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

IN THE HOUSE OF REPRESENTATIVES

Mr. Murphy of Pennsylvania introduced the following bill; which was referred to the Committee on

A BILL

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

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

2 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

3 (a) Short Title.—This Act may be cited as the “Helping Families in Mental Health Crisis Act of 2013”.

4 (b) Table of Contents.—The table of contents for this Act is as follows:
Sec. 1. Short title; table of contents.

TITLE I—ASSISTANT SECRETARY FOR MENTAL HEALTH

Sec. 101. Assistant Secretary for Mental Health and Substance Use Disorders.
Sec. 102. Interagency Serious Mental Illness Coordinating Committee.
Sec. 103. Assisted outpatient treatment grant program.
Sec. 104. Tele-psychiatry and primary care physician training grant program.

TITLE II—FEDERALLY QUALIFIED BEHAVIORAL HEALTH CLINICS

Sec. 201. Demonstration program to improve federally qualified community behavioral health clinic services.

TITLE III—HIPAA AND FERPA CAREGIVERS

Sec. 301. Promoting appropriate treatment for mentally ill individuals by treating their caregivers as personal representatives for purposes of HIPAA privacy regulations.
Sec. 302. Caregivers permitted access to certain education records under FERPA.

TITLE IV—DEPARTMENT OF JUSTICE REFORMS

Sec. 401. Additional purposes for certain Federal grants.
Sec. 402. Reauthorization and additional amendments to the Mentally Ill Offender Treatment and Crime Reduction Act.
Sec. 403. Assisted outpatient treatment.
Sec. 404. Improvements to the Department of Justice data collection and reporting of mental illness in crime.
Sec. 405. Reports on the number of seriously mentally ill who are imprisoned.

TITLE V—MEDICARE AND MEDICAID REFORMS

Sec. 501. Enhanced Medicaid coverage relating to certain mental health services.
Sec. 502. Access to mental health prescription drugs under Medicare and Medicaid.

TITLE VI—RESEARCH BY NATIONAL INSTITUTE OF MENTAL HEALTH

Sec. 601. Increase in funding for certain research.

TITLE VII—COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT REFORM

Sec. 701. Administration of block grants by Assistant Secretary.
Sec. 702. Additional program requirements.
Sec. 703. Period for expenditure of grant funds.
Sec. 704. Treatment standard under State law.
Sec. 705. Assisted outpatient treatment under State law.
Sec. 706. Best available science and models of care.
Sec. 707. Paperwork reduction study.

TITLE VIII—BEHAVIORAL HEALTH AWARENESS PROGRAM

Sec. 801. Reducing the stigma of serious mental illness.
TITLE IX—BEHAVIORAL HEALTH INFORMATION TECHNOLOGY

Sec. 901. Extension of health information technology assistance for behavioral and mental health and substance abuse.

Sec. 902. Extension of eligibility for Medicare and Medicaid health information technology implementation assistance.

TITLE X—EXPANDING ACCESS TO CARE THROUGH HEALTH CARE PROFESSIONAL VOLUNTEERISM

Sec. 1001. Liability protections for health care professional volunteers at community health centers and federally qualified community behavioral health clinics.

TITLE XI—SAMSHA REAUTHORIZATION AND REFORMS

Subtitle A—Organization and General Authorities

Sec. 1101. In general.
Sec. 1102. Advisory councils.
Sec. 1103. Peer review.
Sec. 1104. Data collection.

Subtitle B—Center for Mental Health Services

Sec. 1111. Center for Mental Health Services.
Sec. 1112. Reauthorization of priority mental health needs of regional and national significance.
Sec. 1113. Garrett Lee Smith Reauthorization.

Subtitle C—Children With Serious Emotional Disturbances

Sec. 1121. Comprehensive community mental health services for children with serious emotional disturbances.
Sec. 1122. General provisions; report; funding.

Subtitle D—Projects for Children and Violence

Sec. 1131. Children and violence.
Sec. 1132. Reauthorization of National Child Traumatic Stress Network.

Subtitle E—Protection and Advocacy for Individuals With Mental Illness

Sec. 1141. Prohibition against lobbying by systems accepting Federal funds to protect and advocate the rights of individuals with mental illness.

Subtitle F—Limitations on Authority

Sec. 1151. Limitations on SAMHSA programs.
Sec. 1152. Elimination of unauthorized SAMHSA programs.
TITLE I—ASSISTANT SECRETARY FOR MENTAL HEALTH

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

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

“SEC. 501A. ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE DISORDERS.

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

“(1) report directly to the Secretary;

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

“(3) be selected from among individuals who—

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

“(ii) graduated from an Accreditation Council for Graduate Medical Education-certified psychiatric residency program; and
“(iii) have an understanding of biological, psychosocial, and pharmaceutical treatments of mental illness; or

“(B) have a doctoral degree in psychology with—

“(i) clinical and research experience;

and

“(ii) an understanding of biological, psychosocial, and pharmaceutical treatments of mental illness.

“(b) RELATION TO SAMSHA ADMINISTRATOR.—The Administrator of the Substance Abuse and Mental Health Services Administration shall be under the supervision and direction of the Assistant Secretary.

“(c) DUTIES.—The Assistant Secretary shall—

“(1) promote the coordination of service programs conducted by other departments, agencies, organizations, and individuals that are or may be related to the problems of individuals suffering from substance abuse and mental illness;

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

“(A) to improve the treatment of, and related services to, individuals with respect to substance abuse and mental illness;
“(B) to improve prevention services for such individuals; and

“(C) to protect the legal rights of individuals with mental illnesses and individuals who are substance abusers;

“(3) carry out the administrative and financial management, policy development and planning, evaluation, knowledge dissemination, and public information functions that are required for the implementation of mental health programs, including block grants, treatments, and data collection;

“(4) ensure that the Substance Abuse and Mental Health Services Administration conducts and coordinates demonstration projects, evaluations, and service system assessments and other activities necessary to improve the availability and quality of treatment, prevention, and related services related to substance abuse;

“(5) within the Department of Health and Human Services, oversee and coordinate all programs and activities relating to the prevention of, or treatment or rehabilitation for, mental health or substance use disorders;

“(6) across the Federal Government—
“(A) review programs and activities described in paragraph (5);

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

“(C) formulate recommendations for the coordination and improvement of such programs and activities; and

“(7) supervise data collection for and disseminate best practices by the National Mental Health Policy Laboratory.

“(d) Prioritization of Integration of Services and Early Diagnosis and Intervention.—In carrying out the duties described in subsection (c), the Assistant Secretary shall prioritize—

“(1) the integration of services for the purpose of preventing, treating, or providing rehabilitation for the prevention of, and treatment or rehabilitation for, mental health or substance use disorders with primary care services; and

“(2) early diagnosis and intervention services for the prevention of, and treatment or rehabilitation for, serious mental health or substance use disorders.

“(e) National Mental Health Policy Laboratory.—
“(1) IN GENERAL.—The Assistant Secretary for Mental Health and Substance Use Disorders shall establish, within the Office of the Assistant Secretary, the National Mental Health Policy Laboratory (in this section referred to as the ‘NMHPL’), to be headed by a Director.

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

“(A) identify and implement policy changes and other trends likely to have the most significant impact on mental health services and monitor their impact in accordance with the principles outlined in National Advisory Mental Health Council’s 2006 report entitled ‘The Road Ahead: Research Partnerships To Transform Services’;

“(B) collect information from grantees under programs established or amended by the Helping Families in Mental Health Crisis Act of 2013 and under other mental health programs under this Act, including grantees that are federally qualified community behavioral health clinics certified under section 201 of the Helping Families in Mental Health Crisis Act of 2013 and States receiving funds under a
block grant under part B of title XIX of this Act; and

“(C) evaluate and disseminate to such grantees evidence-based practices and services delivery models using the best available science shown to reduce program expenditures while enhancing the quality of care furnished to individuals by other such grantees.

“(3) Evidence-based practices and service delivery models.—In selecting evidence-based practices and services delivery models for evaluation and dissemination under paragraph (2)(C), the Director of the NMHPL—

“(A) shall give preference to models that improve the coordination, quality, and efficiency of health care services furnished to individuals with serious mental illness; and

“(B) may include clinical protocols and practices used in the Recovery After Initial Schizophrenia Episode (RAISE) project and the North American Prodrome Longitudinal Study (NAPLS) of the National Institute of Mental Health.

“(4) Deadline for beginning implementation.—The Director of the NMHPL shall begin im-
plementation of the duties described in this sub-
section not later than January 1, 2016.

“(5) CONSULTATION.—In carrying out the du-
ties under this section, the Director of the NMHPL
shall consult with—

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

“(B) other appropriate Federal agencies;

and

“(C) clinical and analytical experts with
expertise in medicine, psychiatric and clinical
psychological care, and health care manage-
ment.

“(6) EVALUATION.—

“(A) IN GENERAL.—The Director of the
NMHPL shall conduct an evaluation of grant
programs described in paragraph (2)(B). Such
evaluation shall include an analysis of—

“(i) the quality of care furnished
under the respective services delivery
model, including the measurement of pa-
tient-level outcomes and public health out-
comes such as reduced mortality rates, re-
duced hospitalization from psychotic epi-
isodes, and other criteria determined by the
Assistant Secretary; and

“(ii) the changes in spending under
such programs by reason of the model.

“(B) INFORMATION.—The Assistant Sec-
retary shall make the results of each evaluation
under this paragraph available to the public in
a timely fashion and may establish require-
ments for States and other entities partici-
pating in the testing of models under grant pro-
grams described in paragraph (2)(B) to collect
information that the Assistant Secretary deter-
mines is necessary to monitor and evaluate such
models.

“(f) EXPANSION OF MODELS.—

“(1) IN GENERAL.—Taking into account the re-
sults of evaluations under subsection (e), the Assistant
Secretary may, by rule, as part of the program
of block grants for community mental health services
under subpart I of part B of title XIX, provide for
expanded use across the Nation of service delivery
models by providers funded under such block grants,
so long as—
“(A) the Assistant Secretary determines that such expansion will—

“(i) reduce spending under such block grants without reducing the quality of care; or

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

“(B) the Director of the National Institute of Mental Health determines that such expansion would improve the quality of patient care.

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

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

“(1) summarizing the activities of the Assistant Secretary;

“(2) analyzing the efficiency and effectiveness of Federal programs and activities relating to the prevention of, or treatment or rehabilitation for,
mental health or substance use disorders, including
an accounting of the costs of such programs and ac-
tivities with administrative costs disaggregated from
the costs of services and care provided;
“(3) evaluating the impact on public health of
projects addressing priority mental health needs of
regional and national significance under section
520A to determine—
“(A) whether each such project has re-
duced the mortality rate, prevalence, and emer-
gency room visits for persons with serious men-
tal illness; and
“(B) the effect of such projects on other
public health measures;
“(4) formulating recommendations for the co-
ordination and improvement of Federal programs
and activities described in paragraph (2); and
“(5) identifying any such programs and activi-
ties that are duplicative.
“(h) FUNDING.—Of the amounts made available to
carry out the block grant for community mental health
services for each of fiscal years 2014 through 2019, not
more than 5 percent of such amounts are authorized to
be appropriated to carry out this section.”.
SEC. 102. INTERAGENCY SERIOUS MENTAL ILLNESS CO-
ORDINATING COMMITTEE.

