

**SUBSTITUTE FOR THE AMENDMENT IN THE
NATURE OF A SUBSTITUTE TO H.R. 2646
OFFERED BY M . _____**

Strike all after the enacting clause and insert the following:

1 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

2 (a) SHORT TITLE.—This Act may be cited as the
3 “Comprehensive Behavioral Health Reform and Recovery
4 Act of 2015”.

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

Sec. 1. Short title; table of contents.

TITLE I—STRENGTHENING AND INVESTING IN SAMHSA
PROGRAMS

Sec. 101. Assistant Secretary for Mental Health and Substance Use Disorders.

Sec. 102. Office of Chief Medical Officer.

Sec. 103. Independent audit of SAMHSA.

Sec. 104. Center for Behavioral Health Statistics and Quality.

Sec. 105. Innovation grants.

Sec. 106. Demonstration grants.

Sec. 107. Early intervention and treatment in childhood.

Sec. 108. Block grants.

Sec. 109. Children’s recovery from trauma.

Sec. 110. Garrett Lee Smith Memorial Act reauthorization.

Sec. 111. National Suicide Prevention Lifeline Program.

Sec. 112. Adult suicide prevention.

Sec. 113. Peer Review and Advisory councils.

Sec. 114. Adult trauma.

Sec. 115. Reducing the stigma of serious mental illness.

Sec. 116. Report on mental health and substance abuse treatment in the
States.

Sec. 117. Mental health first aid training grants.

Sec. 118. Acute care bed registry grant for States.

Sec. 119. Older adult mental health grants.

TITLE II—INTERAGENCY SERIOUS MENTAL ILLNESS
COORDINATING COMMITTEE

Sec. 201. Interagency Serious Mental Illness Coordinating Committee.

TITLE III—COMMUNICATIONS BETWEEN INDIVIDUALS, FAMILIES,
AND PROVIDERS

Sec. 301. Clarification of circumstances under which disclosure of protected health information of mental illness patients is permitted.

Sec. 302. Development and dissemination of model training programs.

Sec. 303. Modernizing privacy protections.

Sec. 304. Improving communication with individuals, families, and providers.

TITLE IV—IMPROVING MEDICAID AND MEDICARE MENTAL
HEALTH SERVICES

Sec. 401. Enhanced Medicaid coverage relating to certain mental health services.

Sec. 402. Reports on Medicare part D and Medicaid formulary and appeals practices with respect to coverage of mental health drugs.

Sec. 403. Elimination of 190-day lifetime limit on coverage of inpatient psychiatric hospital services under Medicare.

Sec. 404. Modifications to Medicare discharge planning requirements.

Sec. 405. Extension and Expansion of Demonstration Programs to Improve Community Mental Health Services.

Sec. 406. Extension and expansion of medicaid emergency psychiatric demonstration project.

TITLE V—STRENGTHENING THE BEHAVIORAL HEALTH
WORKFORCE AND IMPROVING ACCESS TO CARE

Sec. 501. Nationwide Workforce Strategy.

Sec. 502. Report on best practices for peer-Support specialist programs, training, and certification.

Sec. 503. Advisory Council on Graduate Medical Education.

Sec. 504. Telepsychiatry and primary care provider training grant program.

Sec. 505. Liability protections for health care professional volunteers at community health centers and federally qualified community behavioral health clinics.

Sec. 506. Minority Fellowship Program.

Sec. 507. National Health Service Corps.

Sec. 508. SAMHSA grant program for development and implementation of curricula for continuing education on serious mental illness.

Sec. 509. Peer professional workforce development grant program.

Sec. 510. Demonstration grant program to recruit, train, and professionally support psychiatric physicians in Indian health programs.

Sec. 511. Education and training on eating disorders for health professionals.

Sec. 512. Primary and behavioral health care integration grant programs.

Sec. 513. Health professions competencies to address racial, ethnic, sexual, and gender minority behavioral health disparities.

Sec. 514. Behavioral health crisis systems.

Sec. 515. Mental health in schools.

Sec. 516. Examining mental health care for children.

Sec. 517. Reporting compliance study.

Sec. 518. Strengthening connections to community care demonstration grant program.

Sec. 519. Assertive community treatment grant program for individuals with serious mental illness.

TITLE VI—IMPROVING MENTAL HEALTH RESEARCH AND COORDINATION

Sec. 601. Increase in funding for certain research.

TITLE VII—BEHAVIORAL HEALTH INFORMATION TECHNOLOGY

Sec. 701. Extension of health information technology assistance for behavioral and mental health and substance abuse.

Sec. 702. Extension of eligibility for Medicare and Medicaid health information technology implementation assistance.

TITLE VIII—MAKING PARITY WORK

Sec. 801. Strengthening parity in mental health and substance use disorder benefits.

Sec. 802. Report on investigations regarding parity in mental health and substance use disorder benefits.

Sec. 803. GAO study on preventing discriminatory coverage limitations for individuals with serious mental illness and substance use disorders.

Sec. 804. Report to Congress on Federal assistance to State insurance regulators regarding mental health parity enforcement.

TITLE IX—SUBSTANCE ABUSE

Subtitle A—Prescriber Education Proposal

Sec. 901. Practitioner Education.

Subtitle B—Recovery Enhancement for Addiction Treatment

Sec. 911. Expansion of patient limits under waiver.

Sec. 912. Definitions.

Sec. 913. Evaluation by assistant Secretary for planning and evaluation.

Subtitle C—Co-Prescribing to Reduce Overdoses

Sec. 921. Co-prescribing opioid overdose reversal drugs grant program.

Sec. 922. Opioid overdose reversal co-prescribing guidelines.

Sec. 923. Authorization of appropriations.

Subtitle D—Improving Treatment for Pregnant and Postpartum Women

Sec. 931. Reauthorization of residential treatment programs for pregnant and postpartum women.

Sec. 932. Pilot program grants for State substance abuse agencies.

Subtitle E—Evidence-based Opioid and Heroin Treatment and Interventions Demonstration

Sec. 941. Evidence-based opioid and heroin treatment and interventions demonstration.

Subtitle F—Grants to Enhance and Expand Recovery Support Services

Sec. 951. Grants to enhance and expand recovery support services.

1 **TITLE I—STRENGTHENING AND**
2 **INVESTING IN SAMHSA PRO-**
3 **GRAMS**

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

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

8 (1) in subsection (c)(1), by adding at the end
9 the following: “The Administrator shall be selected
10 from individuals who have appropriate education and
11 experience. The Administrator shall also be the As-
12 sistant Secretary for Mental Health and Substance
13 Abuse.”;

14 (2) in subsection (d)—

15 (A) by striking “The Secretary” and all
16 that follows through “(1) supervise the func-
17 tions” and inserting the following:

18 “(1) SECRETARY’S AUTHORITIES.—The Sec-
19 retary, acting through the Administrator, shall—

20 “(A) supervise the functions”;

21 (B) by moving the indentation of each of
22 paragraphs (2) through (18) 2 ems to the right
23 and redesignating such paragraphs as subpara-
24 graphs (B) through (R), respectively; and

25 (3) by adding at the end the following:

1 “(2) ASSISTANT SECRETARY’S AUTHORITIES.—
2 The Assistant Secretary for Mental Health and Sub-
3 stance Abuse shall—

4 “(A) serve as the effective and visible advo-
5 cate for individuals with, or at risk for, mental
6 illness and substance use disorders within the
7 Department of Health and Human Services and
8 with other departments, agencies, and instru-
9 mentalities of the Federal Government;

10 “(B) assist the Secretary in all matters
11 pertaining to issues that impact the prevention,
12 treatment, and recovery of individuals with
13 mental illness or substance use disorders;

14 “(C) coordinate Federal programs and ac-
15 tivities related to promoting mental health and
16 preventing substance abuse;

17 “(D) coordinate activities with Federal en-
18 tities to implement and build awareness of pro-
19 grams providing benefits affecting individuals
20 with mental illness or substance use disorders;

21 “(E) promote and coordinate research,
22 treatment, and services across departments,
23 agencies, organizations, and individuals with re-
24 spect to prevention, treatment, and recovery
25 support research and programs for individuals

1 with, or at risk for, substance use disorders or
2 mental illness;

3 “(F) coordinate functions within the De-
4 partment of Health and Human Services—

5 “(i) to improve the treatment of, and
6 related services to, individuals with sub-
7 stance use disorders or mental illness;

8 “(ii) to improve substance misuse and
9 abuse prevention and mental health pro-
10 motion services;

11 “(iii) to ensure access to effective, evi-
12 dence-based treatment for individuals with
13 mental illnesses and individuals with a sub-
14 stance use disorder;

15 “(iv) to ensure that grant programs of
16 the Department adhere to scientific stand-
17 ards for individuals with mental illness or
18 substance use disorders; and

19 “(v) to support the development and
20 implementation of initiatives to encourage
21 individuals to pursue careers (especially in
22 underserved areas and populations) as psy-
23 chiatrists, psychologists, psychiatric nurse
24 practitioners, clinical social workers, physi-
25 cian assistants, and other licensed or cer-

1 tified mental health and substance abuse
2 professionals;

3 “(G) within the Department of Health and
4 Human Services, coordinate all programs and
5 activities relating to—

6 “(i) the prevention of, and treatment
7 and recovery for, mental health or sub-
8 stance use disorders; or

9 “(ii) the reduction of homelessness
10 among individuals with mental illness or
11 substance use disorders;

12 “(H) across the Federal Government, in
13 conjunction with the Interagency Serious Men-
14 tal Illness Coordinating Committee under sec-
15 tion 501A—

16 “(i) review all programs and activities
17 relating to the prevention of, or treatment
18 or rehabilitation for, mental illness or sub-
19 stance use disorders;

20 “(ii) identify any such programs and
21 activities that are duplicative;

22 “(iii) identify any such programs and
23 activities that are not evidence-based, ef-
24 fective, or efficient; and

1 “(iv) formulate recommendations for
2 expanding, coordinating, eliminating, and
3 improving programs and activities identi-
4 fied pursuant to subparagraph (B) or (C)
5 and merging such programs and activities
6 into other, successful programs and activi-
7 ties; and

8 “(I) identify evidence-based best practices
9 across the Federal Government for treatment
10 and services for those with mental health and
11 substance use disorders by reviewing practices
12 for efficiency, effectiveness, quality, coordina-
13 tion, and cost effectiveness.”.

14 (b) PRIORITIZATION OF INTEGRATION OF SERVICES,
15 EARLY DIAGNOSIS, INTERVENTION, AND WORKFORCE
16 DEVELOPMENT.—In carrying out the duties described in
17 section 501(d)(2) of the Public Health Service Act, as
18 added by subsection (a), the Assistant Secretary shall
19 prioritize—

20 (1) the integration of mental health, substance
21 use, and physical health services for the purpose of
22 diagnosing, preventing, treating, or providing reha-
23 bilitation for mental illness or substance use dis-
24 orders, including any such services provided through
25 the justice system (including departments of correc-

1 tion) or other entities other than the Department of
2 Health and Human Services;

3 (2) crisis intervention for, early diagnosis and
4 intervention services for the prevention of, and treat-
5 ment and rehabilitation for, serious mental illness or
6 substance use disorders; and

7 (3) workforce development for—

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

10 (B) research activities that advance sci-
11 entific and clinical understandings of these dis-
12 orders, including the development and imple-
13 mentation of a continuing nationwide strategy
14 to increase the psychiatric workforce with psy-
15 chiatrists, child and adolescent psychiatrists,
16 psychologists, psychiatric nurse practitioners,
17 clinical social workers, and peer support special-
18 ists.

19 (c) REQUIREMENTS AND RESTRICTIONS ON AUTHOR-
20 ITY TO AWARD GRANTS.—In awarding any grant or fi-
21 nancial assistance, the Administration of the Substance
22 Abuse and Mental Health Services Administration, and
23 any agency or official within such Administration, shall
24 comply with the following:

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

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

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

7 (2) The programs and activities to be funded
8 shall, as appropriate, use evidence-based best prac-
9 tices or emerging evidence-based practices that are
10 translational and can be expanded or replicated to
11 other States, local communities, agencies, tribes, or
12 through the Medicaid program under title XIX of
13 the Social Security Act.

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

22 (4) Applicants shall be evaluated and selected
23 through a blind, peer-review process by individuals
24 with expertise appropriate to the grant or other fi-
25 nancial assistance, such as health care providers

1 with professional experience in mental health or sub-
2 stance abuse research or treatment.

3 (5) The Secretary shall adopt a policy that en-
4 sures that any member of a peer review group does
5 not have a conflict of interest with respect to any
6 program or grant to be reviewed.

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

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

15 (B) Federal funds are being used as re-
16 quired by the conditions of the award.

17 (7) Award recipients that fail an audit or fail
18 to provide information pursuant to an audit shall
19 have their awards terminated or shall be placed on
20 a corrective action plan to address the issues raised
21 in the audit findings.

22 (d) DEFINITION.—In this Act, except as inconsistent
23 with the provisions of this Act, the term “Assistant Sec-
24 retary” means the Assistant Secretary for Mental Health
25 and Substance Use Disorders.

1 **SEC. 102. OFFICE OF CHIEF MEDICAL OFFICER.**

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

4 (1) by redesignating subsections (g) through (o)
5 as subsections (h) through (p), respectively; and

6 (2) by inserting after subsection (f) the fol-
7 lowing:

8 “(g) CHIEF MEDICAL OFFICE.—The Administrator
9 shall establish within the Administration a Chief Medical
10 Office, to be headed by a Chief Medical Officer. The Chief
11 Medical Office shall be staffed by mental health and sub-
12 stance abuse providers.”.

13 (b) CONFORMING CHANGES.—Title V of the Public
14 Health Service Act (42 U.S.C. 290aa et seq.) is amend-
15 ed—

16 (1) in subsections (e)(3)(C) and (f)(2)(C)(iii) of
17 section 501, by striking “subsection (k)” and insert-
18 ing “subsection (l)”; and

19 (2) in section 508(p), by striking “501(k)” and
20 inserting “501(l)”.

21 **SEC. 103. INDEPENDENT AUDIT OF SAMHSA.**

22 (a) IN GENERAL.— The Secretary shall enter into an
23 contract or cooperative agreement with an external, inde-
24 pendent entity to conduct a full assessment and review of
25 the Substance Abuse and Mental Health Services Admin-
26 istration (in this section referred to as “SAMHSA”).

1 (b) REPORT.—The contract or cooperative agreement
2 under subsection (a) shall require that, not later than 18
3 months after the date of enactment of this Act, the exter-
4 nal, independent entity will submit to the Energy and
5 Commerce Committee of the House of Representatives
6 and the Health, Education, Labor and Pensions Com-
7 mittee of the Senate a report on the findings and conclu-
8 sion of the assessment and review.

9 (c) TOPICS.—The assessment and review conducted
10 pursuant to subsection (a), and the report submitted pur-
11 suant to subsection (b), shall address each of the fol-
12 lowing:

13 (1) Whether the mission of SAMHSA is appro-
14 priate.

15 (2) Whether the program authority of
16 SAMHSA is appropriate.

17 (3) Whether SAMHSA has adequate staffing,
18 including technical expertise, to fulfill its mission.

19 (4) Whether SAMHSA is funded appropriately.

20 (5) The efficacy of the programs funded by
21 SAMHSA.

22 (6) Whether funding is being spent in a way
23 that effectively supports and promotes the authori-
24 ties vested by section 501(d) of the Public Health
25 Service Act, as amended by section 101 of this Act.

1 (7) Whether SAMHSA’s focus on recovery is
2 appropriate.

3 (8) Additional steps SAMHSA can take to ful-
4 fill its charge of leading public health efforts to ad-
5 vance the behavioral health of the Nation and reduce
6 the impact of substance abuse and mental illness on
7 the Nation’s communities.

8 (9) Whether standards for SAMHSA’s grant
9 programs are effective.

10 (10) Whether standards for SAMHSA’s ap-
11 pointment of peer-review panels to evaluate grant
12 applications is appropriate.

13 (11) How SAMHSA serves individuals with
14 mental illness, serious mental illness, substance use
15 disorders, and individuals with co-occurring condi-
16 tions.

17 **SEC. 104. CENTER FOR BEHAVIORAL HEALTH STATISTICS**
18 **AND QUALITY.**

19 Title V of the Public Health Service Act (42 U.S.C.
20 290aa et seq.) is amended—

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

23 “(4) The Center for Behavioral Health Statis-
24 tics and Quality.”;

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

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

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

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

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

11 (3) in part B (42 U.S.C. 290bb et seq.) by add-
12 ing at the end the following new subpart:

13 **“Subpart 4—Center for Behavioral Health Statistics**
14 **and Quality**

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

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

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

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

3 “(A) surveillance and data collection (in-
4 cluding that authorized by section 505);

5 “(B) evaluation;

6 “(C) statistical and analytic support;

7 “(D) service systems research; and

8 “(E) performance and quality information
9 systems;

10 “(2) maintain operation of the National Reg-
11 istry of Evidence-Based Programs and Practices to
12 provide for the evaluation and dissemination to the
13 Administration of the evidence-based practices and
14 services delivery models of grantees and other inter-
15 ested parties;

16 “(3) recommend a core set of measurement
17 standards for grant programs administered by the
18 Administration; and

19 “(4) lead evaluation efforts for the grant pro-
20 grams, contracts, and collaborative agreements of
21 the Administration.

22 “(c) BIENNIAL REPORT TO CONGRESS.—Not later
23 than 2 years after the date of enactment of this section,
24 and every 2 years thereafter, the Director of the Center
25 shall submit to Congress a report on the quality of services

1 furnished through grant programs of the Administration,
2 including applicable measures of outcomes for individuals
3 and public outcomes such as—

4 “(1) the number of patients screened positive
5 for unhealthy alcohol use who receive brief coun-
6 seling as appropriate; the number of patients
7 screened positive for tobacco use and receiving
8 smoking cessation interventions; the number of pa-
9 tients with a new diagnosis of major depressive epi-
10 sode who are assessed for suicide risk; the number
11 of patients screened positive for clinical depression
12 with a documented follow-up plan; and the number
13 of patients with a documented pain assessment that
14 have a follow-up treatment plan when pain is
15 present; and satisfaction with care;

16 “(2) the incidence and prevalence of substance
17 use and mental disorders; the number of suicide at-
18 tempts and suicide completions; overdoses seen in
19 emergency rooms resulting from alcohol and drug
20 use; emergency room boarding; overdose deaths;
21 emergency psychiatric hospitalizations; new criminal
22 justice involvement while in treatment; stable hous-
23 ing; and rates of involvement in employment, edu-
24 cation, and training; and

1 “(3) such other measures for outcomes of serv-
2 ices as the Director may determine.

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

7 “(1) professionals with clinical and research ex-
8 pertise in the prevention and treatment of, and re-
9 covery from, substance use and mental disorders;

10 “(2) professionals with training and expertise in
11 statistics or research and survey design and meth-
12 odologies; and

13 “(3) other related fields in the social and behav-
14 ioral sciences, as specified by relevant position de-
15 scriptions.

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

20 “(f) DEFINITION.—In this section, the term ‘emer-
21 gency room boarding’ means the practice of admitting pa-
22 tients to an emergency department and holding such pa-
23 tients in the department until inpatient psychiatric beds
24 become available.”.

1 **SEC. 105. INNOVATION GRANTS.**

2 (a) IN GENERAL.—The Assistant Secretary, acting
3 through the Substance Abuse and Mental Health Services
4 Administration, shall award grants to State and local gov-
5 ernments, tribes and tribal organizations, educational in-
6 stitutions, and nonprofit organizations for expanding a
7 model that has been scientifically demonstrated to show
8 promise, but would benefit from further applied research,
9 for—

10 (1) enhancing the screening, diagnosis, and
11 treatment of mental illness and serious mental ill-
12 ness; or

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

15 (b) DURATION.—A grant under this section shall be
16 for a period of not less than 3 years and not more than
17 5 years.

18 (c) LIMITATIONS.—Of the amounts made available
19 for carrying out this section for a fiscal year, not less than
20 one-third shall be awarded for screening, diagnosis, treat-
21 ment, or services, as described in subsection (a), for indi-
22 viduals (or subpopulations of individuals) who are below
23 the age of 18 when activities funded through the grant
24 award are initiated.

25 (d) GUIDELINES.—As a condition on receipt of an
26 award under this section, an applicant shall agree to ad-

1 here to any requirements or guidelines issued by the Sec-
2 retary on research designs and data collection.

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

5 (1) the recipient is not providing information
6 requested by the Secretary in connection with the
7 award; or

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

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

13 (1) to report to the Secretary the results of pro-
14 grams and activities funded through the award; and

15 (2) to include in such reporting any relevant
16 data requested by the Secretary.

17 (g) AUTHORIZATION OF APPROPRIATIONS.—For the
18 purpose of providing grants under this section, there is
19 authorized to be appropriated \$40,000,000 for each of fis-
20 cal year 2016 through 2020.

21 **SEC. 106. DEMONSTRATION GRANTS.**

22 (a) GRANTS.—The Secretary of Health and Human
23 Services (in this section referred to as the “Secretary”),
24 acting through the Substance Abuse and Mental Health
25 Services Administration, shall award grants to States,

1 counties, local governments, tribes, educational institu-
2 tions, and private nonprofit organizations for the expan-
3 sion, replication, or scaling of evidence-based programs
4 across a wider area to enhance effective screening, early
5 diagnosis, intervention, and treatment with respect to
6 mental illness and serious mental illness, primarily by—

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

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

11 (b) DURATION.—A grant under this section shall be
12 for a period of not less than 3 years and not more than
13 5 years.

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

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

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

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

1 (4) no amounts shall be made available solely
2 for the purpose of expanding facilities or increasing
3 staff at an existing program, although funds may be
4 so used by an existing program if such an expansion
5 or increase is needed to support the implementation
6 of a new program under this section.

7 (d) **TERMINATION.**—The Secretary may terminate
8 any award under this section upon a determination that—

9 (1) the recipient is not providing information
10 requested by the Secretary in connection with the
11 award; or

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

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

17 (1) to report to the Secretary the results of pro-
18 grams and activities funded through the award; and

19 (2) to include in such reporting any relevant
20 data requested by the Secretary.

21 (f) **AUTHORIZATION OF APPROPRIATIONS.**—For the
22 purpose of providing grants under this section, there is
23 authorized to be appropriated \$80,000,000 for each of fis-
24 cal years 2016 through 2020.

1 **SEC. 107. EARLY INTERVENTION AND TREATMENT IN**
2 **CHILDHOOD.**

3 (a) GRANTS.—The Secretary of Health and Human
4 Services (in this Act referred to as the “Secretary”), act-
5 ing through the Substance Abuse and Mental Health Serv-
6 ices Administration, shall award—

7 (1) grants to eligible entities to initiate and un-
8 dertake, for eligible children, early childhood inter-
9 vention and treatment programs, and specialized
10 preschool and elementary school programs, with the
11 goal of preventing chronic and serious mental illness;

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

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

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

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

25 (A) is duly accredited by State mental
26 health or education agencies, as applicable, for

1 the treatment or education of children from 0
2 to 12 years of age; and

3 (B) provides services that include early
4 childhood intervention and specialized preschool
5 and elementary school programs focused on
6 children whose primary need is a social or emo-
7 tional disability (in addition to any learning dis-
8 ability).

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

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

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

18 (C) who could benefit from early childhood
19 intervention and specialized preschool or ele-
20 mentary school programs with the goal of pre-
21 venting or treating chronic and serious mental
22 illness.

23 (c) APPLICATION.—An eligible entity seeking a grant
24 under subsection (a) shall submit to the Secretary an ap-

1 plication at such time, in such manner, and containing
2 such information as the Secretary may require.

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

7 (1) Deliver (or facilitate) for eligible children
8 treatment and education, early childhood interven-
9 tion, and specialized preschool and elementary school
10 programs, including the provision of medically based
11 child care and early education services.

12 (2) Treat and educate eligible children, includ-
13 ing startup, curricula development, operating and
14 capital needs, staff and equipment, assessment and
15 intervention services, administration and medication
16 requirements, enrollment costs, collaboration with
17 primary care providers and psychiatrists, other re-
18 lated services to meet emergency needs of children,
19 and communication with families and medical pro-
20 fessionals concerning the children.

21 (3) Develop and implement other strategies to
22 address identified treatment and educational needs
23 of eligible children that have reliable and valid eval-
24 uation modalities built into assess outcomes based
25 on sound scientific metrics.

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

5 (1) the individuals treated and educated;

6 (2) the success of such treatment and education
7 in avoiding the onset of serious mental illness or the
8 preparation of such children for the care and man-
9 agement of serious mental illness;

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

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

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

23 (g) AMOUNT OF AWARDS.—

24 (1) AMOUNTS FOR EARLY CHILDHOOD INTER-
25 VENTION AND TREATMENT PROGRAMS.—The

1 amount of an award to an eligible entity under sub-
2 section (a)(1) shall be not more than \$600,000 per
3 fiscal year.

4 (2) AMOUNTS FOR LONGITUDINAL STUDY.—

5 The total amount of an award to an eligible entity
6 under subsection (a)(2) (for one or more fiscal
7 years) shall be not less than \$1,000,000 and not
8 greater than \$2,000,000.

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

10 (1) for awards under subsection (a)(1), shall be
11 not less than 3 fiscal years and not more than 5 fis-
12 cal years; and

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

15 (i) MATCHING FUNDS.—The Secretary may not
16 award a grant under this section to an eligible entity un-
17 less the eligible entity agrees, with respect to the costs to
18 be incurred by the eligible entity in carrying out the activi-
19 ties described in subparagraph (D), to make available non-
20 Federal contributions (in cash or in kind) toward such
21 costs in an amount equal to not less than 10 percent of
22 Federal funds provided 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. 108. 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 Substance Abuse and Mental Health Services
9 Administration, acting in collaboration with the Director
10 of the National Institute of Mental Health, shall require
11 States to obligate at least 5 percent of the amounts appro-
12 priated for a fiscal year under subsection (a) to support
13 evidence-based programs that address the needs of individ-
14 uals with early serious mental illness, including psychotic
15 disorders, regardless of the age of individual onset. Such
16 models shall translate evidence-based interventions and
17 best available science into systems of care, such as through
18 models such as—

19 “(1) the Recovery After an Initial Schizo-
20 phrenia Episode research project of the National In-
21 stitute of Mental Health; and

22 “(2) the North American Prodrome Longitu-
23 dinal Study.”.

24 (b) ADDITIONAL PROGRAM REQUIREMENTS.—

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

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

6 “(A) The plan provides”;

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

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

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

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

1 attempts, substance abuse, overdose deaths,
2 emergency hospitalizations, incarceration,
3 crimes, arrest, victimization, homelessness, job-
4 lessness, medication nonadherence, and edu-
5 cation and vocational programs drop outs. The
6 plan must also include a detailed list of services
7 available for individuals in each county or coun-
8 ty equivalent.

9 “(C) The plan shall include a separate de-
10 scription of active programs that seek to engage
11 individuals with serious mental illness in
12 proactively making their own health care deci-
13 sions and enhancing communication among
14 themselves, their families, and their treatment
15 providers by allowing for early intervention by
16 reducing legal proceedings related to involun-
17 tary treatment. Such programs may include
18 services that help develop psychiatric advanced
19 directives.”.

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

23 (A) by striking “The plan contains an esti-
24 mate of” and inserting the following: “The plan
25 contains—

1 “(A) an estimate of”;

2 (B) in subparagraph (A), as inserted by
3 paragraph (1), by inserting “, such as reduc-
4 tions in homelessness, emergency hospitaliza-
5 tion, incarceration, and unemployment” after
6 “targets”;

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

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

11 “(B) an agreement by the State to report
12 to the Secretary such data as may be required
13 by the Secretary concerning—

14 “(i) comprehensive community mental
15 health services in the State; and

16 “(ii) public health outcomes for per-
17 sons with serious mental illness in the
18 State, such as rates of suicides, suicide at-
19 tempts, substance abuse, overdose deaths,
20 emergency hospitalizations, incarceration,
21 crimes, arrest, victimization, homelessness,
22 joblessness, medication non-adherence, and
23 education and vocational programs drop
24 outs.”.

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

4 (A) by striking “Except as provided” and
5 inserting:

6 “(A) Except as provided”; and

7 (B) by adding at the end the following new
8 subparagraph:

9 “(B) For individuals receiving treatment
10 through funds awarded under a grant under
11 section 1911, a State shall include in the State
12 plan for the first year beginning after the date
13 of the enactment of this subparagraph and each
14 subsequent year, a de-individualized report, con-
15 taining information that is de-identified, on the
16 services provided to those individuals, includ-
17 ing—

18 “(i) outcomes and the overall cost of
19 such treatment provided; and

20 “(ii) county or county equivalent level
21 data on such population, such as overall
22 costs and raw number data on rates of in-
23 voluntary commitment orders, suicides,
24 suicide attempts, substance abuse, over-
25 dose deaths, emergency hospitalizations,

1 incarceration, crimes, arrest, victimization,
2 homelessness, joblessness, medication non-
3 adherence, and education and vocational
4 programs drop outs.”.

5 (c) INCENTIVES FOR STATE-BASED OUTCOME MEAS-
6 URES.—Section 1920 of the Public Health Service Act (42
7 U.S.C. 300x–9) is amended by adding at the end the fol-
8 lowing:

9 “(c) INCENTIVES FOR STATE-BASED OUTCOME
10 MEASURES.—

11 “(1) IN GENERAL.—In addition to the amounts
12 made available under subsection (a) for each fiscal
13 year, the Secretary shall provide to each State that
14 meets the conditions under paragraph (2) by the end
15 of the first quarter of the subsequent fiscal year, an
16 equally divided share of the funding under para-
17 graph (3).

