifying and responding appro-
7 priately to personal stressors, triggers, and
8 indicators;

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

11 (vii) teaching individuals how to ac-
12 cess or participate in community mental
13 health and related services; and

14 (viii) identifying circumstances when
15 it is appropriate to request assistance from
16 other professionals to help meet the con-
17 sumer's recovery goals.

18 (G) Requirements for continuing education
19 credits annually.

20 (c) REPORT ON THE STATE OF THE STATES IN MEN-
21 TAL HEALTH AND SUBSTANCE USE TREATMENT.—Not
22 later than 1 year after the date of enactment of this Act,
23 and not less than every 2 years thereafter, the Assistant
24 Secretary shall submit to the Congress and make available
25 to the public a report on the state of the States in serious

1 mental illness, serious emotional disturbance, and sub-
2 stance use treatment, including the following:

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

6 (A) The numbers of individuals with seri-
7 ous mental illness, serious emotional disturb-
8 ance, or substance use disorders who are served
9 with Federal funds.

10 (B) The types of programs made available
11 to individuals with serious mental illness, seri-
12 ous emotional disturbance, or substance use dis-
13 orders.

14 (2) A summary of best practice models in the
15 States highlighting programs that are cost effective,
16 provide evidence-based care, increase access to care,
17 integrate physical, psychiatric, psychological, and be-
18 havioral medicine, and improve outcomes for individ-
19 uals with mental illness or substance use disorders.

20 (3) A statistical report of outcome measures in
21 each State, including—

22 (A) rates of suicide, suicide attempts, sub-
23 stance abuse, overdose, overdose deaths, emer-
24 gency psychiatric hospitalizations, and emer-
25 gency room boarding; and

1 (B) for those with mental illness, arrests,
2 incarceration, victimization, homelessness, job-
3 lessness, employment, and enrollment in edu-
4 cational or vocational programs.

5 (4) Outcome measures on State-assisted out-
6 patient treatment programs, including—

7 (A) rates of keeping treatment appoint-
8 ments and compliance with prescribed medica-
9 tions;

10 (B) participants' perceived effectiveness of
11 the program;

12 (C) rates of the programs helping those
13 with serious mental illness or serious emotional
14 disturbance gain control over their lives;

15 (D) alcohol and drug abuse rates;

16 (E) incarceration and arrest rates;

17 (F) violence against persons or property;

18 (G) homelessness; and

19 (H) total treatment costs for compliance
20 with the program.

21 (5) For States and counties with assisted out-
22 patient treatment programs, the information re-
23 ported under this subsection shall include a compari-
24 son of the outcomes of individuals with serious men-
25 tal illness or serious emotional disturbance who par-

1 participated in the programs versus the outcomes of in-
2 dividuals who did not participate but were eligible to
3 do so by nature of their history.

4 (6) For States and counties without assisted
5 outpatient treatment programs, the information re-
6 ported under this subsection shall include data on
7 individuals with mental illness who—

8 (A) have a history of violence, incarcer-
9 ation, and arrests;

10 (B) have a history of emergency psy-
11 chiatric hospitalizations;

12 (C) are substantially unlikely to participate
13 in treatment on their own;

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

18 (E) have a history of mental illness or con-
19 dition that is likely to substantially deteriorate
20 if the individual is not provided with timely
21 treatment; and

22 (F) due to their mental illness, have a lack
23 of capacity to fully understand or lack judg-
24 ment, or diminished capacity to make informed

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

3 (d) REPORTING COMPLIANCE STUDY.—

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

14 (A) community mental health centers
15 meeting the criteria specified in section 1913(c)
16 of the Public Health Service Act (42 U.S.C.
17 300x–2), including such centers meeting such
18 criteria as in effect on the day before the date
19 of enactment of this Act; and

20 (B) certified community behavioral health
21 clinics certified pursuant to section 223 of the
22 Protecting Access to Medicare Act of 2014
23 (Public Law 113–93), as amended by section
24 505.

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

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

20 (B) establish an estimate of the per capita
21 cost to each center or clinic described in sub-
22 paragraph (A) or (B) of paragraph (1) to com-
23 ply with such requirements, in terms of both
24 administrative funding and staff time; and

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

7 **SEC. 104. ADVISORY COUNCIL ON GRADUATE MEDICAL**
8 **EDUCATION.**

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

11 (1) by redesignating paragraphs (4) through
12 (6) as paragraphs (5) through (7), respectively; and
13 (2) by inserting after paragraph (3) the fol-
14 lowing:

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

17 **TITLE II—GRANT REFORM AND**
18 **RESTRUCTURING**

19 **SEC. 201. NATIONAL MENTAL HEALTH POLICY LABORA-**
20 **TORY.**

21 (a) IN GENERAL.—

22 (1) ESTABLISHMENT.—The Assistant Secretary
23 for Mental Health and Substance Use Disorders
24 shall establish, within the Office of the Assistant
25 Secretary, the National Mental Health Policy Lab-

1 oratory (in this section referred to as the
2 “NMHPL”).

3 (2) DUTIES.—The Assistant Secretary, acting
4 through the NMHPL, shall—

5 (A) identify, coordinate, and implement
6 policy changes and other trends likely to have
7 the most significant impact on mental health
8 services and monitor their impact for grants ad-
9 ministered by the Assistant Secretary;

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

15 (C) establish standards for the appoint-
16 ment of scientific peer-review panels to evaluate
17 grant applications;

18 (D) establish standards for mental health
19 grant programs under subsection (b); and

20 (E) make public recommendations on how
21 sharing patients’ protected health information
22 among community-based mental health and
23 substance use disorder providers can improve
24 care coordination, medication adherence, and

1 the management of patients' care during transi-
2 tions from one care setting to another.

3 (3) EVIDENCE-BASED PRACTICES AND SERVICE
4 DELIVERY MODELS.—In selecting evidence-based
5 best practices and service delivery models for evalua-
6 tion and dissemination under paragraph (2)(C), the
7 Assistant Secretary, acting through the NMHPL—

8 (A) shall give preference to models that
9 improve—

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

12 (ii) the coordination among such pro-
13 viders and the justice and corrections sys-
14 tem; and

15 (iii) the cost effectiveness, quality, ef-
16 fectiveness, and efficiency of health care
17 services furnished to individuals with seri-
18 ous mental illness or serious emotional dis-
19 turbance, in mental health crisis, or at risk
20 to themselves, their families, and the gen-
21 eral public; and

22 (B) may include clinical protocols and
23 practices used in the Recovery After Initial
24 Schizophrenia Episode (RAISE) project and the
25 North American Prodrome Longitudinal Study

1 (NAPLS) of the National Institute of Mental
2 Health.

3 (4) DEADLINE FOR BEGINNING IMPLEMENTA-
4 TION.—The Assistant Secretary, acting through the
5 NMHPL, shall begin implementation of the duties
6 described in this subsection not later than January
7 1, 2018.

8 (5) CONSULTATION.—In carrying out the duties
9 under this subsection, the Assistant Secretary, act-
10 ing through the NMHPL, shall consult with—

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

15 (B) other appropriate Federal agencies;

16 (C) clinical and analytical experts with ex-
17 pertise in psychiatric medical care and clinical
18 psychological care, health care management,
19 education, corrections health care, and mental
20 health court systems; and

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

24 (b) STANDARDS FOR GRANT PROGRAMS.—

1 (1) IN GENERAL.—The Assistant Secretary,
2 acting through the NMHPL, shall set standards for
3 mental health grant programs administered by the
4 Assistant Secretary, including standards for—

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

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

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

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

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

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

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

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

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

13 (2) PUBLIC DISCLOSURE OF RESULTS.—The
14 Assistant Secretary, acting through the NMHPL—

15 (A) shall make the standards under para-
16 graph (1) available to the public in a timely
17 fashion; and

18 (B) may establish requirements for States
19 and other entities receiving funds through
20 grants under programs established or amended
21 by this Act and under other mental health pro-
22 grams under the Public Health Service Act, in-
23 cluding under a block grant under part B of
24 title XIX of the Public Health Service Act (42
25 U.S.C. 300x et seq.), to collect information on

1 evidence-based best practices and services deliv-
2 ery models selected under section 101(c)(2), as
3 the Assistant Secretary determines necessary to
4 monitor and evaluate such models.

5 (c) COMPOSITION.—In selecting the staff of the
6 NMHPL, the Assistant Secretary, acting through the
7 NMHPL, in consultation with the Director of the National
8 Institute of Mental Health, shall ensure that the staff
9 shall consist of 5 categories of persons (for a total of 100
10 percent) as follows:

11 (1) At least 20 percent of the staff shall—

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

15 (B) have graduated from an Accreditation
16 Council for Graduate Medical Education-ac-
17 credited psychiatric residency program; and

18 (C) have an understanding of biological,
19 psychosocial, and pharmaceutical treatments of
20 mental illness and substance use disorders.

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

23 (A) clinical and research experience re-
24 garding mental illness and substance use dis-
25 orders; and

1 (B) an understanding of biological, psycho-
2 social, and pharmaceutical treatments of mental
3 illness and substance use disorders.

4 (3) At least 20 percent of the staff shall be pro-
5 fessionals or academics with clinical or research ex-
6 pertise in substance use disorders and treatment.

7 (4) At least 20 percent of the staff shall be pro-
8 fessionals or academics with expertise in research
9 design and methodologies.

10 (5) At least 20 percent of the staff shall be
11 mental health or substance use disorder treatment
12 professionals, including those specializing in youth
13 and adolescent treatment.

14 (d) REPORT ON QUALITY OF CARE.—Not later than
15 1 year after the date of enactment of this Act, and every
16 2 years thereafter, the Assistant Secretary, acting through
17 the NMHPL, shall submit to the Congress and make pub-
18 licly available a report on the quality of care furnished
19 through grant programs administered by the Assistant
20 Secretary under the respective services delivery models, in-
21 cluding measurement of patient-level outcomes and public
22 health outcomes such as—

23 (1) reduced rates of suicide, suicide attempts,
24 substance abuse, overdose, overdose deaths, emer-
25 gency psychiatric hospitalizations, emergency room

1 boarding, incarceration, crime, arrest, victimization,
2 homelessness, and joblessness;

3 (2) rates of employment and enrollment in edu-
4 cational and vocational programs; and

5 (3) such other criteria as the Assistant Sec-
6 retary may determine.

7 **SEC. 202. INNOVATION GRANTS.**

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

14 (1) enhancing the screening, diagnosis, and
15 treatment of mental illness, serious mental illness,
16 serious emotional disturbance, and substance use
17 disorders; or

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

20 (b) DURATION.—A grant under this section shall be
21 not less than 2 and not more than 5 years.

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

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

1 (2) not less than one-third shall be awarded for
2 screening, diagnosis, treatment, or services, as de-
3 scribed in subsection (a), for individuals (or sub-
4 populations of individuals) who are below the age of
5 18 when activities funded through the grant award
6 are initiated.

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

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

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

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

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

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

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

3 (2) to make each such report publicly available;
4 and

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

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

13 (h) FUNDING.—Of the amounts made available to the
14 Center for Mental Health Services for fiscal year 2016 and
15 each subsequent fiscal year, \$20,000,000 are authorized
16 to be used to carry out this section.

17 **SEC. 203. DEMONSTRATION GRANTS.**

18 (a) GRANTS.—The Assistant Secretary shall award
19 grants to States, counties, local governments, educational
20 institutions, and private nonprofit organizations for the
21 expansion, replication, or scaling of evidence-based pro-
22 grams across a wider area to enhance effective screening,
23 early diagnosis, intervention, and treatment with respect
24 to mental illness, serious mental illness, serious emotional
25 disturbance, and substance use disorders, primarily by—

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

3 (2) integrating models of care across specialties
4 and jurisdictions; and

5 (3) assuring the sharing by providers, con-
6 sistent with Federal and State privacy protections,
7 of patients' protected health information—

8 (A) to facilitate care coordination and
9 medication adherence; and

10 (B) to better manage patients' care during
11 changes from one care setting to another.

12 (b) DURATION.—A grant under this section shall be
13 for a period of not less than 5 years and not more than
14 10 years.

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

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

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

1 approved unanimously by the staff of the National
2 Mental Health Policy Laboratory;

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

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

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

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

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

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

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

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

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

3 (2) to make each such report publicly available;
4 and

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

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

13 (h) FUNDING.—Of the amounts made available to the
14 Center for Mental Health Services for fiscal year 2016 and
15 each subsequent fiscal year, \$20,000,000 are authorized
16 to be used to carry out this section.