Title V of the Public Health Service Act, as amended
by section 701, is further amended by inserting after sec-
tion 501A of such Act the following:

“SEC. 501B. INTERAGENCY SERIOUS MENTAL ILLNESS CO-
ORDINATING COMMITTEE.

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

“(b) RESPONSIBILITIES.—The Committee shall—

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

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

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

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

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

“(6) submit to the Congress such strategic plan
and any updates to such plan.

“(c) Membership.—

“(1) In general.—The Committee shall be
composed of—

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

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

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

“(D) the Director of the Centers for Dis-
ease Control and Prevention (or the Director’s
designee);
“(E) the Director of the National Institutes of Health (or the Director’s designee);

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

“(G) representatives, appointed by the Assistant Secretary, of Federal agencies that are outside of the Department of Health and Human Services and serve individuals with serious mental illness, such as the Department of Education;

“(H) the Administrator of Substance Abuse and Mental Health Services Administration; and

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

“(2) ADDITIONAL MEMBERS.—Not fewer than 9 members of the Committee, or 1/3 of the total membership of the Committee, whichever is greater, shall be composed of non-Federal public members to be appointed by the Assistant Secretary, of which—

“(A) at least one such member shall be an individual with a diagnosis of serious mental ill-
ness who has benefitted from and is receiving medical treatment under the care of a physician;

“(B) at least one such member shall be a parent or legal guardian of an individual with an serious mental illness;

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

“(D) at least one member shall be a psychiatrist;

“(E) at least one member shall be a clinical psychologist;

“(F) at least one member shall be a judge with successful experiences applying assisted outpatient treatment;

“(G) at least one member shall be a law enforcement officer; and

“(H) at least one member shall be a corrections officer.

“(d) ADMINISTRATIVE SUPPORT; TERMS OF SERVICE; OTHER PROVISIONS.—The following provisions shall apply with respect to the Committee:
“(1) The Assistant Secretary shall provide such administrative support to the Committee as may be necessary for the Committee to carry out its responsibilities.

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

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

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

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

SEC. 103. ASSISTED OUTPATIENT TREATMENT GRANT PROGRAM.

(a) IN GENERAL.—The Assistant Secretary for Mental Health and Substance Use Disorders (in this section referred to as the “Assistant Secretary”), in consultation with the Director of the National Institute of Mental Health and the Attorney General of the United States, shall establish a 4-year pilot program to award not more than 50 grants each year to counties, cities, mental health systems, mental health courts, and any other entities with authority under the law of a State to implement, monitor, and oversee assisted outpatient treatment programs. The Assistant Secretary may only award grants under this section to applicants that have not previously implemented an assisted outpatient treatment program. The Assistant Secretary shall evaluate applicants based on their potential to reduce hospitalization, homelessness, incarceration, and interaction with the criminal justice system while improving health outcomes, such as adherence to medication usage.

(b) USE OF GRANT.—An assisted outpatient treatment program carried out with a grant awarded under this section shall include—
(1) evaluating and seeking out eligible individuals who may benefit from assisted outpatient treatment;

(2) preparing and executing treatment plans for eligible patients and filing petitions for assisted outpatient treatment in appropriate courts;

(3) providing case management services to eligible patients who are participating in the program to provide such patients with resources, monitoring, and oversight, including directly monitoring a participant’s level of compliance and the delivery of services by other providers pursuant to the court order;

(4) carrying out referrals and medical evaluations, and paying the costs of legal counsel for commitment orders to be submitted and evaluated by the courts.

(c) DATA COLLECTION.—Grantees under this section shall provide in a timely fashion any data collected pursuant to the grant to the National Mental Health Policy Laboratory, as requested by the Assistant Secretary, concerning health outcomes and treatments.

(d) REPORT.—The Assistant Secretary shall submit an annual report to the Committees on Energy and Commerce and the Judiciary of the House of Representatives,
the Committees on Health, Education, Labor and Pensions and the Judiciary of the Senate, and the Congressional Budget Office on the grant program under this section. Each such report shall include an evaluation of the following:

(1) Cost savings and public health outcomes such as mortality, suicide, substance abuse, hospitalization, and use of services.

(2) Rates of incarceration by patients.

(3) Rates of employment by patients.

(4) Rates of homelessness.

e) DEFINITIONS.—In this section:

(1) ASSISTED OUTPATIENT TREATMENT.—The term “assisted outpatient treatment” means—

(A) except as provided in subparagraph (B), medically prescribed treatment that an eligible patient must undergo while living in a community under the terms of a law authorizing a State or local court to order such treatment; and

(B) in the case of a State that does not have a law described in subparagraph (A) in effect on the date of enactment—

(i) a court-ordered treatment plan for an eligible patient that requires such pa-
tient to obtain outpatient mental health
treatment while the patient is living in a
community; and

(ii) is designed to improve access and
adherence by such patient to intensive be-
havioral health services in order to—

(I) avert relapse, repeated hos-
pitalizations, arrest, incarceration,
suicide, property destruction, and vio-

tent behavior; and

(II) provide such patient with the
opportunity to live in a less restrictive
alternative to incarceration or involun-
tary hospitalization.

(2) ELIGIBLE PATIENT.—The term “eligible pa-
tient” means an adult, mentally ill person who, as
determined by the court—

(A) has a history of violence, incarceration,
or medically unnecessary hospitalizations;

(B) without supervision and treatment,
may be a danger to self or others in the com-

munity;

(C) is substantially unlikely to voluntarily
participate in treatment;
(D) may be unable, for reasons other than indigence, to provide for any of his or her basic needs, such as food, clothing, shelter, health, or safety;

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

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

(f) FUNDING.—

(1) Amount of Grants.—A grant under this section shall be in an amount that is not more than $1,000,000 for each of grant years 2014 through 2017. Subject to the preceding sentence, the Assistant Secretary shall determine the amount of each grant based on the population of patients of the area to be served under the grant.

(2) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section $15,000,000 for each of fiscal years 2014 through 2017.
SEC. 104. TELE-PSYCHIATRY AND PRIMARY CARE PHYSICIAN TRAINING GRANT PROGRAM.

(a) In general.—The Assistant Secretary of Mental Health and Substance Use Disorders (in this section referred to as the “Assistant Secretary”) shall establish a grant program (in this section referred to as the “grant program”) under which the Assistant Secretary shall award to 10 eligible States (as described in subsection (e)) grants for carrying out all 3 of the purposes described in subsections (b), (c), and (d).

(b) Training program for certain primary care physicians.—For purposes of subsection (a), the purpose described in this subsection, with respect to a grant awarded to a State under the grant program, is for the State to establish a training program to train primary care physicians in—

1. approved standardized behavioral-health screening tools, including—
   (A) Ages and Stages Questionnaires (ASQ: SE);
   (B) Brief Infant-Toddler Social and Emotional Assessment (BITSEA);
   (C) screening for substance abuse, known as Car, Relax, Alone, Forget, Friends, Trouble, (CRAFFT);
(D) screening for autism, known as Modified Checklist for Autism in Toddlers (M–CAT);

(E) Parents’ Evaluation of Developmental Status (PEDS);

(F) screening for depression, known as Patient Health Questionnaire-9 (PHQ–9);

(G) Pediatric Symptom Checklist (PSC) and Pediatric Symptom Checklist-Youth Report (Y–PSC);

(H) Strengths and Difficulties Questionnaire (SDQ); and

(I) any additional areas that the Assistant Secretary determines applicable;

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

(3) knowing what to do when a behavioral-health need is identified.

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

(1) For purposes of subsection (a), the purpose described in this subsection, with respect to a grant awarded to a State under the grant program, is for the State to provide, in accordance with this subsection, in the case of a primary care physician that
participates in the training program of the State establish pursuant to subsection (b), payments to the primary care physician for services furnished by the primary care physician.

(2) The Assistant Secretary, in determining the structure, quality, and form of payment under paragraph (1) shall seek to find innovative payment systems which may take into account—

(A) quality of services rendered;

(B) patients' health outcome;

(C) geographical location of where services were provided;

(D) severity of patients' medical condition;

(E) duration of services provided; and

(F) feasibility of replicating that payment model in other States nationwide.

(d) Telehealth Services for Mental Health Disorders.—

(1) In general.—For purposes of subsection (a), the purpose described in this subsection, with respect to a grant awarded to a State under the grant program, is for the State to provide, in the case of an individual furnished items and services by a primary care physician during an office visit, for payment for a consultation provided by a psychia-
trist or psychologist to such physician with respect to such individual through the use of qualified tele-
health technology for the identification, diagnosis, mitigation, or treatment of a mental health disorder if such consultation occurs not later than the first business day that follows such visit.

(2) QUALIFIED TELEHEALTH TECHNOLOGY.— For purposes of subsection (C)(1), the term “quali-
fied telehealth technology”, with respect to the provi-
sion of items and services to a patient by a health care provider—

(A) includes the use of interactive audio, audio-only telephone conversation, video, or other telecommunications technology by a health care provider to deliver health care serv-
ices within the scope of the provider’s practice at a site other than the site where the patient is located, including the use of electronic media for consultation relating to the health care diag-

nosis or treatment of the patient; and

(B) does not include the use of electronic mail message or facsimile transmission.

(e) ELIGIBLE STATE.—

(1) IN GENERAL.—For purposes of this section, an eligible State is a State that has submitted to the
Assistant Secretary an application under paragraph (a) and has been selected under paragraph (3).

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

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

(4) SELECTION.—A State shall be determined eligible for the grant program by the Assistant Secretary on a competitive basis among States with applications meeting the requirements of paragraphs (2) and (3). In selecting State applications for the grant program, the Secretary shall seek to achieve an appropriate national balance in the geographic
distribution of grants awarded under the grant program.

(d) **LENGTH OF GRANT PROGRAM.**—The grant program established under this section shall be conducted for a period of 3 consecutive years.

(e) **AUTHORIZATION OF APPROPRIATIONS.**—Out of any funds in the Treasury not otherwise appropriated, there is authorized to be appropriated to carry out this section, $3,000,000 for each of the fiscal years 2015 through 2017.

(f) **REPORTS.**—

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

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

(B) Recommendations on how to improve access to mental health services at grantee locations.
(C) An assessment of access to mental health services under the program.

(D) An assessment of the impact of the demonstration project on the costs of the full range of mental health services (including inpatient, emergency and ambulatory care).

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

(2) REPORT.—Not later than December 31, 2017, the Assistant Secretary and the National Mental Health Policy Laboratory shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1) and also a policy outline on how Congress can expand the grant program to the national level.

TITLE II—FEDERALLY QUALIFIED BEHAVIORAL HEALTH CLINICS

SEC. 201. DEMONSTRATION PROGRAM TO IMPROVE FEDERALLY QUALIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC SERVICES.

(a) ESTABLISHMENT.—Not later than January 1, 2016, the Secretary of Health and Human Services (referred to in this section as the “Secretary”), in coordination with the Assistant Secretary for Mental Health and
Substance Use Disorders, shall award planning grants to
not to exceed 10 States to enable such States to carry
out 5-year demonstration programs to improve the provi-
sion of behavioral health services provided by federally
qualified community behavioral health clinics in the State.