18 “(2) CONDITIONS.—The Secretary shall define
19 the conditions under which a State is eligible to re-
20 ceive the additional amount under paragraph (1).

21 “(3) AUTHORIZATION OF APPROPRIATIONS.—
22 For purposes of this subsection, there is authorized
23 to be appropriated \$25,000,000 for each of fiscal
24 years 2016 through 2020. Any amounts made avail-

1 able under paragraph (1) shall be in addition to the
2 State’s block grant allocation.”.

3 (d) EVIDENCE-BASED SERVICES DELIVERY MOD-
4 ELS.—Section 1912 of the Public Health Service Act (42
5 U.S.C. 300x–1) is amended by adding at the end the fol-
6 lowing new subsection:

7 “(e) EXPANSION OF MODELS.—

8 “(1) IN GENERAL.—Taking into account the re-
9 sults of evaluations of block grant programs, the
10 Secretary may, as part of the program of block
11 grants under this subpart, provide for expanded use
12 across the Nation of evidence-based service delivery
13 models by providers funded under such block grants,
14 so long as—

15 “(A) the Secretary determines that such
16 expansion will—

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

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

23 “(B) the Secretary determines that such
24 expansion would improve the quality of patient
25 care; and

1 “(C) the Secretary determines that the
2 change will—

3 “(i) significantly reduce severity and
4 duration of symptoms of mental illness;

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

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

14 “(2) DEFINITION.—In this subsection, the term
15 ‘emergency room boarding’ means the practice of ad-
16 mitting patients to an emergency department and
17 holding them in the department until inpatient psy-
18 chiatric beds become available.”.

19 (e) PERIOD FOR EXPENDITURE OF GRANT FUNDS.—
20 Section 1913 of the Public Health Service Act (42 U.S.C.
21 300x-2), as amended, is further amended by adding at
22 the end the following:

23 “(d) PERIOD FOR EXPENDITURE OF GRANT
24 FUNDS.—In implementing a plan submitted under section
25 1912(a), a State receiving grant funds under section 1911

1 may make such funds available to providers of services de-
2 scribed in subsection (b) for the provision of services with-
3 out fiscal year limitation, so long as any carryover is spent
4 within 3 years of the year in which the funding was pro-
5 vided.”.

6 (f) ACTIVE OUTREACH AND ENGAGEMENT.—Section
7 1915 of the Public Health Service Act (42 U.S.C. 300x-
8 4) is amended by adding at the end of the following:

9 “(c) ACTIVE OUTREACH AND ENGAGEMENT TO PER-
10 SONS WITH SERIOUS MENTAL ILLNESS.—

11 “(1) IN GENERAL.—A funding agreement for a
12 grant under section 1911 is that the State involved
13 has in effect active programs that seek to engage in-
14 dividuals with serious mental illness in comprehen-
15 sive services in order to avert relapse, repeated hos-
16 pitalizations, arrest, incarceration, suicide, and to
17 provide the individuals with the opportunity to live
18 in the least restrictive setting, through a comprehen-
19 sive program of evidence-based and culturally rel-
20 evant assertive outreach and engagement services fo-
21 cusing on individuals who are homeless, have co-oc-
22 ccurring disorders, are at risk for incarceration or re-
23 incarceration, or have a history of treatment failure,
24 including repeated hospitalizations or emergency
25 room usage.

1 “(2) EVIDENCE-BASED ASSERTIVE OUTREACH
2 AND ENGAGEMENT SERVICES.—

3 “(A) SAMHSA.—The Administrator of
4 the Substance Abuse and Mental Health Serv-
5 ices Administration, in cooperation with the Di-
6 rector of the National Institute of Mental
7 Health, shall develop—

8 “(i) a list of evidence-based culturally
9 and linguistically relevant assertive out-
10 reach and engagement services; and

11 “(ii) criteria to be used to assess the
12 scope and effectiveness of the approaches
13 taken by such services, such as the ability
14 to provide same-day appointments for
15 emergent situations.

16 “(B) TYPES OF ASSERTIVE OUTREACH
17 AND ENGAGEMENT SERVICES.—For purposes of
18 paragraph (1), appropriate programs of evi-
19 dence-based assertive outreach and engagement
20 services may include peer support programs;
21 the Wellness Recovery Action Plan, Assertive
22 Community Treatment, and Forensic Assertive
23 Community Treatment of the Substance Abuse
24 and Mental Health Services Administration; ap-
25 propriate supportive housing programs incor-

1 porating a Housing First model; and intensive,
2 evidence-based approaches to early intervention
3 in psychosis, such as the Recovery After an Ini-
4 tial Schizophrenia Episode model of the Na-
5 tional Institute of Mental Health and the Spe-
6 cialized Treatment Early in Psychosis pro-
7 gram.”.

8 **SEC. 109. CHILDREN’S RECOVERY FROM TRAUMA.**

9 Section 582 of the Public Health Service Act (42
10 U.S.C. 290hh–1) is amended—

11 (1) in subsection (a), by striking “developing
12 programs” and all that follows through the period at
13 the end and inserting “developing and maintaining
14 programs that provide for—

15 “(1) the continued operation of the National
16 Child Traumatic Stress Initiative (referred to in this
17 section as the ‘NCTSI’), which includes a coordi-
18 nating center, that focuses on the mental, behav-
19 ioral, and biological aspects of psychological trauma
20 response, prevention of the long-term consequences
21 of child trauma, and early intervention services and
22 treatment to address the long-term consequences of
23 child trauma; and

24 “(2) the development of knowledge with regard
25 to evidence-based practices for identifying and treat-

1 ing mental, behavioral, and biological disorders of
2 children and youth resulting from witnessing or ex-
3 periencing a traumatic event.”;

4 (2) in subsection (b)—

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

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

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

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

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

22 “(c) CHILD OUTCOME DATA.—The NCTSI coordi-
23 nating center shall collect, analyze, and report NCTSI-
24 wide child treatment process and outcome data regarding
25 the early identification and delivery of evidence-based

1 treatment and services for children and families served by
2 the NCTSI grantees.

3 “(d) TRAINING.—The NCTSI coordinating center
4 shall facilitate the coordination of training initiatives in
5 evidence-based and trauma-informed treatments, interven-
6 tions, and practices offered to NCTSI grantees, providers,
7 and partners.

8 “(e) DISSEMINATION AND COLLABORATION.—The
9 NCTSI coordinating center shall, as appropriate, collabo-
10 rate with—

11 “(1) the Secretary, in the dissemination of evi-
12 dence-based and trauma-informed interventions,
13 treatments, products, and other resources to appro-
14 priate stakeholders; and

15 “(2) appropriate agencies that conduct or fund
16 research within the Department of Health and
17 Human Services, for purposes of sharing NCTSI ex-
18 pertise, evaluation data, and other activities, as ap-
19 propriate.

20 “(f) REVIEW.—The Secretary shall, consistent with
21 the peer review process, ensure that NCTSI applications
22 are reviewed by appropriate experts in the field as part
23 of a consensus review process. The Secretary shall include
24 review criteria related to expertise and experience in child
25 trauma and evidence-based practices.”;

1 (5) in subsection (g) (as so redesignated), by
2 striking “with respect to centers of excellence are
3 distributed equitably among the regions of the coun-
4 try” and inserting “are distributed equitably among
5 the regions of the United States”;

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

10 (7) in subsection (j) (as so redesignated), by
11 striking “\$50,000,000” and all that follows through
12 “2006” and inserting “\$46,000,000 for each of fis-
13 cal years 2016 through 2020”.

14 **SEC. 110. GARRETT LEE SMITH MEMORIAL ACT REAUTHOR-**
15 **IZATION.**

16 (a) **SUICIDE PREVENTION TECHNICAL ASSISTANCE**
17 **CENTER.**—Section 520C of the Public Health Service Act
18 (42 U.S.C. 290bb–34) is amended—

19 (1) in the section heading, by striking the sec-
20 tion heading and inserting “**SUICIDE PREVENTION**
21 **TECHNICAL ASSISTANCE CENTER.**”;

22 (2) in subsection (a), by striking “and in con-
23 sultation with” and all that follows through the pe-
24 riod at the end of paragraph (2) and inserting “shall
25 establish a research, training, and technical assist-

1 ance resource center to provide appropriate informa-
2 tion, training, and technical assistance to States, po-
3 litical subdivisions of States, federally recognized In-
4 dian tribes, tribal organizations, institutions of high-
5 er education, public organizations, or private non-
6 profit organizations regarding the prevention of sui-
7 cide among all ages, particularly among groups that
8 are at high risk for suicide.”;

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

10 (4) by redesignating subsection (d) as sub-
11 section (b);

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

13 (A) by striking the subsection heading and
14 inserting “RESPONSIBILITIES OF THE CEN-
15 TER.”;

16 (B) in the matter preceding paragraph (1),
17 by striking “The additional research” and all
18 that follows through “nonprofit organizations
19 for” and inserting “The center operated and
20 maintained under subsection (a) shall”;

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

23 (D) in paragraph (1)—

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

4 (ii) by inserting “for all ages, particu-
5 larly among groups that are at high risk
6 for suicide” before the semicolon at the
7 end;

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

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

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

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

18 (I) in paragraph (9), by striking “and be-
19 havioral health” and inserting “health and sub-
20 stance use disorder”; and

21 (J) in paragraph (10), by inserting “con-
22 ducting” before “other”; and

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

1 “(c) AUTHORIZATION OF APPROPRIATIONS.—For the
2 purpose of carrying out this section, there are authorized
3 to be appropriated \$6,000,000 for each of fiscal years
4 2016 through 2020.”.

5 (b) YOUTH SUICIDE EARLY INTERVENTION AND
6 PREVENTION STRATEGIES.—Section 520E of the Public
7 Health Service Act (42 U.S.C. 290bb–36) is amended—

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

12 (2) in subsection (b)(2)—

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

18 (B) by striking “been awarded” and insert-
19 ing “received”; and

20 (3) in subsection (c)(1), by striking “abuse”
21 and inserting “use disorder”;

22 (4) in subsection (l)(4) by striking “24” and in-
23 serting “26”; and

24 (5) by striking subsection (m) and inserting the
25 following:

1 “(m) AUTHORIZATION OF APPROPRIATIONS.—For
2 the purpose of carrying out this section, there are author-
3 ized to be appropriated \$35,427,000 for each of fiscal
4 years 2016 through 2020.”.

5 (c) SUICIDE PREVENTION FOR YOUTH.—Section
6 520E-1 of the Public Health Service Act (42 U.S.C.
7 290bb-36a) is amended—

8 (1) by amending the section heading to read as
9 follows: “**SUICIDE PREVENTION FOR YOUTH**”;
10 and

11 (2) by striking (n) and inserting the following:

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

16 (d) MENTAL HEALTH AND SUBSTANCE USE DIS-
17 ORDER SERVICES.—Section 520E-2 of the Public Health
18 Service Act (42 U.S.C. 290bb-36b) is amended—

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

22 (2) in subsection (a)—

23 (A) by striking “may” and inserting
24 “shall”;

1 (B) by striking “Services,” and inserting
2 “Services and”;

3 (C) by striking “and behavioral health
4 problems” and inserting “health or substance
5 use disorders”;

6 (D) by striking “substance abuse” and in-
7 serting “substance use disorders”; and

8 (E) by striking “that can lead” through
9 the end of the paragraph and inserting “and to
10 develop best practices for delivering such serv-
11 ices”;

12 (3) in subsection (b)—

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

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

18 “(1) The provision of mental health and sub-
19 stance use disorder services to students, including
20 prevention, promotion of mental health, voluntary
21 screening, early intervention, voluntary assessment,
22 treatment, and management of mental health and
23 substance use disorder issues.

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

4 “(3) The operation of hotlines.

5 “(4) Preparing informational material.

6 “(5) Providing outreach services to notify stu-
7 dents about available mental health and substance
8 use disorder services.

9 “(6) The employment of appropriately trained
10 staff, including administrative staff.

11 “(7) Supporting the training of students, fac-
12 ulty, and staff to respond effectively to students with
13 mental health and substance use disorders.

14 “(8) Creating a network infrastructure to link
15 colleges and universities with health care providers
16 who treat mental health and substance use dis-
17 orders.

18 “(9) Developing, supporting, evaluating, and
19 disseminating evidence-based and emerging best
20 practices.”;

21 (4) in subsection (c)(4), by striking “or” at the
22 end;

23 (5) in subsection (c)(5)—

24 (A) by striking “substance abuse” and in-
25 serting “substance use disorder”; and

1 (B) by striking the period at the end and
2 inserting “; or”; and

3 (6) in subsection (c), by adding at the end the
4 following:

5 “(6) any other entity that provides mental
6 health and substance use disorder services at an in-
7 stitution of higher education.”;

8 (7) in subsection (d)—

9 (A) in the matter preceding paragraph (1),
10 by striking “An institution of higher education
11 desiring a grant under this section” and insert-
12 ing “To be eligible to receive a grant under this
13 section, an institution of higher education”;

14 (B) in paragraph (1)—

15 (i) by striking “and behavioral
16 health” and inserting “health and sub-
17 stance use disorder”; and

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

21 (C) after paragraph (5), by inserting the
22 following:

23 “(6) A plan, when applicable, to meet the spe-
24 cific mental health and substance use disorder needs

1 of veterans attending institutions of higher edu-
2 cation.

3 “(7) A plan to seek input from the community
4 mental health providers, when available, community
5 groups and other public and private entities in car-
6 rying out the program under the grant.”;

7 (8) by designating subsection (e) through (h) as
8 subsections (f) through (i), respectively;

9 (9) by inserting after subsection (d) the fol-
10 lowing new subsection:

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

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

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

22 (10) in subsection (f)(1) (as so redesignated),
23 by striking “and behavioral health problems” and in-
24 serting “health and substance use disorders”;

25 (11) in subsection (g)(2) (as so redesignated)—

1 (A) by striking “and behavioral health”
2 and inserting “health and substance use dis-
3 order”; and

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

7 (12) in subsection (i) (as so redesignated), by
8 striking “\$5,000,000 for fiscal year 2005” and all
9 that follows through the period at the end and in-
10 serting “\$6,500,000 for each of fiscal years 2016
11 through 2020.”.

12 **SEC. 111. NATIONAL SUICIDE PREVENTION LIFELINE PRO-**
13 **GRAM.**

14 Subpart 3 of part B of title V of the Public Health
15 Service Act is amended by inserting after section 520E-
16 2 of such Act (42 U.S.C. 290bb-36b), as amended, the
17 following:

18 **“SEC. 520E-3. NATIONAL SUICIDE PREVENTION LIFELINE**
19 **PROGRAM.**

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

23 “(1) coordinating a network of crisis centers
24 across the United States for providing suicide pre-

1 vention and crisis intervention services to individuals
2 seeking help at any time, day or night;

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

6 “(3) consulting with the Secretary of Veterans
7 Affairs to ensure that veterans calling the suicide
8 prevention hotline have access to a specialized vet-
9 erans’ suicide prevention hotline.

10 “(b) AUTHORIZATION OF APPROPRIATIONS.—To
11 carry out this section, there are authorized to be appro-
12 priated \$8,000,000 for each of fiscal years 2016 through
13 2020.”.

14 **SEC. 112. ADULT SUICIDE PREVENTION.**

15 (a) GRANTS.—

16 (1) AUTHORITY.—The Administrator of the
17 Substance Abuse and Mental Health Services Ad-
18 ministration (referred to in this section as the “Ad-
19 ministrator”) may award grants to eligible entities
20 in order to implement suicide prevention efforts
21 amongst adults 25 and older.

22 (2) PURPOSE.—The grant program under this
23 section shall be designed to raise suicide awareness,
24 establish referral processes, and improve clinical care

1 practice standards for treating suicide ideation,
2 plans, and attempts among adults.

3 (3) RECIPIENTS.—To be eligible to receive a
4 grant under this section, an entity shall be a com-
5 munity-based primary care or behavioral health care
6 setting, an emergency department, a State mental
7 health agency, an Indian tribe, a tribal organization,
8 or any other entity the Administrator deems appro-
9 priate.

10 (4) NATURE OF ACTIVITIES.—The grants
11 awarded under paragraph (1) shall be used to imple-
12 ment programs that—

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

15 (B) implement evidence-based practices to
16 treat individuals who are at suicide risk, includ-
17 ing appropriate follow-up services; and

18 (C) raise awareness, reduce stigma, and
19 foster open dialog about suicide prevention.

20 (b) ADDITIONAL ACTIVITIES.—The Administrator
21 shall—

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

1 (2) disseminate the findings from the evaluation
2 as the Administrator considers appropriate; and

3 (3) provide appropriate information, training,
4 and technical assistance to eligible entities that re-
5 ceive a grant under this section, in order to help
6 such entities to meet the requirements of this sec-
7 tion, including assistance with—

8 (A) selection and implementation of evi-
9 dence-based interventions and frameworks to
10 prevent suicide, such as the Zero Suicide frame-
11 work;

12 (B) other activities as the Administrator
13 determines appropriate.

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

16 (d) AUTHORIZATION OF APPROPRIATIONS.—

17 (1) IN GENERAL.—There is authorized to be
18 appropriated to carry out this section \$15,000,000
19 for each of fiscal year 2016 through 2020.

20 (2) USE OF CERTAIN FUNDS.—Of the funds ap-
21 propriated to carry out this section in any fiscal
22 year, the lesser of 5 percent of such funds or
23 \$500,000 shall be available to the Administrator for
24 purposes of carrying out subsection (b).

1 **SEC. 113. PEER REVIEW AND ADVISORY COUNCILS.**

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

4 (1) in subsection (i), as redesignated by section
5 102, by inserting at the end the following: “For any
6 such peer-review group reviewing a proposal or grant
7 related to the treatment of mental illness, no fewer
8 than half of the members of the group shall be expe-
9 rienced mental health providers.”; and

10 (2) in subsection (m), as redesignated by sec-
11 tion 102—

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

14 (B) in paragraph (3), by striking the pe-
15 riod at the end and inserting “; and”.

16 (b) ADVISORY COUNCILS.—Paragraph (3) of section
17 502(b) of the Public Health Service Act (42 U.S.C.
18 290aa–1(b)) is amended by adding at the end the fol-
19 lowing:

20 “(C) No fewer than one-third of the mem-
21 bers of an advisory council for the Center for
22 Mental Health Services shall be mental health
23 care providers with—

24 “(i) experience in mental health re-
25 search or treatment; and

1 “(ii) expertise in the fields on which
2 they are advising.

3 “(D) The Secretary shall adopt a policy
4 that ensures members of advisory councils do
5 not have conflicts of interest with any program
6 or grant about which the members are to ad-
7 vise.”.

8 (c) PEER REVIEW.—Section 504 of the Public Health
9 Service Act (42 U.S.C. 290aa–3) is amended—

10 (1) by adding at the end of subsection (b) the
11 following: “At least half of the members of any peer-
12 review group established under subsection (a) that
13 pertains to the treatment of mental illness shall be
14 licensed and experienced mental health profes-
15 sionals.”; and

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

17 “(e) SCIENTIFIC CONTROLS AND STANDARDS.—Peer
18 review under this section shall ensure that any research
19 concerning an intervention is based on scientific evidence
20 indicating whether the intervention reduces symptoms, im-
21 proves medical or behavioral outcomes, or improves social
22 functioning.”.

23 **SEC. 114. ADULT TRAUMA.**

24 (a) GRANTS.—

1 (1) AUTHORITY.—The Administrator of the
2 Substance Abuse and Mental Health Services Ad-
3 ministration (referred to in this section as the “Ad-
4 ministrator”) may award grants to eligible entities
5 in order to implement trauma-informed care in pri-
6 mary care and public health settings.

7 (2) PURPOSE.—The grant program under this
8 section shall be designed to facilitate and evaluate
9 the impact of appropriate trauma screening and re-
10 sponses in primary care settings in order to further
11 advance the nation’s understanding of the need for
12 addressing trauma in non-behavioral health settings.

13 (3) RECIPIENTS.—To be eligible to receive a
14 grant under this section, an entity shall be a com-
15 munity-based, primary care setting, an academic re-
16 search setting in conjunction with primary care set-
17 tings, or any other entity the Administrator deems
18 appropriate.

19 (4) NATURE OF ACTIVITIES.—The grants
20 awarded under paragraph (1) shall be used to imple-
21 ment programs that—

22 (A) screen for trauma in adults, provide
23 intervention and referral to treatment, and pro-
24 vide follow-up services, as appropriate; and

1 (B) engage and involve trauma survivors,
2 people receiving services, and family members
3 receiving services in program design.

4 (5) PRACTITIONERS.—As a condition on receipt
5 of a grant under paragraph (1), an entity shall
6 agree that practitioners used to carry out any pro-
7 gram through the grant will be trained in interven-
8 tions that, as described in “SAMHSA’s Concept of
9 Trauma and Guidance for a Trauma-Informed Ap-
10 proach”, are—

11 (A) based on the best available empirical
12 evidence and science;

13 (B) are culturally appropriate; and

14 (C) reflect principles of a trauma-informed
15 approach.

16 (b) ADDITIONAL ACTIVITIES.—The Director shall—

17 (1) evaluate the activities supported by grants
18 awarded under subsection (a) in order to further the
19 Nation’s understanding of the need for, and com-
20 plexity of, addressing trauma in non-behavioral
21 health settings;

22 (2) disseminate the findings from the evaluation
23 as the Administrator considers appropriate;

24 (3) provide appropriate information, training,
25 and technical assistance to eligible entities that re-

1 ceive a grant under this section, in order to help
2 such entities to meet the requirements of this sec-
3 tion, including assistance with—

4 (A) selection and implementation of cul-
5 turally appropriate, evidence-based interven-
6 tions that reflect the principles of trauma-in-
7 formed approach;

8 (B) incorporating principles of peer sup-
9 port and trauma-informed care in hiring, super-
10 vision, and staff evaluation;

11 (C) establishment of organizational prac-
12 tices and policies to support trauma-informed
13 approaches to care; and

14 (D) other activities as the Administrator
15 determines appropriate.

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

18 (d) AUTHORIZATION OF APPROPRIATIONS.—

19 (1) IN GENERAL.—There is authorized to be
20 appropriated to carry out this section \$3,000,000 for
21 each of fiscal year 2016 through 2020.

22 (2) USE OF CERTAIN FUNDS.—Of the funds ap-
23 propriated to carry out this section in any fiscal
24 year, the lesser of 5 percent of such funds or

1 \$500,000 shall be available to the Director for pur-
2 poses of carrying out subsection (b).

3 **SEC. 115. REDUCING THE STIGMA OF SERIOUS MENTAL ILL-**
4 **NESS.**

5 (a) IN GENERAL.—The Secretary of Health and
6 Human Services and the Secretary of Education shall or-
7 ganize a national awareness campaign involving public
8 health organizations, advocacy groups for persons with se-
9 rious mental illness, and social media companies to assist
10 secondary school students and postsecondary students
11 in—

12 (1) reducing the stigma associated with serious
13 mental illness;

14 (2) understanding how to assist an individual
15 who is demonstrating signs of a serious mental ill-
16 ness; and

17 (3) understanding the importance of seeking
18 treatment from a physician, clinical psychologist,
19 psychiatric nurse practitioner, or licensed mental
20 health professional when a student believes the stu-
21 dent may be suffering from a serious mental illness
22 or behavioral health disorder.

23 (b) DATA COLLECTION.—The Secretary of Health
24 and Human Services shall evaluate the program under
25 subsection (a) on public health to determine whether the

1 program has made an impact on public health, such as
2 reducing mortality rates of persons with serious mental
3 illness, prevalence of serious mental illness, physician and
4 clinical psychological visits, emergency room visits.

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

9 **SEC. 116. REPORT ON MENTAL HEALTH AND SUBSTANCE**
10 **ABUSE TREATMENT IN THE STATES.**

11 (a) IN GENERAL.—Not later than 18 months after
12 the date of enactment of this Act, and not less than every
13 2 years thereafter, the Secretary of Health and Human
14 Services shall submit to the Congress and make available
15 to the public a report on mental health and substance use
16 treatment in the States, including the following:

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

20 (A) The numbers of individuals with men-
21 tal illness, serious mental illness, substance use
22 disorders, or co-occurring disorders who are
23 served with Federal funds.

24 (B) The types of programs made available
25 to individuals with mental illness, serious men-

1 tal illness, substance use disorders, or co-occur-
2 ring disorders.

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

9 (3) A statistical report of outcome measures in
10 each State, for individuals with mental illness, seri-
11 ous mental illness, substance use disorders, and co-
12 occurring disorders, such as—

13 (A) rates of suicide, suicide attempts, sub-
14 stance abuse, overdose, overdose deaths, health
15 outcomes, emergency psychiatric hospitaliza-
16 tions, and emergency room boarding; and

17 (B) arrests, incarcerations, victimization,
18 homelessness, joblessness, employment, and en-
19 rollment in educational or vocational programs.

20 (b) DEFINITION.—In this subsection, the term
21 “emergency room boarding” means the practice of admit-
22 ting patients to an emergency department and holding
23 them in the department until inpatient psychiatric beds
24 become available.

1 **SEC. 117. MENTAL HEALTH FIRST AID TRAINING GRANTS.**

2 Section 520J of the Public Health Service Act (42
3 U.S.C. 290bb–41) is amended to read as follows:

4 **“SEC. 520J. MENTAL HEALTH FIRST AID TRAINING GRANTS.**

5 “(a) GRANTS.—The Secretary, acting through the
6 Administrator, shall award grants to States, political sub-
7 divisions of States, Indian tribes, tribal organizations, and
8 nonprofit private entities to initiate and sustain mental
9 health first aid training programs.

10 “(b) PROGRAM REQUIREMENTS.—

11 “(1) IN GENERAL.—To be eligible for funding
12 under subsection (a), a mental health first aid train-
13 ing program shall—

14 “(A) be designed to train individuals in the
15 categories listed in paragraph (2) to accomplish
16 the objectives described in paragraph (3);

17 “(B) ensure that training is conducted by
18 trainers that are properly licensed and
19 credentialed by nonprofit entities as designated
20 by the Secretary; and

21 “(C) include—

22 “(i) at a minimum—

23 “(I) a core live training course
24 for individuals in the categories listed
25 in paragraph (2) on the skills, re-
26 sources, and knowledge to assist indi-

1 individuals in crisis to connect with ap-
2 propriate local mental health care
3 services;

4 “(II) training on mental health
5 resources, including the location of
6 community mental health centers de-
7 scribed in section 1913(c), in the
8 State and local community; and

9 “(III) training on action plans
10 and protocols for referral to such re-
11 sources; and

12 “(ii) where feasible, continuing edu-
13 cation and updated training for individuals
14 in the categories listed in paragraph (2).

15 “(2) CATEGORIES OF INDIVIDUALS TO BE
16 TRAINED.—The categories of individuals listed in
17 this paragraph are the following:

18 “(A) Emergency services personnel and
19 other first responders.

20 “(B) Police officers and other law enforce-
21 ment personnel.

22 “(C) Teachers and school administrators.

23 “(D) Human resources professionals.

24 “(E) Faith community leaders.

1 “(F) Nurses and other primary care per-
2 sonnel.

3 “(G) Students enrolled in an elementary
4 school, a secondary school, or an institution of
5 higher education.

6 “(H) The parents of students described in
7 subparagraph (G).

8 “(I) Veterans.

9 “(J) Other individuals, audiences or train-
10 ing populations as determined appropriate by
11 the Secretary.

12 “(3) OBJECTIVES OF TRAINING.—To be eligible
13 for funding under subsection (a), a mental health
14 first aid training program shall be designed to train
15 individuals in the categories listed in paragraph (2)
16 to accomplish each of the following objectives (as ap-
17 propriate for the individuals to be trained, taking
18 into consideration their age):

19 “(A) Safe de-escalation of crisis situations.

20 “(B) Recognition of the signs and symp-
21 toms of mental illness, including such common
22 psychiatric conditions as schizophrenia, bipolar
23 disorder, major clinical depression, and anxiety
24 disorders.

1 “(C) Timely referral to mental health serv-
2 ices in the early stages of developing mental
3 disorders in order to—

4 “(i) avoid more costly subsequent be-
5 havioral health care; and

6 “(ii) enhance the effectiveness of men-
7 tal health services.

8 “(c) DISTRIBUTION OF AWARDS.—In awarding
9 grants under this section, the Secretary shall—

10 “(1) ensure that grants are equitably distrib-
11 uted among the geographical regions of the United
12 States; and

13 “(2) pay particular attention to the mental
14 health training needs of populations and target audi-
15 ences residing in rural areas.

16 “(d) APPLICATION.—A State, political subdivision of
17 a State, Indian tribe, tribal organization, or nonprofit pri-
18 vate entity that desires a grant under this section shall
19 submit an application to the Secretary at such time, in
20 such manner, and containing such information as the Sec-
21 retary may require, including a plan for the rigorous eval-
22 uation of activities that are carried out with funds received
23 under such grant.

24 “(e) EVALUATION.—A State, political subdivision of
25 a State, Indian tribe, tribal organization, or nonprofit pri-

1 vate entity that receives a grant under this section shall
2 prepare and submit an evaluation to the Secretary at such
3 time, in such manner, and containing such information as
4 the Secretary may reasonably require, including an evalua-
5 tion of activities carried out with funds received under
6 such grant and a process and outcome evaluation.