17 **SEC. 204. EARLY CHILDHOOD INTERVENTION AND TREAT-**
18 **MENT.**

19 (a) GRANTS.—The Assistant Secretary, acting
20 through the National Mental Health Policy Laboratory (in
21 this section referred to as the “NMHPL”), shall—

22 (1) award grants to eligible entities to initiate
23 and undertake, for eligible children, early childhood
24 intervention and treatment programs, and special-
25 ized preschool and elementary school programs, with

1 the goal of preventing chronic and serious mental ill-
2 ness or serious emotional disturbance;

3 (2) award grants to not more than 3 eligible en-
4 tities for intervention outcomes study of children be-
5 fore and after treatment in programs funded under
6 paragraph (1) on eligible children who were treated
7 5 or more years prior to the enactment of this Act;
8 and

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

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

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

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

21 (B) provides services that include early
22 childhood intervention and specialized preschool
23 and elementary school programs focused on
24 children whose primary need is a social or emo-

1 tional disability (in addition to any learning dis-
2 ability).

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

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

9 (B) who is at risk of developing serious
10 mental illness or serious emotional disturbance
11 or shows early signs of mental illness; and

12 (C) who could benefit from early childhood
13 intervention and specialized preschool or ele-
14 mentary school programs with the goal of pre-
15 venting or treating chronic and serious mental
16 illness or serious emotional disturbance.

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

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

1 (1) Deliver (or facilitate) for eligible children
2 treatment and education, early childhood interven-
3 tion, and specialized preschool and elementary school
4 programs, including the provision of medically based
5 child care and early education services.

6 (2) Treat and educate eligible children, includ-
7 ing startup, curricula development, operating and
8 capital needs, staff and equipment, assessment and
9 intervention services, administration and medication
10 requirements, enrollment costs, collaboration with
11 primary care physicians, psychiatrists, and other li-
12 censed mental health professionals, other related
13 services to meet emergency needs of children, and
14 communication with families and medical profes-
15 sionals concerning the children.

16 (3) Develop and implement other strategies to
17 address identified treatment and educational needs
18 of eligible children that have reliable and valid eval-
19 uation modalities built into assess outcomes based
20 on sound scientific metrics as determined by the
21 NMHPL.

22 (e) USE OF FUNDS FOR INTERVENTION OUTCOMES
23 STUDY.—In conducting a study on intervention outcomes
24 through a grant under subsection (a)(2), an eligible entity
25 shall include an analysis of—

1 (1) the individuals treated and educated;

2 (2) the success of such treatment and education
3 in avoiding the onset of serious mental illness or se-
4 rious emotional disturbance or the preparation of
5 such children for the care and management of seri-
6 ous mental illness or serious emotional disturbance;

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

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

12 (f) REQUIREMENTS.—In carrying out this section,
13 the Secretary shall ensure that each entity receiving a
14 grant under subsection (a) maintains a written agreement
15 with the Secretary, and provides regular written reports,
16 as required by the Secretary, regarding the quality, effi-
17 ciency, and effectiveness of intervention and treatment for
18 eligible children preventing or treating the development
19 and onset of serious mental illness or serious emotional
20 disturbance.

21 (g) AMOUNT OF AWARDS.—

22 (1) AMOUNTS FOR EARLY CHILDHOOD INTER-
23 VENTION AND TREATMENT PROGRAMS.—The
24 amount of an award to an eligible entity under sub-

1 section (a)(1) shall be not more than \$600,000 per
2 fiscal year.

3 (2) AMOUNTS FOR INTERVENTION OUTCOMES
4 STUDY.—The total amount of an award to an eligi-
5 ble entity under subsection (a)(2) (for one or more
6 fiscal years) shall be not less than \$1,000,000 and
7 not greater than \$2,000,000.

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

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

12 (2) for awards under subsection (a)(2), shall be
13 not more than 10 fiscal years.

14 (i) MATCHING FUNDS.—The Assistant Secretary,
15 acting through the NMHPL, may not award a grant
16 under this section to an eligible entity unless the eligible
17 entity agrees, with respect to the costs to be incurred by
18 the eligible entity in carrying out the activities described
19 in subsection (d), to make available non-Federal contribu-
20 tions (in cash or in kind) toward such costs in an amount
21 equal to not less than 10 percent of Federal funds pro-
22 vided in the grant.

23 (j) FUNDING.—Of the amounts made available to the
24 Center for Mental Health Services for fiscal year 2016 and

1 each subsequent fiscal year, \$5,000,000 are authorized to
2 be used to carry out this section.

3 **SEC. 205. EXTENSION OF ASSISTED OUTPATIENT TREAT-**
4 **MENT GRANT PROGRAM FOR INDIVIDUALS**
5 **WITH SERIOUS MENTAL ILLNESS OR SERIOUS**
6 **EMOTIONAL DISTURBANCE.**

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

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

11 (2) in subsection (g)—

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

14 (B) in paragraph (2)—

15 (i) by striking “\$15,000,000” and in-
16 sserting “\$20,000,000”; and

17 (ii) by striking “2018” and inserting
18 “2020”; and

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

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

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

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

3 **SEC. 206. BLOCK GRANTS.**

4 (a) BEST PRACTICES IN CLINICAL CARE MODELS.—
5 Section 1920 of the Public Health Service Act (42 U.S.C.
6 300x-9) is amended by adding at the end the following:

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

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

18 “(2) the North American Prodrome Longitu-
19 dinal Study.”.

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

1 (c) ADDITIONAL PROGRAM REQUIREMENTS.—

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

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

7 “(A) The plan provides”;

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

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

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

24 “(B) The plan shall include a separate de-
25 scription of case management services and pro-

1 vide for activities leading to the reduction of
2 rates of suicides, suicide attempts, substance
3 abuse, overdose deaths, emergency hospitaliza-
4 tions, incarceration, crimes, arrest, and victim-
5 ization, and the increase of rates of secure
6 housing, employment, medication adherence,
7 and educational attainment. The plan shall also
8 include a detailed list of services available for
9 eligible patients (as defined in subsection
10 (d)(3)) in each county or county equivalent, in-
11 cluding assisted outpatient treatment.”.

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

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

18 “(A) an estimate of”;

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

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

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

5 “(B) an agreement by the State to report
6 to the National Mental Health Policy Labora-
7 tory and make publicly available such data as
8 may be required by the Secretary concerning—

9 “(i) comprehensive community mental
10 health services in the State; and

11 “(ii) public health outcomes for per-
12 sons with serious mental illness or serious
13 emotional disturbance in the State, includ-
14 ing changes in rates of—

15 “(I) suicides, suicide attempts,
16 substance abuse, overdose deaths,
17 emergency hospitalizations, incarcer-
18 ation, crimes, arrest, and victimiza-
19 tion; and

20 “(II) secure housing, employ-
21 ment, medication adherence, and edu-
22 cational attainment.”.

23 (3) IMPLEMENTATION OF PLAN.—Subsection
24 (d) of section 1912 of the Public Health Service Act
25 (42 U.S.C. 300x–1(d)) is amended—

1 (A) in paragraph (1)—

2 (i) by striking “Except as provided”

3 and inserting:

4 “(A) Except as provided”; and

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

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

16 “(i) outcomes and the overall cost of
17 such treatment provided; and

18 “(ii) county or county equivalent level
19 data on such patient population, including
20 overall costs and raw number data on rates
21 of involuntary inpatient and outpatient
22 commitment orders, suicides, suicide at-
23 tempts, substance abuse, overdose deaths,
24 emergency hospitalizations, incarceration,
25 crimes, arrest, victimization, secure hous-

1 ing, employment, medication adherence,
2 and educational attainment.”; and

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

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

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

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

14 “(C) is substantially unlikely to voluntarily
15 participate in treatment;

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

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

24 “(F) due to mental illness, lacks capacity
25 to fully understand or lacks judgment to make

1 informed decisions regarding his or her need for
2 treatment, care, or supervision; and

3 “(G) is likely to improve in mental health
4 and reduce the symptoms of serious mental ill-
5 ness or serious emotional disturbance when in
6 treatment.”.

7 (4) TREATMENT UNDER STATE LAW.—

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

12 “(e) ASSISTED OUTPATIENT TREATMENT UNDER
13 STATE LAW.—

14 “(1) IN GENERAL.—To receive a funding in-
15 crease under section 1918(d)(1), a State shall have
16 in effect a law under which a State court may order
17 a treatment plan for an eligible patient that—

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

21 “(B) is designed to improve access and ad-
22 herence by such patient to intensive behavioral
23 health services in order to—

24 “(i) avert relapse, repeated hos-
25 pitalizations, arrest, incarceration, suicide,

1 property destruction, and violent behavior;
2 and

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

7 “(2) CERTIFICATION OF STATE COMPLIANCE.—

8 A State may receive a funding increase under sec-
9 tion 1918(d)(1) only if the Assistant Secretary for
10 Mental Health and Substance Use Disorders reviews
11 the State’s law and certifies that it satisfies the cri-
12 teria specified in paragraph (1).

13 “(3) MAINTENANCE OF EFFORT.—With respect
14 to a law described in paragraph (1) for which a
15 State seeks an increase under section 1918(d)(1),
16 the State may receive such an increase only if the
17 State agrees to maintain expenditures of non-Fed-
18 eral amounts for carrying out such law at a level
19 that is not less than the average level of such ex-
20 penditures maintained by the State for two years
21 preceding the fiscal year for which the State is seek-
22 ing the increase.

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

24 “(1) IN GENERAL.—To receive a funding in-
25 crease under section 1918(d)(2)—

1 “(A) a State shall have in effect a law
2 under which, if a State court finds by clear and
3 convincing evidence that an individual, as a re-
4 sult of mental illness, is a danger to self, is a
5 danger to others, is persistently or acutely dis-
6 abled, or is gravely disabled and in need of
7 treatment, and is either unwilling or unable to
8 accept voluntary treatment, the court may order
9 the individual to undergo inpatient or out-
10 patient treatment; or

11 “(B) a State shall have in effect a law
12 under which a State court must order an indi-
13 vidual with a mental illness to undergo inpa-
14 tient or outpatient treatment, the law was in ef-
15 fect on the date of enactment of the Helping
16 Families in Mental Health Crisis Act of 2015,
17 and the Secretary finds that the law allows a
18 State court to order such treatment across all
19 or a sufficient range of the type of cir-
20 cumstances described in subparagraph (A).

21 “(2) DEFINITION.—For purposes of paragraph
22 (1), the term ‘persistently or acutely disabled’ refers
23 to a serious mental illness or serious emotional dis-
24 turbance that meets all the following criteria:

1 “(A) If not treated, the illness has a sub-
2 stantial probability of causing the individual to
3 suffer or continue to suffer severe and abnor-
4 mal mental, emotional, or physical harm that
5 significantly impairs judgment, reason, behav-
6 ior, or capacity to recognize reality.

7 “(B) The illness substantially impairs the
8 individual’s capacity to make an informed deci-
9 sion regarding treatment, and this impairment
10 causes the individual to be incapable of under-
11 standing and expressing an understanding of
12 the advantages and disadvantages of accepting
13 treatment and understanding and expressing an
14 understanding of the alternatives to the par-
15 ticular treatment offered after the advantages,
16 disadvantages, and alternatives are explained to
17 that individual.

18 “(C) The illness has a reasonable prospect
19 of being treatable by outpatient, inpatient, or
20 combined inpatient and outpatient treatment.”.

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

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

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

6 “(d) INCREASES FOR CERTAIN STATES.—With re-
7 spect to fiscal year 2016 and each subsequent fiscal year,
8 the amount of the allotment of a State under section 1911
9 shall be for such fiscal year the amount that would other-
10 wise be determined, without application of this subsection,
11 for such State for such fiscal year—

12 “(1) increased by 2 percent (in addition to any
13 increase under subparagraph (B)) if the State that
14 has in effect a law described in section 1912(e)(1),
15 which increase shall be solely for carrying out such
16 law; and

17 “(2) increased by 2 percent (in addition to any
18 increase under subparagraph (A)) if the State that
19 has in effect a law described in subparagraph (A) or
20 (B) of section 1912(f)(1).”

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

1 “(g) EXPANSION OF MODELS.—

2 “(1) IN GENERAL.—Taking into account the re-
3 sults of evaluations under section 201(a)(2)(C) of
4 the Helping Families in Mental Health Crisis Act of
5 2015, the Assistant Secretary may, by rule, as part
6 of the program of block grants under this subpart,
7 provide for expanded use across the Nation of evi-
8 dence-based service delivery models by providers
9 funded under such block grants, so long as—

10 “(A) the Assistant Secretary for Mental
11 Health and Substance Use Disorders (in this
12 subsection referred to as the ‘Assistant Sec-
13 retary’) determines that such expansion will—

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

17 “(ii) improve the quality of patient
18 care without significantly increasing spend-
19 ing;

20 “(B) the Director of the National Institute
21 of Mental Health determines that such expan-
22 sion would improve the quality of patient care;
23 and

24 “(C) the Assistant Secretary determines
25 that the change will—

1 “(i) significantly reduce severity and
2 duration of symptoms of mental illness;

3 “(ii) reduce rates of suicide, suicide
4 attempts, substance abuse, overdose, emer-
5 gency hospitalizations, emergency room
6 boarding, incarceration, crime, arrest, vic-
7 timization, homelessness, or joblessness; or

8 “(iii) significantly improve the quality
9 of patient care and mental health crisis
10 outcomes without significantly increasing
11 spending.