(b) Eligibility.—

(1) Application.—To be eligible to receive a
grant under subsection (a), a State shall—

(A) submit to the Secretary an application
at such time, in such manner, and containing
such information as the Secretary may require;

(B) certify to the Secretary that behavioral
health providers that are provided assistance
under the demonstration program are federally
qualified community behavioral health clinics;

(C) certify to the Secretary that, with re-
spect to the behavioral health providers pro-
vided assistance under the demonstration pro-
gram, not more than 75 percent of the total
number of such providers are participating pro-
viders under the State Medicaid plan under title
XIX of the Social Security Act (42 U.S.C. 1396
et seq.);

(D) demonstrate the actuarial soundness
of the demonstration program to be carried out
under the grant by providing a detailed estimate of eligible clinics and Medicaid expenditures over the entire projected period of the demonstration program; and

(E) comply with any other requirement determined appropriate by the Secretary.

(2) WAIVER OF MEDICAID REQUIREMENTS.—In approving States to conduct demonstration programs under this section, the Secretary shall waive such provisions of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) as are necessary to conduct the demonstration program in accordance with the requirements of this section, including section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396a(a)(1)) (relating to statewideness).

(e) REQUIREMENTS.—In awarding grants under this section, the Secretary shall—

(1) ensure the geographic diversity of grantee States;

(2) ensure that federally qualified community behavioral health clinics in such States that are located in rural areas, as defined by the Secretary, and other mental health professional shortage areas are fairly and appropriately considered with the ob-
jective of facilitating access to mental health services in such areas;

(3) take into account the ability of clinics in such States to provide required services, and the ability of such clinics to report required data as required under this section; and

(4) take into account the ability of such States to provide such required services on a statewide basis.

(d) Treatment of Certain Services Provided by Community Behavioral Health Clinics as Medical Assistance.—

(1) In general.—For purposes of the demonstration program under this section, community behavioral health clinic services (as defined in subsection (f)(1)) that are provided by federally qualified community behavioral health clinics receiving assistance under this section shall be considered medical assistance for purposes of payments to States under paragraph (3)(C).

(2) Grant condition.—As a condition of receiving a grant under this section, a State shall agree to provide for payment for community behavioral health clinic services in accordance with the
prospective payment system established by the Secretary under paragraph (3).

(3) PROSPECTIVE PAYMENT SYSTEM.—

(A) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the Secretary shall establish a prospective payment system for community behavioral health clinic services furnished by a community behavioral health clinic receiving assistance under this section in the same manner as payments are required to be made under section 1902(bb) of the Social Security Act (42 U.S.C. 1396a(bb)) for services described in section 1905(a)(2)(C) of such Act (42 U.S.C. 1396d(a)(2)(C)) furnished by a federally qualified health center and services described in section 1905(a)(2)(B) of such Act (42 U.S.C. 1396d(a)(2)(B)) furnished by a rural health clinic.

(B) REQUIREMENTS.—The prospective payment system established by the Secretary under subparagraph (A) shall provide that—

(i) no payment shall be made for inpatient care, residential treatment, room and board expenses, or any other non-
ambulatory services, as determined by the Secretary; and

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

(C) Payments to States.—The Secretary shall pay each State awarded a grant under this section an amount each quarter equal to the enhanced FMAP (as defined in section 2105(b) of the Social Security Act (42 U.S.C. 1397dd(b)) but without regard to the second and third sentences of that section) of the State’s expenditures in the quarter for medical assistance for community behavioral health clinic services provided by federally qualified community behavioral health clinics in the State that receive assistance under this section. Payments to States made under this subparagraph shall be considered to have been under, and are subject to the requirements of, section 1903 of the Social Security Act (42 U.S.C. 1396b).

(e) Annual Report.—
(1) IN GENERAL.—Not later than 1 year after the date on which the first grants are awarded under this section, and annually thereafter, the Secretary shall submit to Congress an annual report on the use of funds provided under the demonstration program. Each such report shall include—

(A) an assessment of access to community-based mental health services under the Medicaid program in the States awarded such grants;

(B) an assessment of the quality and scope of services provided by federally qualified community behavioral health clinics under the grants as compared against community-based mental health services provided in States that are not receiving such grants;

(C) an assessment of the impact of the demonstration programs on the costs of a full range of mental health services (including inpatient, emergency and ambulatory services); and

(D) a peer-reviewed assessment of the public health impact, including but not limited to rates of community mortality, hospitalization, and other measures as determined by the Director of the National Institute of Mental Health.
(2) RECOMMENDATIONS.—Not later than December 31, 2019, the Secretary shall submit to Congress recommendations concerning whether the demonstration programs under this section should be continued and expanded on a national basis.

(3) DATA COLLECTION.—Grantees shall provide in a timely fashion any such data to the National Mental Health Policy Laboratory, as requested by the Assistant Secretary concerning health outcomes and treatments.

(f) CRITERIA FOR FEDERALLY QUALIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS.—

(1) IN GENERAL.—The Assistant Secretary for Mental Health and Substance Use Disorders shall certify federally qualified community behavioral health clinics as meeting the criteria specified in this subsection.

(2) CRITERIA.—The criteria referred to in this subsection are that the clinic performs each of the following:

(A) Provide required primary health services (as defined by the Assistant Secretary for Mental Health and Substance Use Disorders).

(B) Provide services in locations that ensure services will be available and accessible
promptly and in a manner which preserves
human dignity and assures continuity of care.

(C) Provide services in a mode of service
delivery appropriate for the target population.

(D) Provide individuals with a choice of
service options where there is more than one
evidence-based treatment.

(E) Employ a core staff that is sufficiently
trained in child and adolescent psychiatry or
psychology.

(F) Employ a core staff that is sufficiently
trained in child and adolescent psychiatry, dual
diagnosis issues, crisis management and sta-
bilization and interventions with patients at
high risk for violence.

(G) Provide services, within the limits of
the capacities of the center, to any individual
residing or employed in the service area of the
center, regardless of the ability of the individual
to pay.

(H) Provide, directly or through contract,
to the extent covered for adults in the State
Medicaid plan under title XIX of the Social Se-
curity Act and for children in accordance with
section 1905(r) of such Act regarding early and
periodic screening, diagnosis, and treatment, each of the following services:

(i) Screening, assessment, and diagnosis, including risk assessment.

(ii) Person-centered treatment planning or similar processes, including risk assessment and crisis planning.

(iii) Outpatient mental health and substance use services, including screening, assessment, diagnosis, psychotherapy, medication management, and integrated treatment for mental illness and substance abuse which shall be evidence-based (including cognitive behavioral therapy and other such therapies which are evidence-based).

(iv) Outpatient clinic primary care screening and monitoring of key health indicators and health risk (including screening for diabetes, hypertension, and cardiovascular disease and monitoring of weight, height, body mass index (BMI), blood pressure, blood glucose or HbA1C, and lipid profile).
(v) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

(vi) Targeted case management (services provided by a social worker to assist individuals gaining access to needed medical, social, educational, and other services and applying for income security and other benefits to which they may be entitled).

(vii) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutic foster care services, and such other evidence-based practices as the Secretary may require.

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

(ix) Supported education and supported employment for individuals with serious mental illness after an initial psychotic episode.
(x) Case management services for individuals with serious mental illness after an initial psychotic episode.

(I) Use and share electronic health records consistent with other applicable law.

(J) Be available to provide assisted outpatient treatment that is ordered by a State court pursuant to a State law described in section 1915(d).

(K) Be available to participate in research projects conducted or supported by the National Institute of Mental Health.

(L) Maintain linkages, and where possible enter into formal contracts with the following:

(i) Federally qualified health centers.

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

(iii) Adult and youth peer support and counselor services.

(iv) Family support services for families of children with serious mental or substance use disorders.
(v) Other community or regional services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies and facilities (including mental health courts, local police forces, and local jails and other detention facilities), housing agencies and programs, employers, and other social services such as schools and religious organizations.

(vi) Integrating care with primary care services, including, to the extent feasible, through a common delivery site.

(vii) Enabling services, including outreach, transportation, and translation.

(viii) Health and wellness services, including services for tobacco cessation.

(ix) Adopt models of first episode psychosis training, supervision, team meetings, and coordination with adjacent care organizations.

(M) Where feasible, provide outreach and engagement to encourage individuals who could benefit from mental health care to freely participate in receiving the services described in this subsection.
(3) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting States receiving funds appropriated through the Community Mental Health Services Block Grant under this subpart from financing qualified community programs (whether such programs meet the definition of eligible programs prior to or after the date of enactment of this subsection).

(g) DEFINITIONS.—In this section:

(1) COMMUNITY BEHAVIORAL HEALTH CLINIC SERVICES.—The term “community behavioral health clinic services” means ambulatory behavioral health services of the type described in subparagraphs (I), (L), (M), and (N) of subsection (f)(2) that are provided by federally qualified community behavioral health clinics receiving assistance under this section.

(2) STATE.—The term “State” has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(3) FEDERALLY QUALIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC.—The term “federally qualified community behavioral health clinic” means a federally qualified behavioral health clinic with a certification in effect under this section.
(h) Authorization of Appropriations.—In order to fund State planning grants and the administrative costs associated with certifying community behavioral health clinics, there is authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2016, to remain available until expended.

**TITLE III—HIPAA AND FERPA CAREGIVERS**

**SEC. 301. PROMOTING APPROPRIATE TREATMENT FOR MENTALLY ILL INDIVIDUALS BY TREATING THEIR CAREGIVERS AS PERSONAL REPRESENTATIVES FOR PURPOSES OF HIPAA PRIVACY REGULATIONS.**

(a) Caregiver Access to Information.—In applying section 164.502(g) of title 45, Code of Federal Regulations, to an individual with a serious mental illness who does not provide consent for the disclosure of protected health information to a caregiver of such individual, the caregiver shall be treated by a covered entity as a personal representative (as described under such section 164.502(g)) of such individual with respect to protected health information of such individual when the provider furnishing services to the individual reasonably believes it is necessary for protected health information of the individual to be made available to the caregiver in order to
protect the health, safety, or welfare of such individual or
the safety of one or more other individuals.

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

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

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

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

(A) immediate family member of such indi-

(B) individual who assumes primary re-

(C) a personal representative of the indi-

(4) INDIVIDUAL WITH A SERIOUS MENTAL ILL-

(4) INDIVIDUAL WITH A SERIOUS MENTAL ILL-

(5) INDIVIDUAL WITH A SERIOUS MENTAL ILL-

...
caregiver of protected health information of an individual, an individual who—

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

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

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

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

SEC. 302. CAREGIVERS PERMITTED ACCESS TO CERTAIN EDUCATION RECORDS UNDER FERPA.

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

“(k) DISCLOSURES TO CAREGIVERS OF THE MENTALLY ILL.—

“(1) IN GENERAL.—Nothing in this Act, the Elementary and Secondary Education Act of 1965,
or the Higher Education Act of 1965 shall be con-
strued to prohibit an educational agency or institu-
tion from disclosing, to a caregiver of an individual
with a serious mental illness who has not explicitly
provided consent to the agency or institution for the
disclosure of protected health information, an edu-
cation record of such individual if a physician, psy-
chologist, or other recognized mental health profes-
sional or paraprofessional acting in his or her pro-
fessional or paraprofessional capacity, or assisting in
that capacity reasonably believes such disclosure to
the caregiver is necessary to protect the health, safe-
ty, or welfare of such individual or the safety of one
or more other individuals.

“(2) DEFINITIONS.—In this subsection:

“(A) CAREGIVER.—The term ‘caregiver’
means, with respect to an individual with a seri-
ous mental illness, a family member or imme-
diate past legal guardian who assumes a pri-
mary responsibility for providing a basic need
of such individual (such as a family member or
past legal guardian of the individual who has
assumed the responsibility of co-signing a loan
with the individual).
“(B) Education Record.—Notwithstanding subsection (a)(4)(B), the term ‘education record’ shall include a record described in clause (iv) of such subsection.