7 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
8 carry out this section, there are authorized to be appro-
9 priated \$20,000,000 for fiscal year 2016 and such sums
10 as may be necessary for each of fiscal years 2017 and
11 2018.”.

12 **SEC. 118. ACUTE CARE BED REGISTRY GRANT FOR STATES.**

13 (a) IN GENERAL.—The Secretary of Health and
14 Human Services, acting through Administrator of the
15 Substance Abuse and Mental Health Services Administra-
16 tion, shall award grants to State mental health agencies
17 to develop and administer, or maintain an existing, real-
18 time Internet-based bed registry described in subsection
19 (b), to collect, aggregate, and display information about
20 available beds in public and private inpatient psychiatric
21 facilities and public and private residential crisis stabiliza-
22 tion units, and residential community mental health and
23 residential substance abuse treatment facilities to facili-
24 tate the identification and designation of facilities for the

1 temporary treatment of individuals in psychiatric or sub-
2 stance abuse crisis.

3 (b) REGISTRY REQUIREMENTS.—A bed registry de-
4 scribed in this subsection is a registry that—

5 (1) includes descriptive information for every
6 public and private inpatient psychiatric facility,
7 every public and private residential crisis stabiliza-
8 tion unit, and residential community mental health
9 and residential substance abuse facility in the State
10 involved, including contact information for the facil-
11 ity or unit;

12 (2) provides real-time information about the
13 number of beds available at each facility or unit and,
14 for each available bed, the type of patient that may
15 be admitted, the level of security provided, and any
16 other information that may be necessary to allow for
17 the proper identification of appropriate facilities for
18 treatment of individuals in psychiatric or substance
19 abuse crisis; and

20 (3) allows employees and designees of commu-
21 nity mental health and substance abuse service pro-
22 viders, employees of inpatient psychiatric facilities,
23 public and private residential crisis stabilization
24 units, or residential substance abuse treatment fa-
25 cilities, and health care providers working in an

1 emergency room of a hospital or clinic or other facil-
2 ity rendering emergency medical care to perform
3 searches of the registry to identify available beds
4 that are appropriate for the treatment of individuals
5 in psychiatric crisis or substance abuse crisis.

6 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
7 out this section, there are authorized to be appropriated
8 \$15,000,000 for each of fiscal years 2016 through 2020.

9 **SEC. 119. OLDER ADULT MENTAL HEALTH GRANTS.**

10 (a) IN GENERAL.—The Secretary of Health and
11 Human Services, acting through the Director of the Cen-
12 ter for Mental Health Services, shall award grants, con-
13 tracts, and cooperative agreements to public and private
14 nonprofit entities for projects that address the mental
15 health needs of older adults, including programs to—

16 (1) support the establishment and maintenance
17 of interdisciplinary geriatric mental health specialist
18 outreach teams in community settings where older
19 adults reside or receive social services, in order to
20 provide screening, referrals, and evidence-based
21 intervention and treatment services, including serv-
22 ices provided by licensed mental health professionals;

23 (2) develop and implement older adult suicide
24 early intervention and prevention strategies in 1 or
25 more settings that serve seniors, and collect and

1 analyze data on older adult suicide early intervention
2 and prevention services for purposes of monitoring,
3 research, and policy development; and

4 (3) otherwise improve the mental health of
5 older adults, as determined by the Secretary.

6 (b) CONSIDERATIONS IN AWARDING GRANTS.—In
7 awarding grants under this section, the Secretary, to the
8 extent feasible, shall ensure that—

9 (1) projects are funded in a variety of geo-
10 graphic areas, including urban and rural areas;

11 (2) a variety of populations, including racial
12 and ethnic minorities and low-income populations,
13 are served by projects funded under this section; and

14 (3) older adult suicide intervention and preven-
15 tion programs are targeted towards areas with high
16 older adult suicide rates.

17 (c) APPLICATION.—To be eligible to receive a grant
18 under this section, a public or private nonprofit entity
19 shall—

20 (1) submit an application to the Secretary (in
21 such form, containing such information, and at such
22 time as the Secretary may specify);

23 (2) agree to report to the Secretary standard-
24 ized clinical and behavioral data or other perform-
25 ance data necessary to evaluate patient or program

1 outcomes and to facilitate evaluations across partici-
2 pating projects; and

3 (3) demonstrate how such applicant will col-
4 laborate with other State and local public and pri-
5 vate nonprofit organizations.

6 (d) DURATION.—A project may receive funding under
7 a grant under this section for a period of up to 3 years,
8 and such funding may be extended for a period of 2 addi-
9 tional years, at the discretion of the Secretary.

10 (e) SUPPLEMENT, NOT SUPPLANT.—Funds made
11 available under this section shall be used to supplement,
12 and not supplant, other Federal, State, or local funds
13 available to an entity to carry out activities described in
14 this section.

15 (f) REPORT.—Grantees under this section shall, be-
16 ginning with the end of the second year of the grant, sub-
17 mit yearly reports to the Secretary on the activities of the
18 grantee in support of the grant and the latest performance
19 data. Such reports shall contain recommendations as how
20 to replicate the project funded through the grant.

21 (g) DEFINITIONS.—In this section, the term “older
22 adult” has the meaning given the term “older individual”
23 in section 102 of the Older Americans Act of 1965 (42
24 U.S.C. 3002).

1 (h) AUTHORIZATION OF APPROPRIATIONS.—There is
2 authorized to be appropriated to carry out this section,
3 \$5,000,000 for each of fiscal years 2016 through 2020.

4 **TITLE II—INTERAGENCY SERI-**
5 **OUS MENTAL ILLNESS CO-**
6 **ORDINATING COMMITTEE**

7 **SEC. 201. INTERAGENCY SERIOUS MENTAL ILLNESS CO-**
8 **ORDINATING COMMITTEE.**

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

12 **“SEC. 501A. INTERAGENCY SERIOUS MENTAL ILLNESS CO-**
13 **ORDINATING COMMITTEE.**

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

21 “(b) RESPONSIBILITIES.—The Committee, in coordi-
22 nation with the Assistant Secretary, shall—

23 “(1) develop and annually update a summary of
24 advances in serious mental illness research related to
25 causes, prevention, treatment, early screening, diag-

1 nosis or rule out, intervention, and access to services
2 and supports for individuals with serious mental ill-
3 ness;

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

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

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

13 “(5) develop and update every 5 years a stra-
14 tegic plan for the conduct and support of programs
15 and services to assist individuals with serious mental
16 illness, including—

17 “(A) a summary of the advances in serious
18 mental illness research developed under para-
19 graph (1);

20 “(B) a list of the Federal programs and
21 activities identified under paragraph (2);

22 “(C) an analysis of the efficiency, effective-
23 ness, quality, coordination, and cost-effective-
24 ness of Federal programs and activities relating
25 to the prevention, diagnosis, treatment, or reha-

1 bilitation of serious mental illness, including an
2 accounting of the costs of such programs and
3 activities with administrative costs
4 disaggregated from the costs of services and
5 care; and

6 “(D) a plan with recommendations—

7 “(i) for the coordination and improve-
8 ment of Federal programs and activities
9 related to serious mental illness, including
10 budgetary requirements;

11 “(ii) for improving outcomes for indi-
12 viduals with a serious mental illness in-
13 cluding appropriate benchmarks to meas-
14 ure progress on achieving improvements;

15 “(iii) for the mental health workforce;

16 “(iv) to disseminate relevant informa-
17 tion developed by the coordinating com-
18 mittee to the public, health care providers,
19 social service providers, public health offi-
20 cials, courts, law enforcement, and other
21 relevant groups;

22 “(v) to identify research needs, includ-
23 ing longitudinal studies of pediatric popu-
24 lations; and

1 “(vi) for vulnerable and underserved
2 populations, including pediatric popu-
3 lations, geriatric populations, and racial,
4 ethnic, sexual, and gender minorities; and
5 “(6) submit to the Congress such strategic plan
6 and any updates to such plan.

7 “(c) MEMBERSHIP.—

8 “(1) IN GENERAL.—The Committee shall be
9 composed of—

10 “(A) the Assistant Secretary for Mental
11 Health and Substance Use Disorders (or the
12 Assistant Secretary’s designee), who shall serve
13 as the Chair of the Committee;

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

16 “(C) the Attorney General of the United
17 States (or the Attorney General’s designee);

18 “(D) the Director of the Centers for Dis-
19 ease Control and Prevention (or the Director’s
20 designee);

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

23 “(F) the Director of the Indian Health
24 Service;

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

3 “(H) representatives, appointed by the As-
4 sistant Secretary, of Federal agencies that are
5 outside of the Department of Health and
6 Human Services and serve individuals with seri-
7 ous mental illness, including representatives of
8 the Bureau of Indian Affairs, the Department
9 of Defense, the Department of Education, the
10 Department of Housing and Urban Develop-
11 ment, the Department of Labor, the Depart-
12 ment of Veterans Affairs, and the Social Secu-
13 rity Administration; and

14 “(I) the additional members appointed
15 under paragraph (2).

16 “(2) ADDITIONAL MEMBERS.—Not fewer than
17 20 members of the Committee, or $\frac{1}{3}$ of the total
18 membership of the Committee, whichever is greater,
19 shall be composed of non-Federal public members to
20 be appointed by the Assistant Secretary, of which—

21 “(A) at least five such members shall be
22 an individual in recovery from a diagnosis of se-
23 rious mental illness who has benefitted from
24 medical treatment under the care of a licensed
25 mental health professional;

1 “(B) at least three such members shall be
2 a parent or legal guardian of an individual with
3 a history of serious mental illness, including at
4 least one of whom is the parent or legal guard-
5 ian of a child who has either attempted suicide
6 or is incarcerated for a crime committed while
7 experiencing a serious mental illness;

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

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

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

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

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

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

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

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

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

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

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

15 “(L) at least one member shall be a judge
16 with experience adjudicating cases related to
17 criminal justice and serious mental illness;

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

23 “(N) at least one member shall be a cor-
24 rections officer with extensive experience in

1 interfacing with psychiatric and psychological
2 disorders or individuals in mental health crisis.

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

7 “(1) evaluating the impact of projects address-
8 ing priority mental health needs of regional and na-
9 tional significance under sections 501, 509, 516, and
10 520A including measurement of public health out-
11 comes such as—

12 “(A) reduced rates of suicide, suicide at-
13 tempts, substance abuse, overdose, overdose
14 deaths, emergency hospitalizations, emergency
15 room boarding, incarceration, crime, arrest, vic-
16 timization, homelessness, and joblessness;

17 “(B) increased rates of employment and
18 enrollment in educational and vocational pro-
19 grams; and

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

22 “(2) formulating recommendations for the co-
23 ordination and improvement of Federal programs
24 and activities that affect individuals with serious
25 mental illness;

1 “(3) identifying any such programs and activi-
2 ties that are duplicative; and

3 “(4) summarizing all recommendations made,
4 activities carried out, and results achieved pursuant
5 to the workforce development strategy under section
6 501.

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

10 “(1) The Assistant Secretary shall provide such
11 administrative support to the Committee as may be
12 necessary for the Committee to carry out its respon-
13 sibilities.

14 “(2) Members of the Committee appointed
15 under subsection (c)(2) shall serve for a term of 4
16 years, and may be reappointed for one or more addi-
17 tional 4-year terms. Any member appointed to fill a
18 vacancy for an unexpired term shall be appointed for
19 the remainder of such term. A member may serve
20 after the expiration of the member’s term until a
21 successor has taken office.

22 “(3) The Committee shall meet at the call of
23 the chair or upon the request of the Assistant Sec-
24 retary. The Committee shall meet not fewer than 2
25 times each year.

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

4 “(f) SUBCOMMITTEES; ESTABLISHMENT AND MEM-
5 BERSHIP.—In carrying out its functions, the Committee
6 may establish subcommittees and convene workshops and
7 conferences. Such subcommittees shall be composed of
8 Committee members and may hold such meetings as are
9 necessary to enable the subcommittees to carry out their
10 duties.

11 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
12 is authorized to be appropriated \$1,000,000 to carry out
13 the staffing functions under subsection (e)(1) for each of
14 fiscal years 2016 through 2020.”.

15 **TITLE III—COMMUNICATIONS**
16 **BETWEEN INDIVIDUALS, FAM-**
17 **ILIES, AND PROVIDERS**

18 **SEC. 301. CLARIFICATION OF CIRCUMSTANCES UNDER**
19 **WHICH DISCLOSURE OF PROTECTED HEALTH**
20 **INFORMATION OF MENTAL ILLNESS PA-**
21 **TIENTS IS PERMITTED.**

22 The HITECH Act (title XIII of division A of Public
23 Law 111–5) is amended by adding at the end of subtitle
24 D of such Act (42 U.S.C. 17921 et seq.) the following:

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

6 “(a) IN GENERAL.—Not later than one year after the
7 date of enactment of this section, the Secretary shall pro-
8 mulgate final regulations clarifying the circumstances
9 under which, consistent with the standards governing the
10 privacy and security of individually identifiable health in-
11 formation promulgated by the Secretary under sections
12 262(a) and 264 of the Health Insurance Portability and
13 Accountability Act of 1996, health care providers and cov-
14 ered entities may disclose the protected health information
15 of patients with a mental illness, including for purposes
16 of—

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

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

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

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

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

5 “(A) the patient consents; or

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

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

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

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

23 “(9) communicating to law enforcement and
24 family members or caregivers about the admission of
25 a patient to receive care at a facility or the release

1 of a patient who was admitted to a facility for an
2 emergency psychiatric hold or involuntary treatment.

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

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

13 **SEC. 302. DEVELOPMENT AND DISSEMINATION OF MODEL**
14 **TRAINING PROGRAMS.**

15 (a) INITIAL PROGRAMS AND MATERIALS.—Not later
16 than one year after promulgating final regulations under
17 section 13431 of the HITECH Act, as added by section
18 301, the Secretary of Health and Human Services (in this
19 section referred to as the “Secretary”) shall develop and
20 disseminate—

21 (1) a model program and materials for training
22 health care providers (including physicians, emer-
23 gency medical personnel, psychologists, counselors,
24 therapists, behavioral health facilities and clinics,
25 care managers, and hospitals) regarding the cir-

1 cumstances under which, consistent with the stand-
2 ards governing the privacy and security of individ-
3 ually identifiable health information promulgated by
4 the Secretary under sections 262(a) and 264 of the
5 Health Insurance Portability and Accountability Act
6 of 1996, the protected health information of patients
7 with a mental illness may be disclosed with and
8 without patient consent;

9 (2) a model program and materials for training
10 lawyers and others in the legal profession on such
11 circumstances; and

12 (3) a model program and materials for training
13 patients and their families regarding their rights to
14 protect and obtain information under the standards
15 specified in paragraph (1).

16 (b) PERIODIC UPDATES.—The Secretary shall—

17 (1) periodically review and update the model
18 programs and materials developed under subsection

19 (a); and

20 (2) disseminate the updated model programs
21 and materials.

22 (c) CONTENTS.—The programs and materials devel-
23 oped under subsection (a) shall address the guidance enti-
24 tled “HIPAA Privacy Rule and Sharing Information Re-

1 lated to Mental Health”, issued by the Department of
2 Health and Human Services on February 20, 2014.

3 (d) COORDINATION.—The Secretary shall carry out
4 this section in coordination with the Director of the Office
5 for Civil Rights within the Department of Health and
6 Human Services, the Administrator of the Substance
7 Abuse and Mental Health Services Administration, the
8 Administrator of the Health Resources and Services Ad-
9 ministration, and the heads of other relevant agencies
10 within the Department of Health and Human Services.

11 (e) INPUT OF CERTAIN ENTITIES.—In developing the
12 model programs and materials required by subsections (a)
13 and (b), the Secretary shall solicit the input of relevant
14 national, State, and local associations, medical societies,
15 and licensing boards.

16 (f) FUNDING.—There is authorized to be appro-
17 priated to carry out this section \$5,000,000 for fiscal year
18 2016 and \$25,000,000 for the period of fiscal years 2017
19 through 2022.

20 **SEC. 303. MODERNIZING PRIVACY PROTECTIONS.**

21 Not later than two years after the date of the enact-
22 ment of this Act, the Secretary of Health and Human
23 Services shall issue a final rule modernizing the privacy
24 protections under section 543 of the Public Health Service
25 Act (42 U.S.C. 290dd–2).

1 **SEC. 304. IMPROVING COMMUNICATION WITH INDIVID-**
2 **UALS, FAMILIES, AND PROVIDERS.**

3 (a) GRANTS.—

4 (1) AUTHORITY.—The Secretary of Health and
5 Human Services, acting through the Administrator
6 of the Substance Abuse and Mental Health Services
7 Administration, shall award grants to eligible enti-
8 ties for the implementation of pilot programs de-
9 signed to enhance care and promote recovery by sup-
10 porting communication between individuals in treat-
11 ment, their families, providers, and other individuals
12 involved in their care.

13 (2) RECIPIENTS.—To be eligible to receive a
14 grant under this section, an entity shall be a State,
15 county, city, tribe, tribal organization, institutions of
16 higher education, public organization, or private
17 nonprofit organizations.

18 (3) NATURE OF ACTIVITIES.—The grants
19 awarded under paragraph (1) shall be used to imple-
20 ment evidence-based or innovative programs, such as
21 Adapted or Open Dialogue, that enhance care and
22 promote recovery by supporting communities be-
23 tween individuals and those involved in their treat-
24 ment, care, and support.

25 (b) ADDITIONAL ACTIVITIES.—The Secretary shall—

1 (1) evaluate the activities supported by grants
2 awarded under subsection (a) in order to further the
3 Nation's understanding of effective communication
4 strategies between individuals with mental illness
5 and their families and health care providers;

6 (2) disseminate the findings from the evaluation
7 as the Secretary considers appropriate;

8 (3) make recommendations for scaling up suc-
9 cessful models across the country, including in pub-
10 licly funded programs; and

11 (4) other activities as the Secretary determines
12 appropriate.

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

15 (d) AUTHORIZATION OF APPROPRIATIONS.—

16 (1) IN GENERAL.—There is authorized to be
17 appropriated to carry out this section \$2,000,000 for
18 each of fiscal years 2016 through 2020.

19 (2) USE OF CERTAIN FUNDS.—Of the funds ap-
20 propriated to carry out this section in any fiscal
21 year, no more than 5 percent shall be available to
22 the Secretary for the purposes of carrying out sub-
23 section (b).

1 **TITLE IV—IMPROVING MED-**
2 **ICAID AND MEDICARE MEN-**
3 **TAL HEALTH SERVICES**

4 **SEC. 401. ENHANCED MEDICAID COVERAGE RELATING TO**
5 **CERTAIN MENTAL HEALTH SERVICES.**

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

9 (1) IN GENERAL.—Section 1902(a) of the So-
10 cial Security Act (42 U.S.C. 1396a(a)) is amended
11 by inserting after paragraph (77) the following new
12 paragraph:

13 “(78) in the case of a State that does not have
14 in effect (as of the date of the enactment of this
15 paragraph) under its State plan a payment method-
16 ology that allows for full reimbursement of all same-
17 day qualifying services through a single payment,
18 not prohibit payment under the plan for a mental
19 health service or primary care service furnished to
20 an individual at a community mental health center
21 meeting the criteria specified in section 1913(c) of
22 the Public Health Service Act or a federally qualified
23 health center (as defined in section 1861(aa)(3)) for
24 which payment would otherwise be payable under
25 the plan, with respect to such individual, if such

1 service were not a same-day qualifying service (as
2 defined in subsection (ll));”.

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

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

10 “(1) a primary care service furnished to an in-
11 dividual by a provider at a facility on the same day
12 a mental health service is furnished to such indi-
13 vidual by such provider (or another provider) at the
14 facility; and

15 “(2) a mental health service furnished to an in-
16 dividual by a provider at a facility on the same day
17 a primary care service is furnished to such individual
18 by such provider (or another provider) at the facil-
19 ity.”.

20 (b) PROVIDING FULL-RANGE OF EPSDT SERVICES
21 TO CHILDREN IN IMDs.—Section 1905(h) of the Social
22 Security Act (42 U.S.C. 1396d(h)) is amended by adding
23 at the end the following new paragraph:

1 “(3) Such term includes the full-range of early and
2 periodic screening, diagnostic, and treatment services (as
3 defined in subsection (r)).”.

4 (c) OPTIONAL LIMITED COVERAGE OF INPATIENT
5 SERVICES FURNISHED IN INSTITUTIONS FOR MENTAL
6 DISEASES.—Section 1903(m)(2) of the Social Security
7 Act (42 U.S.C. 1396b(m)(2)) is amended by adding at the
8 end the following new subparagraph:

9 “(I)(i) Notwithstanding the limitation
10 specified in the subdivision (B) following para-
11 graph (29) of section 1905(a), beginning on the
12 date of the enactment of this subparagraph, a
13 State may provide, as part of the monthly
14 capitated payment made by the State under
15 this title to a medicaid managed care organiza-
16 tion or a prepaid inpatient health plan (as de-
17 fined in section 438.2 of title 42, Code of Fed-
18 eral Regulations (or any successor regulation)),
19 for payment for limited inpatient psychiatric
20 hospital services provided by such organization
21 or health plan, at the option of the individual
22 receiving such services, in lieu of services cov-
23 ered under the State plan during the month for
24 which the payment is made.

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

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

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

17 (d) EFFECTIVE DATE.—

18 (1) IN GENERAL.—Subject to paragraph (2),
19 the amendments made by subsections (a) and (b)
20 shall apply to items and services furnished after the
21 date of the enactment of this section.

22 (2) EXCEPTION FOR STATE LEGISLATION.—In
23 the case of a State plan under title XIX of the So-
24 cial Security Act, which the Secretary of Health and
25 Human Services determines requires State legisla-

1 tion in order for the respective plan to meet any re-
2 quirement imposed by amendments made by sub-
3 sections (a) and (b), the respective plan shall not be
4 regarded as failing to comply with the requirements
5 of such title solely on the basis of its failure to meet
6 such an additional requirement before the first day
7 of the first calendar quarter beginning after the
8 close of the first regular session of the State legisla-
9 ture that begins after the date of enactment of this
10 Act. For purposes of the previous sentence, in the
11 case of a State that has a 2-year legislative session,
12 each year of the session shall be considered to be a
13 separate regular session of the State legislature.

14 **SEC. 402. REPORTS ON MEDICARE PART D AND MEDICAID**
15 **FORMULARY AND APPEALS PRACTICES WITH**
16 **RESPECT TO COVERAGE OF MENTAL HEALTH**
17 **DRUGS.**

18 (a) MEDICAID.—

19 (1) IN GENERAL.—Not later than one year
20 after the date of the enactment of this Act, the
21 Comptroller General of the United States shall sub-
22 mit to Congress a report that, with respect to men-
23 tal health drugs, describes the practices of the State
24 with respect to—

25 (A) the establishment of formularies; and

1 (B) the appeal of any coverage determina-
2 tion.

3 (2) MENTAL HEALTH DRUG DEFINED.—In this
4 section, the term “mental health drug” means a cov-
5 ered outpatient drug (as defined in section 1927(k)
6 of the Social Security Act (42 U.S.C. 1396r–8(k)))
7 that—

8 (A) is used for the treatment of a mental
9 health disorder, including major depression, bi-
10 polar (manic-depressive) disorder, panic dis-
11 order, obsessive-compulsive disorder, schizo-
12 phrenia, and schizoaffective disorder; and

13 (B) is covered under the State plan under
14 title XIX of the Social Security Act (42 U.S.C.
15 1396 et seq.) (or under a waiver of such plan).

16 (b) MEDICARE PART D APPEALS-RELATED PROC-
17 ESSES.—

18 (1) STUDY.—

19 (A) IN GENERAL.—The Inspector General
20 of the Department of Health and Human Serv-
21 ices shall conduct a study that examines, with
22 respect to the Medicare program established
23 under title XVIII of the Social Security Act (42
24 U.S.C. 1395 et seq.), the extent to which Medi-
25 care part D appeals-related processes are trans-

1 parent, fair, effective, and in compliance with
2 existing statutory and regulatory requirements.

3 (B) INCLUDED ELEMENTS OF STUDY.—

4 The study required under paragraph (1) shall
5 include—

6 (i) an identification, with respect to a
7 two-year period beginning not earlier than
8 January 1, 2010, of—

9 (I) the number of grievances, re-
10 considerations, and independent re-
11 views and appeals pursuant to Medi-
12 care part D appeals-related processes
13 that were lodged, requested, or other-
14 wise filed during such period by part
15 D eligible individuals who were en-
16 rolled in prescription drug plans of-
17 fered by PDP sponsors under part D
18 of title XVIII of the Social Security
19 Act (42 U.S.C. 1395 et seq.); and

20 (II) with respect to such griev-
21 ances, reconsiderations, and inde-
22 pendent reviews and appeals that were
23 so lodged, requested, or otherwise
24 filed during such period by such indi-
25 viduals, the number of such griev-

1 ances, reconsiderations, and inde-
2 pendent reviews and appeals that were
3 decided in favor of such individuals;
4 and

5 (ii) an examination of the extent to
6 which Medicare part D appeals-related
7 processes, with respect to grievances, re-
8 considerations, and independent reviews
9 and appeals that relate to benefits for psy-
10 chiatric medications under such part, are
11 transparent, fair, effective, and in compli-
12 ance with existing statutory and regulatory
13 requirements.

14 (2) REPORT.—Not later than one year after the
15 date of the enactment of this Act, such Inspector
16 General shall submit to Congress a report on the re-
17 sults of the study described in subsection (a), includ-
18 ing the recommendations of such Inspector General,
19 if any, for improvements that can be made to Medi-
20 care part D appeals-related processes.

21 (3) DEFINITIONS.—For purposes of this sec-
22 tion:

23 (A) MEDICARE PART D APPEALS-RELATED
24 PROCESSES.—The term “Medicare part D ap-
25 peals-related processes” means—

1 (i) grievance procedures provided by
2 PDP sponsors pursuant to subsection (f)
3 of section 1860D–4 of the Social Security
4 Act (42 U.S.C. 1395w–104);

5 (ii) reconsiderations provided by PDP
6 sponsors pursuant to subsection (g) of
7 such section; and

8 (iii) independent reviews and appeals
9 to which part D eligible individuals are en-
10 titled under subsection (h) of such section.

11 (B) PART D TERMS.—The terms “part D
12 eligible individual”, “prescription drug plan”,
13 and “PDP sponsor” have the meanings given
14 such terms by section 1840D–41 of the Social
15 Security Act (42 U.S.C. 1395w–151).

16 **SEC. 403. ELIMINATION OF 190-DAY LIFETIME LIMIT ON**
17 **COVERAGE OF INPATIENT PSYCHIATRIC HOS-**
18 **PITAL SERVICES UNDER MEDICARE.**

19 Section 1812 of the Social Security Act (42 U.S.C.
20 1395d) is amended—

21 (1) in subsection (b)—

22 (A) in paragraph (1), by adding “or” at
23 the end;

24 (B) in paragraph (2), by striking “; or” at
25 the end and inserting a period; and

1 (C) by striking paragraph (3); and

2 (2) in subsection (c), by striking “or in deter-
3 mining the 190-day limit under subsection (b)(3)”.

4 **SEC. 404. MODIFICATIONS TO MEDICARE DISCHARGE PLAN-**
5 **NING REQUIREMENTS.**

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

8 (1) in paragraph (1), by inserting “and, in the
9 case of a psychiatric hospital or a psychiatric unit
10 (as described in the matter following clause (v) of
11 section 1886(d)(1)(B)), if it also meets the guide-
12 lines and standards established by the Secretary
13 under paragraph (4)” before the period at the end;
14 and

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

17 “(4) The Secretary shall develop guidelines and
18 standards, in addition to those developed under paragraph
19 (2), for the discharge planning process of a psychiatric
20 hospital or a psychiatric unit (as described in the matter
21 following clause (v) of section 1886(d)(1)(B)) in order to
22 ensure a timely and smooth transition to the most appro-
23 priate type of and setting for posthospital or rehabilitative
24 care, taking into account variations in posthospital care
25 access, including mental health professional shortage

1 areas designated by the Health Resources and Services
2 Administration. The Secretary shall issue final regulations
3 implementing such guidelines and standards not later than
4 24 months after the date of the enactment of this para-
5 graph. The guidelines and standards shall include the fol-
6 lowing:

7 “(A) The hospital or unit must identify the
8 types of services needed upon discharge for the pa-
9 tients being treated by the hospital or unit.

10 “(B) The hospital or unit must—

11 “(i) identify organizations that offer com-
12 munity services to the community that is served
13 by the hospital or unit and the types of services
14 provided by the organizations; and

15 “(ii) make demonstrated efforts to estab-
16 lish connections, relationships, and partnerships
17 with such organizations.

18 “(C) The hospital or unit must arrange (with
19 the participation of the patient and of any other in-
20 dividuals selected by the patient for such purpose)
21 for the development and implementation of a dis-
22 charge plan for the patient as part of the patient’s
23 overall treatment plan from admission to discharge.
24 Such discharge plan shall meet the requirements de-

1 scribed in subparagraphs (G) and (H) of paragraph
2 (2).

3 “(D) The hospital or unit shall coordinate with
4 the patient (or assist the patient with) the referral
5 for posthospital or rehabilitative care and as part of
6 that referral the hospital or unit shall include trans-
7 mitting to the receiving organization, in a timely
8 manner, appropriate information about the care fur-
9 nished to the patient by the hospital or unit and rec-
10 ommendations for posthospital or rehabilitative care
11 to be furnished to the patient by the organization.”.