12 “(2) CONGRESSIONAL REVIEW.—Any rule pro-
13 mulgated pursuant to paragraph (1) is deemed to be
14 a major rule subject to congressional review and dis-
15 approval under chapter 8 of title 5, United States
16 Code.”.

17 (d) PERIOD FOR EXPENDITURE OF GRANT FUNDS.—
18 Section 1913 of the Public Health Service Act (42 U.S.C.
19 300x-2), as amended, is further amended by adding at
20 the end the following:

21 “(d) PERIOD FOR EXPENDITURE OF GRANT
22 FUNDS.—In implementing a plan submitted under section
23 1912(a), a State receiving grant funds under section 1911
24 may make such funds available to providers of services de-

1 scribed in subsection (b) for the provision of services with-
2 out fiscal year limitation.”.

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

6 “(c) ACTIVE OUTREACH AND ENGAGEMENT TO PER-
7 SONS WITH SERIOUS MENTAL ILLNESS OR SERIOUS
8 EMOTIONAL DISTURBANCE.—A funding agreement for a
9 grant under section 1911 is that the State involved has
10 in effect active programs which may include assisted out-
11 patient treatment, to engage persons with serious mental
12 illness or serious emotional disturbance who are substan-
13 tially unlikely to voluntarily seek treatment, in comprehen-
14 sive services in order to avert relapse, repeated hospitaliza-
15 tions, arrest, incarceration, and suicide to provide the pa-
16 tient with the opportunity to live in the community
17 through evidence-based (as defined in section 2 of the
18 Helping Families in Mental Health Crisis Act of 2015)
19 assertive outreach and engagement services targeting indi-
20 viduals that are homeless, have co-occurring disorders, or
21 have a history of treatment failure. The Assistant Sec-
22 retary for Mental Health and Substance Use Disorders
23 shall work with the Director of the National Institute of
24 Mental Health to develop a list of such evidence-based (as
25 defined in section 2 of the Helping Families in Mental

1 Health Crisis Act of 2015) assertive outreach and engage-
2 ment services, as well as criteria to be used to assess the
3 scope and effectiveness of such approaches. These pro-
4 grams may include assistant outpatient treatment pro-
5 grams under State law where State courts may order a
6 treatment plan for an eligible patient that requires—

7 “(1) such patient to obtain outpatient mental
8 health treatment while the patient is living in the
9 community; and

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

12 (f) FLEXIBLE USE OF MENTAL HEALTH AND SUB-
13 STANCE USE DISORDER BLOCK GRANT FUNDS.—Section
14 1952 of the Public Health Service Act (42 U.S.C. 300x-
15 62) is amended—

16 (1) by striking “Any amounts” and inserting
17 “(a) AVAILABILITY IN SUBSEQUENT FISCAL
18 YEARS.—Any amounts”; and

19 (2) by adding at the end the following new sub-
20 section:

21 “(b) FLEXIBLE USE OF MENTAL HEALTH AND SUB-
22 STANCE USE DISORDER BLOCK GRANT FUNDS.—Not-
23 withstanding subparts I and II, any amounts paid to a
24 State for a fiscal year under section 1911 may be used
25 by the State in accordance with subpart II and any

1 amounts paid to a State for a fiscal year under section
2 1921 may be used by the State in accordance with subpart
3 I.”.

4 **SEC. 207. WORKFORCE DEVELOPMENT.**

5 (a) TELEPSYCHIATRY AND PRIMARY CARE PHYSI-
6 CIAN TRAINING GRANT PROGRAM.—

7 (1) IN GENERAL.—The Assistant Secretary of
8 Mental Health and Substance Use Disorders (in this
9 subsection referred to as the “Assistant Secretary”)
10 shall establish a grant program (in this subsection
11 referred to as the “grant program”) under which the
12 Assistant Secretary shall award to 10 eligible States
13 (as described in paragraph (5)) grants for carrying
14 out all of the purposes described in paragraphs (2),
15 (3), and (4).

16 (2) TRAINING PROGRAM FOR CERTAIN PRIMARY
17 CARE PHYSICIANS.—For purposes of paragraph (1),
18 the purpose described in this paragraph, with re-
19 spect to a grant awarded to a State under the grant
20 program, is for the State to establish a training pro-
21 gram to train primary care physicians in—

22 (A) valid and reliable behavioral-health
23 screening tools and interventions for violence
24 and suicide risk, early signs of serious mental
25 illness or serious emotional disturbance, and

1 untreated substance abuse, which may include
2 any standardized behavioral-health screening
3 tools and interventions that are determined ap-
4 propriate by the Assistant Secretary;

5 (B) implementing the use of mental-health
6 screening tools in their practices;

7 (C) establishment of recommended inter-
8 vention and treatment protocols for individuals
9 with early warning signs of mental illness or
10 mental health crisis, including interventions for
11 parents with children at risk for developing
12 mental illness, and especially for individuals
13 whose illness makes them less receptive to men-
14 tal health services; and

15 (D) implementing the evidence-based col-
16 laborative care model of integrated medical-be-
17 havioral health care in their practices.

18 (3) PAYMENTS FOR MENTAL HEALTH SERVICES
19 PROVIDED BY CERTAIN PRIMARY CARE PHYSI-
20 CIANS.—

21 (A) IN GENERAL.—For purposes of para-
22 graph (1), the purpose described in this para-
23 graph, with respect to a grant awarded to a
24 State under the grant program, is for the State
25 to provide, in accordance with this paragraph,

1 in the case of a primary care physician who
2 participates in the training program of the
3 State established pursuant to paragraph (2),
4 payments to the primary care physician for
5 services furnished by the primary care physi-
6 cian.

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

12 (i) the nature and quality of services
13 rendered;

14 (ii) the patients' health outcome;

15 (iii) the geographical location where
16 services were provided;

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

19 (v) the duration of services provided;

20 (vi) the feasibility of replicating the
21 payment model in other locations nation-
22 wide; and

23 (vii) proper triage and enduring link-
24 age to appropriate treatment providers for
25 subspecialty care in child or forensic

1 issues; family crisis intervention; drug or
2 alcohol rehabilitation; management of sui-
3 cidal or violent behavior risk, and treat-
4 ment for serious mental illness or serious
5 emotional disturbance.

6 (4) TELEHEALTH SERVICES FOR MENTAL
7 HEALTH DISORDERS.—

8 (A) IN GENERAL.—For purposes of para-
9 graph (1), the purpose described in this para-
10 graph, with respect to a grant awarded to a
11 State under the grant program, is for the State
12 to provide, in the case of an individual fur-
13 nished items and services by a primary care
14 physician during an office visit, for payment for
15 a consultation provided by a psychiatrist or psy-
16 chologist to such physician with respect to such
17 individual through the use of qualified tele-
18 health technology for the identification, diag-
19 nosis, mitigation, or treatment of a mental
20 health disorder if such consultation occurs not
21 later than the first business day that follows
22 such visit.

23 (B) QUALIFIED TELEHEALTH TECH-
24 NOLOGY.—For purposes of subparagraph (A),
25 the term “qualified telehealth technology”, with

1 respect to the provision of items and services to
2 a patient by a health care provider, includes the
3 use of interactive audio, audio-only telephone
4 conversation, video, or other telecommuni-
5 cations technology by a health care provider to
6 deliver health care services within the scope of
7 the provider's practice at a site other than the
8 site where the patient is located, including the
9 use of electronic media for consultation relating
10 to the health care diagnosis or treatment of the
11 patient.

12 (5) ELIGIBLE STATE.—

13 (A) IN GENERAL.—For purposes of this
14 subsection, an eligible State is a State that has
15 submitted to the Assistant Secretary an appli-
16 cation under subparagraph (B) and has been
17 selected under subparagraph (D).

18 (B) APPLICATION.—A State seeking to
19 participate in the grant program under this
20 subsection shall submit to the Assistant Sec-
21 retary, at such time and in such format as the
22 Assistant Secretary requires, an application
23 that includes such information, provisions, and
24 assurances as the Assistant Secretary may re-
25 quire.

1 (C) MATCHING REQUIREMENT.—The As-
2 sistant Secretary may not make a grant under
3 the grant program unless the State involved
4 agrees, with respect to the costs to be incurred
5 by the State in carrying out the purposes de-
6 scribed in this subsection, to make available
7 non-Federal contributions (in cash or in kind)
8 toward such costs in an amount equal to not
9 less than 20 percent of Federal funds provided
10 in the grant.

11 (D) SELECTION.—A State shall be deter-
12 mined eligible for the grant program by the As-
13 sistant Secretary on a competitive basis among
14 States with applications meeting the require-
15 ments of subparagraphs (B) and (C). In select-
16 ing State applications for the grant program,
17 the Secretary shall seek to achieve an appro-
18 priate national balance in the geographic dis-
19 tribution of grants awarded under the grant
20 program.

21 (6) TARGET POPULATION.—In seeking a grant
22 under this subsection, a State shall demonstrate how
23 the grant will improve care for individuals with co-
24 occurring mental health and physical health condi-
25 tions, vulnerable populations, socially isolated popu-

1 lations, rural populations, and other populations who
2 have limited access to qualified mental health pro-
3 viders.

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

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

13 (9) AUTHORIZATION OF APPROPRIATIONS.—Out
14 of any funds in the Treasury not otherwise appro-
15 priated, there is authorized to be appropriated to
16 carry out this subsection, \$3,000,000 for each of the
17 fiscal years 2016 through 2020.

18 (10) REPORTS.—

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

1 (i) An evaluation of the grant pro-
2 gram outcomes, including a summary of
3 activities carried out with the grant and
4 the results achieved through those activi-
5 ties.

6 (ii) Recommendations on how to im-
7 prove access to mental health services at
8 grantee locations.

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

11 (iv) An assessment of the impact of
12 the demonstration project on the costs of
13 the full range of mental health services (in-
14 cluding inpatient, emergency, and ambula-
15 tory care).

16 (v) Recommendations on congres-
17 sional action to improve the grant.

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

20 (B) REPORT.—Not later than December
21 31, 2018, the Assistant Secretary and the Na-
22 tional Mental Health Policy Laboratory shall
23 submit to Congress and make available to the
24 public a report on the findings of the evaluation
25 under subparagraph (A) and also a policy out-

1 line on how Congress can expand the grant pro-
2 gram to the national level.

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

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

11 “(A) a federally qualified community behavioral
12 health clinic with a certification in effect under sec-
13 tion 223 of the Protecting Access to Medicare Act
14 of 2014; or

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

17 “(2) For purposes of this section, a health care pro-
18 fessional volunteer at an entity described in subsection
19 (g)(4) or a federally qualified community behavioral health
20 clinic shall, in providing health care services eligible for
21 funding under section 330 or subpart I of part B of title
22 XIX to an individual, be deemed to be an employee of the
23 Public Health Service for a calendar year that begins dur-
24 ing a fiscal year for which a transfer was made under

1 paragraph (5)(C). The preceding sentence is subject to the
2 provisions of this subsection.

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

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

14 “(B) The center or entity is sponsoring the
15 health care professional volunteer pursuant to para-
16 graph (4)(B).

17 “(C) The health care professional does not re-
18 ceive any compensation for the service from the indi-
19 vidual or from any third-party payer (including re-
20 imbursement under any insurance policy or health
21 plan, or under any Federal or State health benefits
22 program), except that the health care professional
23 may receive repayment from the entity described in
24 subsection (g)(4) or the center for reasonable ex-

1 penses incurred by the health care professional in
2 the provision of the service to the individual.

3 “(D) Before the service is provided, the health
4 care professional or the center or entity described in
5 subsection (g)(4) posts a clear and conspicuous no-
6 tice at the site where the service is provided of the
7 extent to which the legal liability of the health care
8 professional is limited pursuant to this subsection.

9 “(E) At the time the service is provided, the
10 health care professional is licensed or certified in ac-
11 cordance with applicable law regarding the provision
12 of the service.

13 “(4) Subsection (g) (other than paragraphs (3) and
14 (5)) and subsections (h), (i), and (l) apply to a health care
15 professional for purposes of this subsection to the same
16 extent and in the same manner as such subsections apply
17 to an officer, governing board member, employee, or con-
18 tractor of an entity described in subsection (g)(4), subject
19 to paragraph (5) and subject to the following:

20 “(A) The first sentence of paragraph (2) ap-
21 plies in lieu of the first sentence of subsection
22 (g)(1)(A).