“(C) Individual with a Serious Mental Illness.—The term ‘individual with a serious mental illness’ means, with respect to the disclosure to a caregiver of protected health information of an individual, an individual who—

“(i) is 18 years of age or older; and

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

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

“(II) results in functional impairment of the individual that substantially interferes with or limits one or more major life activities of the individual.”.
TITLE IV—DEPARTMENT OF JUSTICE REFORMS

SEC. 401. ADDITIONAL PURPOSES FOR CERTAIN FEDERAL GRANTS.

(a) Modifications to the Edward Byrne Memorial Justice Assistance Grant Program.—Section 501(a)(1) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3751(a)(1)) is amended by adding at the end the following:

“(H) Mental health programs and operations by law enforcement or corrections officers.”.

(b) Modifications to the Community Oriented Policing Services Program.—Section 1701(b) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796dd(b)) is amended—

(1) in paragraph (16), by striking “and” at the end;

(2) by redesignating paragraph (17) as paragraph (19);

(3) by inserting after paragraph (16) the following:

“(17) to provide specialized training to law enforcement officers (including village public safety officers (as defined in section 247 of the Indian Arts
and Crafts Amendments Act of 2010 (42 U.S.C. 3796dd note))) to recognize individuals who have mental illness and how to properly intervene with individuals with mental illness, and to establish programs that enhance the ability of law enforcement agencies to address the mental health, behavioral, and substance abuse problems of individuals encountered in the line of duty;

“(18) to provide specialized training to enhance the ability of corrections officers to address the mental health of individuals under the care and custody of jails and prisons; and”; and

(4) in paragraph (19), as redesignated, by striking “through (16)” and inserting “through (19)”.

(e) Modifications to the Staffing for Adequate Fire and Emergency Response Grants.— Section 34(a)(1)(B) of Public Law 93–498 (15 U.S.C. 2229a(a)(1)(B)) is amended by inserting before the period at the end the following: “and to provide specialized training to paramedics, emergency medical services workers, and other first responders to recognize individuals who have mental illness and how to properly intervene with individuals with mental illness”.
SEC. 402. REAUTHORIZATION AND ADDITIONAL AMENDMENTS TO THE MENTALLY ILL OFFENDER TREATMENT AND CRIME REDUCTION ACT.

(a) Safe Communities.—

(1) In general.—Section 2991(a) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa(a)) is amended—

(A) in paragraph (7)—

(i) in the heading, by striking “MENTAL ILLNESS” and inserting “MENTAL ILLNESS; MENTAL HEALTH DISORDER”; and

(ii) by striking “term ‘mental illness’ means” and inserting “terms ‘mental illness’ and ‘mental health disorder’ mean”; and

(B) by striking paragraph (9) and inserting the following:

“(9) Preliminarily Qualified Offender.—

“(A) In general.—The term ‘preliminarily qualified offender’ means an adult or juvenile accused of an offense who—

“(i)(I) previously or currently has been diagnosed by a qualified mental health professional as having a mental ill-
ness or co-occurring mental illness and
substance abuse disorders;

“(II) manifests obvious signs of men-
tal illness or co-occurring mental illness
and substance abuse disorders during ar-
rest or confinement or before any court; or

“(III) in the case of a veterans treat-
ment court provided under subsection (i),
has been diagnosed with, or manifests ob-
vious signs of, mental illness or a sub-
stance abuse disorder or co-occurring men-
tal illness and substance abuse disorder;

and

“(ii) has been unanimously approved
for participation in a program funded
under this section by, when appropriate,
the relevant—

“(I) prosecuting attorney;

“(II) defense attorney;

“(III) probation or corrections
official;

“(IV) judge; and

“(V) a representative from the
relevant mental health agency de-
scribed in subsection (b)(5)(B)(i).
“(B) DETERMINATION.—In determining whether to designate a defendant as a preliminarily qualified offender, the relevant prosecuting attorney, defense attorney, probation or corrections official, judge, and mental health or substance abuse agency representative shall take into account—

“(i) whether the participation of the defendant in the program would pose a substantial risk of violence to the community;

“(ii) the criminal history of the defendant and the nature and severity of the offense for which the defendant is charged;

“(iii) the views of any relevant victims to the offense;

“(iv) the extent to which the defendant would benefit from participation in the program;

“(v) the extent to which the community would realize cost savings because of the defendant’s participation in the program; and

“(vi) whether the defendant satisfies the eligibility criteria for program partici-
partition unanimously established by the relevant prosecuting attorney, defense attorney, probation or corrections official, judge and mental health or substance abuse agency representative.”.

(2) TECHNICAL AND CONFORMING AMENDMENT.—Section 2927(2) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797s–6(2)) is amended—

(A) by striking “has the meaning given that term in section 2991(a).” and inserting the following: “means an offense that—”; and

(B) by adding at the end the following:

“(A) does not have as an element the use, attempted use, or threatened use of physical force against the person or property of another; or

“(B) is not a felony that by its nature involves a substantial risk that physical force against the person or property of another may be used in the course of committing the offense.”.

(b) EVIDENCE BASED PRACTICES.—Section 2991(c) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa(c)) is amended—
(1) in paragraph (3), by striking “or” at the end;

(2) by redesignating paragraph (4) as paragraph (6); and

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

“(4) propose interventions that have been shown by empirical evidence to reduce recidivism;

“(5) when appropriate, use validated assessment tools to target preliminarily qualified offenders with a moderate or high risk of recidivism and a need for treatment and services; or”.

(c) ACADEMY TRAINING.—Section 2991(h) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa(h)) is amended—

(1) in paragraph (1), by adding at the end the following:

“(F) ACADEMY TRAINING.—To provide support for academy curricula, law enforcement officer orientation programs, continuing education training, and other programs that teach law enforcement personnel how to identify and respond to incidents involving persons with mental health disorders or co-occurring mental health and substance abuse disorders.”; and
(2) by adding at the end the following:

“(4) PRIORITY CONSIDERATION.—The Attorney General, in awarding grants under this subsection, shall give priority to programs that law enforcement personnel and members of the mental health and substance abuse professions develop and administer cooperatively.”.

(d) ASSISTING VETERANS.—Section 2991 of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa) is further amended—

(1) by redesignating subsection (i) as subsection (n); and

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

“(i) ASSISTING VETERANS.—

“(1) DEFINITIONS.—In this subsection:

“(A) PEER TO PEER SERVICES OR PROGRAMS.—The term ‘peer to peer services or programs’ means services or programs that connect qualified veterans with other veterans for the purpose of providing support and mentorship to assist qualified veterans in obtaining treatment, recovery, stabilization, or rehabilitation.
“(B) QUALIFIED VETERAN.—The term ‘qualified veteran’ means a preliminarily qualified offender who—

“(i) has served on active duty in any branch of the Armed Forces, including the National Guard and reserve components; and

“(ii) was discharged or released from such service under conditions other than dishonorable.

“(C) VETERANS TREATMENT COURT PROGRAM.—The term ‘veterans treatment court program’ means a court program involving collaboration among criminal justice, veterans, and mental health and substance abuse agencies that provides qualified veterans with—

“(i) intensive judicial supervision and case management, which may include random and frequent drug testing where appropriate;

“(ii) a full continuum of treatment services, including mental health services, substance abuse services, medical services, and services to address trauma;
“(iii) alternatives to incarceration;

and

“(iv) other appropriate services, in-
cluding housing, transportation, mentoring,
employment, job training, education, and
assistance in applying for and obtaining
available benefits.

“(2) VETERANS ASSISTANCE PROGRAM.—

“(A) IN GENERAL.—The Attorney General,
in consultation with the Secretary of Veterans
Affairs, may award grants under this sub-
section to applicants to establish or expand—

“(i) veterans treatment court pro-
grams;

“(ii) peer to peer services or programs
for qualified veterans;

“(iii) practices that identify and pro-
vide treatment, rehabilitation, legal, transi-
tional, and other appropriate services to
qualified veterans who have been incarcera-
ted; and

“(iv) training programs to teach
criminal justice, law enforcement, correc-
tions, mental health, and substance abuse
personnel how to identify and appro-
priately respond to incidents involving qualified veterans.

“(B) PRIORITY.—In awarding grants under this subsection, the Attorney General shall give priority to applications that—

“(i) demonstrate collaboration between and joint investments by criminal justice, mental health, substance abuse, and veterans service agencies;

“(ii) promote effective strategies to identify and reduce the risk of harm to qualified veterans and public safety; and

“(iii) propose interventions with empirical support to improve outcomes for qualified veterans.”.

(e) CORRECTIONAL FACILITIES.—Section 2991 of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa) is further amended by inserting after subsection (i), as so added by subsection (d), the following:

“(j) CORRECTIONAL FACILITIES.—

“(1) DEFINITIONS.—

“(A) CORRECTIONAL FACILITY.—The term ‘correctional facility’ means a jail, prison, or other detention facility used to house people
who have been arrested, detained, held, or convicted by a criminal justice agency or a court.

“(B) ELIGIBLE INMATE.—The term ‘eligible inmate’ means an individual who—

“(i) is being held, detained, or incarcerated in a correctional facility; and

“(ii) manifests obvious signs of a mental illness or has been diagnosed by a qualified mental health professional as having a mental illness.

“(2) CORRECTIONAL FACILITY GRANTS.—The Attorney General may award grants to applicants to enhance the capabilities of a correctional facility—

“(A) to identify and screen for eligible inmates;

“(B) to plan and provide—

“(i) initial and periodic assessments of the clinical, medical, and social needs of inmates; and

“(ii) appropriate treatment and services that address the mental health and substance abuse needs of inmates;

“(C) to develop, implement, and enhance—

“(i) post-release transition plans for eligible inmates that, in a comprehensive
manner, coordinate health, housing, medical, employment, and other appropriate services and public benefits;

“(ii) the availability of mental health care services and substance abuse treatment services; and

“(iii) alternatives to solitary confinement and segregated housing and mental health screening and treatment for inmates placed in solitary confinement or segregated housing; and

“(D) to train each employee of the correctional facility to identify and appropriately respond to incidents involving inmates with mental health or co-occurring mental health and substance abuse disorders.”.

(f) Reauthorization of Appropriations.—Section 2991(n) of title I of the Omnibus Crime Control and Safe Streets Act of 1968, as redesignated in subsection (d), is amended—

(1) in paragraph (1)—

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

(B) in subparagraph (C), by striking the period and inserting “; and”; and
(C) by adding at the end the following:

“(D) $40,000,000 for each of fiscal years 2015 through 2019.”; and.

(2) by adding at the end the following:

“(3) LIMITATION.—Not more than 20 percent of the funds authorized to be appropriated under this section may be used for purposes described in subsection (i) (relating to veterans).”.

SEC. 403. ASSISTED OUTPATIENT TREATMENT.

Section 2201(2)(B) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796ii(2)(B)) is amended by inserting before the semicolon the following: “, or court-ordered assisted outpatient treatment (as defined in section 14(a) of the Helping Families in Mental Health Crisis Act of 2013) when the court has determined such treatment to be necessary”.

SEC. 404. IMPROVEMENTS TO THE DEPARTMENT OF JUSTICE DATA COLLECTION AND REPORTING OF MENTAL ILLNESS IN CRIME.