12 **SEC. 405. EXTENSION AND EXPANSION OF DEMONSTRA-**
13 **TION PROGRAMS TO IMPROVE COMMUNITY**
14 **MENTAL HEALTH SERVICES.**

15 Paragraph (3) of section 223(d) of the Protecting Ac-
16 cess to Medicare Act of 2014 (Public Law 113-93; 128
17 Stat. 1077) is amended to read as follows:

18 “(3) NUMBER AND LENGTH OF DEMONSTRA-
19 TION PROGRAMS.—

20 “(A) IN GENERAL.—Except as provided in
21 subparagraphs (B) and (C), not more than 8
22 States shall be selected for 2-year demonstra-
23 tion programs under this subsection.

24 “(B) THREE-YEAR EXTENSION.—A State
25 selected to participate in the demonstration

1 project under this subsection shall, upon the re-
2 quest of the State, be permitted to continue to
3 participate in the demonstration project for an
4 additional 3-year period, if the Secretary makes
5 the determination specified in subparagraph
6 (D) with respect to the State. The Secretary
7 shall provide each such State with notice of that
8 determination.

9 “(C) EXPANSION TO ADDITIONAL
10 STATES.—

11 “(i) IN GENERAL.—The Secretary
12 may, after a reasonable period that begins
13 on the date on which States are initially
14 selected to participate in the demonstration
15 project, expand the number of eligible
16 States participating in the demonstration
17 project, if, with respect to any such State,
18 the Secretary makes the determination
19 specified in subparagraph (D). The period
20 of the participation of any such eligible
21 State in the demonstration project shall
22 end on December 31, 2022, regardless of
23 the date on which the State begins partici-
24 pating in the demonstration project.

1 “(ii) NOTIFICATION.—The Secretary
2 shall provide each State that applies to be
3 added to the demonstration project under
4 this subsection with notice of the deter-
5 mination under subparagraph (D) and the
6 standards used to make such determina-
7 tion.

8 “(D) DETERMINATION.—The determina-
9 tion specified in this subparagraph is that the
10 Secretary determines that, in the case of a re-
11 quest under subparagraph (B) or an expansion
12 of the demonstration project under subpara-
13 graph (C)—

14 “(i) the continued participation of a
15 State in the demonstration project under
16 this subsection or an expansion of the
17 project to any additional State (as applica-
18 ble) will measurably improve access to, and
19 participation in, services described in sub-
20 section (a)(2)(D) by individuals eligible for
21 medical assistance under the State Med-
22 icaid program; and

23 “(ii) any such State is in full compli-
24 ance with the reporting requirements
25 under paragraph (7) and any quality re-

1 porting requirements established by the
2 Secretary.”.

3 **SEC. 406. EXTENSION AND EXPANSION OF MEDICAID EMER-**
4 **GENCY PSYCHIATRIC DEMONSTRATION**
5 **PROJECT.**

6 (a) IN GENERAL.—Subsection (d) of section 2707 of
7 the Patient Protection and Affordable Care Act (42
8 U.S.C. 1396a note; Public Law 111–148) is amended to
9 read as follows:

10 “(d) LENGTH OF DEMONSTRATION PROJECT.—

11 “(1) IN GENERAL.—Except as provided in para-
12 graphs (2) and (3), the demonstration project estab-
13 lished under this section shall be conducted for a pe-
14 riod of 3 consecutive years.

15 “(2) TEMPORARY EXTENSION OR EXPANSION
16 OF PARTICIPATION ELIGIBILITY FOR CERTAIN
17 STATES.—

18 “(A) ONE-YEAR EXTENSION.—

19 “(i) IN GENERAL.—Subject to clause
20 (ii) and paragraph (5), a State selected as
21 an eligible State to participate in the dem-
22 onstration project on or prior to March 13,
23 2012, shall, upon the request of the State,
24 be permitted to continue to participate in
25 the demonstration project through Sep-

1 tember 30, 2016, if the conditions specified
2 in paragraph (4) are met with respect to
3 the State.

4 “(ii) NOTICE OF PROJECTIONS.—The
5 Secretary shall provide each State selected
6 to participate in the demonstration project
7 on or prior to March 13, 2012, with notice
8 of the State meeting the conditions speci-
9 fied in paragraph (4).

10 “(B) 5-YEAR EXTENSION OR EXPAN-
11 SION.—

12 “(i) EXTENSION.—Taking into ac-
13 count the recommendations submitted to
14 Congress pursuant to subsection (f)(3), the
15 Secretary may permit an eligible State par-
16 ticipating in the demonstration project as
17 of the date on which such recommenda-
18 tions are submitted to continue to partici-
19 pate in the demonstration project through
20 December 31, 2019, if the conditions spec-
21 ified in paragraph (4) are met with respect
22 to the State.

23 “(ii) EXPANSION.—Taking into ac-
24 count the recommendations submitted to
25 Congress pursuant to subsection (f)(3), the

1 Secretary may expand the number of eligi-
2 ble States participating in the demonstra-
3 tion project through December 31, 2019, if
4 the conditions specified in paragraph (4)
5 are met with respect to any newly eligible
6 State.

7 “(iii) NOTICE.—The Secretary shall
8 provide each State participating in the
9 demonstration project as of the date the
10 Secretary submits recommendations to
11 Congress under subsection (f)(3), and any
12 additional State that applies to be added to
13 the demonstration project, with notice of
14 the State meeting the conditions specified
15 in paragraph (4)—

16 “(I) in the case of a State par-
17 ticipating in the demonstration project
18 as of the date the Secretary submits
19 recommendations to Congress under
20 subsection (f)(3), not later than Octo-
21 ber 31, 2016; and

22 “(II) in the case of an additional
23 State that applies to be added to the
24 demonstration project, prior to the

1 State making a final election to par-
2 ticipate in the project.

3 “(3) PERMANENT EXTENSION AND NATION-
4 WIDE EXPANSION OF DEMONSTRATION PROJECT.—

5 “(A) PERMANENT EXTENSION; NATION-
6 WIDE EXPANSION.—Taking into account the
7 recommendations submitted to Congress pursu-
8 ant to subsection (f)(4), the Secretary may per-
9 manently continue the demonstration project
10 after December 31, 2019, expand the number
11 of eligible States participating in the dem-
12 onstration project after such date (including on
13 a nationwide basis), or both, if, with respect to
14 such extension or expansion, the conditions
15 specified in paragraph (4) are met.

16 “(B) NOTICE OF PROJECTIONS.—The Sec-
17 retary shall provide each State participating in
18 the demonstration project as of the date the
19 Secretary submits recommendations to Con-
20 gress under subsection (f)(4), and any addi-
21 tional State that applies to be added to the
22 demonstration project, with notice of the State
23 meeting the conditions specified in paragraph
24 (4), and the standards used to determine that
25 such conditions have been met—

1 “(i) in the case of a State partici-
2 pating in the demonstration project as of
3 the date the Secretary submits rec-
4 ommendations to Congress under sub-
5 section (f)(4), not later than August 31,
6 2019; and

7 “(ii) in the case of an additional State
8 that applies to be added to the demonstra-
9 tion project, prior to the State making a
10 final election to so participate.

11 “(4) DETERMINATION AND CERTIFICATION OF
12 BUDGET NEUTRALITY.—The conditions specified in
13 this paragraph are that the Secretary—

14 “(A) determines that the continued partici-
15 pation of a State in the demonstration project
16 established under this section, the permanent
17 extension of the project, or the expansion of the
18 project to additional States (or on a nationwide
19 basis), as applicable, is projected not to increase
20 net program spending under title XIX of the
21 Social Security Act; and

22 “(B) certifies that such extension for that
23 State, such permanent extension, or such per-
24 manent expansion, as applicable, is projected
25 not to increase such net program spending.

1 “(5) AUTHORITY TO ENSURE BUDGET NEU-
2 TRALITY.—The Secretary annually shall review each
3 participating State’s demonstration project expendi-
4 tures to ensure compliance with the conditions speci-
5 fied in paragraph (4). If the Secretary determines
6 with respect to a State’s participation in the dem-
7 onstration project that the State’s net program
8 spending under title XIX of the Social Security Act
9 has increased as a result of the State’s participation
10 in the project, the Secretary shall treat any such in-
11 creased expenditures in the same manner as an over-
12 payment under section 1903 of the Social Security
13 Act is treated under subsection (d) of such section
14 1903.”.

15 (b) FUNDING.—Subsection (e) of section 2707 of
16 such Act (42 U.S.C. 1396a note) is amended—

17 (1) in the subsection heading, by striking “LIM-
18 ITATIONS ON FEDERAL”;

19 (2) in paragraph (2)—

20 (A) in the paragraph heading, by striking
21 “5-YEAR AVAILABILITY” and inserting “AVAIL-
22 ABILITY”; and

23 (B) by striking “through December 31,
24 2015” and inserting “until expended”;

25 (3) by striking paragraph (3);

1 (4) by redesignating paragraphs (4) and (5) as
2 paragraphs (3) and (4), respectively;

3 (5) in paragraph (3) (as so redesignated), by
4 striking “and the availability of funds”; and

5 (6) in paragraph (4) (as so redesignated)—

6 (A) in the first sentence, by striking
7 “paragraph (4)” and inserting “paragraph
8 (3)”; and

9 (B) by inserting after the first sentence
10 the following: “In addition to any payments
11 made to an eligible State under the preceding
12 sentence, the Secretary shall, during any period
13 in effect under paragraph (2) or (3) of sub-
14 section (d), pay each eligible State, an amount
15 each quarter equal to the Federal medical as-
16 sistance percentage of expenditures in the quar-
17 ter during such period for medical assistance
18 described in subsection (a). Payments made to
19 a State for emergency psychiatric demonstra-
20 tion services under this section during the ex-
21 tension period shall be treated as medical as-
22 sistance under the State plan for purposes of
23 section 1903(a)(1) of the Social Security Act
24 (42 U.S.C. 1396b(a)(1)).”.

1 (c) RECOMMENDATIONS TO CONGRESS.—Subsection
2 (f) of section 2707 of such Act (42 U.S.C. 1396a note)
3 is amended by adding at the end the following:

4 “(3) RECOMMENDATION TO CONGRESS REGARD-
5 ING 5-YEAR EXTENSION OR EXPANSION OF
6 PROJECT.—Not later than September 30, 2016, the
7 Secretary shall submit to Congress and make avail-
8 able to the public recommendations based on an
9 evaluation of the demonstration project, including
10 the use of appropriate quality measures, regarding—

11 “(A) whether the demonstration project
12 should be continued after September 30, 2016;
13 and

14 “(B) whether the demonstration project
15 should be expanded to additional States.

16 “(4) RECOMMENDATION TO CONGRESS REGARD-
17 ING PERMANENT EXTENSION AND NATIONWIDE EX-
18 PANSION OF PROJECT.—

19 “(A) IN GENERAL.—Not later than April
20 1, 2019, the Secretary shall submit to Congress
21 and make available to the public recommenda-
22 tions based on an evaluation of the demonstra-
23 tion project, including the use of appropriate
24 quality measures, regarding—

1 “(i) whether the demonstration
2 project should be permanently continued
3 after December 31, 2019, in one or more
4 States; and

5 “(ii) whether the demonstration
6 project should be expanded to additional
7 States (including on a nationwide basis).

8 “(B) REQUIREMENT.—Any recommenda-
9 tion submitted under subparagraph (A) to per-
10 manently continue the project in a State, or to
11 expand the project to 1 or more other States
12 (including on a nationwide basis) shall include
13 a certification that permanently continuing the
14 project in a particular State, or expanding the
15 project to a particular State (or all States) will
16 not increase net program spending under title
17 XIX of the Social Security Act.

18 “(5) FUNDING.—Out of any funds in the
19 Treasury not otherwise appropriated, there is appro-
20 priated to the Centers for Medicare & Medicaid
21 Services Program Management Account to carry out
22 this subsection, \$500,000 for fiscal year 2016, to re-
23 main available until expended.”.

24 (d) CONFORMING AMENDMENTS.—Section 2707 of
25 such Act (42 U.S.C. 1396a note) is amended—

1 (1) in subsection (a), in the matter before para-
2 graph (1), by inserting “publicly or” after “an insti-
3 tution for mental diseases that is”; and

4 (2) in subsection (f), in the subsection heading,
5 by striking “AND REPORT” and inserting “, RE-
6 PORT, AND RECOMMENDATIONS”.

7 **TITLE V—STRENGTHENING THE**
8 **BEHAVIORAL HEALTH WORK-**
9 **FORCE AND IMPROVING AC-**
10 **CESS TO CARE**

11 **SEC. 501. NATIONWIDE WORKFORCE STRATEGY.**

12 (a) IN GENERAL.—Not later than one year after the
13 date of enactment of this Act, the Substance Abuse Men-
14 tal Health and Services Administration shall, submit to
15 the Congress a report containing a nationwide strategy to
16 increase the culturally aware behavioral health workforce
17 and recruit professionals for the treatment of individuals
18 with mental illness and substance use disorders.

19 (b) DESIGN.—The nationwide strategy shall be de-
20 signed—

21 (1) to encourage and incentivize students en-
22 rolled in accredited medical or osteopathic medical
23 school to enter the specialty of psychiatry;

24 (2) to promote greater research-oriented psy-
25 chiatrist residency training on evidence-based service

1 delivery models for individuals with serious mental
2 illness or substance use disorders;

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

5 (A) evidence-based collaborative care mod-
6 els; and

7 (B) the necessary trained and culturally
8 aware preventionists, health care practitioners,
9 paraprofessionals, and peers.

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

14 (5) to identify populations and locations that
15 are most underserved by mental health and sub-
16 stance use professionals and the most in need of
17 psychiatrists (including child and adolescent psychia-
18 trists), psychologists, psychiatric nurse practitioners,
19 physician assistants, clinical social workers, mental
20 health counselors, substance abuse counselors, peer-
21 support specialists, recovery coaches, and other men-
22 tal health and substance use disorder professionals.

1 **SEC. 502. REPORT ON BEST PRACTICES FOR PEER-SUP-**
2 **PORT SPECIALIST PROGRAMS, TRAINING,**
3 **AND CERTIFICATION.**

4 (a) IN GENERAL.—Not later than 2 years after the
5 date of enactment of this Act, the Secretary shall submit
6 to the Congress and make publicly available a report on
7 best practices and professional standards in States for—

8 (1) establishing and operating health care pro-
9 grams using peer-support specialists; and

10 (2) training and certifying peer-support special-
11 ists.

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

15 (1) uses his or her lived experience of recovery
16 from mental illness or substance abuse, plus skills
17 learned in formal training, to facilitate support
18 groups, and to work on a one-on-one basis, with in-
19 dividuals with a serious mental illness or a substance
20 use disorder;

21 (2) has benefited or is benefiting from mental
22 health or substance use treatment services or sup-
23 ports;

24 (3) provides non-medical services; and

1 (4) performs services only within his or her
2 area of training, expertise, competence, or scope of
3 practice.

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

7 (1) Hours of formal work or volunteer experi-
8 ence related to mental health and substance use
9 issues.

10 (2) Types of peer support specialists used by
11 different health care programs.

12 (3) Types of peer specialist exams required.

13 (4) Code of ethics.

14 (5) Additional training required prior to certifi-
15 cation, including in areas such as—

16 (A) ethics;

17 (B) scope of practice;

18 (C) crisis intervention;

19 (D) State confidentiality laws;

20 (E) Federal privacy protections, including

21 under the Health Insurance Portability and Ac-

22 countability Act of 1996; and

23 (F) other areas as determined by the Sec-
24 retary.

1 (6) Requirements to explain what, where, when,
2 and how to accurately complete all required docu-
3 mentation activities.

4 (7) Required or recommended skill sets, such as
5 knowledge of—

6 (A) risk indicators, including individual
7 stressors, triggers, and indicators of escalating
8 symptoms;

9 (B) basic de-escalation techniques;

10 (C) basic suicide prevention concepts and
11 techniques;

12 (D) indicators that the consumer may be
13 experiencing abuse or neglect;

14 (E) stages of change or recovery;

15 (F) the typical process that should be fol-
16 lowed to access or participate in community
17 mental health and related services; and

18 (G) circumstances when it is appropriate
19 to request assistance from other professionals
20 to help meet the consumer's recovery goals.

21 (8) Requirements for continuing education.

22 **SEC. 503. ADVISORY COUNCIL ON GRADUATE MEDICAL**
23 **EDUCATION.**

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

1 (1) by redesignating paragraphs (4) through
2 (6) as paragraphs (5) through (7), respectively; and
3 (2) by inserting after paragraph (3) the fol-
4 lowing:
5 “(4) the Assistant Secretary for Mental Health
6 and Substance Use Disorders;”.

7 **SEC. 504. TELEPSYCHIATRY AND PRIMARY CARE PROVIDER**
8 **TRAINING GRANT PROGRAM.**

9 (a) IN GENERAL.—The Secretary of Health and
10 Human Services shall establish a grant program (in this
11 subsection referred to as the “grant program”) under
12 which the Secretary shall award to 10 eligible States (as
13 described in subsection (e)) grants for carrying out all of
14 the purposes described in subsections (b), (c), and (d).

15 (b) TRAINING PROGRAM FOR CERTAIN PRIMARY
16 CARE PROVIDERS.—For purposes of subsection (a), the
17 purpose described in this paragraph, with respect to a
18 grant awarded to a State under the grant program, is for
19 the State to establish a training program to train primary
20 care providers in—

21 (1) valid and reliable behavioral-health screen-
22 ing tools for violence and suicide risk, early signs of
23 serious mental illness, and untreated substance
24 abuse, including any standardized behavioral-health

1 screening tools that are determined appropriate by
2 the Secretary;

3 (2) implementing the use of behavioral-health
4 screening tools in their practices;

5 (3) establishment of recommended intervention
6 and treatment protocols for individuals in mental
7 health crisis, especially for individuals whose illness
8 makes them less receptive to mental health services;
9 and

10 (4) implementing the evidence-based collabo-
11 rative care model of integrated medical-behavioral
12 health care in their practices.

13 (c) PAYMENTS FOR MENTAL HEALTH SERVICES
14 PROVIDED BY CERTAIN PRIMARY CARE PROVIDERS.—

15 (1) IN GENERAL.—For purposes of subsection
16 (a), the purpose described in this paragraph, with
17 respect to a grant awarded to a State under the
18 grant program, is for the State to provide, in ac-
19 cordance with this paragraph, in the case of a pri-
20 mary care physician who participates in the training
21 program of the State establish pursuant to sub-
22 section (b), payments to the primary care providers
23 for services furnished by the primary care providers.

24 (2) CONSIDERATIONS.—The Secretary, in de-
25 termining the structure, quality, and form of pay-

1 ment under paragraph (1) shall seek to find innova-
2 tive payment systems which may take into account—

3 (A) the nature and quality of services ren-
4 dered;

5 (B) the patients' health outcome;

6 (C) the geographical location where serv-
7 ices were provided;

8 (D) the acuteness of the patient's medical
9 condition;

10 (E) the duration of services provided;

11 (F) the feasibility of replicating the pay-
12 ment model in other locations nationwide; and

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

19 (d) TELEHEALTH SERVICES FOR MENTAL HEALTH
20 DISORDERS.—

21 (1) IN GENERAL.—For purposes of subsection
22 (a), the purpose described in this paragraph, with
23 respect to a grant awarded to a State under the
24 grant program, is for the State to provide, in the
25 case of an individual furnished items and services by

1 a primary care physician during an office visit, for
2 payment for a consultation provided by a psychia-
3 trist or psychologist to such primary care provider
4 with respect to such individual through the use of
5 qualified telehealth technology for the identification,
6 diagnosis, mitigation, or treatment of a mental
7 health disorder if such consultation occurs not later
8 than the first business day that follows such visit.

9 (2) QUALIFIED TELEHEALTH TECHNOLOGY.—

10 For purposes of paragraph (1), the term “qualified
11 telehealth technology”, with respect to the provision
12 of items and services to a patient by a health care
13 provider, includes the use of interactive audio, audio-
14 only telephone conversation, video, or other tele-
15 communications technology by a health care provider
16 to deliver health care services within the scope of the
17 provider’s practice including the use of electronic
18 media for consultation relating to the health care di-
19 agnosis or treatment of the patient.

20 (e) ELIGIBLE STATE.—

21 (1) IN GENERAL.—For purposes of this sub-
22 section, an eligible State is a State that has sub-
23 mitted to the Secretary an application under para-
24 graph (2) and has been selected under paragraph
25 (4).

1 (2) APPLICATION.—A State seeking to partici-
2 pate in the grant program under this subsection
3 shall submit to the Secretary, at such time and in
4 such format as the Secretary requires, an applica-
5 tion that includes such information, provisions, and
6 assurances as the Secretary may require.

7 (3) MATCHING REQUIREMENT.—The Secretary
8 may not make a grant under the grant program un-
9 less the State involved agrees, with respect to the
10 costs to be incurred by the State in carrying out the
11 purposes described in this subsection, to make avail-
12 able non-Federal contributions (in cash or in kind)
13 toward such costs in an amount equal to not less
14 than 20 percent of Federal funds provided in the
15 grant.

16 (4) SELECTION.—A State shall be determined
17 eligible for the grant program by the Secretary on
18 a competitive basis among States with applications
19 meeting the requirements of paragraphs (2) and (3).
20 In selecting State applications for the grant pro-
21 gram, the Secretary shall seek to achieve an appro-
22 priate national balance in the geographic distribu-
23 tion of grants awarded under the grant program.

24 (f) TARGET POPULATION.—In seeking a grant under
25 this subsection, a State shall demonstrate how the grant

1 will improve care for individuals with co-occurring behav-
2 ioral health and physical health conditions, vulnerable pop-
3 ulations, socially isolated populations, rural populations,
4 and other populations who have limited access to qualified
5 mental health providers.

6 (g) LENGTH OF GRANT PROGRAM.—The grant pro-
7 gram under this subsection shall be conducted for a period
8 of 3 consecutive years.

9 (h) PUBLIC AVAILABILITY OF FINDINGS AND CON-
10 CLUSIONS.—Subject to Federal privacy protections with
11 respect to individually identifiable information, the Sec-
12 retary shall make the findings and conclusions resulting
13 from the grant program under this subsection available
14 to the public.

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

20 (j) REPORTS.—

21 (1) REPORTS.—For each fiscal year that grants
22 are awarded under this subsection, the Secretary
23 shall conduct a study on the results of the grants
24 and submit to the Congress a report on such results
25 that includes the following:

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

5 (B) Recommendations on how to improve
6 access to mental health services at grantee loca-
7 tions.

8 (C) An assessment of access to mental
9 health services under the program.

10 (D) An assessment of the impact of the
11 demonstration project on the costs of the full
12 range of mental health services (including inpa-
13 tient, emergency and ambulatory care).

14 (E) Recommendations on congressional ac-
15 tion to improve the grant.

16 (F) Recommendations to improve training
17 of primary care providers.

18 (2) REPORT.—Not later than December 31,
19 2018, the Secretary shall submit to Congress and
20 make available to the public a report on the findings
21 of the evaluation under subparagraph (A) and also
22 a policy outline on how Congress can expand the
23 grant program to the national level.

1 **SEC. 505. LIABILITY PROTECTIONS FOR HEALTH CARE**
2 **PROFESSIONAL VOLUNTEERS AT COMMU-**
3 **NITY HEALTH CENTERS AND FEDERALLY**
4 **QUALIFIED COMMUNITY BEHAVIORAL**
5 **HEALTH CLINICS.**

6 Section 224 of the Public Health Service Act (42
7 U.S.C. 233) is amended by adding at the end the fol-
8 lowing:

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

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

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

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

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

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

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

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

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

21 “(B) With respect to an entity described in sub-
22 section (g)(4) or a federally qualified community be-
23 havioral health clinic, a health care professional is
24 not a health professional volunteer at such center
25 unless the center sponsors the health care profes-

1 sional. For purposes of this subsection, the center
2 shall be considered to be sponsoring the health care
3 professional if—

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

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

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

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

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

6 “(B) Not later than May 1 of each fiscal year, the
7 Attorney General, in consultation with the Secretary, shall
8 submit to the Congress a report providing an estimate of
9 the amount of claims (together with related fees and ex-
10 penses of witnesses) that, by reason of the acts or omis-
11 sions of health care professional volunteers, will be paid
12 pursuant to this subsection during the calendar year that
13 begins in the following fiscal year. Subsection (k)(1)(B)
14 applies to the estimate under the preceding sentence re-
15 garding health care professional volunteers to the same
16 extent and in the same manner as such subsection applies
17 to the estimate under such subsection regarding officers,
18 governing board members, employees, and contractors of
19 entities described in subsection (g)(4).

20 “(C) Not later than December 31 of each fiscal year,
21 the Secretary shall transfer from the fund under sub-
22 section (k)(2) to the appropriate accounts in the Treasury
23 an amount equal to the estimate made under subpara-
24 graph (B) for the calendar year beginning in such fiscal
25 year, subject to the extent of amounts in the fund.

1 “(6)(A) This subsection takes effect on October 1,
2 2017, except as provided in subparagraph (B).

3 “(B) Effective on the date of the enactment of this
4 subsection—

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

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

11 **SEC. 506. MINORITY FELLOWSHIP PROGRAM.**

12 Title V of the Public Health Service Act (42 U.S.C.
13 290aa et seq.), as amended, is further amended by adding
14 at the end the following:

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

16 **“SEC. 597. FELLOWSHIPS.**

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

21 “(1) increasing behavioral health practitioners’
22 knowledge of issues related to prevention, treatment,
23 and recovery support for mental and substance use
24 disorders among racial and ethnic minority popu-
25 lations;

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

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

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

16 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
17 carry out this section, there are authorized to be appro-
18 priated \$11,000,000 for each of fiscal years 2016 through
19 2020.”.

20 **SEC. 507. NATIONAL HEALTH SERVICE CORPS.**

21 (a) DEFINITIONS.—

22 (1) PRIMARY HEALTH SERVICES.—Section
23 331(a)(3)(D) of the Public Health Service Act (42
24 U.S.C. 254d(a)(3)) is amended by inserting “(in-

1 including pediatric mental health subspecialty serv-
2 ices)” after “pediatrics”.

3 (2) BEHAVIORAL AND MENTAL HEALTH PRO-
4 FESSIONALS.—Clause (i) of section 331(a)(3)(E) of
5 the Public Health Service Act (42 U.S.C.
6 254d(a)(3)(E)) is amended by inserting “(and pedi-
7 atric subspecialists thereof)” before the period at the
8 end.

9 (b) ELIGIBILITY TO PARTICIPATE IN LOAN REPAY-
10 MENT PROGRAM.—Section 338B(b)(1)(B) of the Public
11 Health Service Act (42 U.S.C. 254l–1(b)(1)(B)) is amend-
12 ed by inserting “, including any physician child and ado-
13 lescent psychiatry residency or fellowship training pro-
14 gram” after “be enrolled in an approved graduate training
15 program in medicine, osteopathic medicine, dentistry, be-
16 havioral and mental health, or other health profession”.

17 **SEC. 508. SAMHSA GRANT PROGRAM FOR DEVELOPMENT**
18 **AND IMPLEMENTATION OF CURRICULA FOR**
19 **CONTINUING EDUCATION ON SERIOUS MEN-**
20 **TAL ILLNESS.**

21 Title V of the Public Health Service Act is amended
22 by inserting after section 520I (42 U.S.C. 290bb–40) the
23 following:

1 **“SEC. 520I-1. CURRICULA FOR CONTINUING EDUCATION ON**
2 **SERIOUS MENTAL ILLNESS.**

3 “(a) GRANTS.—The Secretary may award grants to
4 eligible entities for the development and implementation
5 of curricula for providing continuing education and train-
6 ing to health care professionals on identifying, referring,
7 and treating individuals with serious mental illness.

8 “(b) ELIGIBLE ENTITIES.—To be eligible to seek a
9 grant under this section, an entity shall be a public or
10 nonprofit entity that—

11 “(1) provides continuing education or training
12 to health care professionals; or

13 “(2) applies for the grant in partnership with
14 another entity that provides such education and
15 training.

16 “(c) PREFERENCE.—In awarding grants under this
17 section, the Secretary shall give preference to eligible enti-
18 ties proposing to develop and implement curricula for pro-
19 viding continuing education and training to—

20 “(1) health care professionals in primary care
21 specialties; or

22 “(2) health care professionals who are required,
23 as a condition of State licensure, to participate in
24 continuing education or training specific to mental
25 health.

1 “(d) AUTHORIZATION OF APPROPRIATIONS.—To
2 carry out this section, there are authorized to be appro-
3 priated \$1,000,000 for each of fiscal years 2016 through
4 2020.”.

5 **SEC. 509. PEER PROFESSIONAL WORKFORCE DEVELOP-**
6 **MENT GRANT PROGRAM.**

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

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

14 (1) to increase the number of behavioral health
15 paraprofessionals, including trained peers, recovery
16 coaches, mental health and addiction specialists, pre-
17 vention specialists, and pre-masters-level addiction
18 counselors; and

19 (2) to help communities develop the infrastruc-
20 ture to train and certify peers as behavioral health
21 paraprofessionals.

22 (c) ELIGIBLE ENTITIES.—To be eligible to receive a
23 grant under this section, an entity shall be a community
24 college or other education entity the Secretary deems ap-
25 propriate.

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

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

9 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
10 out this section, there is authorized to be appropriated to
11 carry out this section \$5,000,000 for each of fiscal years
12 2016 through 2020.