23 “(B) With respect to an entity described in sub-
24 section (g)(4) or a federally qualified community be-
25 havioral health clinic, a health care professional is

1 not a health professional volunteer at such center
2 unless the center sponsors the health care profes-
3 sional. For purposes of this subsection, the center
4 shall be considered to be sponsoring the health care
5 professional if—

6 “(i) with respect to the health care profes-
7 sional, the center submits to the Secretary an
8 application meeting the requirements of sub-
9 section (g)(1)(D); and

10 “(ii) the Secretary, pursuant to subsection
11 (g)(1)(E), determines that the health care pro-
12 fessional is deemed to be an employee of the
13 Public Health Service.

14 “(C) In the case of a health care professional
15 who is determined by the Secretary pursuant to sub-
16 section (g)(1)(E) to be a health professional volun-
17 teer at such center, this subsection applies to the
18 health care professional (with respect to services de-
19 scribed in paragraph (2)) for any cause of action
20 arising from an act or omission of the health care
21 professional occurring on or after the date on which
22 the Secretary makes such determination.

23 “(D) Subsection (g)(1)(F) applies to a health
24 professional volunteer for purposes of this subsection
25 only to the extent that, in providing health services

1 to an individual, each of the conditions specified in
2 paragraph (3) is met.

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

8 “(B) Not later than May 1 of each fiscal year, the
9 Attorney General, in consultation with the Secretary, shall
10 submit to the Congress and make publicly available a re-
11 port providing an estimate of the amount of claims (to-
12 gether with related fees and expenses of witnesses) that,
13 by reason of the acts or omissions of health care profes-
14 sional volunteers, will be paid pursuant to this subsection
15 during the calendar year that begins in the following fiscal
16 year. Subsection (k)(1)(B) applies to the estimate under
17 the preceding sentence regarding health care professional
18 volunteers to the same extent and in the same manner
19 as such subsection applies to the estimate under such sub-
20 section regarding officers, governing board members, em-
21 ployees, and contractors of entities described in subsection
22 (g)(4).

23 “(C) Not later than December 31 of each fiscal year,
24 the Secretary shall transfer from the fund under sub-
25 section (k)(2) to the appropriate accounts in the Treasury

1 an amount equal to the estimate made under subpara-
2 graph (B) for the calendar year beginning in such fiscal
3 year, subject to the extent of amounts in the fund.

4 “(6)(A) This subsection takes effect on October 1,
5 2017, except as provided in subparagraph (B).

6 “(B) Effective on the date of the enactment of this
7 subsection—

8 “(i) the Secretary may issue regulations for car-
9 rying out this subsection, and the Secretary may ac-
10 cept and consider applications submitted pursuant to
11 paragraph (4)(B); and

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

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

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

19 **“SEC. 597. FELLOWSHIPS.**

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

24 “(1) increasing behavioral health practitioners’
25 knowledge of issues related to prevention, treatment,

1 and recovery support for mental and substance use
2 disorders among racial and ethnic minority popu-
3 lations;

4 “(2) improving the quality of mental and sub-
5 stance use disorder prevention and treatment deliv-
6 ered to ethnic minorities; and

7 “(3) increasing the number of culturally com-
8 petent behavioral health professionals who teach, ad-
9 minister, conduct services research, and provide di-
10 rect mental health or substance use services to un-
11 derserved minority populations.

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

18 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
19 carry out this section, there are authorized to be appro-
20 priated \$11,000,000 for fiscal year 2016, \$14,000,000 for
21 fiscal year 2017, \$16,000,000 for fiscal year 2018,
22 \$18,000,000 for fiscal year 2019, and \$20,000,000 for fis-
23 cal year 2020.”.

24 (d) NATIONAL HEALTH SERVICE CORPS.—

25 (1) DEFINITIONS.—

1 (A) PRIMARY HEALTH SERVICES.—Section
2 331(a)(3)(D) of the Public Health Service Act
3 (42 U.S.C. 254d(a)(3)) is amended by inserting
4 “(including pediatric mental health subspecialty
5 services)” after “pediatrics”.

6 (B) BEHAVIORAL AND MENTAL HEALTH
7 PROFESSIONALS.—Clause (i) of section
8 331(a)(3)(E)(i) of the Public Health Service
9 Act (42 U.S.C. 254d(a)(3)(E)(i)) is amended
10 by inserting “(and pediatric subspecialists
11 thereof)” before the period at the end.

12 (C) HEALTH PROFESSIONAL SHORTAGE
13 AREA.—Section 332(a)(1) of the Public Health
14 Service Act is amended by inserting “(including
15 children and adolescents)” after “population
16 group”.

17 (D) MEDICAL FACILITY.—Section
18 332(a)(2)(A) of the Public Health Service Act
19 is amended by inserting “medical residency or
20 fellowship training site for training in child and
21 adolescent psychiatry,” before “facility operated
22 by a city or county health department,”.

23 (2) ELIGIBILITY TO PARTICIPATE IN LOAN RE-
24 PAYMENT PROGRAM.—Section 338A(b)(1)(B) of the
25 Public Health Service Act (42 U.S.C. 254I-

1 1(b)(1)(B)) is amended by inserting “, including any
2 physician child and adolescent psychiatry residency
3 or fellowship training program” after “be enrolled in
4 an approved graduate training program in medicine,
5 osteopathic medicine, dentistry, behavioral and men-
6 tal health, or other health profession”.

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

9 (1) GRANTS.—The Assistant Secretary may
10 award grants to provide specialized training to law
11 enforcement officers, corrections officers, para-
12 medics, emergency medical services workers, and
13 other first responders (including village public safety
14 officers (as defined in section 247 of the Indian Arts
15 and Crafts Amendments Act of 2010 (42 U.S.C.
16 3796dd note)))—

17 (A) to recognize individuals who have men-
18 tal illness and how to properly intervene with
19 individuals with mental illness; and

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

1 (2) FUNDING.—Of the amounts made available
2 to the Center for Mental Health Services for fiscal
3 year 2016 and each subsequent fiscal year,
4 \$5,000,000 are authorized to be used to carry out
5 this section.

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

7 (a) CHILDREN’S RECOVERY FROM TRAUMA.—Sec-
8 tion 582 of the Public Health Service Act (42 U.S.C.
9 290hh–1) is amended—

10 (1) in subsection (a), by striking “developing
11 programs” and all that follows and inserting the fol-
12 lowing: “developing and maintaining programs that
13 provide for—

14 “(1) the continued operation of the National
15 Child Traumatic Stress Initiative (referred to in this
16 section as the ‘NCTSI’), which includes a coordi-
17 nating center, that focuses on the mental, behav-
18 ioral, and biological aspects of psychological trauma
19 response; and

20 “(2) the development of knowledge with regard
21 to evidence-based (as defined in section 2 of the
22 Helping Families in Mental Health Crisis Act of
23 2015) practices for identifying and treating mental,
24 behavioral, and biological disorders of children and

1 youth resulting from witnessing or experiencing a
2 traumatic event.”;

3 (2) in subsection (b)—

4 (A) by striking “subsection (a) related”
5 and inserting “subsection (a)(2) (related”;

6 (B) by striking “treating disorders associ-
7 ated with psychological trauma” and inserting
8 “treating mental, behavioral, and biological dis-
9 orders associated with psychological trauma”);
10 and

11 (C) by striking “mental health agencies
12 and programs that have established clinical and
13 basic research” and inserting “universities, hos-
14 pitals, mental health agencies, and other pro-
15 grams that have established clinical expertise
16 and research”;

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

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

21 “(c) CHILD OUTCOME DATA.—The NCTSI coordi-
22 nating center shall collect, analyze, report, and make pub-
23 licly available NCTSI-wide child treatment process and
24 outcome data regarding the early identification and deliv-
25 ery of evidence-based (as defined in section 2 of the Help-

1 ing Families in Mental Health Crisis Act of 2015) treat-
2 ment and services for children and families served by the
3 NCTSI grantees.

4 “(d) TRAINING.—The NCTSI coordinating center
5 shall facilitate the coordination of training initiatives in
6 evidence-based (as defined in section 2 of the Helping
7 Families in Mental Health Crisis Act of 2015) and trau-
8 ma-informed treatments, interventions, and practices of-
9 fered to NCTSI grantees, providers, and partners.

10 “(e) DISSEMINATION.—The NCTSI coordinating
11 center shall, as appropriate, collaborate with the Secretary
12 in the dissemination of evidence-based and trauma-in-
13 formed interventions, treatments, products, and other re-
14 sources to appropriate stakeholders.

15 “(f) REVIEW.—The Secretary shall, consistent with
16 the peer-review process, ensure that NCTSI applications
17 are reviewed by appropriate experts in the field as part
18 of a consensus review process. The Secretary shall include
19 review criteria related to expertise and experience in child
20 trauma and evidence-based (as defined in section 2 of the
21 Helping Families in Mental Health Crisis Act of 2015)
22 practices.”;

23 (5) in subsection (g) (as so redesignated), by
24 striking “with respect to centers of excellence are
25 distributed equitably among the regions of the coun-

1 try” and inserting “are distributed equitably among
2 the regions of the United States”;

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

7 (7) in subsection (j) (as so redesignated), by
8 striking “\$50,000,000” and all that follows through
9 “2006” and inserting “\$46,000,000 for each of fis-
10 cal years 2016 through 2020”.

11 (b) REDUCING THE STIGMA OF SERIOUS MENTAL
12 ILLNESS OR SERIOUS EMOTIONAL DISTURBANCE.—

13 (1) IN GENERAL.—The Secretary of Education,
14 along with the Assistant Secretary for Mental
15 Health and Substance Use Disorders, shall organize
16 a national awareness campaign involving public
17 health organizations, advocacy groups for persons
18 with serious mental illness or serious emotional dis-
19 turbance, and social media companies to assist sec-
20 ondary school students and postsecondary students
21 in—

22 (A) reducing the stigma associated with se-
23 rious mental illness or serious emotional dis-
24 turbance;

1 (B) understanding how to assist an indi-
2 vidual who is demonstrating signs of a serious
3 mental illness or serious emotional disturbance;

4 (C) understanding the importance of seek-
5 ing treatment from a physician, clinical psychol-
6 ogist, or licensed mental health professional
7 when a student believes the student may be suf-
8 fering from a serious mental illness, serious
9 emotional disturbance, or behavioral health dis-
10 order; and

11 (D) understanding how serious mental ill-
12 ness or serious emotional disturbance can cause
13 hallucinations, delusions, and cognitive impair-
14 ment that affect behavior.

15 (2) DATA COLLECTION.—The Assistant Sec-
16 retary for Mental Health and Substance Use Dis-
17 orders shall—

18 (A) evaluate the program under subsection
19 (a) on public health to determine whether the
20 program has made an impact on public health,
21 including mortality rates of persons with seri-
22 ous mental illness or serious emotional disturb-
23 ance, prevalence of serious mental illness and
24 serious emotional disturbance, physician and

1 clinical psychological visits, emergency room vis-
2 its; and

3 (B) submit a report on the evaluation to
4 the National Mental Health Policy Laboratory
5 and make such report publicly available.

6 (3) SECONDARY SCHOOL DEFINED.—For pur-
7 poses of this section, the term “secondary school”
8 has the meaning given the term in section 9101 of
9 the Elementary and Secondary Education Act of
10 1965 (20 U.S.C. 7801).

11 (c) GARRETT LEE SMITH REAUTHORIZATION.—

12 (1) INTERAGENCY RESEARCH, TRAINING, AND
13 TECHNICAL ASSISTANCE CENTERS.—Section 520C of
14 the Public Health Service Act (42 U.S.C. 290bb–34)
15 is amended—

16 (A) in subsection (d)—

17 (i) in paragraph (1), by striking
18 “youth suicide early intervention and pre-
19 vention strategies” and inserting “suicide
20 early intervention and prevention strategies
21 for all ages, particularly for youth”;

22 (ii) in paragraph (2), by striking
23 “youth suicide early intervention and pre-
24 vention strategies” and inserting “suicide

- 1 early intervention and prevention strategies
2 for all ages, particularly for youth”;
- 3 (iii) in paragraph (3)—
- 4 (I) by striking “youth”; and
5 (II) by inserting before the semi-
6 colon the following: “for all ages, par-
7 ticularly for youth”;
- 8 (iv) in paragraph (4), by striking
9 “youth suicide” and inserting “suicide for
10 all ages, particularly among youth”;
- 11 (v) in paragraph (5), by striking
12 “youth suicide early intervention tech-
13 niques and technology” and inserting “sui-
14 cide early intervention techniques and tech-
15 nology for all ages, particularly for youth”;
- 16 (vi) in paragraph (7)—
- 17 (I) by striking “youth”; and
18 (II) by inserting “for all ages,
19 particularly for youth,” after “strate-
20 gies”; and
- 21 (vii) in paragraph (8)—
- 22 (I) by striking “youth suicide”
23 each place that such appears and in-
24 serting “suicide”; and

1 (II) by striking “in youth” and
2 inserting “among all ages, particularly
3 among youth”; and

4 (B) by amending subsection (e) to read as
5 follows:

6 “(e) AUTHORIZATION OF APPROPRIATIONS.—For the
7 purpose of carrying out this section, there is authorized
8 to be appropriated \$5,988,000 for each of fiscal years
9 2016 through 2020.”.