Notwithstanding any other provision of law, any data prepared by or submitted to the Attorney General or the Director of the Federal Bureau of Investigation on or after the date of enactment of this Act/that is 90 days after the date of enactment of this Act with respect to the incidences of homicides, law enforcement officers killed
and assaulted, or individuals killed by law enforcement officers shall include data with respect to the involvement of mental illness in such incidences, if any. Not later than 90 days after the date of the enactment of this Act, the Attorney General shall promulgate or revise regulations as necessary to carry out this section.

SEC. 405. REPORTS ON THE NUMBER OF SERIOUSLY MENTALLY ILL WHO ARE IMPRISONED.

(a) Report on the Cost of Treating the Mentally Ill in the Criminal Justice System.—Not later than 12 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report detailing the cost of imprisonment for persons who have serious mental illness by the Federal Government or a State or local government. The report shall calculate the number and type of crimes committed by persons with serious mental illness each year, and detail strategies or ideas for preventing crimes by those individuals with serious mental illness from occurring.

(b) Definition.—For purposes of this section, the Attorney General, in consultation with the Assistant Secretary of Mental Health and Substance Use Disorders shall determine an appropriate definition of “serious mental illness” based on the “Health Care Reform for Ameri-
cans with Severe Mental Illnesses: Report” of the National
Advisory Mental Health Council, American Journal of
Psychiatry 1993; 150:1447–1465.

TITLE V—MEDICARE AND
MEDICAID REFORMS

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

(a) Medicaid Coverage of Mental Health Services and Primary Care Services Furnished on
the Same Day.—

(1) In general.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended
by inserting after paragraph (77) the following new paragraph:

“(78) not prohibit payment under the plan for
a mental health service or primary care service fur-
nished to an individual at a federally qualified com-
munity behavioral health center (as defined in sec-
tion 1905(l)(4)) or a federally qualified health center
(as defined in section 1861(aa)(3)) for which pay-
ment would otherwise be payable under the plan,
with respect to such individual, if such service were
not a same-day qualifying service (as defined in sub-
section (ll));”.

(565953112)

December 12, 2013 (12:45 a.m.)
(2) Same-day qualifying services defined.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

“(ll) Same-Day Qualifying Services Defined.—For purposes of subsection (a)(78), the term ‘same-day qualifying service’ means—

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

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

(b) State option to provide medical assistance for certain inpatient psychiatric services to nonelderly adults.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (a)(16)—

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

(2) in the subdivision (B) that follows paragraph (29), by inserting “(other than services described in subparagraphs (B) and (C) of paragraph (16) for individuals described in such subparagraphs)” after “mental diseases”; and

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

“(3) For purposes of subsection (a)(16)(B), the term ‘qualified inpatient psychiatric hospital services’ means, with respect to individuals described in such subsection, services described in subparagraphs (A) and (B) of paragraph (1) that are furnished in an acute care psychiatric unit in a State-operated psychiatric hospital or a psychiatric hospital (as defined section 1861(f)) if such unit or hospital, as ap-
(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made this section shall apply to items and services furnished after the first day of the first calendar year that begins after the date of the enactment of this section.

(2) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act, which the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet any requirement imposed by amendments made by this section, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an ad-
ditional requirement before the first day of the first
calendar quarter beginning after the close of the
first regular session of the State legislature that be-
gins after the date of enactment of this section. For
purposes of the previous sentence, in the case of a
State that has a 2-year legislative session, each year
of the session shall be considered to be a separate
regular session of the State legislature.

SEC. 502. ACCESS TO MENTAL HEALTH PRESCRIPTION

DRUGS UNDER MEDICARE AND MEDICAID.

(a) COVERAGE OF PRESCRIPTION DRUGS USED TO
TREAT MENTAL HEALTH DISORDERS UNDER MEDI-
CARE.—Section 1860D–4(b)(3)(G)(i)(II) of the Social Se-
curity Act (42 U.S.C. 1395w–104(b)(3)(G)(i)(II)) is
amended by inserting “, for categories and classes of
drugs other than the categories and classes of drugs speci-
fied in subclauses (II) and (IV) of clause (iv),” before “ex-
ceptions”.

(b) COVERAGE OF PRESCRIPTION DRUGS USED TO
TREAT MENTAL HEALTH DISORDERS UNDER MED-
ICAID.—Section 1927(d) of the Social Security Act (42
U.S.C. 1396r–8(d)) is amended by adding at the end the
following new paragraph:

“(8) ACCESS TO MENTAL HEALTH DRUGS.—

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

**TITLE VI—RESEARCH BY NATIONAL INSTITUTE OF MENTAL HEALTH**

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

Section 402A(a) of the Public Health Service Act (42 U.S.C. 282a(a)) is amended—

(1) by striking “For the purpose of” and inserting the following: “(1) IN GENERAL.—For the purpose of”; and

(2) by adding at the end the following: “(2) FUNDING FOR THE BRAIN INITIATIVE AT THE NATIONAL INSTITUTE OF MENTAL HEALTH.—

“(A) FUNDING.—In addition to amounts made available pursuant to paragraph (1), there are authorized to be appropriated to the National Institute of Mental Health for the purpose described in subparagraph (B)(ii)
$40,000,000 for each of fiscal years 2015 through 2019.

“(B) PURPOSES.—Amounts appropriated pursuant to subparagraph (A) shall be used exclusively for the purpose of conducting or supporting—

“(i) research on the determinants of self- and other directed-violence in mental illness, including studies directed at reducing the risk of self harm, suicide, and interpersonal violence; or

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

TITLE VII—COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT REFORM

SEC. 701. ADMINISTRATION OF BLOCK GRANTS BY ASSISTANT SECRETARY.

Section 1911(a) of the Public Health Service Act (42 U.S.C. 300x) is amended by striking “acting through the Director of the Center for Mental Health Services” and inserting “acting through the Assistant Secretary for Mental Health and Substance Use Disorders”.

SEC. 702. ADDITIONAL PROGRAM REQUIREMENTS.

(a) INTEGRATED SERVICES.—Subsection (b)(1) of section 1912 of the Public Health Service Act (42 U.S.C. 300x–1) is amended by inserting “integration of” after “The description of the system of care shall include”.

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

(1) by striking “The plan contains an estimate of” and inserting the following: “The plan contains—

“(A) an estimate of”;

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

(3) by adding at the end the following:

“(B) an agreement by the State to report to the National Mental Health Policy Laboratory—

“(i) such data as may be required by the Secretary concerning—

“(I) comprehensive community mental health services in the State; and

“(II) public health outcomes for persons with serious mental illness in the State, including mortality, emer-
gencies, room visits, and medication adher-
ence.”.

SEC. 703. PERIOD FOR EXPENDITURE OF GRANT FUNDS.

Section 1913 of the Public Health Service Act (42
U.S.C. 300x–2), as amended, is further amended by add-
ing at the end the following:

“(d) Period for Expenditure of Grant
Funds.—In implementing a plan submitted under section
1912(a), a State receiving grant funds under section 1911
may make such funds available to providers of services de-
scribed in subsection (b) for the provision of services with-
out fiscal year limitation.”.

SEC. 704. TREATMENT STANDARD UNDER STATE LAW.

Section 1915 of the Public Health Service Act (42
U.S.C. 300x–4) is amended by adding at the end the fol-
lowing:

“(c) Treatment Standard Under State Law.—

“(1) In General.—A funding agreement for a
grant under section 1911 is that—

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

“(B) the State involved has in effect a law under which a State court must order an individual with a mental illness to undergo inpatient or outpatient treatment, the law was in effect on the date of enactment of the Helping Families in Mental Health Crisis Act of 2013, and the Secretary finds that the law requires a State court to order such treatment across all or a sufficient range of the type of circumstances described in subparagraph (A).

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

“(A) If not treated, the illness has a substantial probability of causing the individual to suffer or continue to suffer severe and abnormal mental, emotional, or physical harm that significantly impairs judgment, reason, behavior, or capacity to recognize reality.
“(B) The illness substantially impairs the individual's capacity to make an informed decision regarding treatment, and this impairment causes the individual to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment and understanding and expressing an understanding of the alternatives to the particular treatment offered after the advantages, disadvantages, and alternatives are explained to that individual.

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

SEC. 705. ASSISTED OUTPATIENT TREATMENT UNDER STATE LAW.

Section 1915 of the Public Health Service Act (42 U.S.C. 300x–4), as amended, is further amended by adding at the end the following:

“(d) ASSISTED OUTPATIENT TREATMENT UNDER STATE LAW.—

“(1) IN GENERAL.—A funding agreement for a grant under section 1911 is that the State involved has in effect a law under which a State court may order a treatment plan for an eligible patient that—
“(A) requires such patient to obtain outpatient mental health treatment while the patient is living in a community; and

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

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

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

“(2) Certification of State Compliance.—

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

“(3) Definition.—In this subsection, the term ‘eligible patient’ means an adult, mentally ill person who, as determined by the court—

“(A) has a history of violence, incarceration, or medically unnecessary hospitalizations;
“(B) without supervision and treatment, may be a danger to self or others in the community;

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

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

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

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

SEC. 706. BEST AVAILABLE SCIENCE AND MODELS OF CARE.

Section 1920 of the Public Health Service Act (42 U.S.C. 300x–9) is amended by adding at the end the following:

“(e) Best Practices in Clinical Care Models.—For the purpose of translating evidence-based medicine and best available science into systems of care, the
Assistant Secretary for Mental Health and Substance Use Disorders shall obligate 5 percent of the amounts appropriated under subsection (a) for a fiscal year through the National Mental Health Laboratory created under this Act. These models may include the Recovery After an Initial Schizophrenia Episode research project of the National Institute of Mental Health and the North American Prodrome Longitudinal Study.”.

SEC. 707. PAPERWORK REDUCTION STUDY.

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

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

(2) federally qualified community mental health clinics certified pursuant to section 201 of this Act.
(b) Scope.—In preparing the report under section 1(a), the Institute of Medicine (or, if applicable, other appropriate entity) shall examine licensing, certification, service definitions, claims payment, billing codes, and financial auditing requirements used by the Office of Management and Budget, the Centers for Medicare & Medicaid Services, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Office of the Inspector General of the Department of Health and Human Services, State Medicaid agencies, State departments of health, State departments of education, and State and local juvenile justice and social service agencies to—

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

(2) establish an estimate of the per capita cost to each center described in paragraph (1) or (2) of subsection (a) to comply with such requirements, in terms of both administrative funding and staff time; and

(3) make administrative and statutory recommendations to Congress (which recommendations may include a uniform methodology) to reduce the
paperwork burden experienced by centers described
in paragraph (1) or (2) of subsection (a).

**TITLE VIII—BEHAVIORAL HEALTH AWARENESS PROGRAM**

**SEC. 801. REDUCING THE STIGMA OF SERIOUS MENTAL ILLNESS.**

(a) **IN GENERAL.**—The Secretary of Education, along with the Assistant Secretary for Mental Health and Substance Use Disorders, shall organize a national awareness campaign involving public health organizations, advocacy groups for persons with serious mental illness, and social media companies to assist secondary school students and postsecondary students in—

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

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

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

(b) **DATA COLLECTION.**—The Secretary of Education shall—
(1) evaluate the program under subsection (a) on public health to determine whether the program has made an impact on public health, including mortality rates of persons with serious mental illness, prevalence of serious mental illness, physician and clinical psychological visits, emergency room visits; and

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

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

TITLE IX—BEHAVIORAL HEALTH INFORMATION TECHNOLOGY

SEC. 901. EXTENSION OF HEALTH INFORMATION TECHNOLOGY ASSISTANCE FOR BEHAVIORAL AND MENTAL HEALTH AND SUBSTANCE ABUSE.