13 **SEC. 510. DEMONSTRATION GRANT PROGRAM TO RECRUIT,**
14 **TRAIN, AND PROFESSIONALLY SUPPORT PSY-**
15 **CHIATRIC PHYSICIANS IN INDIAN HEALTH**
16 **PROGRAMS.**

17 (a) ESTABLISHMENT.—The Secretary of Health and
18 Human Services (in this section referred to as the “Sec-
19 retary”), in consultation with the Director of the Indian
20 Health Service and demonstration programs established
21 under section 123 of the Indian Health Care Improvement
22 Act (25 U.S.C. 1616p), shall award one 5-year grant to
23 one eligible entity to carry out a demonstration program
24 (in this Act referred to as the “Program”) under which

1 the eligible entity shall carry out the activities described
2 in subsection (b).

3 (b) ACTIVITIES TO BE CARRIED OUT BY RECIPIENT
4 OF GRANT UNDER PROGRAM.—Under the Program, the
5 grant recipient shall—

6 (1) create a nationally-replicable workforce
7 model that identifies and incorporates best practices
8 for recruiting, training, deploying, and professionally
9 supporting Native American and non-Native Amer-
10 ican psychiatric physicians to be fully integrated into
11 medical, mental, and behavioral health systems in
12 Indian health programs;

13 (2) recruit to participate in the Program Native
14 American and non-Native American psychiatric phy-
15 sicians who demonstrate interest in providing spe-
16 cialty health care services (as defined in section
17 313(a)(3) of the Indian Health Care Improvement
18 Act (25 U.S.C. 1638g(a)(3))) and primary care serv-
19 ices to American Indians and Alaska Natives;

20 (3) provide such psychiatric physicians partici-
21 pating in the Program with not more than 1 year of
22 supplemental clinical and cultural competency train-
23 ing to enable such physicians to provide such spe-
24 cialty health care services and primary care services
25 in Indian health programs;

1 (4) with respect to such psychiatric physicians
2 who are participating in the Program and trained
3 under paragraph (3), deploy such physicians to prac-
4 tice specialty care or primary care in Indian health
5 programs for a period of not less than 2 years and
6 professionally support such physicians for such pe-
7 riod with respect to practicing such care in such pro-
8 grams; and

9 (5) not later than 1 year after the last day of
10 the 5-year period for which the grant is awarded
11 under subsection (a), submit to the Secretary and to
12 the appropriate committees of Congress a report
13 that shall include—

14 (A) the workforce model created under
15 paragraph (1);

16 (B) strategies for disseminating the work-
17 force model to other entities with the capability
18 of adopting it; and

19 (C) recommendations for the Secretary and
20 Congress with respect to supporting an effective
21 and stable psychiatric and mental health work-
22 force that serves American Indians and Alaska
23 Natives.

24 (c) ELIGIBLE ENTITIES.—

1 (1) REQUIREMENTS.—To be eligible to receive
2 the grant under this section, an entity shall—

3 (A) submit to the Secretary an application
4 at such time, in such manner, and containing
5 such information as the Secretary may require;

6 (B) be a department of psychiatry within
7 a medical school in the United States that is
8 accredited by the Liaison Committee on Medical
9 Education or a public or private non-profit enti-
10 ty affiliated with a medical school in the United
11 States that is accredited by the Liaison Com-
12 mittee on Medical Education; and

13 (C) have in existence, as of the time of
14 submission of the application under subpara-
15 graph (A), a relationship with Indian health
16 programs in at least two States with a dem-
17 onstrated need for psychiatric physicians and
18 provide assurances that the grant will be used
19 to serve rural and non-rural American Indian
20 and Alaska Native populations in at least two
21 States.

22 (2) PRIORITY IN SELECTING GRANT RECIPI-
23 ENT.—In awarding the grant under this section, the
24 Secretary shall give priority to an eligible entity that
25 satisfies each of the following:

1 (A) Demonstrates sufficient infrastructure
2 in size, scope, and capacity to undertake the
3 supplemental clinical and cultural competency
4 training of a minimum of 5 psychiatric physi-
5 cians, and to provide ongoing professional sup-
6 port to psychiatric physicians during the de-
7 ployment period to an Indian health program.

8 (B) Demonstrates a record in successfully
9 recruiting, training, and deploying physicians
10 who are American Indians and Alaska Natives.

11 (C) Demonstrates the ability to establish a
12 program advisory board, which may be pri-
13 marily composed of representatives of federally-
14 recognized tribes, Alaska Natives, and Indian
15 health programs to be served by the Program.

16 (d) ELIGIBILITY OF PSYCHIATRIC PHYSICIANS TO
17 PARTICIPATE IN THE PROGRAM.—

18 (1) IN GENERAL.—To be eligible to participate
19 in the Program, as described in subsection (b), a
20 psychiatric physician shall—

21 (A) be licensed or eligible for licensure to
22 practice in the State to which the physician is
23 to be deployed under subsection (b)(4); and

24 (B) demonstrate a commitment beyond the
25 one year of training described in subsection

1 (b)(3) and two years of deployment described in
2 subsection (b)(4) to a career as a specialty care
3 physician or primary care physician providing
4 mental health services in Indian health pro-
5 grams.

6 (2) PREFERENCE.—In selecting physicians to
7 participate under the Program, as described in sub-
8 section (b)(2), the grant recipient shall give pref-
9 erence to physicians who are American Indians and
10 Alaska Natives.

11 (e) LOAN FORGIVENESS.—Under the Program, any
12 psychiatric physician accepted to participate in the Pro-
13 gram shall, notwithstanding the provisions of subsection
14 (b) of section 108 of the Indian Health Care Improvement
15 Act (25 U.S.C. 1616a) and upon acceptance into the Pro-
16 gram, be deemed eligible and enrolled to participate in the
17 Indian Health Service Loan Repayment Program under
18 such section 108. Under such Loan Repayment Program,
19 the Secretary shall pay on behalf of the physician for each
20 year of deployment under the Program under this section
21 up to \$35,000 for loans described in subsection (g)(1) of
22 such section 108.

23 (f) DEFERRAL OF CERTAIN SERVICE.—The starting
24 date of required service of individuals in the National
25 Health Service Corps Service Program under title II of

1 the Public Health Service Act (42 U.S.C. 202 et seq.) who
2 are psychiatric physicians participating under the Pro-
3 gram under this section shall be deferred until the date
4 that is 30 days after the date of completion of the partici-
5 pation of such a physician in the Program under this sec-
6 tion.

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

8 (1) AMERICAN INDIANS AND ALASKA NA-
9 TIVES.—The term “American Indians and Alaska
10 Natives” has the meaning given the term “Indian”
11 in section 447.50(b)(1) of title 42, Code of Federal
12 Regulations, as in existence as of the date of the en-
13 actment of this Act.

14 (2) INDIAN HEALTH PROGRAM.—The term “In-
15 dian health program” has the meaning given such
16 term in section 104(12) of the Indian Health Care
17 Improvement Act (25 U.S.C. 1603(12)).

18 (3) PROFESSIONALLY SUPPORT.—The term
19 “professionally support” means, with respect to psy-
20 chiatric physicians participating in the Program and
21 deployed to practice specialty care or primary care
22 in Indian health programs, the provision of com-
23 pensation to such physicians for the provision of
24 such care during such deployment and may include
25 the provision, dissemination, or sharing of best prac-

1 tices, field training, and other activities deemed ap-
2 propriate by the recipient of the grant under this
3 section.

4 (4) PSYCHIATRIC PHYSICIAN.—The term “psy-
5 chiatric physician” means a medical doctor or doctor
6 of osteopathy in good standing who has successfully
7 completed four-year psychiatric residency training or
8 who is enrolled in four-year psychiatric residency
9 training in a residency program accredited by the
10 Accreditation Council for Graduate Medical Edu-
11 cation.

12 (h) AUTHORIZATION OF APPROPRIATIONS.—There is
13 authorized to be appropriated to carry out this section
14 \$1,000,000 for each of the fiscal years 2016 through
15 2020.

16 **SEC. 511. EDUCATION AND TRAINING ON EATING DIS-**
17 **ORDERS FOR HEALTH PROFESSIONALS.**

18 (a) IN GENERAL.—The Secretary of Health and
19 Human Services, acting through the Administrator of the
20 Substance Abuse and Mental Health Services Administra-
21 tion, shall award grants to eligible entities to integrate
22 training into existing curricula for primary care physi-
23 cians, other licensed or certified health and mental health
24 professionals, and public health professionals that may in-
25 clude—

1 (1) early intervention and identification of eat-
2 ing disorders;

3 (2) types of treatment (including family-based
4 treatment, in-patient, residential, partial hospitaliza-
5 tion programming, intensive outpatient and out-
6 patient);

7 (3) how to properly refer patients to treatment;

8 (4) steps to aid in the prevention of the devel-
9 opment of eating disordered behaviors; and

10 (5) how to treat individuals with eating dis-
11 orders.

12 (b) APPLICATION.—An entity that desires a grant
13 under this section shall submit to the Secretary an appli-
14 cation at such time, in such manner, and containing such
15 information as the Secretary may require, including a plan
16 for the use of funds that may be awarded and an evalua-
17 tion of the training that will be provided.

18 (c) USE OF FUNDS.—An entity that receives a grant
19 under this section shall use the funds made available
20 through such grant to—

21 (1) use a training program containing evidence-
22 based findings, promising emerging best practices,
23 or recommendations that pertain to the identifica-
24 tion, early intervention, prevention of the develop-
25 ment of eating disordered behaviors, and treatment

1 of eating disorders to conduct educational training
2 and conferences, including Internet-based courses
3 and teleconferences, on—

4 (A) how to help prevent the development of
5 eating disordered behaviors, identify, intervene
6 early, and appropriately and adequately treat
7 eating disordered patients;

8 (B) how to identify individuals with eating
9 disorders, and those who are at risk for suf-
10 fering from eating disorders and, therefore, at
11 risk for related severe medical and mental
12 health conditions;

13 (C) how to conduct a comprehensive as-
14 sessment of individual and familial health risk
15 factors; and

16 (D) how to conduct a comprehensive as-
17 sessment of a treatment plan; and

18 (2) evaluate and report to the Secretary on the
19 effectiveness of the training provided by such entity
20 in increasing knowledge and changing attitudes and
21 behaviors of trainees.

22 (d) AUTHORIZATION OF APPROPRIATIONS.—There is
23 authorized to be appropriated to carry out this section
24 \$1,000,000 for each of the fiscal years 2016 through
25 2020.

1 **SEC. 512. PRIMARY AND BEHAVIORAL HEALTH CARE INTE-**
2 **GRATION GRANT PROGRAMS.**

3 Section 520K of the Public Health Service Act (42
4 U.S.C. 290bb–42) is amended to read as follows:

5 **“SEC. 520K. INTEGRATION INCENTIVE GRANTS.**

6 “(a) IN GENERAL.—The Secretary shall establish a
7 primary and behavioral health care integration grant pro-
8 gram. The Secretary may award grants and cooperative
9 agreements to eligible entities to expend funds for im-
10 provements in integrated settings with integrated prac-
11 tices.

12 “(b) DEFINITIONS.—In this section:

13 “(1) INTEGRATED CARE.—The term ‘integrated
14 care’ means full collaboration in merged or trans-
15 formed practices offering behavioral and physical
16 health services within the same shared practice
17 space in the same facility, where the entity—

18 “(A) provides services in a shared space
19 that ensures services will be available and ac-
20 cessible promptly and in a manner which pre-
21 serves human dignity and assures continuity of
22 care;

23 “(B) ensures communication among the in-
24 tegrated care team that is consistent and team-
25 based;

1 “(C) ensures shared decisionmaking be-
2 tween behavioral health and primary care pro-
3 viders;

4 “(D) provides evidence-based services in a
5 mode of service delivery appropriate for the tar-
6 get population;

7 “(E) employs staff who are multidisci-
8 plinary and culturally and linguistically com-
9 petent;

10 “(F) provides integrated services related to
11 screening, diagnosis, and treatment of mental
12 illness and substance use disorder and co-occur-
13 ring primary care conditions and chronic dis-
14 eases; and

15 “(G) provides targeted case management,
16 including services to assist individuals gaining
17 access to needed medical, social, educational,
18 and other services and applying for income se-
19 curity, housing, employment, and other benefits
20 to which they may be entitled.

21 “(2) INTEGRATED CARE TEAM.—The term ‘in-
22 tegrated care team’ means a team that includes—

23 “(A) allopathic or osteopathic medical doc-
24 tors, such as a primary care physician and a
25 psychiatrist;

1 “(B) licensed clinical behavioral health
2 professionals, such as psychologists or social
3 workers;

4 “(C) a case manager; and

5 “(D) other members, such as psychiatric
6 advanced practice nurses, physician assistants,
7 peer-support specialists or other allied health
8 professionals, such as mental health counselors.

9 “(3) SPECIAL POPULATION.—The term ‘special
10 population’ means—

11 “(A) adults with mental illnesses who have
12 co-occurring primary care conditions with
13 chronic diseases;

14 “(B) adults with serious mental illnesses
15 who have co-occurring primary care conditions
16 with chronic diseases;

17 “(C) children and adolescents with serious
18 emotional disorders with co-occurring primary
19 care conditions and chronic diseases;

20 “(D) older adults with mental illness who
21 have co-occurring primary care conditions with
22 chronic conditions;

23 “(E) individuals with substance use dis-
24 order; or

1 “(F) individuals from populations for
2 which there is a significant disparity in the
3 quality, outcomes, cost, or use of mental health
4 or substance use disorder services or a signifi-
5 cant disparity in access to such services, as
6 compared to the general population, such as ra-
7 cial and ethnic minorities and rural populations.

8 “(c) PURPOSE.—The grant program under this sec-
9 tion shall be designed to lead to full collaboration between
10 primary and behavioral health in an integrated practice
11 model to ensure that—

12 “(1) the overall wellness and physical health
13 status of individuals with serious mental illness and
14 co-occurring substance use disorders is supported
15 through integration of primary care into community
16 mental health centers meeting the criteria specified
17 in section 1913(c) of the Social Security Act or cer-
18 tified community behavioral health clinics described
19 in section 223 of the Protecting Access to Medicare
20 Act of 2014; or

21 “(2) the mental health status of individuals
22 with significant co-occurring psychiatric and physical
23 conditions will be supported through integration of
24 behavioral health into primary care settings.

1 “(d) ELIGIBLE ENTITIES.—To be eligible to receive
2 a grant or cooperative agreement under this section, an
3 entity shall be a State department of health, State mental
4 health or addiction agency, State Medicaid agency, or li-
5 censed health care provider or institution. The Adminis-
6 trator may give preference to States that have existing in-
7 tegrated care models, such as those authorized by section
8 1945 of the Social Security Act.

9 “(e) APPLICATION.—An eligible entity desiring a
10 grant or cooperative agreement under this section shall
11 submit an application to the Administrator at such time,
12 in such manner, and accompanied by such information as
13 the Administrator may require, including a description of
14 a plan to achieve fully collaborative agreements to provide
15 services to special populations and—

16 “(1) a document that summarizes the State-
17 specific policies that inhibit the provision of inte-
18 grated care, and the specific steps that will be taken
19 to address such barriers, such as through licensing
20 and billing procedures; and

21 “(2) a plan to develop and share a de-identified
22 patient registry to track treatment implementation
23 and clinical outcomes to inform clinical interven-
24 tions, patient education, and engagement with
25 merged or transformed integrated practices in com-

1 pliance with applicable national and State health in-
2 formation privacy laws.

3 “(f) GRANT AMOUNTS.—The maximum annual grant
4 amount under this section shall be \$2,000,000, of which
5 not more than 10 percent may be allocated to State ad-
6 ministrative functions, and the remaining amounts shall
7 be allocated to health facilities that provide integrated
8 care.

9 “(g) DURATION.—A grant under this section shall be
10 for a period of 5 years.

11 “(h) REPORT ON PROGRAM OUTCOMES.—An entity
12 receiving a grant or cooperative agreement under this sec-
13 tion shall submit an annual report to the Administrator
14 that includes—

15 “(1) the progress to reduce barriers to inte-
16 grated care, including regulatory and billing bar-
17 riers, as described in the entity’s application under
18 subsection (d); and

19 “(2) a description of functional outcomes of
20 special populations, such as—

21 “(A) with respect to individuals with seri-
22 ous mental illness, participation in supportive
23 housing or independent living programs, en-
24 gagement in social or education activities, par-
25 ticipation in job training or employment oppor-

1 tunities, attendance at scheduled medical and
2 mental health appointments, and compliance
3 with treatment plans;

4 “(B) with respect to individuals with co-oc-
5 curring mental illness and primary care condi-
6 tions and chronic diseases, attendance at sched-
7 uled medical and mental health appointments,
8 compliance with treatment plans, and participa-
9 tion in learning opportunities related to im-
10 proved health and lifestyle practice; and

11 “(C) with respect to children and adoles-
12 cents with serious emotional disorders who have
13 co-occurring primary care conditions and chron-
14 ic diseases, attendance at scheduled medical
15 and mental health appointments, compliance
16 with treatment plans, and participation in
17 learning opportunities at school and extra-
18 curricular activities.

19 “(i) TECHNICAL ASSISTANCE CENTER FOR PRIMARY-
20 BEHAVIORAL HEALTH CARE INTEGRATION.—

21 “(1) IN GENERAL.—The Secretary shall estab-
22 lish a program through which such Secretary shall
23 provide appropriate information, training, and tech-
24 nical assistance to eligible entities that receive a
25 grant or cooperative agreement under this section, in

1 order to help such entities to meet the requirements
2 of this section, including assistance with—

3 “(A) development and selection of inte-
4 grated care models;

5 “(B) dissemination of evidence-based inter-
6 ventions in integrated care;

7 “(C) establishment of organizational prac-
8 tices to support operational and administrative
9 success; and

10 “(D) other activities, as the Secretary de-
11 termines appropriate.

12 “(2) ADDITIONAL DISSEMINATION OF TECH-
13 NICAL INFORMATION.—The information and re-
14 sources provided by the technical assistance program
15 established under paragraph (1) shall be made avail-
16 able to States, political subdivisions of a State, In-
17 dian tribes or tribal organizations (as defined in sec-
18 tion 4 of the Indian Self-Determination and Edu-
19 cation Assistance Act), outpatient mental health and
20 addiction treatment centers, community mental
21 health centers that meet the criteria under section
22 1913(e), certified community behavioral health clin-
23 ics described in section 223 of the Protecting Access
24 to Medicare Act of 2014, primary care organizations
25 such as Federally qualified health centers or rural

1 health centers, other community-based organiza-
2 tions, or other entities engaging in integrated care
3 activities, as the Secretary determines appropriate.

4 “(j) AUTHORIZATION OF APPROPRIATIONS.—To
5 carry out this section, there are authorized to be appro-
6 priated \$50,000,000 for each of fiscal years 2016 through
7 2020, of which \$2,000,000 shall be available to the tech-
8 nical assistance program under subsection (i).”.

9 **SEC. 513. HEALTH PROFESSIONS COMPETENCIES TO AD-**
10 **DRESS RACIAL, ETHNIC, SEXUAL, AND GEN-**
11 **DER MINORITY BEHAVIORAL HEALTH DIS-**
12 **PARITIES.**

13 (a) IN GENERAL.—The Secretary of Health and
14 Human Services shall award grants to national organiza-
15 tions for the purpose of developing, and disseminating to
16 health professional educational programs, curricula or
17 core competencies addressing behavioral health disparities
18 among racial, ethnic, sexual, and gender minority groups.

19 (b) USE OF FUNDS.—Organizations receiving funds
20 under subsection (a) shall use the funds to develop and
21 disseminate curricula or core competencies, as described
22 in such subsection, for use in the training of students in
23 the professions of social work, psychology, psychiatry,
24 nursing, physician assistants, marriage and family ther-
25 apy, mental health counseling, substance abuse coun-

1 seling, or other mental health and substance use disorder
2 providers that the Secretary deems appropriate.

3 (c) ALLOWABLE ACTIVITIES.—Organizations receiv-
4 ing funds under subsection (a) may use the funds to en-
5 gage in the following activities related to the development
6 and dissemination of curricula or core competencies:

7 (1) Formation of committees or working groups
8 comprised of experts from accredited health profes-
9 sions schools to identify core competencies relating
10 to mental health disparities among racial and ethnic
11 minority groups.

12 (2) Planning of workshops in national fora to
13 allow for public input into the educational needs as-
14 sociated with mental health disparities among racial
15 and ethnic minority groups.

16 (3) Dissemination and promotion of the use of
17 curricula or core competencies in undergraduate and
18 graduate health professions training programs na-
19 tionwide.

20 (d) DEFINITIONS.—In this section, the term “racial
21 and ethnic minority group” has the meaning given to such
22 term in section 1707(g) of the Public Health Service Act
23 (42 U.S.C. 300u–6(g)).

1 (e) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 \$1,000,000 for each of fiscal years 2016 through 2020.

4 **SEC. 514. BEHAVIORAL HEALTH CRISIS SYSTEMS.**

5 (a) DEFINITIONS.—For purposes of this section, the
6 following definitions shall apply:

7 (1) ELIGIBLE ENTITY.—The term “eligible enti-
8 ty” means a State, political subdivision of a State,
9 or nonprofit private entity.

10 (2) SECRETARY.—The term “Secretary” means
11 the Secretary of Health and Human Services.

12 (3) STATE.—The term “State” means each
13 State of the United States, the District of Columbia,
14 each commonwealth, territory or possession of the
15 United States, and each federally recognized Indian
16 tribe.

17 (b) ESTABLISHMENT OF GRANT PROGRAM.—

18 (1) ESTABLISHMENT.—The Secretary shall es-
19 tablish a program to award grants to eligible entities
20 to establish and implement a system for preventing
21 and de-escalating behavioral health crises.

22 (2) USE OF FUNDS.—

23 (A) IN GENERAL.—Grants under this sec-
24 tion may be used to carry out programs that—

1 (i) expand early intervention and
2 treatment services to improve access to be-
3 havioral health crisis assistance and ad-
4 dress unmet behavioral health care needs;

5 (ii) expand the continuum of services
6 to address crisis prevention, crisis interven-
7 tion, and crisis stabilization; and

8 (iii) reduce unnecessary hospitaliza-
9 tions by appropriately utilizing community-
10 based services and improving access to
11 timely behavioral health crisis assistance.

12 (B) AUTHORIZED ACTIVITIES.—The pro-
13 grams described in subparagraph (A) may in-
14 clude activities such as:

15 (i) Mobile support or crisis support
16 centers that provide field-based behavioral
17 health assistance to individuals with men-
18 tal health or substance use disorders and
19 links such individuals in crisis to appro-
20 priate services.

21 (ii) School and community-based early
22 intervention and prevention programs that
23 provide mobile response, screening and as-
24 sessment, training and education, and
25 peer-based and family services.

1 (iii) Mental health crisis intervention
2 and response training for law enforcement
3 officers to increase officers' understanding
4 and recognition of mental illnesses as well
5 as increase their awareness of health care
6 services available to individuals in crisis.

7 (3) APPLICATION.—To be considered for a
8 grant under this section, an eligible entity shall sub-
9 mit an application to the Secretary at such time, in
10 such manner, and containing such information as
11 the Secretary may require. At minimum, such appli-
12 cation shall include a description of—

13 (A) the activities to be funded with the
14 grant;

15 (B) community needs;

16 (C) the population to be served; and

17 (D) the interaction between the activities
18 described in subparagraph (A) and public sys-
19 tems of health and mental health care, law en-
20 forcement, social services, and related assist-
21 ance programs.

22 (4) SELECTING AMONG APPLICANTS.—

23 (A) IN GENERAL.—Grants shall be award-
24 ed to eligible entities on a competitive basis.

1 (B) SELECTION CRITERIA.—The Secretary
2 shall evaluate applicants based on such criteria
3 as the Secretary determines to be appropriate,
4 including the ability of an applicant to carry
5 out the activities described in paragraph (2).

6 (5) REPORTS.—

7 (A) ANNUAL REPORTS.—

8 (i) ELIGIBLE ENTITIES.—As a condi-
9 tion of receiving a grant under this section,
10 an eligible entity shall agree to submit a
11 report to the Secretary, on an annual
12 basis, describing the activities carried out
13 with the grant and assessing the effective-
14 ness of such activities.

15 (ii) SECRETARY.—The Secretary
16 shall, on an annual basis, and using the re-
17 ports received under clause (i), report to
18 Congress on the overall impact and effec-
19 tiveness of the grant program under this
20 section.

21 (B) FINAL REPORT.—Not later than Janu-
22 ary 15, 2020, the Secretary shall submit to
23 Congress a final report that includes rec-
24 ommendations with respect to the feasibility
25 and advisability of extending or expanding the

1 grant program. The report shall also provide an
2 assessment of which systems and system ele-
3 ments proved most effective.

4 (6) COLLECTION OF DATA.—The Secretary
5 shall collect data on the grant program to determine
6 its effectiveness in reducing the social impact of
7 mental health crises and the feasibility and advis-
8 ability of extending the grant program.

9 (c) AUTHORIZATION OF APPROPRIATIONS.—There is
10 authorized to be appropriated to carry out this section
11 \$10,000,000 for each of fiscal years 2016 through 2020.

12 **SEC. 515. MENTAL HEALTH IN SCHOOLS.**

13 (a) TECHNICAL AMENDMENTS.—The second part G
14 (relating to services provided through religious organiza-
15 tions) of title V of the Public Health Service Act (42
16 U.S.C. 290kk et seq.) is amended—

17 (1) by redesignating such part as part J; and

18 (2) by redesignating sections 581 through 584
19 as sections 596 through 596C, respectively.

20 (b) SCHOOL-BASED MENTAL HEALTH AND CHIL-
21 DREN AND VIOLENCE.—Section 581 of the Public Health
22 Service Act (42 U.S.C. 290hh) is amended to read as fol-
23 lows:

1 **“SEC. 581. SCHOOL-BASED MENTAL HEALTH AND CHIL-**
2 **DREN AND VIOLENCE.**

3 “(a) IN GENERAL.—The Secretary, in collaboration
4 with the Secretary of Education and in consultation with
5 the Attorney General, shall, directly or through grants,
6 contracts, or cooperative agreements awarded to public en-
7 tities and local education agencies, assist local commu-
8 nities and schools in applying a public health approach
9 to mental health services both in schools and in the com-
10 munity. Such approach should provide comprehensive age
11 appropriate services and supports, be linguistically and
12 culturally appropriate, be trauma-informed, and incor-
13 porate age appropriate strategies of positive behavioral
14 interventions and supports. A comprehensive school men-
15 tal health program funded under this section shall assist
16 children in dealing with trauma and violence.

17 “(b) ACTIVITIES.—Under the program under sub-
18 section (a), the Secretary may—

19 “(1) provide financial support to enable local
20 communities to implement a comprehensive cul-
21 turally and linguistically appropriate, trauma-in-
22 formed, and age-appropriate, school mental health
23 program that incorporates positive behavioral inter-
24 ventions, client treatment, and supports to foster the
25 health and development of children;

1 “(2) provide technical assistance to local com-
2 munities with respect to the development of pro-
3 grams described in paragraph (1);

4 “(3) provide assistance to local communities in
5 the development of policies to address child and ado-
6 lescent trauma and mental health issues and violence
7 when and if it occurs;

8 “(4) facilitate community partnerships among
9 families, students, law enforcement agencies, edu-
10 cation systems, mental health and substance use dis-
11 order service systems, family-based mental health
12 service systems, welfare agencies, health care service
13 systems (including physicians), faith-based pro-
14 grams, trauma networks, and other community-
15 based systems; and

16 “(5) establish mechanisms for children and ado-
17 lescents to report incidents of violence or plans by
18 other children, adolescents, or adults to commit vio-
19 lence.

20 “(c) REQUIREMENTS.—

21 “(1) IN GENERAL.—To be eligible for a grant,
22 contract, or cooperative agreement under subsection
23 (a), an entity shall—

24 “(A) be a partnership between a local edu-
25 cation agency and at least one community pro-

1 gram or agency that is involved in mental
2 health; and

3 “(B) submit an application, that is en-
4 dorsed by all members of the partnership, that
5 contains the assurances described in paragraph
6 (2).

7 “(2) REQUIRED ASSURANCES.—An application
8 under paragraph (1) shall contain assurances as fol-
9 lows:

10 “(A) That the applicant will ensure that,
11 in carrying out activities under this section, the
12 local educational agency involved will enter into
13 a memorandum of understanding—

14 “(i) with, at least one, public or pri-
15 vate mental health entity, health care enti-
16 ty, law enforcement or juvenile justice enti-
17 ty, child welfare agency, family-based men-
18 tal health entity, family or family organiza-
19 tion, trauma network, or other community-
20 based entity; and

21 “(ii) that clearly states—

22 “(I) the responsibilities of each
23 partner with respect to the activities
24 to be carried out;

1 “(II) how each such partner will
2 be accountable for carrying out such
3 responsibilities; and

4 “(III) the amount of non-Federal
5 funding or in-kind contributions that
6 each such partner will contribute in
7 order to sustain the program.

8 “(B) That the comprehensive school-based
9 mental health program carried out under this
10 section supports the flexible use of funds to ad-
11 dress—

12 “(i) the promotion of the social, emo-
13 tional, and behavioral health of all students
14 in an environment that is conducive to
15 learning;

16 “(ii) the reduction in the likelihood of
17 at risk students developing social, emo-
18 tional, behavioral health problems, or sub-
19 stance use disorders;

20 “(iii) the early identification of social,
21 emotional, behavioral problems, or sub-
22 stance use disorders and the provision of
23 early intervention services;

24 “(iv) the treatment or referral for
25 treatment of students with existing social,

1 emotional, behavioral health problems, or
2 substance use disorders; and

3 “(v) the development and implementa-
4 tion of programs to assist children in deal-
5 ing with trauma and violence.