10 (2) YOUTH SUICIDE EARLY INTERVENTION AND
11 PREVENTION STRATEGIES.—Section 520E of the
12 Public Health Service Act (42 U.S.C. 290bb–36) is
13 amended—

14 (A) in subsection (b), by striking para-
15 graph (2) and inserting the following:

16 “(2) LIMITATION.—In carrying out this section,
17 the Secretary shall ensure that a State does not re-
18 ceive more than one grant or cooperative agreement
19 under this section at any one time. For purposes of
20 the preceding sentences, a State shall be considered
21 to have received a grant or cooperative agreement if
22 the eligible entity involved is the State or an entity
23 designated by the State under paragraph (1)(B).
24 Nothing in this paragraph shall be construed to

1 apply to entities described in paragraph (1)(C).”;
2 and

3 (B) by striking subsection (m) and insert-
4 ing the following:

5 “(m) AUTHORIZATION OF APPROPRIATIONS.—For
6 the purpose of carrying out this section, there is author-
7 ized to be appropriated \$35,427,000 for each of fiscal
8 years 2016 through 2020.”.

9 (3) MENTAL AND BEHAVIORAL HEALTH SERV-
10 ICES ON CAMPUS.—Section 520E–2(h) of the Public
11 Health Service Act (42 U.S.C. 290bb–36b(h)) is
12 amended by striking “\$5,000,000 for fiscal year
13 2005” and all that follows through the period and
14 inserting “\$6,488,000 for each of fiscal years 2016
15 through 2020.”.

16 **SEC. 209. SENSE OF CONGRESS ON PRIORITIZING NATIVE**
17 **AMERICAN YOUTH AND SUICIDE PREVEN-**
18 **TION PROGRAMS.**

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

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

23 (2) Among American Indians and Alaska Na-
24 tives who are 10 to 34 years of age, suicide is the
25 second leading cause of death.

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

6 (b) SENSE OF CONGRESS.—It is the sense of Con-
7 gress that the Secretary of Health and Human Services,
8 in carrying out programs for Native American youth and
9 suicide prevention programs for youth suicide interven-
10 tion, should prioritize programs and activities for individ-
11 uals who have a high risk or disproportional burden of
12 suicide, such as Native Americans.

13 **TITLE III—INTERAGENCY SERI-**
14 **OUS MENTAL ILLNESS CO-**
15 **ORDINATING COMMITTEE**

16 **SEC. 301. INTERAGENCY SERIOUS MENTAL ILLNESS CO-**
17 **ORDINATING COMMITTEE.**

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

21 **“SEC. 501A. INTERAGENCY SERIOUS MENTAL ILLNESS CO-**
22 **ORDINATING COMMITTEE.**

23 “(a) ESTABLISHMENT.—The Assistant Secretary for
24 Mental Health and Substance Use Disorders (in this sec-
25 tion referred to as the ‘Assistant Secretary’) shall convene

1 a committee, to be known as the Interagency Serious Men-
2 tal Illness Coordinating Committee (in this section re-
3 ferred to as the ‘Committee’), to assist the Assistant Sec-
4 retary in carrying out the Assistant Secretary’s duties.

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

6 “(1) develop and annually update a summary of
7 advances in serious mental illness and serious emo-
8 tional disturbance research related to causes, preven-
9 tion, treatment, early screening, diagnosis or rule
10 out, intervention, and access to services and sup-
11 ports for individuals with serious mental illness or
12 serious emotional disturbance;

13 “(2) review Federal activities with respect to se-
14 rious mental illness and serious emotional disturb-
15 ance;

16 “(3) make recommendations to the Assistant
17 Secretary regarding any appropriate changes to such
18 activities, including recommendations to the Director
19 of NIH with respect to the strategic plan developed
20 under paragraph (6);

21 “(4) make recommendations to the Assistant
22 Secretary regarding public participation in decisions
23 relating to serious mental illness or serious emo-
24 tional disturbance;

1 “(5) develop and annually update a strategic
2 plan for advancing—

3 “(A) public utilization of effective mental
4 health services; and

5 “(B) adherence with treatment;

6 “(6) develop and annually update a strategic
7 plan for the conduct of, and support for, serious
8 mental illness and serious emotional disturbance re-
9 search, including proposed budgetary requirements;

10 “(7) develop a plan—

11 “(A) to end incarceration of individuals
12 with serious mental illness or serious emotional
13 disturbance for nonviolent offenses within 10
14 years; and

15 “(B) to use the resulting savings for fund-
16 ing the prevention, treatment, and rehabilita-
17 tion of mental illness and substance abuse, and
18 other services authorized under this Act; and

19 “(8) submit to the Congress such strategic plan
20 and any updates to such plan.

21 “(c) MEMBERSHIP.—

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

24 “(A) the Assistant Secretary for Mental
25 Health and Substance Use Disorders (or the

1 Assistant Secretary's designee), who shall serve
2 as the Chair of the Committee;

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

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

7 "(D) the Director of the Centers for Dis-
8 ease Control and Prevention (or the Director's
9 designee);

10 "(E) the Administrator of the Centers for
11 Medicare & Medicaid Services;

12 "(F) the Director of the National Insti-
13 tutes of Health (or the Director's designee);

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

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

21 "(I) the Director of the Bureau of Indian
22 Affairs (or the Director's designee);

23 "(J) the Secretary of Defense (or the Sec-
24 retary's designee);

1 “(K) the Secretary of Education (or the
2 Secretary’s designee);

3 “(L) the Secretary of Housing and Urban
4 Development (or the Secretary’s designee);

5 “(M) the Secretary of Labor (or the Sec-
6 retary’s designee);

7 “(N) the Secretary of Veterans Affairs (or
8 the Secretary’s designee);

9 “(O) the Commissioner of Social Security
10 (or the Commissioner’s designee); and

11 “(P) 4 members, of which—

12 “(i) 1 shall be appointed by the
13 Speaker of the House of Representatives;

14 “(ii) 1 shall be appointed by the mi-
15 nority leader of the House of Representa-
16 tives;

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

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

21 “(Q) the additional members appointed
22 under paragraph (2).

23 “(2) ADDITIONAL MEMBERS.—Not fewer than
24 14 members of the Committee, or $\frac{1}{3}$ of the total
25 membership of the Committee, whichever is greater,

1 shall be composed of non-Federal public members to
2 be appointed by the Assistant Secretary, of which—

3 “(A) at least one such member shall be an
4 individual in recovery from a diagnosis of seri-
5 ous mental illness or serious emotional disturb-
6 ance who has benefitted from (or is benefitting
7 from) and is receiving medical treatment under
8 the care of a licensed mental health profes-
9 sional;

10 “(B) at least one such member shall be a
11 parent or legal guardian of an individual with
12 a history of serious mental illness or serious
13 emotional disturbance who has either attempted
14 suicide or is incarcerated for violence committed
15 while experiencing a serious mental illness or
16 serious emotional disturbance;

17 “(C) at least one such member shall be a
18 representative of a leading research, advocacy,
19 and service organization for individuals with se-
20 rious mental illness or serious emotional dis-
21 turbance;

22 “(D) at least one such member shall be—
23 “(i) a licensed psychiatrist with expe-
24 rience treating serious mental illness or se-
25 rious emotional disturbance; or

1 “(ii) a licensed clinical psychologist
2 with experience treating serious mental ill-
3 ness and serious emotional disturbance;

4 “(E) at least one member shall be a li-
5 censed mental health counselor or
6 psychotherapist;

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

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

11 “(H) at least one member shall be a men-
12 tal health professional with a significant focus
13 in his or her practice working with children and
14 adolescents;

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

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

23 “(K) at least one such member shall be an
24 accredited or State certified mental health peer
25 specialist;

1 “(L) at least one member shall be a judge
2 with experiences applying assisted outpatient
3 treatment;

4 “(M) at least one member shall be a law
5 enforcement officer with extensive experience in
6 interfacing with individuals in mental health
7 crisis; and

8 “(N) at least one member shall be a local
9 corrections officer.

10 “(d) REPORTS TO CONGRESS.—Not later than 1 year
11 after the date of enactment of this Act, and every 2 years
12 thereafter, the Committee shall submit and make publicly
13 available a report to the Congress—

14 “(1) analyzing the efficiency, effectiveness,
15 quality, coordination, and cost effectiveness of Fed-
16 eral programs and activities relating to the preven-
17 tion of, or treatment or rehabilitation for, mental
18 health or substance use disorders, including an ac-
19 counting of the costs of such programs and activi-
20 ties, with administrative costs disaggregated from
21 the costs of services and care provided;

22 “(2) evaluating the impact on public health of
23 projects addressing priority mental health needs of
24 regional and national significance under sections

1 501, 509, 516, and 520A including measurement of
2 public health outcomes such as—

3 “(A) reduced rates of suicide, suicide at-
4 tempts, substance abuse, overdose, overdose
5 deaths, emergency hospitalizations, emergency
6 room boarding, incarceration, crime, arrest, vic-
7 timization, homelessness, and joblessness;

8 “(B) increased rates of employment and
9 enrollment in educational and vocational pro-
10 grams; and

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

13 “(3) formulating recommendations for the co-
14 ordination and improvement of Federal programs
15 and activities described in paragraph (2);

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

18 “(5) summarizing all recommendations made,
19 activities carried out, and results achieved pursuant
20 to the workforce development strategy under section
21 501(b)(9) of the Public Health Service Act, as
22 amended by section 101.

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

1 “(1) The Assistant Secretary shall provide such
2 administrative support to the Committee as may be
3 necessary for the Committee to carry out its respon-
4 sibilities.

5 “(2) Members of the Committee appointed
6 under subsection (c)(2) shall serve for a term of 4
7 years, and may be reappointed for one or more addi-
8 tional 4-year terms. Any member appointed to fill a
9 vacancy for an unexpired term shall be appointed for
10 the remainder of such term. A member may serve
11 after the expiration of the member’s term until a
12 successor has taken office.

13 “(3) The Committee shall meet at the call of
14 the chair or upon the request of the Assistant Sec-
15 retary. The Committee shall meet not fewer than 2
16 times each year.

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

20 “(f) SUBCOMMITTEES; ESTABLISHMENT AND MEM-
21 BERSHIP.—In carrying out its functions, the Committee
22 may establish subcommittees and convene workshops and
23 conferences. Such subcommittees shall be composed of
24 Committee members and may hold such meetings as are

1 necessary to enable the subcommittees to carry out their
2 duties.”.

3 **TITLE IV—COMPASSIONATE**
4 **COMMUNICATION UNDER**
5 **HIPAA AND FERPA**

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

11 (a) CAREGIVER ACCESS TO INFORMATION.—In ap-
12 plying section 164.502(g) of title 45, Code of Federal Reg-
13 ulations, to an individual with a serious mental illness or
14 serious emotional disturbance who does not provide con-
15 sent for the disclosure of protected health information of
16 such individual to a caregiver of such individual, the care-
17 giver shall be treated by a covered entity as a personal
18 representative of such individual if—

19 (1) the provider furnishing services to the indi-
20 vidual reasonably believes that making the protected
21 health information of such individual available to the
22 caregiver is necessary to protect the health, safety,
23 or welfare of the individual or the safety of one or
24 more other individuals;

1 (2) such disclosure is for information limited to
2 the diagnoses, treatment recommendations, appoint-
3 ment scheduling, medications, and medication-re-
4 lated instructions, but not including any personal
5 psychotherapy notes; and

6 (3) the absence of such information and proper
7 treatment will lead to a worsening prognosis or an
8 acute medical condition (which may include diabetes,
9 heart disease, lung disease, or infectious disease) or
10 mental health condition.

11 (b) TRAINING.—In applying section 164.530 of title
12 45, Code of Federal Regulations, the training described
13 in paragraph (b)(1) of such section shall include training
14 with respect to the permissible disclosure of information
15 under section 164.502(g) of such title.

16 (c) AGE OF MAJORITY.—In applying section
17 164.502(g) of title 45, Code of Federal Regulations, not-
18 withstanding any other provision of law, an
19 unemancipated minor shall be an individual under the age
20 of 18 years.

21 (d) PROVIDER ACCESS TO INFORMATION.—Health
22 care providers may listen to information or review medical
23 history provided by family members or other caregivers
24 who may have concerns about the health and well-being

1 of the patient, so the health care provider can factor that
2 information into the patient's care.

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

4 (1) COVERED ENTITY.—The term “covered en-
5 tity” has the meaning given such term in section
6 106.103 of title 45, Code of Federal Regulations.