Section 3000(3) of the Public Health Service Act (42 U.S.C. 300jj(3)) is amended by inserting before “and any other category” the following: “behavioral and mental health professionals (as defined in section 331(a)(3)(E)(i)), a substance abuse professional, a psychiatric hospital (as defined in section 1861(f) of the So-
cial Security Act), a community mental health center meeting the criteria specified in section 1913(e), a federally qualified community behavioral health clinic certified under section 201 of the Helping Families in Mental Health Crisis Act of 2013, a residential or outpatient mental health or substance abuse treatment facility,”.

SEC. 902. EXTENSION OF ELIGIBILITY FOR MEDICARE AND MEDICAID HEALTH INFORMATION TECHNOLOGY IMPLEMENTATION ASSISTANCE.

(a) Payment Incentives for Eligible Professionals Under Medicare.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (a)(7)—

(A) in subparagraph (E), by adding at the end the following new clause:

“(iv) Additional Eligible Professional.—The term ‘additional eligible professional’ means a clinical psychologist providing qualified psychologist services (as defined in section 1861(ii)).”; and

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

“(F) Application to Additional Eligible Professionals.—The Secretary shall apply the provisions of this paragraph with re-
spect to an additional eligible professional in
the same manner as such provisions apply to an
eligible professional, except in applying sub-
paragraph (A)—

“(i) in clause (i), the reference to
2015 shall be deemed a reference to 2019;

“(ii) in clause (ii), the references to
2015, 2016, and 2017 shall be deemed ref-
ferences to 2019, 2020, and 2021, respec-
tively; and

“(iii) in clause (iii), the reference to
2018 shall be deemed a reference to
2022.”; and

(2) in subsection (o)—

(A) in paragraph (5), by adding at the end
the following new subparagraph:

“(D) ADDITIONAL ELIGIBLE PROFES-
SIONAL.—The term ‘additional eligible profes-
sional’ means a clinical psychologist providing
qualified psychologist services (as defined in
section 1861(ii)).”; and

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

“(6) APPLICATION TO ADDITIONAL ELIGIBLE
PROFESSIONALS.—The Secretary shall apply the
provisions of this subsection with respect to an additional eligible professional in the same manner as such provisions apply to an eligible professional, except in applying—

“(A) paragraph (1)(A)(ii), the reference to 2016 shall be deemed a reference to 2020;

“(B) paragraph (1)(B)(ii), the references to 2011 and 2012 shall be deemed references to 2015 and 2016, respectively;

“(C) paragraph (1)(B)(iii), the references to 2013 shall be deemed references to 2017;

“(D) paragraph (1)(B)(v), the references to 2014 shall be deemed references to 2018; and

“(E) paragraph (1)(E), the reference to 2011 shall be deemed a reference to 2015.”.

(b) Eligible Hospitals.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended—

(1) in subsection (b)(3)(B)(ix), by adding at the end the following new subclause:

“(V) The Secretary shall apply the provisions of this subsection with respect to an additional eligible hospital (as defined in subsection (n)(6)(C)) in the same manner as
such provisions apply to an eligible hospital, except in applying—

“(aa) subclause (I), the references to 2015, 2016, and 2017 shall be deemed references to 2019, 2020, and 2021, respectively; and

“(bb) subclause (III), the reference to 2015 shall be deemed a reference to 2019.”;

and

(2) in subsection (n)—

(A) in paragraph (6), by adding at the end the following new subparagraph:

“(C) ADDITIONAL ELIGIBLE HOSPITAL.— The term ‘additional eligible hospital’ means an inpatient hospital that is a psychiatric hospital (as defined in section 1861(f)).”; and

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

“(7) APPLICATION TO ADDITIONAL ELIGIBLE HOSPITALS.—The Secretary shall apply the provisions of this subsection with respect to an additional eligible hospital in the same manner as such provi-
sions apply to an eligible hospital, except in apply-
ing—

“(A) paragraph (2)(E)(ii), the references to 2013 and 2015 shall be deemed references to 2017 and 2019, respectively; and

“(B) paragraph (2)(G)(i), the reference to 2011 shall be deemed a reference to 2015.”.

(c) MEDICAID PROVIDERS.—Section 1903(t) of the Social Security Act (42 U.S.C. 1396b(t)) is amended—

(1) in paragraph (2)(B)—

(A) in clause (i), by striking “, or” and inserting a semicolon;

(B) in clause (ii), by striking the period and inserting a semicolon; and

(C) by adding after clause (ii) the following new clauses:

“(iii) a public hospital that is principally a psychiatric hospital (as defined in section 1861(f));

“(iv) a private hospital that is principally a psychiatric hospital (as defined in section 1861(f)) and that has at least 10 percent of its patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to in-
individuals receiving medical assistance under this title;

“(v) a community mental health center meeting the criteria specified in section 1913(e) of the Public Health Service Act; or

“(vi) a residential or outpatient mental health or substance abuse treatment facility that—

“(I) is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation, or any other national accrediting agency recognized by the Secretary; and

“(II) has at least 10 percent of its patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals receiving medical assistance under this title.”; and

(2) in paragraph (3)(B)—
(A) in clause (iv), by striking “and” after the semicolon;

(B) in clause (v), by striking the period and inserting “; and”; and

(C) by adding at the end the following new clause:

“(vi) clinical psychologist providing qualified psychologist services (as defined in section 1861(ii)), if such clinical psychologist is practicing in an outpatient clinic that—

“(I) is led by a clinical psychologist; and

“(II) is not otherwise receiving payment under paragraph (1) as a Medicaid provider described in paragraph (2)(B).”.

(d) Medicare Advantage Organizations.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (l)—

(A) in paragraph (1)—

(i) by inserting “or additional eligible professionals (as described in paragraph (9))” after “paragraph (2)”; and
(ii) by inserting “and additional eligible professionals” before “under such sections”;

(B) in paragraph (3)(B)—

(i) in clause (i) in the matter preceding subclause (I), by inserting “or an additional eligible professional described in paragraph (9)” after “paragraph (2)” and

(ii) in clause (ii)—

(I) in the matter preceding subclause (I), by inserting “or an additional eligible professional described in paragraph (9)” after “paragraph (2)” and

(II) in subclause (I), by inserting “or an additional eligible professional, respectively,” after “eligible professional”;

(C) in paragraph (3)(C), by inserting “and additional eligible professionals” after “all eligible professionals”;

(D) in paragraph (4)(D), by adding at the end the following new sentence: “In the case that a qualifying MA organization attests that not all additional eligible professionals of the
organization are meaningful EHR users with respect to an applicable year, the Secretary shall apply the payment adjustment under this paragraph based on the proportion of all such additional eligible professionals of the organization that are not meaningful EHR users for such year.”;

(E) in paragraph (6)(A), by inserting “and, as applicable, each additional eligible professional described in paragraph (9)” after “paragraph (2)”;

(F) in paragraph (6)(B), by inserting “and, as applicable, each additional eligible hospital described in paragraph (9)” after “subsection (m)(1)”;

(G) in paragraph (7)(A), by inserting “and, as applicable, additional eligible professionals” after “eligible professionals”;  

(H) in paragraph (7)(B), by inserting “and, as applicable, additional eligible professionals” after “eligible professionals”;  

(I) in paragraph (8)(B), by inserting “and additional eligible professionals described in paragraph (9)” after “paragraph (2)”;}
(J) by adding at the end the following new paragraph:

“(9) ADDITIONAL ELIGIBLE PROFESSIONAL DESCRIBED.—With respect to a qualifying MA organization, an additional eligible professional described in this paragraph is an additional eligible professional (as defined for purposes of section 1848(o)) who—

“(A)(i) is employed by the organization; or

“(ii)(I) is employed by, or is a partner of, an entity that through contract with the organization furnishes at least 80 percent of the entity’s Medicare patient care services to enrollees of such organization; and

“(II) furnishes at least 80 percent of the professional services of the additional eligible professional covered under this title to enrollees of the organization; and

“(B) furnishes, on average, at least 20 hours per week of patient care services.”; and

(2) in subsection (m)—

(A) in paragraph (1)—

(i) by inserting “or additional eligible hospitals (as described in paragraph (7))” after “paragraph (2)”; and
(ii) by inserting “and additional eligible hospitals” before “under such sections”;

(B) in paragraph (3)(A)(i), by inserting “or additional eligible hospital” after “eligible hospital”;

(C) in paragraph (3)(A)(ii), by inserting “or an additional eligible hospital” after “eligible hospital” in each place it occurs;

(D) in paragraph (3)(B)—

(i) in clause (i), by inserting “or an additional eligible hospital described in paragraph (7)” after “paragraph (2)”; and

(ii) in clause (ii)—

(I) in the matter preceding subclause (I), by inserting “or an additional eligible hospital described in paragraph (7)” after “paragraph (2)”; and

(II) in subclause (I), by inserting “or an additional eligible hospital, respectively,” after “eligible hospital”;

(E) in paragraph (4)(A), by inserting “or one or more additional eligible hospitals (as de-
fined in section 1886(n), as appropriate,” after “section 1886(n)(6)(A))”;

(F) in paragraph (4)(D), by adding at the end the following new sentence: “In the case that a qualifying MA organization attests that not all additional eligible hospitals of the organization are meaningful EHR users with respect to an applicable period, the Secretary shall apply the payment adjustment under this paragraph based on the methodology specified by the Secretary, taking into account the proportion of such additional eligible hospitals, or discharges from such hospitals, that are not meaningful EHR users for such period.”;

(G) in paragraph (5)(A), by inserting “and, as applicable, each additional eligible hospital described in paragraph (7)” after “paragraph (2)”;

(H) in paragraph (5)(B), by inserting “and additional eligible hospitals, as applicable,” after “eligible hospitals”;

(I) in paragraph (6)(B), by inserting “and additional eligible hospitals described in paragraph (7)” after “paragraph (2)”; and
(J) by adding at the end the following new paragraph:

“(7) ADDITIONAL ELIGIBLE HOSPITAL DESCRIBED.—With respect to a qualifying MA organization, an additional eligible hospital described in this paragraph is an additional eligible hospital (as defined in section 1886(n)(6)(C)) that is under common corporate governance with such organization and serves individuals enrolled under an MA plan offered by such organization.”.

TITLE X—EXPANDING ACCESS TO CARE THROUGH HEALTH CARE PROFESSIONAL VOLUNTEERISM

SEC. 1001. LIABILITY PROTECTIONS FOR HEALTH CARE PROFESSIONAL VOLUNTEERS AT COMMUNITY HEALTH CENTERS AND FEDERALLY QUALIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS.