6 “(C) That the comprehensive school-based
7 mental health program carried out under this
8 section will provide for in-service training of all
9 school personnel, including ancillary staff and
10 volunteers, in—

11 “(i) the techniques and supports need-
12 ed to identify early children with trauma
13 histories and children with, or at risk of,
14 mental illness;

15 “(ii) the use of referral mechanisms
16 that effectively link such children to appro-
17 priate treatment and intervention services
18 in the school and in the community and to
19 follow-up when services are not available;

20 “(iii) strategies that promote a school-
21 wide positive environment;

22 “(iv) strategies for promoting the so-
23 cial, emotional, mental, and behavioral
24 health of all students; and

1 “(v) strategies to increase the knowl-
2 edge and skills of school and community
3 leaders about the impact of trauma and vi-
4 olence and on the application of a public
5 health approach to comprehensive school-
6 based mental health programs.

7 “(D) That the comprehensive school-based
8 mental health program carried out under this
9 section will include comprehensive training for
10 parents, siblings, and other family members of
11 children with mental health disorders, and for
12 concerned members of the community in—

13 “(i) the techniques and supports need-
14 ed to identify early children with trauma
15 histories, and children with, or at risk of,
16 mental illness;

17 “(ii) the use of referral mechanisms
18 that effectively link such children to appro-
19 priate treatment and intervention services
20 in the school and in the community and
21 follow-up when such services are not avail-
22 able; and

23 “(iii) strategies that promote a school-
24 wide positive environment.

1 “(E) That the comprehensive school-based
2 mental health program carried out under this
3 section will demonstrate the measures to be
4 taken to sustain the program after funding
5 under this section terminates.

6 “(F) That the local education agency part-
7 nership involved is supported by the State edu-
8 cational and mental health system to ensure
9 that the sustainability of the programs is estab-
10 lished after funding under this section termi-
11 nates.

12 “(G) That the comprehensive school-based
13 mental health program carried out under this
14 section will be based on trauma-informed and
15 evidence-based practices.

16 “(H) That the comprehensive school-based
17 mental health program carried out under this
18 section will be coordinated with early inter-
19 vening activities carried out under the Individ-
20 uals with Disabilities Education Act.

21 “(I) That the comprehensive school-based
22 mental health program carried out under this
23 section will be trauma-informed and culturally
24 and linguistically appropriate.

1 “(J) That the comprehensive school-based
2 mental health program carried out under this
3 section will include a broad needs assessment of
4 youth who drop out of school due to policies of
5 ‘zero tolerance’ with respect to drugs, alcohol,
6 or weapons and an inability to obtain appro-
7 priate services.

8 “(K) That the mental health services pro-
9 vided through the comprehensive school-based
10 mental health program carried out under this
11 section will be provided by qualified mental and
12 behavioral health professionals who are certified
13 or licensed by the State involved and practicing
14 within their area of expertise.

15 “(3) COORDINATOR.—Any entity that is a
16 member of a partnership described in paragraph
17 (1)(A) may serve as the coordinator of funding and
18 activities under the grant if all members of the part-
19 nership agree.

20 “(4) COMPLIANCE WITH HIPAA.—A grantee
21 under this section shall be deemed to be a covered
22 entity for purposes of compliance with the regula-
23 tions promulgated under section 264(c) of the
24 Health Insurance Portability and Accountability Act

1 of 1996 with respect to any patient records devel-
2 oped through activities under the grant.

3 “(d) GEOGRAPHICAL DISTRIBUTION.—The Secretary
4 shall ensure that grants, contracts, or cooperative agree-
5 ments under subsection (a) will be distributed equitably
6 among the regions of the country and among urban and
7 rural areas.

8 “(e) DURATION OF AWARDS.—With respect to a
9 grant, contract, or cooperative agreement under sub-
10 section (a), the period during which payments under such
11 an award will be made to the recipient shall be 5 years.
12 An entity may receive only one award under this section,
13 except that an entity that is providing services and sup-
14 ports on a regional basis may receive additional funding
15 after the expiration of the preceding grant period.

16 “(f) EVALUATION AND MEASURES OF OUTCOMES.—

17 “(1) DEVELOPMENT OF PROCESS.—The Ad-
18 ministrator shall develop a fiscally appropriate proc-
19 ess for evaluating activities carried out under this
20 section. Such process shall include—

21 “(A) the development of guidelines for the
22 submission of program data by grant, contract,
23 or cooperative agreement recipients;

24 “(B) the development of measures of out-
25 comes (in accordance with paragraph (2)) to be

1 applied by such recipients in evaluating pro-
2 grams carried out under this section; and

3 “(C) the submission of annual reports by
4 such recipients concerning the effectiveness of
5 programs carried out under this section.

6 “(2) MEASURES OF OUTCOMES.—

7 “(A) IN GENERAL.—The Administrator
8 shall develop measures of outcomes to be ap-
9 plied by recipients of assistance under this sec-
10 tion, and the Administrator, in evaluating the
11 effectiveness of programs carried out under this
12 section. Such measures shall include student
13 and family measures as provided for in sub-
14 paragraph (B) and local educational measures
15 as provided for under subparagraph (C).

16 “(B) STUDENT AND FAMILY MEASURES OF
17 OUTCOMES.—The measures of outcomes devel-
18 oped under paragraph (1)(B) relating to stu-
19 dents and families shall, with respect to activi-
20 ties carried out under a program under this
21 section, at a minimum include provisions to
22 evaluate whether the program is effective in—

23 “(i) increasing social and emotional
24 competency;

1 “(ii) increasing academic competency
2 (as defined by Secretary);

3 “(iii) reducing disruptive and aggres-
4 sive behaviors;

5 “(iv) improving child functioning;

6 “(v) reducing substance use disorders;

7 “(vi) reducing suspensions, truancy,
8 expulsions and violence;

9 “(vii) increasing graduation rates (as
10 defined in section 1111(b)(2)(C)(vi) of the
11 Elementary and Secondary Education Act
12 of 1965); and

13 “(viii) improving access to care for
14 mental health disorders.

15 “(C) LOCAL EDUCATIONAL OUTCOMES.—

16 The outcome measures developed under para-
17 graph (1)(B) relating to local educational sys-
18 tems shall, with respect to activities carried out
19 under a program under this section, at a min-
20 imum include provisions to evaluate—

21 “(i) the effectiveness of comprehensive
22 school mental health programs established
23 under this section;

24 “(ii) the effectiveness of formal part-
25 nership linkages among child and family

1 serving institutions, community support
2 systems, and the educational system;

3 “(iii) the progress made in sustaining
4 the program once funding under the grant
5 has expired;

6 “(iv) the effectiveness of training and
7 professional development programs for all
8 school personnel that incorporate indica-
9 tors that measure cultural and linguistic
10 competencies under the program in a man-
11 ner that incorporates appropriate cultural
12 and linguistic training;

13 “(v) the improvement in perception of
14 a safe and supportive learning environment
15 among school staff, students, and parents;

16 “(vi) the improvement in case-finding
17 of students in need of more intensive serv-
18 ices and referral of identified students to
19 early intervention and clinical services;

20 “(vii) the improvement in the imme-
21 diate availability of clinical assessment and
22 treatment services within the context of
23 the local community to students posing a
24 danger to themselves or others;

1 “(viii) the increased successful matric-
2 ulation to postsecondary school; and

3 “(ix) reduced referrals to juvenile jus-
4 tice.

5 “(3) SUBMISSION OF ANNUAL DATA.—An entity
6 that receives a grant, contract, or cooperative agree-
7 ment under this section shall annually submit to the
8 Administrator a report that includes data to evalu-
9 ate the success of the program carried out by the en-
10 tity based on whether such program is achieving the
11 purposes of the program. Such reports shall utilize
12 the measures of outcomes under paragraph (2) in a
13 reasonable manner to demonstrate the progress of
14 the program in achieving such purposes.

15 “(4) EVALUATION BY ADMINISTRATOR.—Based
16 on the data submitted under paragraph (3), the Ad-
17 ministrator shall annually submit to Congress a re-
18 port concerning the results and effectiveness of the
19 programs carried out with assistance received under
20 this section.

21 “(5) LIMITATION.—A grantee shall use not to
22 exceed 10 percent of amounts received under a grant
23 under this section to carry out evaluation activities
24 under this subsection.

1 “(g) INFORMATION AND EDUCATION.—The Sec-
2 retary shall establish comprehensive information and edu-
3 cation programs to disseminate the findings of the knowl-
4 edge development and application under this section to the
5 general public and to health care professionals.

6 “(h) AMOUNT OF GRANTS AND AUTHORIZATION OF
7 APPROPRIATIONS.—

8 “(1) AMOUNT OF GRANTS.—A grant under this
9 section shall be in an amount that is not more than
10 \$1,000,000 for each of fiscal years 2016 through
11 2020. The Secretary shall determine the amount of
12 each such grant based on the population of children
13 up to age 21 of the area to be served under the
14 grant.

15 “(2) AUTHORIZATION OF APPROPRIATIONS.—
16 There is authorized to be appropriated to carry out
17 this section, \$20,000,000 for each of fiscal years
18 2016 through 2020.”.

19 “(c) CONFORMING AMENDMENT.—Part G of title V of
20 the Public Health Service Act (42 U.S.C. 290hh et seq.),
21 as amended by this section, is further amended by striking
22 the part heading and inserting the following:

1 **“PART G—SCHOOL-BASED MENTAL HEALTH”.**

2 **SEC. 516. EXAMINING MENTAL HEALTH CARE FOR CHILDREN.**
3 **DREN.**

4 (a) **IN GENERAL.**—Not later than one year after the
5 date of enactment of this Act, the Comptroller General
6 of the United States shall conduct an independent evaluation,
7 and submit to the Committee on Health, Education,
8 Labor, and Pensions of the Senate and the Committee on
9 Energy and Commerce of the House of Representatives,
10 a report concerning the utilization of mental health services
11 for children, including the usage of psychotropic medications.
12

13 (b) **CONTENT.**—The report submitted under subsection
14 (a) shall review and assess—

15 (1) the ways in which children access mental
16 health care, including information on whether children
17 are screened and treated by primary care or specialty
18 physicians or other health care providers, what types of
19 referrals for additional care are recommended, and any
20 barriers to accessing this care;

21 (2) the extent to which children prescribed
22 psychotropic medications in the United States face
23 barriers to more comprehensive or other mental health
24 services, interventions, and treatments;

25 (3) the extent to which children are prescribed
26 psychotropic medications in the United States in-

1 including the frequency of concurrent medication
2 usage; and

3 (4) the tools, assessments, and medications that
4 are available and used to diagnose and treat children
5 with mental health disorders.

6 **SEC. 517. REPORTING COMPLIANCE STUDY.**

7 (a) IN GENERAL.—The Secretary of Health and
8 Human Services shall enter into an arrangement with the
9 Institute of Medicine of the National Academies (or, if the
10 Institute declines, another appropriate entity) under
11 which, not later than 2 years after the date of enactment
12 of this Act, the Institute will submit to the appropriate
13 committees of Congress a report that evaluates the com-
14 bined paperwork burden of—

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

20 (2) federally qualified community mental health
21 clinics certified pursuant to section 223 of the Pro-
22 tecting Access to Medicare Act of 2014 (Public Law
23 113–93), as amended by section 505.

24 (b) SCOPE.—In preparing the report under sub-
25 section (a), the Institute of Medicine (or, if applicable,

1 other appropriate entity) shall examine licensing, certifi-
2 cation, service definitions, claims payment, billing codes,
3 and financial auditing requirements used by the Office of
4 Management and Budget, the Centers for Medicare &
5 Medicaid Services, the Health Resources and Services Ad-
6 ministration, the Substance Abuse and Mental Health
7 Services Administration, the Office of the Inspector Gen-
8 eral of the Department of Health and Human Services,
9 State Medicaid agencies, State departments of health,
10 State departments of education, and State and local juve-
11 nile justice, social service agencies, and private insurers
12 to—

13 (1) establish an estimate of the combined na-
14 tionwide cost of complying with such requirements,
15 in terms of both administrative funding and staff
16 time;

17 (2) establish an estimate of the per capita cost
18 to each center or clinic described in subparagraph
19 (A) or (B) of paragraph (1) to comply with such re-
20 quirements, in terms of both administrative funding
21 and staff time; and

22 (3) make administrative and statutory rec-
23 ommendations to Congress (which recommendations
24 may include a uniform methodology) to reduce the
25 paperwork burden experienced by centers and clinics

1 described in subparagraph (A) or (B) of paragraph
2 (1).

3 **SEC. 518. STRENGTHENING CONNECTIONS TO COMMUNITY**
4 **CARE DEMONSTRATION GRANT PROGRAM.**

5 (a) IN GENERAL.—The Secretary of Health and
6 Human Services, acting through the Substance Abuse and
7 Mental Health Services Administration, shall establish a
8 demonstration grant program to award grants to eligible
9 entities to help to connect incarcerated and recently re-
10 leased individuals with mental illness or substance use dis-
11 orders with community-based treatment providers and
12 coverage opportunities upon release from a corrections fa-
13 cility.

14 (b) DESIGN.—The demonstration grant program
15 under this section shall be designed to ensure that incar-
16 cerated and recently released individuals with mental ill-
17 ness or substance use disorders have the information and
18 help they need to connect to community-based care and
19 coverage upon release from a corrections facility.

20 (c) RECIPIENTS.—To be eligible to receive a grant
21 under this section, an entity shall be a State Medicaid
22 agency, State mental health agency, State substance abuse
23 agency, county, city, nonprofit community-based organiza-
24 tion, or any other entity the Secretary deems appropriate.

1 (d) APPLICATION REQUIREMENT.—To seek an award
2 under this section, an applicant shall provide a plan detail-
3 ing the applicant’s strategy for carrying out the program
4 to be funded through the award.

5 (e) SPECIAL CONSIDERATIONS.—In awarding grants
6 under this section, the Secretary may consider—

7 (1) the number of individuals or correctional fa-
8 cilities proposed to be served; and

9 (2) the potential for replicability of the model
10 proposed.

11 (f) REPORTS.—

12 (1) ANNUAL REPORTS.—As a condition of re-
13 ceiving a grant under this section, an eligible entity
14 shall agree to submit a report to the Secretary, on
15 an annual basis, describing the activities carried out
16 with the grant and assessing the effectiveness of
17 such activities. Such information shall include—

18 (A) the number of individuals served with
19 mental illness, serious mental illness, substance
20 use disorders, or co-occurring mental health
21 and substance use disorders;

22 (B) the number of connections completed
23 between individuals and community-based pro-
24 viders;

1 (C) the number of connections completed
2 between individuals and community-based cov-
3 erage; and

4 (D) any other information required by the
5 Secretary.

6 (2) SECRETARY.—The Secretary shall, on an
7 annual basis, and using the reports received under
8 paragraph (1), report to Congress on the overall im-
9 pact and effectiveness of the grant program under
10 this section.

11 (3) FINAL REPORT.—Not later than January
12 15, 2020, the Secretary shall submit to Congress a
13 final report that includes recommendations with re-
14 spect to the feasibility and advisability of extending
15 or expanding the grant program under this section.
16 The report shall also provide an assessment of which
17 programs and program elements proved most effec-
18 tive.

19 (g) AUTHORIZATION OF APPROPRIATIONS.—To carry
20 out this section, there is authorized to be appropriated to
21 carry out this section \$5,000,000 for each of fiscal years
22 2016 through 2020.

1 **SEC. 519. ASSERTIVE COMMUNITY TREATMENT GRANT**
2 **PROGRAM FOR INDIVIDUALS WITH SERIOUS**
3 **MENTAL ILLNESS.**

4 (a) IN GENERAL.—The Secretary of Health and
5 Human Services, acting through the Substance Abuse and
6 Mental Health Services Administration, shall award
7 grants to eligible entities—

8 (1) to establish assertive community treatment
9 programs for individuals with serious mental illness;
10 or

11 (2) to maintain or expand such programs.

12 (b) ELIGIBLE ENTITIES.—To be eligible to receive a
13 grant under this section, an entity shall be a State, county,
14 city, tribes, tribal organizations, mental health system,
15 health care facility, or any other entity the Secretary
16 deems appropriate.

17 (c) SPECIAL CONSIDERATION.—In selecting among
18 applicants for a grant under this section, the Secretary
19 may give special consideration to the potential of the appli-
20 cant's program to reduce hospitalization, homelessness, in-
21 carceration, and interaction with the criminal justice sys-
22 tem while improving the health and social outcomes of the
23 patient.

24 (d) ADDITIONAL ACTIVITIES.—The Secretary shall—
25 (1) at the conclusion of each fiscal year, submit
26 a report to the appropriate congressional committees

1 on the grant program under this section, including
2 an evaluation of—

3 (A) cost savings and public health out-
4 comes such as mortality, suicide, substance
5 abuse, hospitalization, and use of services;

6 (B) rates of incarceration of patients;

7 (C) rates of homelessness among patients;

8 and

9 (D) patient and family satisfaction with
10 program participation; and

11 (2) provide appropriate information, training,
12 and technical assistance to grant recipients under
13 this section to help such recipients to establish,
14 maintain, or expand their assertive community treat-
15 ment programs.

16 (e) AUTHORIZATION OF APPROPRIATIONS.—

17 (1) IN GENERAL.—To carry out this section,
18 there is authorized to be appropriated \$20,000,000
19 for each of fiscal years 2016 through 2020.

20 (2) USE OF CERTAIN FUNDS.—Of the funds ap-
21 propriated to carry out this section in any fiscal
22 year, no more than 5 percent shall be available to
23 the Secretary for carrying out subsection (d).

1 **TITLE VI—IMPROVING MENTAL**
2 **HEALTH RESEARCH AND CO-**
3 **ORDINATION**

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

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

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

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

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

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

1 to reduce the risk of self harm, suicide,
2 and interpersonal violence; or
3 “(ii) brain research through the Brain
4 Research through Advancing Innovative
5 Neurotechnologies Initiative.”.

6 **TITLE VII—BEHAVIORAL**
7 **HEALTH INFORMATION TECH-**
8 **NOLOGY**

9 **SEC. 701. EXTENSION OF HEALTH INFORMATION TECH-**
10 **NOLOGY ASSISTANCE FOR BEHAVIORAL AND**
11 **MENTAL HEALTH AND SUBSTANCE ABUSE.**

12 Section 3000(3) of the Public Health Service Act (42
13 U.S.C. 300jj(3)) is amended by inserting before “and any
14 other category” the following: “behavioral and mental
15 health professionals (as defined in section
16 331(a)(3)(E)(i)), a substance abuse professional, a psy-
17 chiatric hospital (as defined in section 1861(f) of the So-
18 cial Security Act), a community mental health center
19 meeting the criteria specified in section 1913(c), a residen-
20 tial or outpatient mental health or substance use treat-
21 ment facility,”.

1 **SEC. 702. EXTENSION OF ELIGIBILITY FOR MEDICARE AND**
2 **MEDICAID HEALTH INFORMATION TECH-**
3 **NOLOGY IMPLEMENTATION ASSISTANCE.**

4 (a) PAYMENT INCENTIVES FOR ELIGIBLE PROFES-
5 SIONALS UNDER MEDICARE.—Section 1848 of the Social
6 Security Act (42 U.S.C. 1395w–4) is amended—

7 (1) in subsection (a)(7)—

8 (A) in subparagraph (E), by adding at the
9 end the following new clause:

10 “(iv) ADDITIONAL ELIGIBLE PROFES-
11 SIONAL.—The term ‘additional eligible pro-
12 fessional’ means a clinical psychologist pro-
13 viding qualified psychologist services (as
14 defined in section 1861(ii)).”; and

15 (B) by adding at the end the following new
16 subparagraph:

17 “(F) APPLICATION TO ADDITIONAL ELIGI-
18 BLE PROFESSIONALS.—The Secretary shall
19 apply the provisions of this paragraph with re-
20 spect to an additional eligible professional in
21 the same manner as such provisions apply to an
22 eligible professional, except in applying sub-
23 paragraph (A)—

24 “(i) in clause (i), the reference to
25 2015 shall be deemed a reference to 2020;

1 “(ii) in clause (ii), the references to
2 2015, 2016, and 2017 shall be deemed ref-
3 erences to 2020, 2021, and 2022, respec-
4 tively; and

5 “(iii) in clause (iii), the reference to
6 2018 shall be deemed a reference to
7 2023.”; and

8 (2) in subsection (o)—

9 (A) in paragraph (5), by adding at the end
10 the following new subparagraph:

11 “(D) ADDITIONAL ELIGIBLE PROFES-
12 SIONAL.—The term ‘additional eligible profes-
13 sional’ means a clinical psychologist providing
14 qualified psychologist services (as defined in
15 section 1861(ii)).”; and

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

18 “(6) APPLICATION TO ADDITIONAL ELIGIBLE
19 PROFESSIONALS.—The Secretary shall apply the
20 provisions of this subsection with respect to an addi-
21 tional eligible professional in the same manner as
22 such provisions apply to an eligible professional, ex-
23 cept in applying—

24 “(A) paragraph (1)(A)(ii), the reference to
25 2016 shall be deemed a reference to 2021;

1 “(B) paragraph (1)(B)(ii), the references
2 to 2011 and 2012 shall be deemed references to
3 2016 and 2017, respectively;

4 “(C) paragraph (1)(B)(iii), the references
5 to 2013 shall be deemed references to 2018;

6 “(D) paragraph (1)(B)(v), the references
7 to 2014 shall be deemed references to 2019;
8 and

9 “(E) paragraph (1)(E), the reference to
10 2011 shall be deemed a reference to 2016.”.

11 (b) ELIGIBLE HOSPITALS.—Section 1886 of the So-
12 cial Security Act (42 U.S.C. 1395ww) is amended—

13 (1) in subsection (b)(3)(B)(ix), by adding at the
14 end the following new subclause:

15 “(V) The Secretary shall apply
16 the provisions of this subsection with
17 respect to an additional eligible hos-
18 pital (as defined in subsection
19 (n)(6)(C)) in the same manner as
20 such provisions apply to an eligible
21 hospital, except in applying—

22 “(aa) subclause (I), the ref-
23 erences to 2015, 2016, and 2017
24 shall be deemed references to

1 2020, 2021, and 2022, respec-
2 tively; and

3 “(bb) subclause (III), the
4 reference to 2015 shall be
5 deemed a reference to 2020.”;
6 and

7 (2) in subsection (n)—

8 (A) in paragraph (6), by adding at the end
9 the following new subparagraph:

10 “(C) ADDITIONAL ELIGIBLE HOSPITAL.—
11 The term ‘additional eligible hospital’ means an
12 inpatient hospital that is a psychiatric hospital
13 (as defined in section 1861(f)).”; and

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

16 “(7) APPLICATION TO ADDITIONAL ELIGIBLE
17 HOSPITALS.—The Secretary shall apply the provi-
18 sions of this subsection with respect to an additional
19 eligible hospital in the same manner as such provi-
20 sions apply to an eligible hospital, except in apply-
21 ing—

22 “(A) paragraph (2)(E)(ii), the references
23 to 2013 and 2015 shall be deemed references to
24 2018 and 2020, respectively; and

1 “(B) paragraph (2)(G)(i), the reference to
2 2011 shall be deemed a reference to 2016.”.

3 (c) MEDICAID PROVIDERS.—Section 1903(t) of the
4 Social Security Act (42 U.S.C. 1396b(t)) is amended—

5 (1) in paragraph (2)(B)—

6 (A) in clause (i), by striking “, or” at the
7 end and inserting a semicolon;

8 (B) in clause (ii), by striking the period at
9 the end and inserting a semicolon; and

10 (C) by inserting after clause (ii) the fol-
11 lowing new clauses:

12 “(iii) a public hospital that is principally a
13 psychiatric hospital (as defined in section
14 1861(f));

15 “(iv) a private hospital that is principally
16 a psychiatric hospital (as defined in section
17 1861(f)) and that has at least 10 percent of its
18 patient volume (as estimated in accordance with
19 a methodology established by the Secretary) at-
20 tributable to individuals receiving medical as-
21 sistance under this title;

22 “(v) a community mental health center
23 meeting the criteria specified in section 1913(c)
24 of the Public Health Service Act; or

1 “(vi) a residential or outpatient mental
2 health or substance use treatment facility
3 that—

4 “(I) is accredited by the Joint Com-
5 mission on Accreditation of Healthcare Or-
6 ganizations, the Commission on Accredita-
7 tion of Rehabilitation Facilities, the Coun-
8 cil on Accreditation, or any other national
9 accrediting agency recognized by the Sec-
10 retary; and

11 “(II) has at least 10 percent of its pa-
12 tient volume (as estimated in accordance
13 with a methodology established by the Sec-
14 retary) attributable to individuals receiving
15 medical assistance under this title.”; and

16 (2) in paragraph (3)(B)—

17 (A) in clause (iv), by striking “; and” at
18 the end and inserting a semicolon;

19 (B) in clause (v), by striking the period at
20 the end and inserting “; and”; and

21 (C) by adding at the end the following new
22 clause:

23 “(vi) clinical psychologist providing quali-
24 fied psychologist services (as defined in section

1 1861(ii)), if such clinical psychologist is prac-
2 ticing in an outpatient clinic that—

3 “(I) is led by a clinical psychologist;

4 and

5 “(II) is not otherwise receiving pay-
6 ment under paragraph (1) as a Medicaid
7 provider described in paragraph (2)(B).”.

8 (d) **MEDICARE ADVANTAGE ORGANIZATIONS.**—Sec-
9 tion 1853 of the Social Security Act (42 U.S.C. 1395w-
10 23) is amended—

11 (1) in subsection (l)—

12 (A) in paragraph (1)—

13 (i) by inserting “or additional eligible
14 professionals (as described in paragraph
15 (9))” after “paragraph (2)”; and

16 (ii) by inserting “and additional eligi-
17 ble professionals” before “under such sec-
18 tions”;

19 (B) in paragraph (3)(B)—

20 (i) in clause (i) in the matter pre-
21 ceding subclause (I), by inserting “or an
22 additional eligible professional described in
23 paragraph (9)” after “paragraph (2)”; and

24 (ii) in clause (ii)—

1 (I) in the matter preceding sub-
2 clause (I), by inserting “or an addi-
3 tional eligible professional described in
4 paragraph (9)” after “paragraph
5 (2)”; and

6 (II) in subclause (I), by inserting
7 “or an additional eligible professional,
8 respectively,” after “eligible profes-
9 sional”;

10 (C) in paragraph (3)(C), by inserting “and
11 additional eligible professionals” after “all eligi-
12 ble professionals”;

13 (D) in paragraph (4)(D), by adding at the
14 end the following new sentence: “In the case
15 that a qualifying MA organization attests that
16 not all additional eligible professionals of the
17 organization are meaningful EHR users with
18 respect to an applicable year, the Secretary
19 shall apply the payment adjustment under this
20 paragraph based on the proportion of all such
21 additional eligible professionals of the organiza-
22 tion that are not meaningful EHR users for
23 such year.”;

24 (E) in paragraph (6)(A), by inserting
25 “and, as applicable, each additional eligible pro-

1 fessional described in paragraph (9)” after
2 “paragraph (2)”;

3 (F) in paragraph (6)(B), by inserting
4 “and, as applicable, each additional eligible hos-
5 pital described in paragraph (9)” after “sub-
6 section (m)(1)”;

7 (G) in paragraph (7)(A), by inserting
8 “and, as applicable, additional eligible profes-
9 sionals” after “eligible professionals”;

10 (H) in paragraph (7)(B), by inserting
11 “and, as applicable, additional eligible profes-
12 sionals” after “eligible professionals”;

13 (I) in paragraph (8)(B), by inserting “and
14 additional eligible professionals described in
15 paragraph (9)” after “paragraph (2)”;

16 (J) by adding at the end the following new
17 paragraph:

18 “(9) ADDITIONAL ELIGIBLE PROFESSIONAL DE-
19 SCRIBED.—With respect to a qualifying MA organi-
20 zation, an additional eligible professional described
21 in this paragraph is an additional eligible profes-
22 sional (as defined for purposes of section 1848(o))
23 who—

24 “(A)(i) is employed by the organization; or

1 “(ii)(I) is employed by, or is a partner of,
2 an entity that through contract with the organi-
3 zation furnishes at least 80 percent of the enti-
4 ty’s Medicare patient care services to enrollees
5 of such organization; and

6 “(II) furnishes at least 80 percent of the
7 professional services of the additional eligible
8 professional covered under this title to enrollees
9 of the organization; and

10 “(B) furnishes, on average, at least 20
11 hours per week of patient care services.”; and
12 (2) in subsection (m)—

13 (A) in paragraph (1)—

14 (i) by inserting “or additional eligible
15 hospitals (as described in paragraph (7))”
16 after “paragraph (2)”; and

17 (ii) by inserting “and additional eligi-
18 ble hospitals” before “under such sec-
19 tions”;

20 (B) in paragraph (3)(A)(i), by inserting
21 “or additional eligible hospital” after “eligible
22 hospital”;

23 (C) in paragraph (3)(A)(ii), by inserting
24 “or an additional eligible hospital” after “eligi-
25 ble hospital” in each place it occurs;

1 (D) in paragraph (3)(B)—

2 (i) in clause (i), by inserting “or an
3 additional eligible hospital described in
4 paragraph (7)” after “paragraph (2)”; and

5 (ii) in clause (ii)—

6 (I) in the matter preceding sub-
7 clause (I), by inserting “or an addi-
8 tional eligible hospital described in
9 paragraph (7)” after “paragraph
10 (2)”; and

11 (II) in subclause (I), by inserting
12 “or an additional eligible hospital, re-
13 spectively,” after “eligible hospital”;

14 (E) in paragraph (4)(A), by inserting “or
15 one or more additional eligible hospitals (as de-
16 fined in section 1886(n)), as appropriate,” after
17 “section 1886(n)(6)(A)”;

18 (F) in paragraph (4)(D), by adding at the
19 end the following new sentence: “In the case
20 that a qualifying MA organization attests that
21 not all additional eligible hospitals of the orga-
22 nization are meaningful EHR users with re-
23 spect to an applicable period, the Secretary
24 shall apply the payment adjustment under this
25 paragraph based on the methodology specified

1 by the Secretary, taking into account the pro-
2 portion of such additional eligible hospitals, or
3 discharges from such hospitals, that are not
4 meaningful EHR users for such period.”;

5 (G) in paragraph (5)(A), by inserting
6 “and, as applicable, each additional eligible hos-
7 pital described in paragraph (7)” after “para-
8 graph (2)”;

9 (H) in paragraph (5)(B), by inserting
10 “and additional eligible hospitals, as applica-
11 ble,” after “eligible hospitals”;

12 (I) in paragraph (6)(B), by inserting “and
13 additional eligible hospitals described in para-
14 graph (7)” after “paragraph (2)”; and

15 (J) by adding at the end the following new
16 paragraph:

17 “(7) ADDITIONAL ELIGIBLE HOSPITAL DE-
18 SCRIBED.—With respect to a qualifying MA organi-
19 zation, an additional eligible hospital described in
20 this paragraph is an additional eligible hospital (as
21 defined in section 1886(n)(6)(C)) that is under com-
22 mon corporate governance with such organization
23 and serves individuals enrolled under an MA plan of-
24 fered by such organization.”.