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

11 (3) CAREGIVER.—The term “caregiver” means,
12 with respect to an individual with a serious mental
13 illness or serious emotional disturbance—

14 (A) an immediate family member of such
15 individual;

16 (B) an individual who assumes primary re-
17 sponsibility for providing a basic need of such
18 individual; or

19 (C) a personal representative of the indi-
20 vidual as determined by the law of the State in
21 which such individual resides;

22 who can establish a longstanding involvement and is
23 responsible with the individual and the health care
24 of the individual, and who does not have a docu-
25 mented history of abuse of the individual.

1 (4) INDIVIDUAL WITH A SERIOUS MENTAL ILL-
2 NESS OR SERIOUS EMOTIONAL DISTURBANCE.—The
3 term “individual with a serious mental illness or se-
4 rious emotional disturbance” means, with respect to
5 the disclosure to a caregiver of protected health in-
6 formation of an individual, an individual who—

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

8 (B) by nature of the severe mental illness,
9 as determined by a physician or psychologist,
10 has or has had a diminished capacity to fully
11 understand or follow a treatment plan for the
12 medical condition involved or may become
13 gravely disabled in absence of treatment; and

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

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

23 (ii) results in functional impairment
24 of the individual that substantially inter-

1 feres with or limits one or more major life
2 activities of the individual.

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

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

9 Section 444 of the General Education Provisions Act
10 (20 U.S.C. 1232g) is amended by adding at the end the
11 following new subsection:

12 “(k) DISCLOSURES TO CAREGIVERS.—

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

1 giver is necessary to protect the health, safety, or
2 welfare of such student or the safety of one or more
3 other individuals.

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

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

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

17 **SEC. 403. CONFIDENTIALITY OF RECORDS.**

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

20 (1) in subsection (b)(2), by adding at the end
21 the following:

22 “(C)(i) Within accountable care organiza-
23 tions described in section 1899 of the Social Se-
24 curity Act, health information exchanges (as de-
25 fined for purposes of section 3013), health

1 homes (as defined in section 1945(h)(3) of such
2 Act, or other organized health care arrange-
3 ments or community-based systems of care; and

4 “(ii) insofar as the disclosure—

5 “(I) involves the interchange of elec-
6 tronic health records (as defined in section
7 13400 of division A of Public Law 111–
8 5)); and

9 “(II) is for the purposes of enabling
10 treatment, payment, and health care oper-
11 ations as defined in section 164.501 of title
12 45 of the Code of Federal Regulations, or
13 securing and providing patient safety.”;
14 and

15 (2) by adding at the end the following new sub-
16 section:

17 **[(i) CLARIFICATION.—**In applying this section and
18 part 2 of title 42 of the Code of Federal Regulations, the
19 Secretary shall be considered a ‘program director’ and not
20 a ‘third party payor’, as such terms are defined under
21 such part, for purposes of disclosing patient identifying
22 information to qualified researchers. In carrying out the
23 previous sentence, the Secretary shall, by not later than
24 January 1, 2016, and subject to privacy restrictions under
25 such part, restore access to qualified researchers of patient

1 identifying information held by the Centers for Medicare
2 & Medicaid Services for the programs under titles XVIII
3 and XIX of the Social Security Act.”.]

4 **SEC. 404. MODEL PROGRAM AND MATERIALS FOR TRAIN-**
5 **ING HEALTH CARE PROVIDERS ON DIS-**
6 **CLOSING PROTECTED HEALTH INFORMATION**
7 **TO COMMUNITY-BASED PROVIDERS.**

8 To facilitate care coordination and medication adher-
9 ence, and to manage patients’ care during transitions from
10 one care setting to another, the Secretary of Health and
11 Human Services shall develop and disseminate a model
12 program and materials, including examples, for training
13 health care providers (including mental health and sub-
14 stance use disorder providers) on the manner in which,
15 consistent with Federal and State privacy protections, the
16 protected health information of patients with a mental ill-
17 ness or substance use disorder may be disclosed to health
18 care providers of these services.

19 **SEC. 405. CLARIFICATION OF CIRCUMSTANCES UNDER**
20 **WHICH DISCLOSURE OF PROTECTED HEALTH**
21 **INFORMATION OF MENTAL ILLNESS PA-**
22 **TIENTS IS PERMITTED; MODEL TRAINING**
23 **PROGRAMS.**

24 (a) IN GENERAL.—The HITECH Act (title XIII of
25 division A of Public Law 111–5) is amended by adding

1 at the end of subtitle D of such Act (42 U.S.C. 17921
2 et seq.) the following:

3 **“PART 3—IMPROVED PRIVACY AND SECURITY**
4 **PROVISIONS FOR MENTAL ILLNESS PATIENTS**
5 **“SEC. 13431. CLARIFICATION OF CIRCUMSTANCES UNDER**
6 **WHICH DISCLOSURE OF PROTECTED HEALTH**
7 **INFORMATION IS PERMITTED.**

8 “(a) IN GENERAL.—Not later than one year after the
9 date of enactment of the Helping Families in Mental
10 Health Crisis Act of 2015, the Secretary shall promulgate
11 final regulations clarifying the circumstances under which,
12 consistent with the standards governing the privacy and
13 security of individually identifiable health information pro-
14 mulgated by the Secretary under sections 262(a) and 264
15 of the Health Insurance Portability and Accountability
16 Act of 1996, health care providers and covered entities
17 may disclose the protected health information of patients
18 with a mental illness, including for purposes of—

19 “(1) communicating with a patient’s family,
20 caregivers, friends, or others involved in the pa-
21 tient’s care, including communication about treat-
22 ments, side effects, risk factors, and the availability
23 of community resources;

24 “(2) communicating with family or caregivers
25 when the patient is an adult;

1 “(3) communicating with the parent or care-
2 giver of a patient who is a minor;

3 “(4) considering the patient’s capacity to agree
4 or object to the sharing of their information;

5 “(5) communicating and sharing information
6 with a patient’s family or caregivers when—

7 “(A) the patient consents; or

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

12 “(6) involving a patient’s family members,
13 friends, or caregivers, or others involved in the pa-
14 tient’s care in the patient’s care plan, including
15 treatment and medication adherence, in dealing with
16 patient failures to adhere to medication or other
17 therapy;

18 “(7) listening to or receiving information from
19 family members or caregivers about their loved ones
20 receiving mental illness treatment;

21 “(8) communicating with family members, care-
22 givers, law enforcement, or others when the patient
23 presents a serious and imminent threat of harm to
24 self or others; and

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

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

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

16 (b) DEVELOPMENT AND DISSEMINATION OF MODEL
17 TRAINING PROGRAMS.—

18 (1) INITIAL PROGRAMS AND MATERIALS.—Not
19 later than one year after promulgating final regula-
20 tions under section 13431 of the HITECH Act, as
21 added by subsection (a), the Secretary of Health and
22 Human Services (in this section referred to as the
23 “Secretary”) shall develop and disseminate—

24 (A) a model program and materials for
25 training health care providers (including physi-

1 cians, emergency medical personnel, psycholo-
2 gists, counselors, therapists, behavioral health
3 facilities and clinics, care managers, and hos-
4 pitals) regarding the circumstances under
5 which, consistent with the standards governing
6 the privacy and security of individually identifi-
7 able health information promulgated by the
8 Secretary under sections 262(a) and 264 of the
9 Health Insurance Portability and Accountability
10 Act of 1996, the protected health information
11 of patients with a mental illness may be dis-
12 closed with and without patient consent;

13 (B) a model program and materials for
14 training lawyers and others in the legal profes-
15 sion on such circumstances; and

16 (C) a model program and materials for
17 training patients and their families regarding
18 their rights to protect and obtain information
19 under the standards specified in subparagraph
20 (A).

21 (2) PERIODIC UPDATES.—The Secretary
22 shall—

23 (A) periodically review and update the
24 model programs and materials developed under
25 paragraph (1); and

1 (B) disseminate the updated model pro-
2 grams and materials.

3 (3) CONTENTS.—The programs and materials
4 developed under paragraph (1) shall address the
5 guidance entitled “HIPAA Privacy Rule and Shar-
6 ing Information Related to Mental Health”, issued
7 by the Department of Health and Human Services
8 on February 20, 2014.

9 (4) COORDINATION.—The Secretary shall carry
10 out this section in coordination with the Director of
11 the Office for Civil Rights within the Department of
12 Health and Human Services, the Administrator of
13 the Substance Abuse and Mental Health Services
14 Administration, the Administrator of the Health Re-
15 sources and Services Administration, and the heads
16 of other relevant agencies within the Department of
17 Health and Human Services.

18 (5) INPUT OF CERTAIN ENTITIES.—In devel-
19 oping the model programs and materials required by
20 paragraphs (1) and (2), the Secretary shall solicit
21 the input of relevant national, State, and local asso-
22 ciations, medical societies, and licensing boards.

1 **TITLE V—MEDICARE AND**
2 **MEDICAID REFORMS**

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

5 (a) RULE OF CONSTRUCTION RELATED TO MED-
6 ICAID COVERAGE OF MENTAL HEALTH SERVICES AND
7 PRIMARY CARE SERVICES FURNISHED ON THE SAME
8 DAY.—Nothing in title XIX of the Social Security Act (42
9 U.S.C. 1396 et seq.) shall be construed as prohibiting
10 under the State plan under this title (or under a waiver
11 of the plan) the provision of a mental health service or
12 primary care service furnished to an individual which
13 would otherwise be considered medical assistance under
14 such plan, with respect to such individual, if such service
15 were not—

16 (1) a primary care service furnished to the indi-
17 vidual by a provider at a facility on the same day
18 a mental health service is furnished to such indi-
19 vidual by such provider (or another provider) at the
20 facility; or

21 (2) a mental health service furnished to the in-
22 dividual by a provider at a facility on the same day
23 a primary care service is furnished to such individual
24 by such provider (or another provider) at the facil-
25 ity.

1 **[(b) STATE OPTION TO PROVIDE MEDICAL ASSIST-**
2 **ANCE FOR CERTAIN INPATIENT PSYCHIATRIC SERVICES**
3 **TO NONELDERLY ADULTS.—Section 1905 of the Social**
4 **Security Act (42 U.S.C. 1396d) is amended—]**

5 **[(1) in subsection (a)—]**

6 **[(A) in paragraph (16)—]**

7 **[(i) by striking “effective” and insert-**
8 **ing “(A) effective”; and]**

9 **[(ii) by inserting before the semicolon**
10 **at the end the following: “and (B) quali-**
11 **fied inpatient psychiatric hospital services**
12 **(as defined in subsection (h)(3)) for indi-**
13 **viduals over 21 years of age and under 65**
14 **years of age”; and]**

15 **[(B) in the subdivision (B) that follows**
16 **paragraph (29), by inserting “(other than serv-**
17 **ices described in subparagraph (B) of para-**
18 **graph (16) for individuals described in such**
19 **subparagraphs)” after “patient in an institution**
20 **for mental diseases”; and]**

21 **[(2) in subsection (h), by adding at the end the**
22 **following new paragraph:]**

23 **[(“3) For purposes of subsection (a)(16)(B), the**
24 **term ‘qualified inpatient psychiatric hospital services’**
25 **means, with respect to individuals described in such sub-**

1 section, services described in subparagraphs (A) and (B)
2 of paragraph (1) that are furnished—】

3 【“(A) in an acute care psychiatric unit in a
4 State-operated psychiatric hospital or a psychiatric
5 hospital (as defined section 1861(f)); and】

6 【“(B) with respect to such an individual, for a
7 period not to exceed 20 days in any month.”.】

8 【(c) REPORT.—】

9 【(1) IN GENERAL.—The Assistant Secretary
10 for Mental Health and Substance Use Disorders
11 shall report (and make such report publicly avail-
12 able) on the impact of the amendments made by
13 subsection (b) on the funds made available by States
14 for inpatient psychiatric hospital care and for com-
15 munity-based mental health services. Such study
16 shall include an assessment of each of the fol-
17 lowing:】

18 【(A) The amount of funds expended annu-
19 ally by States on qualified inpatient psychiatric
20 hospital services (as defined in paragraph (3) of
21 section 1905(h) of the Social Security Act (42
22 U.S.C. 1396d(h)), as added by subsection
23 (b)(2)).】

24 【(B) The amount of funds expended annu-
25 ally on qualified inpatient psychiatric hospital

1 services through disproportionate share hospital
2 payments under section 1923 of the Social Se-
3 curity Act (42 U.S.C. 1396r-4).】

4 【(C) The reduction in the amount of funds
5 described in subparagraph (A) that is attrib-
6 utable to the amendments made by subsection
7 (b).】

8 【(D) The reduction in the amount of funds
9 described in subparagraph (B) that is attrib-
10 utable to the amendment made by such sub-
11 section.】

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

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

23 【(d) EFFECTIVE DATE.—】

24 【(1) IN GENERAL.—Subject to paragraphs (2)
25 and (3), the amendments made by this section shall