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

“(q)(1) In this subsection, the term ‘federally qualified community behavioral health clinic’ means—
“(A) a federally qualified community behavioral health clinic with a certification in effect under section 201 of the Helping Families in Mental Health Crisis Act of 2013; or

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

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

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

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

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

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

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

“(E) At the time the service is provided, the health care professional is licensed or certified in accordance with applicable law regarding the provision of the service.
“(4) Subsection (g) (other than paragraphs (3) and (5)) and subsections (h), (i), and (l) apply to a health care professional for purposes of this subsection to the same extent and in the same manner as such subsections apply to an officer, governing board member, employee, or contractor of an entity described in subsection (g)(4), subject to paragraph (5) and subject to the following:

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

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

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

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

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

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

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

“(B) Not later than May 1 of each fiscal year, the
Attorney General, in consultation with the Secretary, shall
submit to the Congress a report providing an estimate of
the amount of claims (together with related fees and ex-
penses of witnesses) that, by reason of the acts or omis-
sions of health care professional volunteers, will be paid
pursuant to this subsection during the calendar year that
begins in the following fiscal year. Subsection (k)(1)(B)
applies to the estimate under the preceding sentence re-
regarding health care professional volunteers to the same
extent and in the same manner as such subsection applies
to the estimate under such subsection regarding officers,
governing board members, employees, and contractors of
entities described in subsection (g)(4).

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

“(6)(A) This subsection takes effect on October 1,
2015, except as provided in subparagraph (B).

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

“(i) the Secretary may issue regulations for car-
rying out this subsection, and the Secretary may ac-
cept and consider applications submitted pursuant to
paragraph (4)(B); and
(ii) reports under paragraph (5)(B) may be submitted to the Congress.”.

TITLE XI—SAMSHA REAUTHORIZATION AND REFORMS
Subtitle A—Organization and General Authorities

SEC. 1101. IN GENERAL.
Section 501 of the Public Health Service Act (42 U.S.C. 290aa) is amended—

(1) in subsection (c)(2), by striking “Secretary” and inserting “Assistant Secretary for Mental Health and Substance Use Disorders”;

(2) in subsection (d)—

(A) in paragraph (2)—

(i) by striking “and mental illness”; and

(ii) by striking “promote mental health”; and

(B) in paragraph (4), by inserting “related to substance abuse” after “related services”;

(C) in paragraph (6), by striking “and individuals with mental illness and to develop appropriate mental health services for individuals with such illnesses”; and
(D) in paragraph (18), by striking “mental illness or”;

(3) in subsection (h), by inserting at the end the following: “For any such peer review group reviewing a proposal or grant related to mental illness, no fewer than half of the members of the group shall have a medical degree, or an equivalent doctoral degree in psychology and clinical experience.”;

(4) in subsection (l)—

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

(B) in paragraph (3), by striking the period at the end and inserting “; and”;

(C) by adding at the end the following:

“(4) At least 30 days before awarding a grant, cooperative agreement, or contract, the Administrator shall give written notice of the award to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate.”; and

(5) in subsection (m)—

(A) in paragraph (1), by striking “2.5 percent” and inserting “1.5 percent”; and
(B) in paragraph (3), by striking “Secretary” and inserting “Assistant Secretary for Mental Health and Substance Use Disorders”.

SEC. 1102. ADVISORY COUNCILS.

Paragraph (3) of section 502(b) of the Public Health Service Act (42 U.S.C. 290aa–1(b)) is amended by adding at the end the following:

“(C) No fewer than half of the members of an advisory council shall—

“(i) have a medical degree;

“(ii) have an equivalent doctoral degree in psychology; or

“(iii) serve as a licensed mental health professional.”.

SEC. 1103. PEER REVIEW.

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

(1) by adding at the end of subsection (b) the following: “At least half of the members of any peer review group established under subsection (a) shall have a degree in medicine, or an equivalent doctoral degree in psychology, or be a licensed mental health professional. Before awarding a grant, cooperative agreement, or contract, the Secretary shall provide a list of the members of the peer review group respon-
sible for reviewing the award to the Committee on
Energy and Commerce of the House of Representa-
tives and the Committee on Health, Education,
Labor, and Pensions of the Senate.”; and
(2) by adding at the end the following:
“(e) SCIENTIFIC CONTROLS AND STANDARDS.—Peer
review under this section shall ensure that any research
concerning an intervention is based on scientific controls
and standards indicating whether the intervention reduces
symptoms, improves medical or behavioral outcomes, and
improves social functioning.”.

SEC. 1104. DATA COLLECTION.

(a) TRANSFER OF BEHAVIORAL HEALTH STATISTICS
AND QUALITY.—The Assistant Secretary for Mental
Health and Substance Use Disorders shall transfer all
functions and responsibilities of the Center for Behavioral
Health Statistics and Quality to the National Mental
Health Policy Laboratory, established under section 501A.
(b) TRANSFERRING DATA COLLECTION AND SUR-
VEYS TO THE NATIONAL MENTAL HEALTH POLICY LAB-
ORATORY.—Section 505 of the Public Health Service Act
(42 U.S.C. 290aa-4) is amended—
(1) in subsection (a), by striking “acting
through the Administrator” and inserting “acting
through the National Mental Health Policy Labora-
tory under the Assistant Secretary for Mental Health and Substance Use Disorders (in this section referred to as the ‘Assistant Secretary’) with respect to mental illness and substance abuse’’;

(2) in subsections (a)(2) and (d), by striking “Administrator” each place it appears and inserting “Assistant Secretary”; and

(3) in subsection (b)—

(A) by striking “Administrator” each place it appears and inserting “Assistant Secretary”; and

(B) by striking “and” at the end of paragraph (3);

(C) by striking paragraph (4); and

(D) by adding at the end the following:

“(4) the number of individuals with serious mental illnesses, including those with schizophrenia, bipolar disorder, or major depressive disorder;

“(5) the number of individuals admitted to hospital emergency rooms as a result of serious mental illness;

“(6) the number of individuals who receive inpatient care and are subsequently readmitted to the hospital as a result of their condition within two years; and
“(7) other public health outcomes including mortality rates for individuals with serious mental illness.”

Subtitle B—Center for Mental Health Services

SEC. 1111. CENTER FOR MENTAL HEALTH SERVICES.

Section 520 of the Public Health Service Act (42 U.S.C. 290bb–31) is amended to read as follows:

“SEC. 520. CENTER FOR MENTAL HEALTH SERVICES.

“(a) Establishment.—There is established in the Administration a Center for Mental Health Services (hereafter in this section referred to as the ‘Center’). The Center shall be headed by a Director (hereafter in this section referred to as the ‘Director’) appointed by the Secretary from among individuals with extensive experience or academic qualifications in the provision of mental health services or in the evaluation of mental health service systems.

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

“(1) assist the Assistant Secretary for Mental Health and Substance Use Disorders in designing national goals and establishing national priorities for—

“(A) the prevention of mental illness;

“(B) the treatment of mental illness; and

“(C) the promotion of mental health;
“(2) encourage local entities and State agencies to achieve the goals and priorities described in paragraph (1);

“(3) collaborate with the Department of Education and the Department of Justice to assist local communities in addressing violence among children and adolescents related to mental illness;

“(4) assist the National Institute of Mental Health in deploying improved methods of treating individuals with mental health problems and improved methods of assisting the families of such individuals;

“(5) carry out the provisions of the Protection and Advocacy of Mentally Ill Individuals Act in order to foster independence and protect the legal rights of persons with mental illness;

“(6) carry out the programs under part C; and

“(7) carry out responsibilities for the Human Resource Development programs;

“(8) conduct services-related assessments, including evaluations of the organization and financing of care, self-help, mental health economics, mental health service systems, and rural mental health, and improve the capacity of States to conduct evaluations of publicly funded mental health programs;
“(9) establish a clearinghouse of evidence-based practices, which has first been reviewed and approved by a panel of psychiatrists and clinical psychologists, for mental health information to assure the widespread dissemination of such information to States, political subdivisions, educational agencies and institutions, treatment and prevention service providers, and the general public, including information concerning the practical application of research supported by the National Institute of Mental Health that is applicable to improving the delivery of services;

“(10) provide technical assistance to public and private entities that are providers of mental health services;

“(11) monitor and enforce obligations incurred by community mental health centers pursuant to the Community Mental Health Centers Act (as in effect prior to the repeal of such Act on August 13, 1981, by section 902(e)(2)(B) of Public Law 97–35 (95 Stat. 560)); and

“(12) assist the Assistant Secretary for Mental Health and Substance Use Disorders, and the Director of the Centers for Disease Control and Preven-
tion, with surveys with respect to mental health, such as the National Reporting Program.

Nothing in this subsection shall be construed as authorizing any new grant program or project that is not explicitly authorized or required by other statutory provisions.

“(c) No General Authority for Grants.—Nothing in this section shall be construed as authorizing or requiring any new grant program or project that is not explicitly authorized or required by other statutory provisions.”.

SEC. 1112. REAUTHORIZATION OF PRIORITY MENTAL HEALTH NEEDS OF REGIONAL AND NATIONAL SIGNIFICANCE.

Section 520A of the Public Health Service Act (42 U.S.C. 290bb–32) is amended—

(1) in subsection (a)—

(A) in paragraph (2), by inserting “using evidence-based medicine” after “technical assistance programs”;

(B) by amending paragraph (4) to read as follows:

“(4) evidence-based programs designed in conjunction with the Assistant Secretary for Mental Health and Substance Use Disorders to treat individuals with serious mental illness.”; and
(C) by adding at the end the following:

“Before awarding a grant, cooperative agreement, or contract under this section, the Secretary shall give written notice of the award to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate.”;

(2) in subsection (b)(2), by inserting “, including the primary and behavioral health care integration program under section 520K” after “primary health care systems”; and

(3) by amending subsection (f)(1) to read as follows:

“(1) In general.—For carrying out this section, there is authorized to be appropriated $150,000,000 for each of fiscal years 2014 through 2018.”.

SEC. 1113. GARRETT LEE SMITH REAUTHORIZATION.

(a) Suicide Prevention Technical Assistance Center.—Section 520C of the Public Health Service Act (42 U.S.C. 290bb–34) is amended to read as follows:
“SEC. 520C. SUICIDE PREVENTION TECHNICAL ASSISTANCE CENTER.

“(a) Program Authorized.—The Assistant Secretary for Mental Health and Substance Use Disorders, acting through the Administrator of the Substance Abuse and Mental Health Services Administration, shall award a grant for the operation and maintenance of a research, training, and technical assistance resource center to provide appropriate information, training, and technical assistance to States, political subdivisions of States, federally recognized Indian tribes, tribal organizations, institutions of higher education, public organizations, or private nonprofit organizations concerning the prevention of suicide among all ages, particularly among groups that are at high risk for suicide.

“(b) Responsibilities of the Center.—The center operated and maintained under subsection (a) shall—

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

“(2) ensure the surveillance of suicide early intervention and prevention strategies for all ages, particularly among groups that are at high risk for suicide;
“(3) study the costs and effectiveness of statewide and tribal suicide early intervention and prevention strategies in order to provide information concerning relevant issues of importance to State, tribal, and national policymakers;

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

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

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

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

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

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

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

“(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $4,957,000 for each of the fiscal years 2014 through 2018.”.

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

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

“(a) In General.—The Secretary, acting through the Administrator of the Substance Abuse and Mental Health Services Administration, shall award grants or cooperative agreements to eligible entities to—
“(1) develop and implement State-sponsored statewide or tribal youth suicide early intervention and prevention strategies in schools, educational institutions, juvenile justice systems, substance use disorder programs, mental health programs, foster care systems, and other child and youth support organizations;

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

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

“(4) collect and analyze data on State-sponsored statewide or tribal youth suicide early intervention and prevention services that can be used to monitor the effectiveness of such services and for research, technical assistance, and policy development; and
“(5) assist eligible entities, through State-sponsored statewide or tribal youth suicide early intervention and prevention strategies, in achieving targets for youth suicide reductions under title V of the Social Security Act.