1 **TITLE VIII—MAKING PARITY**
2 **WORK**

3 **SEC. 801. STRENGTHENING PARITY IN MENTAL HEALTH**
4 **AND SUBSTANCE USE DISORDER BENEFITS.**

5 (a) PUBLIC HEALTH SERVICE ACT.—Section
6 2726(a) of the Public Health Service Act (42 U.S.C.
7 300gg–26(a)) is amended by adding at the end the fol-
8 lowing new paragraphs:

9 “(6) DISCLOSURE AND ENFORCEMENT RE-
10 QUIREMENTS.—

11 “(A) DISCLOSURE REQUIREMENTS.—

12 “(i) REGULATIONS.—Not later than
13 December 31, 2016, the Secretary, in co-
14 operation with the Secretaries of Labor
15 and Treasury, as appropriate, shall issue
16 additional regulations for carrying out this
17 section, including an explanation of docu-
18 ments that must be disclosed by plans and
19 issuers, the process governing such disclo-
20 sures by plans and issuers, and analyses
21 that must be conducted by plans and
22 issuers by a group health plan or health in-
23 surance issuer offering health insurance
24 coverage in the group or individual market
25 in order for such plan or issuer to dem-

1 onstrate compliance with the provisions of
2 this section.

3 “(ii) DISCLOSURE REQUIREMENTS.—
4 Documents required to be disclosed by a
5 group health plan or health insurance
6 issuer offering health insurance coverage in
7 the group or individual market under
8 clause (i) shall include an annual report
9 that details the specific analyses performed
10 to ensure compliance of such plan or cov-
11 erage with the law and regulations. At a
12 minimum, with respect to the application
13 of non-quantitative treatment limitations
14 (in this paragraph referred to as NQTLs)
15 to benefits under the plan or coverage,
16 such report shall—

17 “(I) identify the specific factors
18 the plan or coverage used in per-
19 forming its NQTL analysis;

20 “(II) identify and define the spe-
21 cific evidentiary standards relied on to
22 evaluate the factors;

23 “(III) describe how the evi-
24 dentiary standards are applied to each
25 service category for mental health,

1 substance use disorders, medical bene-
2 fits, and surgical benefits;

3 “(IV) disclose the results of the
4 analyses of the specific evidentiary
5 standards in each service category;
6 and

7 “(V) disclose the specific findings
8 of the plan or coverage in each service
9 category and the conclusions reached
10 with respect to whether the processes,
11 strategies, evidentiary standards, or
12 other factors used in applying the
13 NQTL to mental health or substance
14 use disorder benefits are comparable
15 to, and applied no more stringently
16 than, the processes, strategies, evi-
17 dentiary standards, or other factors
18 used in applying the limitation with
19 respect to medical and surgical bene-
20 fits in the same classification

21 “(iii) GUIDANCE.—The Secretary, in
22 cooperation with the Secretaries of Labor
23 and Treasury, as appropriate, shall issue
24 guidance to group health plans and health
25 insurance issuers offering health insurance

1 coverage in the group or individual mar-
2 kets on how to satisfy the requirements of
3 this section with respect to making infor-
4 mation available to current and potential
5 participants and beneficiaries. Such infor-
6 mation shall include certificate of coverage
7 documents and instruments under which
8 the plan or coverage involved is adminis-
9 tered and operated that specify, include, or
10 refer to procedures, formulas, and meth-
11 odologies applied to determine a partici-
12 pant or beneficiary's benefit under the plan
13 or coverage, regardless of whether such in-
14 formation is contained in a document des-
15 ignated as the 'plan document'. Such guid-
16 ance shall include a disclosure of how the
17 plan or coverage involved has provided that
18 processes, strategies, evidentiary stand-
19 ards, and other factors used in applying
20 the NQTL to mental health or substance
21 use disorder benefits are comparable to,
22 and applied no more stringently than, the
23 processes, strategies, evidentiary stand-
24 ards, or other factors used in applying the

1 limitation with respect to medical and sur-
2 gical benefits in the same classification.

3 “(iv) DEFINITIONS.—In this para-
4 graph and paragraph (7), the terms ‘non-
5 quantitative treatment limitations’, ‘com-
6 parable to’, and ‘applied no more strin-
7 gently than’ have the meanings given such
8 terms in sections 146 and 147 of title 45,
9 Code of Federal Regulations (or any suc-
10 cessor regulation).

11 “(B) ENFORCEMENT.—

12 “(i) PROCESS FOR COMPLAINTS.—The
13 Secretary, in cooperation with the Secre-
14 taries of Labor and Treasury, as appro-
15 priate, shall, with respect to group health
16 plans and health insurance issuers offering
17 health insurance coverage in the group or
18 individual market, issue guidance to clarify
19 the process and timeline for current and
20 potential participants and beneficiaries
21 (and authorized representatives and health
22 care providers of such participants and
23 beneficiaries) with respect to such plans
24 and coverage to file formal complaints of
25 such plans or issuers being in violation of

1 this section, including guidance, by plan
2 type, on the relevant State, regional, and
3 national offices with which such complaints
4 should be filed.

5 “(ii) AUTHORITY FOR PUBLIC EN-
6 FORCEMENT.—The Secretary, in consulta-
7 tion with the Secretaries of Labor and
8 Treasury, shall make available to the pub-
9 lic on the Consumer Parity Portal website
10 established under paragraph (7) de-identi-
11 fied information on audits and investiga-
12 tions of group health plans and health in-
13 surance issuers conducted under this sec-
14 tion.

15 “(iii) AUDITS.—

16 “(I) RANDOMIZED AUDITS.—The
17 Secretary in cooperation with the Sec-
18 retaries of Labor and Treasury, is au-
19 thorized to conduct randomized audits
20 of group health plans and health in-
21 surance issuers offering health insur-
22 ance coverage in the group or indi-
23 vidual market to determine compli-
24 ance with this section. Such audits
25 shall be conducted on no fewer than

1 twelve plans and issuers per plan
2 year. Information from such audits
3 shall be made plainly available on the
4 Consumer Parity Portal website es-
5 tablished under paragraph (7).

6 “(II) ADDITIONAL AUDITS.—In
7 the case of a group health plan or
8 health insurance issuer offering health
9 insurance coverage in the group or in-
10 dividual market with respect to which
11 any claim has been filed during a plan
12 year, the Secretary may audit the
13 books and records of such plan or
14 issuer to determine compliance with
15 this section. Information detailing the
16 results of the audit shall be made
17 available on the Consumer Parity Por-
18 tal website established under para-
19 graph (7).

20 “(iv) DENIAL RATES.—The Secretary
21 shall collect information on the rates of
22 and reasons for denial by group health
23 plans and health insurance issuers offering
24 health insurance coverage in the group or
25 individual market of claims for outpatient

1 and inpatient mental health and substance
2 use disorder services compared to the rates
3 of and reasons for denial of claims for
4 medical and surgical services. For the first
5 plan year beginning at least two years
6 after the date of the enactment of this
7 paragraph and each subsequent plan year,
8 the Secretary shall submit to the Energy
9 and Commerce Committee of the House of
10 Representatives and the Committee on
11 Health, Education, Labor, and Pensions of
12 the Senate, and make plainly available on
13 the Consumer Parity Portal website under
14 paragraph (7), the information collected
15 under the previous sentence with respect to
16 the previous plan year.

17 “(7) CONSUMER PARITY PORTAL WEBSITE.—
18 The Secretary, in consultation with the Secretaries
19 of Labor and Treasury, shall establish a one-stop
20 Internet website portal for—

21 “(A) submitting complaints and violations
22 relating to this section, section 712 of the Em-
23 ployee Retirement Income Security Act of 1974,
24 and section 9812 of the Internal Revenue Code
25 of 1986; and

1 “(B) for each of such Secretaries to submit
2 information in order to provide such informa-
3 tion to health care consumers pursuant to para-
4 graph (6), section 712(a)(6) of the Employee
5 Retirement Income Security Act of 1974, and
6 section 9812(a)(6) of the Internal Revenue
7 Code of 1986.

8 Such portal shall have the ability to take basic infor-
9 mation related to the complaint, including name,
10 contact information, and brief narrative, and trans-
11 mit such information in a timely fashion to the ap-
12 propriate State or Federal enforcement agency. Once
13 the consumer information is submitted, such portal
14 shall provide the consumer with contact information
15 for the appropriate enforcement agency to follow-up
16 on the complaint.”.

17 (b) EMPLOYEE RETIREMENT INCOME SECURITY ACT
18 OF 1974.—Section 712(a) of the Employee Retirement In-
19 come Security Act of 1974 (29 U.S.C. 1185a(a)) is
20 amended by adding at the end the following new para-
21 graph:

22 “(6) DISCLOSURE AND ENFORCEMENT RE-
23 QUIREMENTS.—

24 “(A) DISCLOSURE REQUIREMENTS.—

1 “(i) REGULATIONS.—Not later than
2 December 31, 2016, the Secretary, in co-
3 operation with the Secretaries of Health
4 and Human Services and Treasury, as ap-
5 propriate, shall issue additional regulations
6 for carrying out this section, including an
7 explanation of documents that must be dis-
8 closed by plans and issuers, the process
9 governing such disclosures by plans and
10 issuers, and analyses that must be con-
11 ducted by plans and issuers by a group
12 health plan (or health insurance coverage
13 offered in connection with such a plan) in
14 order for such plan or issuer to dem-
15 onstrate compliance with the provisions of
16 this section.

17 “(ii) DISCLOSURE REQUIREMENTS.—
18 Documents required to be disclosed by a
19 group health plan (or health insurance cov-
20 erage offered in connection with such a
21 plan) under clause (i) shall include an an-
22 nual report that details the specific anal-
23 yses performed to ensure compliance of
24 such plan or coverage with the law or regu-
25 lations. At a minimum, with respect to the

1 application of non-quantitative treatment
2 limitations (in this paragraph referred to
3 as NQTLs) to benefits under the plan or
4 coverage, such report shall—

5 “(I) identify the specific factors
6 the plan or coverage used in per-
7 forming its NQTL analysis;

8 “(II) identify and define the spe-
9 cific evidentiary standards relied on to
10 evaluate the factors;

11 “(III) describe how the evi-
12 dentiary standards are applied to each
13 service category for mental health,
14 substance use disorders, medical bene-
15 fits, and surgical benefits;

16 “(IV) disclose the results of the
17 analyses of the specific evidentiary
18 standards in each service category;
19 and

20 “(V) disclose the specific findings
21 of the plan or coverage in each service
22 category and the conclusions reached
23 with respect to whether the processes,
24 strategies, evidentiary standards, or
25 other factors used in applying the

1 NQTL to mental health or substance
2 use disorder benefits are comparable
3 to, and applied no more stringently
4 than, the processes, strategies, evi-
5 dentiary standards, or other factors
6 used in applying the limitation with
7 respect to medical and surgical bene-
8 fits in the same classification

9 “(iii) GUIDANCE.—The Secretary, in
10 cooperation with the Secretaries of Health
11 and Human Services and Treasury, as ap-
12 propriate, shall issue guidance to group
13 health plans (and health insurance cov-
14 erage offered in connection with such a
15 plan) on how to satisfy the requirements of
16 this section with respect to making infor-
17 mation available to current and potential
18 participants and beneficiaries. Such infor-
19 mation shall include certificate of coverage
20 documents and instruments under which
21 the plan or coverage involved is adminis-
22 tered and operated that specify, include, or
23 refer to procedures, formulas, and meth-
24 odologies applied to determine a partici-
25 pant or beneficiary’s benefit under the plan

1 or coverage, regardless of whether such in-
2 formation is contained in a document des-
3 ignated as the ‘plan document’. Such guid-
4 ance shall include a disclosure of how the
5 plan or coverage involved has provided that
6 processes, strategies, evidentiary stand-
7 ards, and other factors used in applying
8 the NQTL to mental health or substance
9 use disorder benefits are comparable to,
10 and applied no more stringently than, the
11 processes, strategies, evidentiary stand-
12 ards, or other factors used in applying the
13 limitation with respect to medical and sur-
14 gical benefits in the same classification.

15 “(iv) DEFINITIONS.—In this para-
16 graph, the terms ‘non-quantitative treat-
17 ment limitations’, ‘comparable to’, and ‘ap-
18 plied no more stringently than’ have the
19 meanings given such terms in sections 146
20 and 147 of title 45, Code of Federal Regu-
21 lations (or any successor regulation).

22 “(B) ENFORCEMENT.—

23 “(i) PROCESS FOR COMPLAINTS.—The
24 Secretary, in cooperation with the Secre-
25 taries of Health and Human Services and

1 Treasury, as appropriate, shall, with re-
2 spect to group health plans (and health in-
3 surance coverage offered in connection
4 with such a plan), issue guidance to clarify
5 the process and timeline for current and
6 potential participants and beneficiaries
7 (and authorized representatives and health
8 care providers of such participants and
9 beneficiaries) with respect to such plans
10 (and coverage) to file formal complaints of
11 such plans (or coverage) being in violation
12 of this section, including guidance, by plan
13 type, on the relevant State, regional, and
14 national offices with which such complaints
15 should be filed.

16 “(ii) AUTHORITY FOR PUBLIC EN-
17 FORCEMENT.—The Secretary, in consulta-
18 tion with the Secretaries of Labor and
19 Treasury, shall make available to the pub-
20 lic on the Consumer Parity Portal website
21 established under section 2726(a)(7) of the
22 Public Health Service Act de-identified in-
23 formation on audits and investigations of
24 group health plans (and health insurance

1 coverage offered in connection with such a
2 plan) conducted under this section.

3 “(iii) AUDITS.—

4 “(I) RANDOMIZED AUDITS.—The
5 Secretary in cooperation with the Sec-
6 retaries of Health and Human Serv-
7 ices and Treasury, is authorized to
8 conduct randomized audits of group
9 health plans (and health insurance
10 coverage offered in connection with
11 such a plan) to determine compliance
12 with this section. Such audits shall be
13 conducted on no fewer than twelve
14 plans and coverage per plan year. In-
15 formation from such audits shall be
16 made plainly available on the Con-
17 sumer Parity Portal website estab-
18 lished under section 2726(a)(7) of the
19 Public Health Service Act.

20 “(II) ADDITIONAL AUDITS.—In
21 the case of a group health plan (or
22 health insurance coverage offered in
23 connection with such a plan) with re-
24 spect to which any claim has been
25 filed during a plan year, the Secretary

1 may audit the books and records of
2 such plan (or coverage) to determine
3 compliance with this section. Informa-
4 tion detailing the results of the audit
5 shall be made available on the Con-
6 sumer Parity Portal website estab-
7 lished under section 2726(a)(7) of the
8 Public Health Service Act.

9 “(iv) DENIAL RATES.—The Secretary
10 shall collect information on the rates of
11 and reasons for denial by group health
12 plans (and health insurance coverage of-
13 fered in connection with such a plan) of
14 claims for outpatient and inpatient mental
15 health and substance use disorder services
16 compared to the rates of and reasons for
17 denial of claims for medical and surgical
18 services. For the first plan year beginning
19 at least two years after the date of the en-
20 actment of this paragraph and each subse-
21 quent plan year, the Secretary shall submit
22 to the Energy and Commerce Committee
23 of the House of Representatives and the
24 Committee on Health, Education, Labor,
25 and Pensions of the Senate, and make

1 plainly available on the Consumer Parity
2 Portal website under section 2726(a)(7) of
3 the Public Health Service Act, the infor-
4 mation collected under the previous sen-
5 tence with respect to the previous plan
6 year.”.

7 (c) INTERNAL REVENUE CODE OF 1986.—Section
8 9812(a) of the Internal Revenue Code of 1986 is amended
9 by adding at the end the following new paragraph:

10 “(6) DISCLOSURE AND ENFORCEMENT RE-
11 QUIREMENTS.—

12 “(A) DISCLOSURE REQUIREMENTS.—

13 “(i) REGULATIONS.—Not later than
14 December 31, 2016, the Secretary, in co-
15 operation with the Secretaries of Health
16 and Human Services and Labor, as appro-
17 priate, shall issue additional regulations for
18 carrying out this section, including an ex-
19 planation of documents that must be dis-
20 closed by plans and issuers, the process
21 governing such disclosures by plans and
22 issuers, and analyses that must be con-
23 ducted by plans and issuers by a group
24 health plan in order for such plan to dem-

1 onstrate compliance with the provisions of
2 this section.

3 “(ii) DISCLOSURE REQUIREMENTS.—
4 Documents required to be disclosed by a
5 group health plan under clause (i) shall in-
6 clude an annual report that details the spe-
7 cific analyses performed to ensure compli-
8 ance of such plan with the law and regula-
9 tions. At a minimum, with respect to the
10 application of non-quantitative treatment
11 limitations (in this paragraph referred to
12 as NQTLs) to benefits under the plan or
13 coverage, such report shall—

14 “(I) identify the specific factors
15 the plan or coverage used in per-
16 forming its NQTL analysis;

17 “(II) identify and define the spe-
18 cific evidentiary standards relied on to
19 evaluate the factors;

20 “(III) describe how the evi-
21 dentiary standards are applied to each
22 service category for mental health,
23 substance use disorders, medical bene-
24 fits, and surgical benefits;

1 “(IV) disclose the results of the
2 analyses of the specific evidentiary
3 standards in each service category;
4 and

5 “(V) disclose the specific findings
6 of the plan in each service category
7 and the conclusions reached with re-
8 spect to whether the processes, strate-
9 gies, evidentiary standards, or other
10 factors used in applying the NQTL to
11 mental health or substance use dis-
12 order benefits are comparable to, and
13 applied no more stringently than, the
14 processes, strategies, evidentiary
15 standards, or other factors used in ap-
16 plying the limitation with respect to
17 medical and surgical benefits in the
18 same classification

19 “(iii) GUIDANCE.—The Secretary, in
20 cooperation with the Secretaries of Health
21 and Human Services and Labor, as appro-
22 priate, shall issue guidance to group health
23 plans on how to satisfy the requirements of
24 this section with respect to making infor-
25 mation available to current and potential

1 participants and beneficiaries. Such infor-
2 mation shall include certificate of coverage
3 documents and instruments under which
4 the plan involved is administered and oper-
5 ated that specify, include, or refer to pro-
6 cedures, formulas, and methodologies ap-
7 plied to determine a participant or bene-
8 ficiary's benefit under the plan, regardless
9 of whether such information is contained
10 in a document designated as the 'plan doc-
11 ument'. Such guidance shall include a dis-
12 closure of how the plan involved has pro-
13 vided that processes, strategies, evidentiary
14 standards, and other factors used in apply-
15 ing the NQTL to mental health or sub-
16 stance use disorder benefits are com-
17 parable to, and applied no more stringently
18 than, the processes, strategies, evidentiary
19 standards, or other factors used in apply-
20 ing the limitation with respect to medical
21 and surgical benefits in the same classi-
22 fication.

23 “(iv) DEFINITIONS.—In this para-
24 graph, the terms ‘non-quantitative treat-
25 ment limitations’, ‘comparable to’, and ‘ap-

1 plied no more stringently than’ have the
2 meanings given such terms in sections 146
3 and 147 of title 45, Code of Federal Regu-
4 lations (or any successor regulation).

5 “(B) ENFORCEMENT.—

6 “(i) PROCESS FOR COMPLAINTS.—The
7 Secretary, in cooperation with the Secre-
8 taries of Health and Human Services and
9 Labor, as appropriate, shall, with respect
10 to group health plans, issue guidance to
11 clarify the process and timeline for current
12 and potential participants and beneficiaries
13 (and authorized representatives and health
14 care providers of such participants and
15 beneficiaries) with respect to such plans
16 (and coverage) to file formal complaints of
17 such plans being in violation of this sec-
18 tion, including guidance, by plan type, on
19 the relevant State, regional, and national
20 offices with which such complaints should
21 be filed.

22 “(ii) AUTHORITY FOR PUBLIC EN-
23 FORCEMENT.—The Secretary, in consulta-
24 tion with the Secretaries of Labor and
25 Treasury, shall make available to the pub-

1 lic on the Consumer Parity Portal website
2 established under section 2726(a)(7) of the
3 Public Health Service Act de-identified in-
4 formation on audits and investigations of
5 group health plans conducted under this
6 section.

7 “(iii) AUDITS.—

8 “(I) RANDOMIZED AUDITS.—The
9 Secretary in cooperation with the Sec-
10 retaries of Health and Human Serv-
11 ices and Labor, is authorized to con-
12 duct randomized audits of group
13 health plans to determine compliance
14 with this section. Such audits shall be
15 conducted on no fewer than twelve
16 plans per plan year. Information from
17 such audits shall be made plainly
18 available on the Consumer Parity Por-
19 tal website established under section
20 2726(a)(7) of the Public Health Serv-
21 ice Act.

22 “(II) ADDITIONAL AUDITS.—In
23 the case of a group health plan with
24 respect to which any claim has been
25 filed during a plan year, the Secretary

1 may audit the books and records of
2 such plan to determine compliance
3 with this section. Information detail-
4 ing the results of the audit shall be
5 made available on the Consumer Par-
6 ity Portal website established under
7 section 2726(a)(7) of the Public
8 Health Service Act.

9 “(iv) DENIAL RATES.—The Secretary
10 shall collect information on the rates of
11 and reasons for denial by group health
12 plans of claims for outpatient and inpa-
13 tient mental health and substance use dis-
14 order services compared to the rates of and
15 reasons for denial of claims for medical
16 and surgical services. For the first plan
17 year beginning at least two years after the
18 date of the enactment of this paragraph
19 and each subsequent plan year, the Sec-
20 retary shall submit to the Energy and
21 Commerce Committee of the House of
22 Representatives and the Committee on
23 Health, Education, Labor, and Pensions of
24 the Senate, and make plainly available on
25 the Consumer Parity Portal website under

1 section 2726(a)(7) of the Public Health
2 Service Act, the information collected
3 under the previous sentence with respect to
4 the previous plan year.”.

5 (d) AUTHORIZATION OF APPROPRIATIONS.—There is
6 authorized to be appropriated \$2,000,000 for each of fis-
7 cal years 2016 through 2020 to carry out this section, in-
8 cluding the amendments made by this section.

9 **SEC. 802. REPORT ON INVESTIGATIONS REGARDING PAR-**
10 **ITY IN MENTAL HEALTH AND SUBSTANCE**
11 **USE DISORDER BENEFITS.**

12 (a) IN GENERAL.—Not later than one year after the
13 date of the enactment of this Act, and annually thereafter,
14 the Administrator of the Centers for Medicare & Medicaid
15 Services, in collaboration with the Assistant Secretary of
16 Labor of the Employee Benefits Security Administration
17 and the Secretary of the Treasury shall submit to the Con-
18 gress a report—

19 (1) identifying Federal investigations conducted
20 or completed during the preceding 12-month period
21 regarding compliance with parity in mental health,
22 substance use disorder benefits, including benefits
23 provided to persons with mental illness, including se-
24 rious mental illness, and substance use disorders
25 under the Paul Wellstone and Pete Domenici Mental

1 Health Parity and Addiction Equity Act of 2008
2 (subtitle B of title V of division C of Public Law
3 110–343); and

4 (2) summarizing the results of such investiga-
5 tions.

6 (b) CONTENTS.—Subject to paragraph (3), each re-
7 port under paragraph (1) shall include the following infor-
8 mation:

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

11 (2) The benefit classification or classifications
12 examined by each investigation.

13 (3) The subject matter or subject matters of
14 each investigation, including quantitative and non-
15 quantitative treatment limitations.

16 (4) A summary of the basis of the final decision
17 rendered for each investigation.

18 (c) LIMITATION.—Individually identifiable informa-
19 tion shall be excluded from reports under paragraph (1)
20 consistent with Federal privacy protections.

1 **SEC. 803. GAO STUDY ON PREVENTING DISCRIMINATORY**
2 **COVERAGE LIMITATIONS FOR INDIVIDUALS**
3 **WITH SERIOUS MENTAL ILLNESS AND SUB-**
4 **STANCE USE DISORDERS.**

5 Not later than one year after the date of the enact-
6 ment of this Act, the Comptroller General of the United
7 States shall submit to Congress a report describing the
8 evidence regarding the extent to which private health in-
9 surance plans have nonquantitative treatment limits for
10 mental health, substance use disorder, and other health
11 services. The report shall also assess the Departments of
12 Health and Human Service, Labor, and Treasury's over-
13 sight of private health insurance plans and Medicaid man-
14 aged care plans under section 1903 of the Social Security
15 Act (42 U.S.C. 1396b), compliance with the Paul
16 Wellstone and Pete Domenici Mental Health Parity and
17 Addiction Equity Act of 2008 (subtitle B of title V of divi-
18 sion C of Public Law 110–343) (as amended by Public
19 Law 111–148) (in this section referred to as the “law”),
20 including—

21 (1) how the responsible Federal departments
22 and agencies ensure that plans comply with the law,
23 including how the plans apply nonquantitative treat-
24 ment limitations and medical necessity criteria to be-
25 havioral health services compared to medical or sur-
26 gical services; and

1 (2) how proper enforcement, education, and co-
2 ordination activities within responsible Federal de-
3 partments and agencies can be used to ensure full
4 compliance with the law, including educational ac-
5 tivities directed to State insurance commissioners.

6 **SEC. 804. REPORT TO CONGRESS ON FEDERAL ASSISTANCE**
7 **TO STATE INSURANCE REGULATORS RE-**
8 **GARDING MENTAL HEALTH PARITY EN-**
9 **FORCEMENT.**

10 Not later than one year after the date of enactment
11 of this Act, the Secretary of Health and Human Services
12 shall submit to Congress a report detailing—

13 (1) the ways in which State governments and
14 State insurance regulators are either empowered or
15 required to enforce the Paul Wellstone and Pete
16 Domenici Mental Health Parity and Addiction Eq-
17 uity Act of 2008 (subtitle B of title V of division C
18 of Public Law 110–343);

19 (2) their capability to carry out these enforce-
20 ment powers or requirements; and

21 (3) any technical assistance to State govern-
22 ment and State insurance regulators that has been
23 communicated by the Department of Health and
24 Human Services.

1 **TITLE IX—SUBSTANCE ABUSE**
2 **Subtitle A—Prescriber Education**
3 **Proposal**

4 **SEC. 901. PRACTITIONER EDUCATION.**

5 (a) EDUCATION REQUIREMENTS.—

6 (1) REGISTRATION CONSIDERATION.—Section
7 303(f) of the Controlled Substances Act (21 U.S.C.
8 823(f)) is amended by inserting after paragraph (5)
9 the following:

10 “(6) The applicant’s compliance with the train-
11 ing requirements described in subsection (g)(3) dur-
12 ing any previous period in which the applicant has
13 been subject to such training requirements.”.

14 (2) TRAINING REQUIREMENTS.—Section 303(g)
15 of the Controlled Substances Act (21 U.S.C. 823(g))
16 is amended by adding at the end the following:

17 “(3)(A) To be registered to prescribe or otherwise
18 dispense methadone or other opioids, a practitioner de-
19 scribed in paragraph (1) shall comply with the 12-hour
20 training requirement of subparagraph (B) at least once
21 during each 3-year period.

22 “(B) The training requirement of this subparagraph
23 is that the practitioner has completed not less than 12
24 hours of training (through classroom situations, seminars

1 at professional society meetings, electronic communica-
2 tions, or otherwise) with respect to—

3 “(i) the treatment and management of opioid-
4 dependent patients;

5 “(ii) pain management treatment guidelines;
6 and

7 “(iii) early detection of opioid addiction, includ-
8 ing through such methods as Screening, Brief Inter-
9 vention, and Referral to Treatment (SBIRT),

10 that is provided by the American Society of Addiction
11 Medicine, the American Academy of Addiction Psychiatry,
12 the American Medical Association, the American Osteo-
13 pathic Association, the American Psychiatric Association,
14 the American Academy of Pain Management, the Amer-
15 ican Pain Society, the American Academy of Pain Medi-
16 cine, the American Board of Pain Medicine, the American
17 Society of Interventional Pain Physicians, or any other or-
18 ganization that the Secretary determines is appropriate
19 for purposes of this subparagraph.”.