1 apply to items and services furnished after the first
2 day of the first calendar year that begins after the
3 date of the enactment of this section.】

4 【(2) CERTIFICATION OF NO INCREASED SPENDING.—The amendments made by this section shall
5 not be effective, with respect to a State, unless the
6 Chief Actuary of the Centers for Medicare & Medicaid Services certifies that the inclusion of qualified
7 inpatient psychiatric hospital services (as defined in
8 section 1905(h) of the Social Security Act (42
9 U.S.C. 1396d(h))) furnished to nonelderly adults as
10 medical assistance under section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as amended
11 by subsection (a), would not result in an increase in
12 such State’s net program spending under title XIX
13 of such Act.】

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

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

9 **【SEC. 502. COVERAGE OF PRESCRIPTION DRUGS USED TO**
10 **TREAT MENTAL HEALTH DISORDERS UNDER**
11 **MEDICAID.**

12 **【(a) IN GENERAL.—**Section 1927(d) of the Social
13 Security Act (42 U.S.C. 1396r–8(d)) is amended by add-
14 ing at the end the following new paragraph:】

15 **【“(8) ACCESS TO MENTAL HEALTH DRUGS.—**A
16 State shall not exclude from coverage or otherwise
17 restrict access to drugs that are being used for the
18 treatment of a diagnosis of major depression, bipolar
19 (manic-depressive) disorder, panic disorder, obses-
20 sive-compulsive disorder, schizophrenia, and
21 schizoaffective disorder other than pursuant to a
22 prior authorization program that is consistent with
23 paragraph (5).”】

24 **【(b) MEDICAID MANAGED CARE ORGANIZATIONS.—**
25 **】**

1 【(1) IN GENERAL.—Section 1932(b) of the So-
2 cial Security Act (42 U.S.C. 1396u–2(b)) is amend-
3 ed by adding at the end the following new para-
4 graph:】

5 【“(9) COVERAGE OF PRESCRIPTION DRUGS
6 USED TO TREAT MENTAL HEALTH DISORDERS.—
7 Each contract with a medicaid managed care organi-
8 zation under section 1903(m) and each contract with
9 a primary care case manager under section
10 1905(t)(3) shall require coverage of all covered out-
11 patient drugs used for the treatment of a mental
12 health disorder, in accordance with section
13 1927(d)(8).”】

14 【(2) EXEMPTION.—Section 1927(j)(1) of the
15 Social Security Act (42 U.S.C. 1396r–8(j)(1)) is
16 amended by inserting “, other than covered out-
17 patient drugs described in subsection (d)(8),” after
18 “Covered outpatient drugs”.】

19 **SEC. 503. MODIFICATIONS TO MEDICARE DISCHARGE PLAN-**
20 **NING REQUIREMENTS.**

21 (a) IN GENERAL.—Section 1861(ee) of the Social Se-
22 curity Act (42 U.S.C. 1395x(ee)) is amended—

23 (1) in subparagraph (2)(A), by inserting “, as
24 well as those patients in a psychiatric hospital or a
25 psychiatric unit of a hospital (as described in the

1 matter following clause (v) of section
2 1886(d)(1)(B))” before the period at the end; and
3 (2) by adding at the end the following new
4 paragraph:

5 “(4) The hospital or unit must identify organizations,
6 as applicable, that offer services such as social, nutrition,
7 and housing to patients receiving services from the hos-
8 pital or unit and communicate with such organizations for
9 the purpose of appropriately referring patients to such or-
10 ganizations.”.

11 (b) REGULATIONS.—Not later than June 1, 2018,
12 the Secretary of Health and Human Services shall issue
13 final regulations implementing the amendments made by
14 subsection (a).

15 **SEC. 504. AT-RISK YOUTH MEDICAID PROTECTION.**

16 (a) IN GENERAL.—Section 1902 of the Social Secu-
17 rity Act (42 U.S.C. 1396a) is amended—

18 (1) in subsection (a)—

19 (A) by striking “and” at the end of para-
20 graph (80);

21 (B) by striking the period at the end of
22 paragraph (81) and inserting “; and”; and

23 (C) by inserting after paragraph (81) the
24 following new paragraph:

25 “(82) provide that—

1 “(A) the State shall not terminate (but
2 may suspend) enrollment under a State plan for
3 medical assistance for an individual who is an
4 eligible juvenile (as defined in subsection (ll)(2))
5 because the juvenile is an inmate of a public in-
6 stitution (as defined in subsection (ll)(3));

7 “(B) the State shall automatically restore
8 enrollment for such medical assistance to such
9 an individual upon the individual’s release from
10 any such public institution and shall take all
11 necessary steps to ensure the enrollment is ef-
12 fective immediately upon release from such in-
13 stitution, unless (and until such date as) there
14 is a determination that the individual no longer
15 meets the eligibility requirements for such med-
16 ical assistance; and

17 “(C) the State shall process any applica-
18 tion for medical assistance submitted by, or on
19 behalf of, a juvenile who is an inmate of a pub-
20 lic institution notwithstanding that the juvenile
21 is such an inmate.”; and

22 (2) by adding at the end the following new sub-
23 section:

1 “(ll) JUVENILE; ELIGIBLE JUVENILE; PUBLIC INSTI-
2 TUTION.—For purposes of subsection (a)(82) and this
3 subsection:

4 “(1) JUVENILE.—The term ‘juvenile’ means an
5 individual who is—

6 “(A) under 19 years of age (or such higher
7 age as the State has elected under section
8 475(8)(B)(iii)); or

9 “(B) is described in subsection
10 (a)(10)(A)(i)(IX).

11 “(2) ELIGIBLE JUVENILE.—The term ‘eligible
12 juvenile’ means a juvenile who is an inmate of a
13 public institution and was enrolled for medical as-
14 sistance under the State plan immediately before be-
15 coming an inmate of such a public institution or who
16 becomes eligible to enroll for such medical assistance
17 while an inmate of a public institution.

18 “(3) INMATE OF A PUBLIC INSTITUTION.—The
19 term ‘inmate of a public institution’ has the meaning
20 given such term for purposes of applying the sub-
21 division (A) following paragraph (29) of section
22 1905(a), taking into account the exception in such
23 subdivision for a patient of a medical institution.”.

24 (b) NO CHANGE IN EXCLUSION FROM MEDICAL AS-
25 SISTANCE FOR INMATES OF PUBLIC INSTITUTIONS.—

1 Nothing in this section shall be construed as changing the
2 exclusion from medical assistance under the subdivision
3 (A) following paragraph (29) of section 1905(a) of the So-
4 cial Security Act (42 U.S.C. 1396d(a)), including any ap-
5 plicable restrictions on a State submitting claims for Fed-
6 eral financial participation under title XIX of such Act
7 for such assistance.

8 (c) EFFECTIVE DATE.—

9 (1) IN GENERAL.—Except as provided in para-
10 graph (2), the amendments made by subsection (a)
11 shall apply to eligibility and enrollment of juveniles
12 who become inmates of public institutions on or
13 after the date that is 1 year after the date of the
14 enactment of this Act.

15 (2) RULE FOR CHANGES REQUIRING STATE
16 LEGISLATION.—In the case of a State plan for med-
17 ical assistance under title XIX of the Social Security
18 Act which the Secretary of Health and Human Serv-
19 ices determines requires State legislation (other than
20 legislation appropriating funds) in order for the plan
21 to meet the additional requirements imposed by the
22 amendments made by subsection (a), the State plan
23 shall not be regarded as failing to comply with the
24 requirements of such title solely on the basis of its
25 failure to meet these additional requirements before

1 the first day of the first calendar quarter beginning
2 after the close of the first regular session of the
3 State legislature that begins after the date of the en-
4 actment of this Act. For purposes of the previous
5 sentence, in the case of a State that has a 2-year
6 legislative session, each year of such session shall be
7 deemed to be a separate regular session of the State
8 legislature.

9 **SEC. 505. OPTIONAL LIMITED COVERAGE OF INPATIENT**
10 **SERVICES FURNISHED IN INSTITUTIONS FOR**
11 **MENTAL DISEASES.**

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

15 “(I)(i) Notwithstanding the limitation
16 specified in the subdivision (B) following para-
17 graph (29) of section 1905(a), beginning on the
18 date of the enactment of this subparagraph, a
19 State may provide, as part of the monthly
20 capitated payment made by the State under
21 this title to a medicaid managed care organiza-
22 tion or a prepaid inpatient health plan (as de-
23 fined in section 438.2 of title 42, Code of Fed-
24 eral Regulations (or any successor regulation)),
25 for payment for limited inpatient psychiatric

1 hospital services provided by such organization
2 or health plan, at the option of the individual
3 receiving such services, in lieu of services cov-
4 ered under the State plan during the month for
5 which the payment is made.

6 “(ii) In this subparagraph, the term ‘lim-
7 ited inpatient psychiatric hospital services’
8 means the services described in subparagraphs
9 (A) and (B) of section 1905(h)(1)—

10 “(I) that are furnished to individuals
11 over 21 years of age and under 65 years
12 of age in an institution for mental diseases
13 (as defined in section 1905(i)) that is an
14 inpatient hospital facility or a sub-acute
15 care facility providing crisis residential
16 services (as defined by the Secretary); and

17 “(II) for which the length of stay in
18 such an institution is for a short-term stay
19 of not more than 15 days during the
20 month for which the capitated payment re-
21 ferred to in clause (i) is made.”.

1 **TITLE VI—RESEARCH BY THE**
2 **NATIONAL INSTITUTE OF**
3 **MENTAL HEALTH**

4 **SEC. 601. INCREASE IN FUNDING FOR CERTAIN RESEARCH.**

5 Section 402A(a) of the Public Health Service Act (42
6 U.S.C. 282a(a)) is amended by adding at the end the fol-
7 lowing:

8 “(3) FUNDING FOR THE BRAIN INITIATIVE AND
9 OTHER RESEARCH AT THE NATIONAL INSTITUTE OF
10 MENTAL HEALTH.—

11 “(A) FUNDING.—In addition to amounts
12 made available pursuant to paragraphs (1) and
13 (2), there are authorized to be appropriated to
14 the National Institute of Mental Health for the
15 purposes described in subparagraph (B)(ii)
16 \$40,000,000 for each of fiscal years 2016
17 through 2020.

18 “(B) PURPOSES.—Amounts appropriated
19 pursuant to subparagraph (A) shall be used ex-
20 clusively for the purpose of conducting or sup-
21 porting—

22 “(i) research on the determinants of
23 self- and other directed-violence in mental
24 illness, including studies directed at reduc-

1 ing the risk of self harm, suicide, and
2 interpersonal violence; or

3 “(ii) brain research through the Brain
4 Research through Advancing Innovative
5 Neurotechnologies Initiative.”.

6 **TITLE VII—REAUTHORIZATION**
7 **AND REFORMS**
8 **Subtitle A—Organization and**
9 **General Authorities**

10 **SEC. 701. IN GENERAL.**

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

13 (1) in subsection (h), by inserting at the end
14 the following: “For any such peer-review group re-
15 viewing a proposal or grant related to mental illness,
16 no fewer than half of the members of the group shall
17 have a medical degree, have a corresponding doctoral
18 degree in psychology, or be a licensed mental health
19 professional with clinical experience.”; and

20 (2) in subsection (l)—

21 (A) in paragraph (2), by striking “and” at
22 the end;

23 (B) in paragraph (3), by striking the pe-
24 riod at the end and inserting “; and”; and

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

1 “(4) At least 60 days before awarding a grant,
2 cooperative agreement, or contract, the Assistant
3 Secretary shall give written notice of the award to
4 the Committee on Energy and Commerce of the
5 House of Representatives and the Committee on
6 Health, Education, Labor, and Pensions of the Sen-
7 ate.”.

8 **SEC. 702. ADVISORY COUNCILS.**

9 Paragraph (3) of section 502(b) of the Public Health
10 Service Act (42 U.S.C. 290aa-1(b)) is amended by adding
11 at the end the following:

12 “(C) No fewer than half of the members of
13 an advisory council shall be mental health care
14 or substance use disorder treatment providers
15 with—

16 “(i) experience in mental health re-
17 search or treatment; and

18 “(ii) expertise in the fields on which
19 they are advising.

20 “(D) None of the appointed members may
21 have at any point been a recipient of any grant,
22 or participated in any program, about which the
23 members are to advise.

24 “(E) None of the appointed members may
25 be related to anyone who has been a recipient

1 of any grant, or participated in any program,
2 about which the members are to advise.

3 “(F) None of the appointed members may
4 have a financial interest in any grant or pro-
5 gram with respect to which they advise, or re-
6 ceive funding separately through the Office of
7 Assistant Secretary.

8 “(G) Each advisory committee must in-
9 clude at least one member of the National Insti-
10 tute of Mental Health and one member from
11 any Federal agency that has a program serving
12 a similar population.”.