“(b) ELIGIBLE ENTITY.—

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

“(A) a State;

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

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

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

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

“(1) provide early intervention and assessment services, including screening programs, to youth who are at risk for mental or emotional disorders that may lead to a suicide attempt, and that are integrated with school systems, educational institutions, juvenile justice systems, substance use disorder programs, mental health programs, foster care systems, and other child and youth support organizations;
“(2) demonstrate collaboration among early intervention and prevention services or certify that entities will engage in future collaboration;

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

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

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

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

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

“(8) offer continuous and up-to-date information and awareness campaigns that target parents,
family members, child care professionals, community

care providers, and the general public and highlight
the risk factors associated with youth suicide and
the life-saving help and care available from early
intervention and prevention services;

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

“(10) provide a timely response system to en-
sure that child-serving professionals and providers
are properly trained in youth suicide early interven-
tion and prevention strategies and that child-serving
professionals and providers involved in early inter-
vention and prevention services are properly trained
in effectively identifying youth who are at risk for
suicide;

“(11) provide continuous training activities for
child care professionals and community care pro-
viders on the latest youth suicide early intervention
and prevention services practices and strategies;
“(12) conduct annual self-evaluations of outcomes and activities, including consulting with interested families and advocacy organizations;

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

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

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

“(e) CONSULTATION AND POLICY DEVELOPMENT.—

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

“(2) CONSULTATION.—In carrying out this section, the Secretary shall consult with—
“(A) State and local agencies, including agencies responsible for early intervention and prevention services under title XIX of the Social Security Act, the State Children’s Health Insurance Program under title XXI of the Social Security Act, and programs funded by grants under title V of the Social Security Act;

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

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

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

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

“(F) qualified professionals who possess the specialized knowledge, skills, experience, and relevant attributes needed to serve youth at risk for suicide and their families; and
“(G) third-party payers, managed care organizations, and related commercial industries.

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

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

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

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

“(g) EVALUATIONS AND REPORT.—

“(1) EVALUATIONS BY ELIGIBLE ENTITIES.—

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

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

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

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

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

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

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

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

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

“(k) RELATION TO EDUCATION PROVISIONS.—Noth-
ing in this section shall be construed to supersede section
444 of the General Education Provisions Act, including
the requirement of prior parental consent for the disclo-
sure of any education records. Nothing in this section shall
be construed to modify or affect parental notification re-
quirements for programs authorized under the Elementary
and Secondary Education Act of 1965 (as amended by the
No Child Left Behind Act of 2001; Public Law 107–110).

“(l) DEFINITIONS.—In this section:

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

“(2) Educational institution; institution of higher education; school.—The term—

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

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

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

“(3) Prevention.—The term ‘prevention’ means a strategy or approach that reduces the likelihood or risk of onset, or delays the onset, of adverse health problems that have been known to lead to suicide.

“(4) Youth.—The term ‘youth’ means individuals who are between 10 and 24 years of age.

“(m) Authorization of Appropriations.—For the purpose of carrying out this section, there are authorized to be appropriated $29,738,000 for each of the fiscal years 2014 through 2018.”.
(c) Suicide Prevention for Youth.—Section 520E–1 of the Public Health Service Act (42 U.S.C. 290bb–36a) is amended—

(1) by amending the section heading to read as follows: “Suicide Prevention for Youth”; and

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

“(n) Authorization of Appropriations.—For the purpose of carrying out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2014 through 2018.”.

(d) Mental Health and Substance Use Disorders Services and Outreach on Campus.—Section 520E–2 of the Public Health Service Act (42 U.S.C. 290bb–36b) is amended to read as follows:

“Sec. 520E–2. Mental Health and Substance Use Disorders Services on Campus.

“(a) In General.—The Secretary, acting through the Director of the Center for Mental Health Services and in consultation with the Secretary of Education, shall award grants on a competitive basis to institutions of higher education to enhance services for students with mental health or substance use disorders and to develop best practices for the delivery of such services.
“(b) USES OF FUNDS.—Amounts received under a grant under this section shall be used for 1 or more of the following activities:

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

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

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

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

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

“(6) The creation of a networking infrastructure to link colleges and universities with providers who can treat mental health and substance use disorders.
“(7) Developing, supporting, evaluating, and disseminating evidence-based and emerging best practices.

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

“(1) college counseling centers;

“(2) college and university psychological service centers;

“(3) mental health centers;

“(4) psychology training clinics;

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

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

“(d) APPLICATION.—To be eligible to receive a grant under this section, an institution of higher education shall prepare and submit to the Secretary an application at such time and in such manner as the Secretary may require. At a minimum, such application shall include the following:
“(1) A description of identified mental health and substance use disorder needs of students at the institution of higher education.

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

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

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

“(5) A plan to seek input from community mental health providers, when available, community groups and other public and private entities in carrying out the program under the grant.

“(6) A plan to evaluate program outcomes, including a description of the proposed use of funds, the program objectives, and how the objectives will be met.
“(7) An assurance that the institution will submit a report to the Secretary each fiscal year concerning the activities carried out with the grant and the results achieved through those activities.

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

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

“(2) demonstrate the greatest potential for replication.

“(f) REQUIREMENT OF MATCHING FUNDS.—

“(1) IN GENERAL.—The Secretary may make a grant under this section to an institution of higher education only if the institution agrees to make available (directly or through donations from public or private entities) non-Federal contributions in an amount that is not less than $1 for each $1 of Federal funds provided under the grant, toward the costs of activities carried out with the grant (as described in subsection (b)) and other activities by the
institution to reduce student mental health and sub-
stance use disorders.

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

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

“(g) **REPORTS.**—For each fiscal year that grants are awarded under this section, the Secretary shall conduct a study on the results of the grants and submit to the Congress a report on such results that includes the follow-

“(1) An evaluation of the grant program outcomes, including a summary of activities carried out with the grant and the results achieved through those activities.
“(2) Recommendations on how to improve access to mental health and substance use disorder services at institutions of higher education, including efforts to reduce the incidence of suicide and substance use disorders.

“(h) DEFINITIONS.—In this section, the term ‘institution of higher education’ has the meaning given such term in section 101 of the Higher Education Act of 1965.

“(i) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $4,975,000 for each of the fiscal years 2014 through 2018.”.

Subtitle C—Children With Serious Emotional Disturbances

SEC. 1121. COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES.

Paragraph (1) of section 564(a) of the Public Health Service Act (42 U.S.C. 290ff(a)) is amended—

(1) by striking ‘‘, acting through the Director of the Center for Mental Health Services,’’; and

(2) by adding at the end the following: ‘‘Before making any such grant, the Assistant Secretary shall consult with the Director of the National Insti-
tutes of Health to ensure that the grant recipient
will use evidence-based practices.”.

SEC. 1122. GENERAL PROVISIONS; REPORT; FUNDING.

Section 565 of the Public Health Service Act (42
U.S.C. 290ff–4) is amended—

(1) in subsection (c)(2), by striking “not later
than 1 year after the date on which amounts are
first appropriated under subsection (c)” and insert-
ing “not later than 1 year after the date of enact-
ment of the Helping Families in Mental Health Cri-
sis Act of 2013”;

(2) in subsection (f)—

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

“(1) AUTHORIZATION OF APPROPRIATIONS.—

For the purpose of carrying out this part, there are
authorized to be appropriated $117,000,000 for fis-
cal year 2015, $120,000,000 for fiscal year 2016,
$123,000,000 for fiscal year 2017, $126,000,000 for
fiscal year 2018, and $130,000,000 for fiscal year
2019.”;

(B) by moving the margin of paragraph

(2) two ems to the right.
Subtitle D—Projects for Children and Violence

SEC. 1131. CHILDREN AND VIOLENCE.
Section 581 of the Public Health Service Act (42 U.S.C. 290hh) are repealed.

SEC. 1132. REAUTHORIZATION OF NATIONAL CHILD TRAUMATIC STRESS NETWORK.

(a) Reauthorization of National Child Traumatic Stress Network.—Section 582(f) of the Public Health Service Act (42 U.S.C. 290hh(f)) is amended to read as follows:

“(f) Authorization of Appropriations.—To carry out this section, there are authorized to be appropriated $50,000,000 for each of the fiscal years 2014 through 2017.”.

(b) Corresponding Reduction in Funding for Protection and Advocacy Systems.—Section 117 of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10827) is amended to read as follows:

“SEC. 117. AUTHORIZATION OF APPROPRIATIONS.

“‘There are authorized to be appropriated for allotments under this title $5,000,000 for each of the fiscal years 2014 through 2017.’.”.
Subtitle E—Protection and Advocacy for Individuals With Mental Illness

SEC. 1141. PROHIBITION AGAINST LOBBYING BY SYSTEMS ACCEPTING FEDERAL FUNDS TO PROTECT AND ADVOCATE THE RIGHTS OF INDIVIDUALS WITH MENTAL ILLNESS.

Section 105(a) of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10805(a)) is amended—

(1) in paragraph (9), by striking “and” at the end;

(2) in paragraph (10), by striking the period at the end and inserting “; and”;

(3) by adding at the end the following:

“(11) agree to refrain, during any period for which funding is provided to the system under this part, from—

“(A) lobbying or retaining a lobbyist for the purpose of influencing a Federal, State, or local governmental entity or officer;

“(B) using such funding to engage in systemic lawsuits, or to investigate and seek legal remedies cases other than individual cases of abuse or neglect; or
“(C) counseling an individual with a serious mental illness who lacks insight into their condition on refusing medical treatment or acting against the wishes of such individual’s caregiver.”.

Subtitle F—Limitations on Authority

SEC. 1151. LIMITATIONS ON SAMHSA PROGRAMS.

(a) No sponsoring conferences.—The Administrator of the Substance Abuse and Mental Health Services Administration shall not host or sponsor any conference that will not be primarily administered by the Substance Abuse and Mental Health Services Administration without giving at least 90 days of prior notification to the Committee on Energy and Commerce and Committee on Appropriations of the House of Representatives and the Committee on Health, Education, Labor, and Pensions and Committee on Appropriations of the Senate.

(b) Evidence-Based Practices.—The Administrator of the Substance Abuse and Mental Health Services Administration shall not provide any financial assistance for any program relating to mental health or substance use diagnosis or treatment, unless such diagnosis and treatment relies on evidence-based practices.
SEC. 1152. ELIMINATION OF UNAUTHORIZED SAMSHA PROGRAMS.

(a) Elimination of Programs Without Explicit Statutory Authorization.—

(1) No New Programs.—The Administrator of the Substance Abuse and Mental Health Services Administration may not establish, and the Secretary of Health and Human Services may not delegate to the Administrator responsibility for, any program or project that is not explicitly authorized or required by statute.

(2) Termination of Existing Programs.—By the end of fiscal year 2014, any program or project of the Substance Abuse and Mental Health Services Administration that is not explicitly authorized or required by statute shall be terminated.

(b) Report.—

(1) In General.—The Assistant Secretary for Mental Health and Substance Use Disorders shall seek to enter into an arrangement with the Institute of Medicine under which the Institute (or, if the Institute declines to enter into such arrangement, another appropriate entity) agrees to submit a report to the Congress not later than July 31, 2014, identifying each program, project, or activity to be terminated under subsection (a).
(2) RECOMMENDATIONS.—The report under paragraph (1) shall recommend whether any of the programs should be retained based on public health data, such as reduced mortality rates and hospitalization within the community for individuals with serious mental illness, thus proving the program has had a demonstrable benefit using public health and epidemiological factors.