20 (b) REQUIREMENTS FOR PARTICIPATION IN OPIOID
21 TREATMENT PROGRAMS.—Effective July 1, 2016, a phy-
22 sician practicing in an opioid treatment program shall
23 comply with the requirements of section 303(g)(3) of the
24 Controlled Substances Act (as added by subsection (a))

1 with respect to required minimum training at least once
2 during each 3-year period.

3 (c) DEFINITION.—In this section, the term “opioid
4 treatment program” has the meaning given such term in
5 section 8.2 of title 42, Code of Federal Regulations (or
6 any successor regulation).

7 (d) FUNDING.—The Drug Enforcement Administra-
8 tion shall fund the enforcement of the requirements speci-
9 fied in section 303(g)(3) of the Controlled Substances Act
10 (as added by subsection (a)) through the use of a portion
11 of the licensing fees paid by controlled substance pre-
12 scribers under the Controlled Substances Act (21 U.S.C.
13 801 et seq.).

14 (e) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated to carry out this section
16 \$1,000,000 for each of fiscal years 2016 through 2020.

17 **Subtitle B—Recovery Enhancement**
18 **for Addiction Treatment**

19 **SEC. 911. EXPANSION OF PATIENT LIMITS UNDER WAIVER.**

20 Section 303(g)(2)(B) of the Controlled Substances
21 Act (21 U.S.C. 823(g)(2)(B)) is amended—

22 (1) in clause (i), by striking “physician” and in-
23 serting “practitioner”;

24 (2) in clause (iii)—

1 (A) by striking “30” and inserting “100”;

2 and

3 (B) by striking “, unless, not sooner” and

4 all that follows through the end and inserting a

5 period; and

6 (3) by inserting at the end the following new

7 clause:

8 “(iv) Not earlier than 1 year after the date

9 on which a qualifying practitioner obtained an

10 initial waiver pursuant to clause (iii), the quali-

11 fying practitioner may submit a second notifica-

12 tion to the Secretary of the need and intent of

13 the qualifying practitioner to treat an unlimited

14 number of patients, if the qualifying practi-

15 tioner—

16 “(I)(aa) satisfies the requirements of

17 item (aa), (bb), (cc), or (dd) of subpara-

18 graph (G)(ii)(I); and

19 “(bb) agrees to fully participate in the

20 Prescription Drug Monitoring Program of

21 the State in which the qualifying practi-

22 tioner is licensed, pursuant to applicable

23 State guidelines; or

1 “(II)(aa) satisfies the requirements of
2 item (ee), (ff), or (gg) of subparagraph
3 (G)(ii)(I);

4 “(bb) agrees to fully participate in the
5 Prescription Drug Monitoring Program of
6 the State in which the qualifying practi-
7 tioner is licensed, pursuant to applicable
8 State guidelines;

9 “(cc) practices in a qualified practice
10 setting; and

11 “(dd) has completed not less than 24
12 hours of training (through classroom situa-
13 tions, seminars at professional society
14 meetings, electronic communications, or
15 otherwise) with respect to the treatment
16 and management of opiate-dependent pa-
17 tients for substance use disorders provided
18 by the American Society of Addiction Med-
19 icine, the American Academy of Addiction
20 Psychiatry, the American Medical Associa-
21 tion, the American Osteopathic Associa-
22 tion, the American Psychiatric Association,
23 or any other organization that the Sec-
24 retary determines is appropriate for pur-
25 poses of this subclause.”.

1 **SEC. 912. DEFINITIONS.**

2 Section 303(g)(2)(G) of the Controlled Substances
3 Act (21 U.S.C. 823(g)(2)(G)) is amended—

4 (1) by striking clause (ii) and inserting the fol-
5 lowing:

6 “(ii) The term ‘qualifying practitioner’
7 means the following:

8 “(I) A physician who is licensed under
9 State law and who meets 1 or more of the
10 following conditions:

11 “(aa) The physician holds a
12 board certification in addiction psychi-
13 atry from the American Board of
14 Medical Specialties.

15 “(bb) The physician holds an ad-
16 diction certification from the Amer-
17 ican Society of Addiction Medicine.

18 “(cc) The physician holds a
19 board certification in addiction medi-
20 cine from the American Osteopathic
21 Association.

22 “(dd) The physician holds a
23 board certification from the American
24 Board of Addiction Medicine.

25 “(ee) The physician has com-
26 pleted not less than 8 hours of train-

1 ing (through classroom situations,
2 seminar at professional society meet-
3 ings, electronic communications, or
4 otherwise) with respect to the treat-
5 ment and management of opiate-de-
6 pendent patients for substance use
7 disorders provided by the American
8 Society of Addiction Medicine, the
9 American Academy of Addiction Psy-
10 chiatry, the American Medical Asso-
11 ciation, the American Osteopathic As-
12 sociation, the American Psychiatric
13 Association, or any other organization
14 that the Secretary determines is ap-
15 propriate for purposes of this sub-
16 clause.

17 “(ff) The physician has partici-
18 pated as an investigator in 1 or more
19 clinical trials leading to the approval
20 of a narcotic drug in schedule III, IV,
21 or V for maintenance or detoxification
22 treatment, as demonstrated by a
23 statement submitted to the Secretary
24 by this sponsor of such approved
25 drug.

1 “(gg) The physician has such
2 other training or experience as the
3 Secretary determines will demonstrate
4 the ability of the physician to treat
5 and manage opiate-dependent pa-
6 tients.

7 “(II) A nurse practitioner or physi-
8 cian assistant who is licensed under State
9 law and meets all of the following condi-
10 tions:

11 “(aa) The nurse practitioner or
12 physician assistant is licensed under
13 State law to prescribe schedule III,
14 IV, or V medications for pain.

15 “(bb) The nurse practitioner or
16 physician assistant satisfies 1 or more
17 of the following:

18 “(AA) Has completed not
19 fewer than 24 hours of training
20 (through classroom situations,
21 seminar at professional society
22 meetings, electronic communica-
23 tions, or otherwise) with respect
24 to the treatment and manage-
25 ment of opiate-dependent pa-

1 tients for substance use disorders
2 provided by the American Society
3 of Addiction Medicine, the Amer-
4 ican Academy of Addiction Psy-
5 chiatry, the American Medical
6 Association, the American Osteo-
7 pathic Association, the American
8 Psychiatric Association, or any
9 other organization that the Sec-
10 retary determines is appropriate
11 for purposes of this subclause.

12 “(BB) Has such other train-
13 ing or experience as the Sec-
14 retary determines will dem-
15 onstrate the ability of the nurse
16 practitioner or physician assist-
17 ant to treat and manage opiate-
18 dependent patients.

19 “(cc) The nurse practitioner or
20 physician assistant practices within
21 the scope of their State license, in-
22 cluding compliance with any super-
23 vision or collaboration requirements
24 under State law.

1 “(dd) The nurse practitioner or
2 physician assistant practice in a quali-
3 fied practice setting.”; and

4 (2) by adding at the end the following:

5 “(iii) The term ‘qualified practice setting’
6 means 1 or more of the following treatment set-
7 tings:

8 “(I) A National Committee for Qual-
9 ity Assurance-recognized Patient-Centered
10 Medical Home or Patient-Centered Spe-
11 cialty Practice.

12 “(II) A Centers for Medicaid & Medi-
13 care Services-recognized Accountable Care
14 Organization.

15 “(III) A clinical facility administered
16 by the Department of Veterans Affairs,
17 Department of Defense, or Indian Health
18 Service.

19 “(IV) A Behavioral Health Home ac-
20 credited by the Joint Commission.

21 “(V) A Federally-qualified health cen-
22 ter (as defined in section 1905(l)(2)(B) of
23 the Social Security Act (42 U.S.C.
24 1396d(l)(2)(B))) or a Federally-qualified
25 health center look-alike.

1 “(VI) A Substance Abuse and Mental
2 Health Services-certified Opioid Treatment
3 Program.

4 “(VII) A clinical program of a State
5 or Federal jail, prison, or other facility
6 where individuals are incarcerated.

7 “(VIII) A clinic that demonstrates
8 compliance with the Model Policy on
9 DATA 2000 and Treatment of Opioid Ad-
10 diction in the Medical Office issued by the
11 Federation of State Medical Boards.

12 “(IX) A treatment setting that is part
13 of an Accreditation Council for Graduate
14 Medical Education, American Association
15 of Colleges of Osteopathic Medicine, or
16 American Osteopathic Association-accred-
17 ited residency or fellowship training pro-
18 gram.

19 “(X) Any other practice setting ap-
20 proved by a State regulatory board or
21 State Medicaid Plan to provide addiction
22 treatment services.

23 “(XI) Any other practice setting ap-
24 proved by the Secretary.”.

1 **SEC. 913. EVALUATION BY ASSISTANT SECRETARY FOR**
2 **PLANNING AND EVALUATION.**

3 Two years after the date on which the first notifica-
4 tion under clause (iv) of section 303(g)(2)(B) of the Con-
5 trolled Substances Act (21 U.S.C. 823(g)(2)(B)), as added
6 by this Act, is received by the Secretary of Health and
7 Human Services, the Assistant Secretary for Planning and
8 Evaluation shall initiate an evaluation of the effectiveness
9 of the amendments made by this Act, which shall include
10 an evaluation of—

11 (1) any changes in the availability and use of
12 medication-assisted treatment for opioid addiction;

13 (2) the quality of medication-assisted treatment
14 programs;

15 (3) the integration of medication-assisted treat-
16 ment with routine healthcare services;

17 (4) diversion of opioid addiction treatment
18 medication;

19 (5) changes in State or local policies and legis-
20 lation relating to opioid addiction treatment;

21 (6) the use of nurse practitioners and physician
22 assistants who prescribe opioid addiction medication;

23 (7) the use of Prescription Drug Monitoring
24 Programs by waived practitioners to maximize safety
25 of patient care and prevent diversion of opioid addic-
26 tion medication;

1 (8) the findings of the Drug Enforcement Ad-
2 ministration inspections of waived practitioners, in-
3 cluding the frequency with which the Drug Enforce-
4 ment Administration finds no documentation of ac-
5 cess to behavioral health services; and

6 (9) the effectiveness of cross-agency collabora-
7 tion between Department of Health and Human
8 Services and the Drug Enforcement Administration
9 for expanding effective opioid addiction treatment.

10 **Subtitle C—Co-Prescribing to**
11 **Reduce Overdoses**

12 **SEC. 921. CO-PRESCRIBING OPIOID OVERDOSE REVERSAL**
13 **DRUGS GRANT PROGRAM.**

14 (a) ESTABLISHMENT.—

15 (1) IN GENERAL.—Not later than six months
16 after the date of the enactment of this Act, the Sec-
17 retary of Health and Human Services shall estab-
18 lish, in accordance with this section, a four-year co-
19 prescribing opioid overdose reversal drugs grant pro-
20 gram (in this Act referred to as the “grant pro-
21 gram”) under which the Secretary shall provide not
22 more than a total of 12 grants to eligible entities to
23 carry out the activities described in subsection (c).

1 (2) MAXIMUM GRANT AMOUNT.—A grant made
2 under this section may not be for more than
3 \$200,000 per grant year.

4 (3) ELIGIBLE ENTITY.—For purposes of this
5 section, the term “eligible entity” means a federally
6 qualified health center (as defined in section
7 1861(aa) of the Social Security Act (42 U.S.C.
8 1395x(aa)), an opioid treatment program under part
9 8 of title 42, Code of Federal Regulations, or section
10 303(g) of the Controlled Substances Act (21 U.S.C.
11 823(g)), or any other entity that the Secretary
12 deems appropriate.

13 (4) CO-PRESCRIBING.—For purposes of this
14 section and section 3, the term “co-prescribing”
15 means, with respect to an opioid overdose reversal
16 drug, the practice of prescribing such drug in con-
17 junction with an opioid prescription for patients at
18 an elevated risk of overdose, or in conjunction with
19 an opioid agonist approved under section 505 of the
20 Federal Food, Drug, and Cosmetic Act (21 U.S.C.
21 355) for the treatment of opioid abuse disorders, or
22 in other circumstances in which a provider identifies
23 a patient at an elevated risk for an intentional or
24 unintentional drug overdose from heroin or prescrip-
25 tion opioid therapies. For purposes of the previous

1 sentence, a patient may be at an elevated risk of
2 overdose if the patient meets the criteria under the
3 existing co-prescribing guidelines that the Secretary
4 deems appropriate, such as the criteria provided in
5 the Opioid Overdose Toolkit published by the Sub-
6 stance Abuse and Mental Health Services Adminis-
7 tration.

8 (b) APPLICATION.—To be eligible to receive a grant
9 under this section, an eligible entity shall submit to the
10 Secretary of Health and Human Services, in such form
11 and manner as specified by the Secretary, an application
12 that describes—

13 (1) the extent to which the area to which the
14 entity will furnish services through use of the grant
15 is experiencing significant morbidity and mortality
16 caused by opioid abuse;

17 (2) the criteria that will be used to identify eli-
18 gible patients to participate in such program; and

19 (3) how such program will work to try to iden-
20 tify State, local, or private funding to continue the
21 program after expiration of the grant.

22 (c) USE OF FUNDS.—An eligible entity receiving a
23 grant under this section may use the grant for any of the
24 following activities:

1 (1) To establish a program for co-prescribing
2 opioid overdose reversal drugs, such as naloxone.

3 (2) To train and provide resources for health
4 care providers and pharmacists on the co-prescribing
5 of opioid overdose reversal drugs.

6 (3) To establish mechanisms and processes for
7 tracking patients participating in the program de-
8 scribed in paragraph (1) and the health outcomes of
9 such patients.

10 (4) To purchase opioid overdose reversal drugs
11 for distribution under the program described in
12 paragraph (1).

13 (5) To offset the co-pays and other cost sharing
14 associated with opioid overdose reversal drugs to en-
15 sure that cost is not a limiting factor for eligible pa-
16 tients.

17 (6) To conduct community outreach, in con-
18 junction with community-based organizations, de-
19 signed to raise awareness of co-prescribing practices,
20 and the availability of opioid overdose reversal
21 drugs.

22 (7) To establish protocols to connect patients
23 who have experienced a drug overdose with appro-
24 priate treatment, including medication assisted

1 treatment and appropriate counseling and behavioral
2 therapies.

3 (d) EVALUATIONS BY RECIPIENTS.—As a condition
4 of receipt of a grant under this section, an eligible entity
5 shall, for each year for which the grant is received, submit
6 to the Secretary of Health and Human Services informa-
7 tion on appropriate outcome measures specified by the
8 Secretary to assess the outcomes of the program funded
9 by the grant, including—

10 (1) the number of prescribers trained;

11 (2) the number of prescribers who have co-pre-
12 scribed an opioid overdose reversal drugs to at least
13 one patient;

14 (3) the total number of prescriptions written for
15 opioid overdose reversal drugs;

16 (4) the percentage of patients at elevated risk
17 who received a prescription for an opioid overdose
18 reversal drug;

19 (5) the number of patients reporting use of an
20 opioid overdose reversal drug; and

21 (6) any other outcome measures that the Sec-
22 retary deems appropriate.

23 (e) REPORTS BY SECRETARY.—For each year of the
24 grant program under this section, the Secretary of Health
25 and Human Services shall submit to the appropriate Com-

1 mittees of the House of Representatives and of the Senate
2 a report aggregating the information received from the
3 grant recipients for such year under subsection (d) and
4 evaluating the outcomes achieved by the programs funded
5 by grants made under this section.

6 **SEC. 922. OPIOID OVERDOSE REVERSAL CO-PRESCRIBING**
7 **GUIDELINES.**

8 (a) IN GENERAL.—The Secretary of Health and
9 Human Services shall establish a grant program under
10 which the Secretary shall award grants to eligible State
11 entities to develop opioid overdose reversal co-prescribing
12 guidelines.

13 (b) ELIGIBLE STATE ENTITIES.—For purposes of
14 subsection (a), eligible State entities are State depart-
15 ments of health in conjunction with State medical boards;
16 city, county, and local health departments; and community
17 stakeholder groups involved in reducing opioid overdose
18 deaths.

19 (c) ADMINISTRATIVE PROVISIONS.—

20 (1) GRANT AMOUNTS.—A grant made under
21 this section may not be for more than \$200,000 per
22 grant.

23 (2) PRIORITIZATION.—In awarding grants
24 under this section, the Secretary shall give priority
25 to eligible State entities which propose to base their

1 guidelines on existing guidelines on co-prescribing to
2 speed enactment, including guidelines of—

3 (A) the Department of Veterans Affairs;

4 (B) nationwide medical societies, such as
5 the American Society of Addiction Medicine or
6 American Medical Association; and

7 (C) the Centers for Disease Control and
8 Prevention.

9 **SEC. 923. AUTHORIZATION OF APPROPRIATIONS.**

10 There is authorized to be appropriated to carry out
11 this Act \$4,000,000 for each of fiscal years 2016 through
12 2020.

13 **Subtitle D—Improving Treatment**
14 **for Pregnant and Postpartum**
15 **Women**

16 **SEC. 931. REAUTHORIZATION OF RESIDENTIAL TREAT-**
17 **MENT PROGRAMS FOR PREGNANT AND**
18 **POSTPARTUM WOMEN.**

19 Section 508 of the Public Health Service Act (42
20 U.S.C. 290bb–1) is amended—

21 (1) in subsection (p), by inserting “(other than
22 subsection (r))” after “section”; and

23 (2) in subsection (r), by striking “such sums”
24 and all that follows through “2003” and inserting

1 “\$40,000,000 for each of fiscal years 2016 through
2 2020”.

3 **SEC. 932. PILOT PROGRAM GRANTS FOR STATE SUBSTANCE**
4 **ABUSE AGENCIES.**

5 (a) IN GENERAL.—Section 508 of the Public Health
6 Service Act (42 U.S.C. 290bb–1) is amended—

7 (1) by redesignating subsection (r), as amended
8 by section 2, as subsection (s); and

9 (2) by inserting after subsection (q) the fol-
10 lowing new subsection:

11 “(r) PILOT PROGRAM FOR STATE SUBSTANCE
12 ABUSE AGENCIES.—

13 “(1) IN GENERAL.—From amounts made avail-
14 able under subsection (s), the Director of the Center
15 for Substance Abuse Treatment shall carry out a
16 pilot program under which competitive grants are
17 made by the Director to State substance abuse agen-
18 cies to—

19 “(A) enhance flexibility in the use of funds
20 designed to support family-based services for
21 pregnant and postpartum women with a pri-
22 mary diagnosis of a substance use disorder, in-
23 cluding opioid use disorders;

24 “(B) help State substance abuse agencies
25 address identified gaps in services furnished to

1 such women along the continuum of care, in-
2 cluding services provided to women in non-resi-
3 dential based settings; and

4 “(C) promote a coordinated, effective, and
5 efficient State system managed by State sub-
6 stance abuse agencies by encouraging new ap-
7 proaches and models of service delivery.

8 “(2) REQUIREMENTS.—In carrying out the
9 pilot program under this subsection, the Director
10 shall—

11 “(A) require State substance abuse agen-
12 cies to submit to the Director applications, in
13 such form and manner and containing such in-
14 formation as specified by the Director, to be eli-
15 gible to receive a grant under the program;

16 “(B) identify, based on such submitted ap-
17 plications, State substance abuse agencies that
18 are eligible for such grants;

19 “(C) require services proposed to be fur-
20 nished through such a grant to support family
21 based treatment and other services for pregnant
22 and postpartum women with a primary diag-
23 nosis of a substance use disorder, including
24 opioid use disorders;

1 “(D) not require that services furnished
2 through such a grant be provided solely to
3 women that reside in facilities;

4 “(E) not require that grant recipients
5 under the program make available through use
6 of the grant all services described in subsection
7 (d); and

8 “(F) consider not applying requirements
9 described in paragraphs (1) and (2) of sub-
10 section (f) to applicants, depending on the cir-
11 cumstances of the applicant.

12 “(3) REQUIRED SERVICES.—

13 “(A) IN GENERAL.—The Director shall
14 specify a minimum set of services required to be
15 made available to eligible women through a
16 grant awarded under the pilot program under
17 this subsection. Such minimum set—

18 “(i) shall include requirements de-
19 scribed in subsection (c) and be based on
20 the recommendations submitted under sub-
21 paragraph (B); and

22 “(ii) may be selected from among the
23 services described in subsection (d) and in-
24 clude other services as appropriate.

1 “(B) STAKEHOLDER INPUT.—The Director
2 shall convene and solicit recommendations from
3 stakeholders, including State substance abuse
4 agencies, health care providers, persons in re-
5 covery from substance abuse, and other appro-
6 priate individuals, for the minimum set of serv-
7 ices described in subparagraph (A).

8 “(4) DURATION.—The pilot program under this
9 subsection shall not exceed 5 years.

10 “(5) EVALUATION AND REPORT TO CON-
11 GRESS.—The Director of the Center for Behavioral
12 Health Statistics and Quality shall fund an evalua-
13 tion of the pilot program at the conclusion of the
14 first grant cycle funded by the pilot program. The
15 Director of the Center for Behavioral Health Statis-
16 tics and Quality, in coordination with the Director of
17 the Center for Substance Abuse Treatment shall
18 submit to the relevant Committees of jurisdiction of
19 the House of Representatives and the Senate a re-
20 port on such evaluation. The report shall include at
21 a minimum outcomes information from the pilot pro-
22 gram, including any resulting reductions in the use
23 of alcohol and other drugs; engagement in treatment
24 services; retention in the appropriate level and dura-
25 tion of services; increased access to the use of medi-

1 cations approved by the Food and Drug Administra-
2 tion for the treatment of substance use disorders in
3 combination with counseling; and other appropriate
4 measures.

5 “(6) STATE SUBSTANCE ABUSE AGENCIES DE-
6 FINED.—For purposes of this subsection, the term
7 ‘State substance abuse agency’ means, with respect
8 to a State, the agency in such State that manages
9 the Substance Abuse Prevention and Treatment
10 Block Grant under part B of title XIX.”.

11 (b) FUNDING.—Subsection (s) of section 508 of the
12 Public Health Service Act (42 U.S.C. 290bb–1), as
13 amended by section 2 and redesignated by subsection (a),
14 is further amended by adding at the end the following new
15 sentence: “Of the amounts made available for a year pur-
16 suant to the previous sentence to carry out this section,
17 not more than 25 percent of such amounts shall be made
18 available for such year to carry out subsection (r), other
19 than paragraph (5) of such subsection.”.

1 **Subtitle E—Evidence-based Opioid**
2 **and Heroin Treatment and**
3 **Interventions Demonstration**

4 **SEC. 941. EVIDENCE-BASED OPIOID AND HEROIN TREAT-**
5 **MENT AND INTERVENTIONS DEMONSTRA-**
6 **TION.**

7 Subpart 1 of part B of title V of the Public Health
8 Service Act (42 U.S.C. 290bb et seq.) is amended—

9 (1) by redesignating section 514 (42 U.S.C.
10 290bb–9), as added by section 3632 of the Meth-
11 amphetamine Anti-Proliferation Act of 2000 (Public
12 Law 106–310; 114 Stat. 1236), as section 514B;
13 and

14 (2) by adding at the end the following:

15 **“SEC. 514C. EVIDENCE-BASED OPIOID AND HEROIN TREAT-**
16 **MENT AND INTERVENTIONS DEMONSTRA-**
17 **TION.**

18 “(a) GRANTS.—

19 “(1) AUTHORITY TO MAKE GRANTS.—The Di-
20 rector of the Center for Substance Abuse Treatment
21 (referred to in this section as the ‘Director’) may
22 award grants to State substance abuse agencies,
23 units of local government, nonprofit organizations,
24 and Indian tribes or tribal organizations (as defined
25 in section 4 of the Indian Health Care Improvement

1 Act (25 U.S.C. 1603)) that have a high rate, or
2 have had a rapid increase, in the use of heroin or
3 other opioids, in order to permit such entities to ex-
4 pand activities, including an expansion in the avail-
5 ability of medication assisted treatment, with respect
6 to the treatment of addiction in the specific geo-
7 graphical areas of such entities where there is a rate
8 or rapid increase in the use of heroin or other
9 opioids.

10 “(2) RECIPIENTS.—The entities receiving
11 grants under paragraph (1) shall be selected by the
12 Director.

13 “(3) NATURE OF ACTIVITIES.—The grant funds
14 awarded under paragraph (1) shall be used for ac-
15 tivities that are based on reliable scientific evidence
16 of efficacy in the treatment of problems related to
17 heroin or other opioids.

18 “(b) GEOGRAPHIC DISTRIBUTION.—The Director
19 shall ensure that grants awarded under subsection (a) are
20 distributed equitably among the various regions of the Na-
21 tion and among rural, urban, and suburban areas that are
22 affected by the use of heroin or other opioids.

23 “(c) ADDITIONAL ACTIVITIES.—The Director shall—
24 “(1) evaluate the activities supported by grants
25 awarded under subsection (a);

1 “(2) disseminate widely such significant infor-
2 mation derived from the evaluation as the Director
3 considers appropriate;

4 “(3) provide States, Indian tribes and tribal or-
5 ganizations, and providers with technical assistance
6 in connection with the provision of treatment of
7 problems related to heroin and other opioids; and

8 “(4) fund only those applications that specifi-
9 cally support recovery services as a critical compo-
10 nent of the grant program.

11 “(d) DEFINITION.—The term ‘medication assisted
12 treatment’ means the use, for problems relating to heroin
13 and other opioids, of medications approved by the Food
14 and Drug Administration in combination with counseling
15 and behavioral therapies.

16 “(e) AUTHORIZATION OF APPROPRIATIONS.—

17 “(1) IN GENERAL.—There are authorized to be
18 appropriated to carry out this section \$35,000,000
19 for each of fiscal years 2016 through 2020.

20 “(2) USE OF CERTAIN FUNDS.—Of the funds
21 appropriated to carry out this section in any fiscal
22 year, the lesser of 5 percent of such funds or
23 \$1,000,000 shall be available to the Director for
24 purposes of carrying out subsection (c).”.

1 **Subtitle F—Grants to Enhance and**
2 **Expand Recovery Support Services**

3 **SEC. 951. GRANTS TO ENHANCE AND EXPAND RECOVERY**
4 **SUPPORT SERVICES.**

5 Subpart 1 of part B of title V of the Public Health
6 Service Act (42 U.S.C. 290bb et seq.), as amended by sec-
7 tion 4, is further amended by adding at the end the fol-
8 lowing:

9 **“SEC. 514F. GRANTS TO ENHANCE AND EXPAND RECOVERY**
10 **SUPPORT SERVICES.**

11 “(a) **IN GENERAL.**—The Secretary, acting through
12 the Administrator of the Substance Abuse and Mental
13 Health Services Administration, shall award grants to
14 State substance abuse agencies and non-profit organiza-
15 tions to develop, expand, and enhance recovery support
16 services for individuals with substance use disorders.

17 “(b) **ELIGIBLE ENTITIES.**—In the case of an appli-
18 cant that is not a State substance abuse agency, to be
19 eligible to receive a grant under this section, the entity
20 shall—

21 “(1) prepare and submit to the Secretary an
22 application at such time, in such manner, and con-
23 tain such information as the Secretary may require,
24 including a plan for the evaluation of any activities

1 carried out with the funds provided under this sec-
2 tion;

3 “(2) demonstrate the inclusion of individuals in
4 recovery from a substance use disorder in leadership
5 levels or governing bodies of the entity;

6 “(3) have as a primary mission the provision of
7 long-term recovery support for substance use dis-
8 orders; and

9 “(4) be accredited by the Council on the Ac-
10 creditation of Peer Recovery Support Services or
11 meet any applicable State certification requirements
12 regarding the provision of the recovery services in-
13 volved.

14 “(c) USE OF FUNDS.—Amounts awarded under a
15 grant under this section shall be used to provide for the
16 following activities:

17 “(1) Educating and mentoring that assists indi-
18 viduals and families with substance use disorders in
19 navigating systems of care.

20 “(2) Peer recovery support services which in-
21 clude peer coaching and mentoring.

22 “(3) Recovery-focused community education
23 and outreach programs, including training on the
24 use of all forms of opioid overdose antagonists used
25 to counter the effects of an overdose.

1 “(4) Training, mentoring, and education to de-
2 velop and enhance peer mentoring and coaching.

3 “(5) Programs aimed at identifying and reduc-
4 ing stigma and discriminatory practices that serve as
5 barriers to substance use disorder recovery and
6 treatment of these disorders.

7 “(6) Developing partnerships between networks
8 that support recovery and other community organi-
9 zations and services, including—

10 “(A) public and private substance use dis-
11 order treatment programs and systems;

12 “(B) health care providers;

13 “(C) recovery-focused addiction and recov-
14 ery professionals;

15 “(D) faith-based organizations;

16 “(E) organizations focused on criminal jus-
17 tice reform;

18 “(F) schools; and

19 “(G) social service agencies in the commu-
20 nity, including educational, juvenile justice,
21 child welfare, housing and mental health agen-
22 cies.

1 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
2 is authorized to be appropriated to carry out this section,
3 \$7,000,000 for fiscal year 2016 through 2020.”.