13 **SEC. 703. PEER REVIEW.**

14 Section 504 of the Public Health Service Act (42
15 U.S.C. 290aa-3) is amended—

16 (1) by adding at the end of subsection (b) the
17 following: “At least half of the members of any peer-
18 review group established under subsection (a) for the
19 review of a proposal or grant related primarily to
20 mental illness shall have a degree in medicine, or a
21 corresponding doctoral degree in psychology, or be a
22 licensed mental health professional. Before awarding
23 a grant, cooperative agreement, or contract, the Sec-
24 retary shall make publicly available and provide to
25 the Committee on Energy and Commerce of the

1 House of Representatives and the Committee on
2 Health, Education, Labor, and Pensions of the Sen-
3 ate a list of the members of the peer-review group
4 responsible for reviewing the award.”; and

5 (2) by adding at the end the following:

6 “(e) SCIENTIFIC CONTROLS AND STANDARDS.—Peer
7 review under this section shall ensure that any research
8 concerning an intervention is based on scientific controls
9 and standards indicating whether the intervention reduces
10 symptoms, improves medical or behavioral outcomes, and
11 improves social functioning.”.

12 **Subtitle B—Protection and Advoca-**
13 **cacy for Individuals With Men-**
14 **tal Illness**

15 **SEC. 711. PROHIBITION AGAINST LOBBYING BY SYSTEMS**
16 **ACCEPTING FEDERAL FUNDS TO PROTECT**
17 **AND ADVOCATE THE RIGHTS OF INDIVID-**
18 **UALS WITH MENTAL ILLNESS.**

19 Section 105(a) of the Protection and Advocacy for
20 Individuals with Mental Illness Act (42 U.S.C. 10805(a))
21 is amended—

22 (1) in paragraph (9), by striking “and” at the
23 end;

24 (2) in paragraph (10), by striking the period at
25 the end and inserting a semicolon; and

1 (3) by adding at the end the following:

2 “(11) agree to refrain, during any period for
3 which funding is provided to the system under this
4 part, from using Federal funds for—

5 “(A) lobbying or retaining a lobbyist for
6 the purpose of influencing a Federal, State, or
7 local governmental entity or officer; and

8 “(B) counseling an individual with a seri-
9 ous mental illness or serious emotional disturb-
10 ance who lacks insight into their condition on
11 refusing medical treatment or acting against
12 the wishes of such individual’s caregiver;”.

13 **SEC. 712. PROTECTION AND ADVOCACY ACTIVITIES TO**
14 **FOCUS EXCLUSIVELY ON SAFEGUARDING**
15 **RIGHTS TO BE FREE FROM ABUSE AND NE-**
16 **GLECT.**

17 (a) PURPOSES.—Section 101(b) of the Protection
18 and Advocacy for Individuals with Mental Illness Act (42
19 U.S.C. 10801(b)) is amended—

20 (1) in paragraph (1), by inserting “to be free
21 from abuse and neglect” before “are protected”; and

22 (2) in paragraph (2)(A), by inserting “to be
23 free from abuse and neglect” before “through activi-
24 ties to ensure”.

1 (b) ALLOTMENTS.—Section 103(2)(A) of the Protec-
2 tion and Advocacy for Individuals with Mental Illness Act
3 (42 U.S.C. 10803(2)(A)) is amended by inserting “to be
4 free from abuse and neglect” before the semicolon.

5 (c) USE OF ALLOTMENTS.—Section 104(a)(1) of the
6 Protection and Advocacy for Individuals with Mental Ill-
7 ness Act (42 U.S.C. 10804(a)(1)) is amended—

8 (1) in subparagraph (A), by striking “and” at
9 the end;

10 (2) in subparagraph (B), by striking the period
11 at the end and inserting “to be free from abuse and
12 neglect; and”;

13 (3) by adding at the end the following:

14 “(C) the protection and advocacy activities
15 of such an agency or organization shall be ex-
16 clusively focused on safeguarding the rights of
17 individuals with mental illness to be free from
18 abuse and neglect and advocating for continuity
19 of care for individuals transitioning from insti-
20 tutional settings to the community for evidence-
21 based community services.”.

22 (d) SYSTEM REQUIREMENTS.—Section 105 of the
23 Protection and Advocacy for Individuals with Mental Ill-
24 ness Act (42 U.S.C. 10805), as amended by sections 711
25 and 712, is further amended—

1 (1) in subsection (a)—

2 (A) in the matter before paragraph (1), by
3 inserting “to be free from abuse and neglect”
4 before “shall”;

5 (B) in paragraph (6)(A), by inserting “to
6 be free from abuse and neglect” before the
7 semicolon; and

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

9 “(12) be exclusively focused on safeguarding
10 the rights of individuals with mental illness to be
11 free from abuse and neglect;”; and

12 (2) in subsection (c)(1)(A), by inserting “to be
13 free from abuse and neglect” before “shall have a
14 governing authority”.

15 (e) APPLICATIONS.—Section 111(a) of the Protection
16 and Advocacy for Individuals with Mental Illness Act (42
17 U.S.C. 10821(a)) is amended—

18 (1) in paragraph (1), by inserting “to be free
19 from abuse and neglect” before the semicolon;

20 (2) in paragraph (3), by striking “and” at the
21 end;

22 (3) by redesignating paragraph (4) as para-
23 graph (5); and

24 (4) by inserting after paragraph (3) the fol-
25 lowing:

1 “(4) assurances that such system, and any
2 State agency or nonprofit organization with which
3 such system may enter into a contract under section
4 10804(a), will be exclusively focused on safeguarding
5 the rights of individuals with mental illness to be
6 free from abuse and neglect; and”.

7 (f) **REPORTS BY SECRETARY.**—Section 114(a) of the
8 Protection and Advocacy for Individuals with Mental Ill-
9 ness Act (42 U.S.C. 10824(a)) is amended—

10 (1) in paragraph (1) in the matter before sub-
11 paragraph (A), by inserting “to be free from abuse
12 and neglect” before “supported with payments”;

13 (2) in paragraph (2)(A), by inserting “to be
14 free from abuse and neglect” before “supported with
15 payments”; and

16 (3) in paragraph (4), by inserting “to be free
17 from abuse and neglect” before “and a description”.

18 **SEC. 713. REPORTING.**

19 (a) **PUBLIC AVAILABILITY OF REPORTS.**—Section
20 105(a)(7) of the Protection and Advocacy for Individuals
21 with Mental Illness Act (42 U.S.C. 10805(a)(7)) is
22 amended by striking “is located a report” and inserting
23 “is located, and make publicly available, a report”.

24 (b) **DETAILED ACCOUNTING.**—Section 114(a) of the
25 Protection and Advocacy for Individuals with Mental Ill-

1 ness Act (42 U.S.C. 10824(a)), as amended, is further
2 amended—

3 (1) in paragraph (3), by striking “and” at the
4 end;

5 (2) in paragraph (4), by striking the period at
6 the end and inserting “; and”; and

7 (3) by adding at the end the following:

8 “(5) a detailed accounting, for each system
9 funded under this title, of how funds are spent,
10 disaggregated according to whether the funds were
11 received from the Federal Government, the State
12 government, a local government, or a private enti-
13 ty.”.

14 **SEC. 714. GRIEVANCE PROCEDURE.**

15 Section 105 of the Protection and Advocacy for Indi-
16 viduals with Mental Illness Act (42 U.S.C. 10805), as
17 amended, is further amended by adding at the end the
18 following:

19 “(d) GRIEVANCE PROCEDURE.—The Assistant Sec-
20 retary shall establish an independent grievance procedure
21 for the types of claims to be adjudicated, at the request
22 of persons described in subsection (a)(9), through a sys-
23 tem’s grievance procedure established under such sub-
24 section.”.

1 **SEC. 715. EVIDENCE-BASED TREATMENT FOR INDIVIDUALS**
2 **WITH SERIOUS MENTAL ILLNESS OR SERIOUS**
3 **EMOTIONAL DISTURBANCE.**

4 Section 105(a) of the Protection and Advocacy for
5 Individuals with Mental Illness Act (42 U.S.C. 10805(a)),
6 as amended by sections 711, 712, and 713, is further
7 amended by adding at the end the following:

8 “(13) ensure that individuals with serious men-
9 tal illness or serious emotional disturbance have ac-
10 cess to and can obtain evidence-based treatment and
11 services (including supported housing, supported em-
12 ployment, and supported education) for their serious
13 mental illness or serious emotional disturbance;
14 and”.

15 **SEC. 716. TRAINING AND CURRICULUM FOR ADVOCATES**
16 **FOR INDIVIDUALS WITH MENTAL ILLNESS.**

17 Section 105(a) of the Protection and Advocacy for
18 Individuals with Mental Illness Act (42 U.S.C. 10805(a)),
19 as amended by sections 711, 712, 713, and 716, is further
20 amended by adding at the end the following:

21 “(14) provide for the development, in partner-
22 ship with an organization representing individuals
23 with experience with mental illness and families of
24 such individuals, of training curriculum—

25 “(A) to train new and existing staff, in-
26 cluding attorneys, who provide advocacy serv-

1 ices to individuals with mental illness on how to
2 most effectively work with clients served by the
3 system and family members and caregivers of
4 such clients; and

5 “(B) that includes training in effective
6 methods of interviewing such clients, families,
7 and caregivers to determine the relevant history
8 and recovery goals, such as avoiding hos-
9 pitalizations or arrests, and obtaining employ-
10 ment, education, housing, and other recovery-
11 based outcomes.”.

12 **TITLE VIII—REPORTING**

13 **SEC. 801. GAO STUDY ON PREVENTING DISCRIMINATORY** 14 **COVERAGE LIMITATIONS FOR INDIVIDUALS** 15 **WITH SERIOUS MENTAL ILLNESS AND SUB-** 16 **STANCE USE DISORDERS.**

17 Not later than 1 year after the date of the enactment
18 of this Act, the Comptroller General of the United States
19 shall submit to Congress and make publicly available a
20 report detailing the extent to which covered group health
21 plans (or health insurance coverage offered in connection
22 with such plans), including Medicaid managed care plans
23 under section 1903 of the Social Security Act (42 U.S.C.
24 1396b), comply with the Paul Wellstone and Pete Domen-
25 ici Mental Health Parity and Addiction Equity Act of

1 2008 (subtitle B of title V of division C of Public Law
2 110–343) (in this section referred to as the “law”), includ-
3 ing—

4 (1) how nonquantitative treatment limitations,
5 including medical necessity criteria and application
6 of such criteria to primary care, of covered group
7 health plans comply with the law;

8 (2) how the responsible Federal departments
9 and agencies ensure that plans comply with the law;
10 and

11 (3) how proper enforcement, education, and co-
12 ordination activities within responsible Federal de-
13 partments and agencies can be used to ensure full
14 compliance with the law, including educational ac-
15 tivities directed to State insurance commissioners.

16 **TITLE IX—MISCELLANEOUS** 17 **PROVISIONS**

18 **SEC. 901. SENSE OF CONGRESS ENCOURAGING MORE PSY-**
19 **CHIATRISTS TO ACCEPT HEALTH INSUR-**
20 **ANCE.**

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

22 (1) There is a shortage of mental health pro-
23 viders in the United States.

1 (2) The majority of Americans, including those
2 with mental illness, rely on health insurance to ac-
3 cess the health care services they need.

4 (3)(A) According to a January 2015 study in
5 JAMA Psychiatry, the percentage of psychiatrists
6 accepting insurance coverage was significantly lower
7 than the percentage of physicians in other special-
8 ties.

9 (B) In 2009 through 2010, 55.3 percent of psy-
10 chiatrists accepted private noncapitated insurance
11 compared to 88.7 percent of other physicians.

12 (C) In 2009 through 2010, 54.8 percent of psy-
13 chiatrists accepted Medicare compared to 86.1 per-
14 cent of other physicians.

15 (D) In 2009 through 2010, 43.1 percent of psy-
16 chiatrists accepted Medicaid compared to 73 percent
17 of other physicians.

18 (b) SENSE OF CONGRESS.—It is the sense of Con-
19 gress that—

20 (1) the failure of mental health providers to ac-
21 cept health insurance restricts access to the already
22 limited supply of mental health providers;

23 (2) to ensure that individuals with mental ill-
24 ness, including serious mental illness, have adequate

1 access to the mental health services they need, men-
2 tal health providers should accept health insurance;

3 (3) to ensure that individuals with mental ill-
4 ness have adequate access to the mental health serv-
5 ices they need, insurers should ensure robust net-
6 works and reimbursement rates that attract partici-
7 pation by more mental health providers; and

8 (4) as the medical specialty that specializes in
9 the diagnosis, treatment, and prevention of mental
10 health problems, psychiatrists should accept private
11 health insurance, Medicare, and Medicaid.