(3) Distribution of awards

The Secretary shall ensure that such grants awarded under this subsection are equitably distributed among the geographical regions of the United States and between urban and rural populations.

(4) Application

A State, political subdivision of a State, Indian Tribe, Tribal organization, or nonprofit private entity that desires a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a plan for the rigorous evaluation of activities that are carried out with funds received under a grant under this subsection.

(5) Use of funds

A State, political subdivision of a State, Indian Tribe, Tribal organization, or nonprofit private entity receiving a grant under this subsection shall use funds from such grant for evidence-based programs that provide training and education in accordance with paragraph (1) on matters including—

(A) recognizing the signs and symptoms of mental illness;

(B)(i) resources available in the community for individuals with a mental illness and other relevant resources; or

(ii) safely de-escalating crisis situations involving individuals with a mental illness; and

(C) suicide intervention and prevention.

(6) Evaluation

A State, political subdivision of a State, Indian Tribe, Tribal organization, or nonprofit private entity that receives a grant under this subsection shall prepare and submit an evaluation to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require, including an evaluation of activities carried out with funds received under the grant under this subsection and a process and outcome evaluation.

(7) Technical assistance

The Secretary may provide technical assistance to grantees in carrying out this section, which may include assistance with—

(A) program evaluation and related activities, including related data collection and reporting;

(B) implementing and disseminating evidence-based practices and programs; and

(C) facilitating collaboration among grantees.

(8) Authorization of appropriations

There is authorized to be appropriated to carry out this subsection $24,963,000 for each of fiscal years 2023 through 2027.

(July 1, 1944, ch. 373, title V, § 520J, as added Pub. L. 106–310, div. B, title XXXII, § 3213, Oct. 17, 2000, 114 Stat. 1206; amended Pub. L. 114–255, div. B, title IX, § 9010, Dec. 13, 2016, 130 Stat. 1244; Pub. L. 117–328, div. FF, title I, § 1122(b), Dec. 29, 2022, 136 Stat. 5651.)

Editorial Notes

AMENDMENTS

2022—Subsec. (b)(1). Pub. L. 117–328, § 1122(b)(1)(A), substituted ''Indian Tribes, Tribal organizations'' for ''Indian tribes, tribal organizations''.

Subsec. (b)(2). Pub. L. 117–328, § 1122(b)(2)(A), substituted ''Emergency services personnel'' for ''Emergency Services Personnel'' in heading.

Subsec. (b)(3). Pub. L. 117–328, § 1122(b)(2)(B), substituted ''Distribution of awards'' for ''Distribution of Awards'' in heading.

Subsec. (b)(4). Pub. L. 117–328, § 1122(b)(1)(B), substituted ''Indian Tribe, Tribal organization'' for ''Indian tribe, tribal organization''.

Subsec. (b)(5). Pub. L. 117–328, § 1122(b)(1)(C)(i), substituted ''Indian Tribe, Tribal organization'' for ''Indian tribe, tribal organization'' in introductory provisions.

Subsec. (b)(5)(C). Pub. L. 117–328, § 1122(b)(1)(C)(ii)–(iv), added subpar. (C).

Subsec. (b)(6). Pub. L. 117–328, § 1122(b)(1)(D), substituted ''Indian Tribe, Tribal organization'' for ''Indian tribe, tribal organization''.

Subsec. (b)(7). Pub. L. 117–328, § 1122(b)(1)(F), added par. (7). Former par. (7) redesignated (8).

Subsec. (b)(8). Pub. L. 117–328, § 1122(b)(1)(E), (G), redesignated par. (7) as (8) and substituted ''$24,963,000 for each of fiscal years 2023 through 2027'' for ''$14,693,000 for each of fiscal years 2018 through 2022''.

2016—Pub. L. 114–255, § 9010(1), inserted ''Mental health awareness'' before ''training'' in section catchline.

Subsec. (b). Pub. L. 114–255, § 9010(2)(A), substituted ''health'' for ''illness'' in heading.

Subsec. (b)(1). Pub. L. 114–255, § 9010(2)(B), inserted ''veterans, law enforcement, and other categories of individuals, as determined by the Secretary,'' after ''emergency services personnel''.

Subsec. (b)(5). Pub. L. 114–255, § 9010(2)(C), substituted ''for evidence-based programs that provide training and education in accordance with paragraph (1) on matters including'' for ''to'' in introductory provisions, added subpars. (A) and (B), and struck out former subpars. (A) to (C) which read as follows:

''(A) train teachers and other relevant school personnel to recognize symptoms of childhood and adolescent mental disorders and appropriately respond;

''(B) train emergency services personnel to identify and appropriately respond to persons with a mental illness; and

''(C) provide education to such teachers and personnel regarding resources that are available in the community for individuals with a mental illness.''

Subsec. (b)(7). Pub. L. 114–255, § 9010(2)(D), substituted ''$14,693,000 for each of fiscal years 2018 through 2022.'' for '', $25,000,000 for fiscal year 2001 and such sums as may be necessary for each of fiscal years 2002 through 2003.''

§ 290bb–42. Improving uptake and patient access to integrated care services

(a) Definitions

In this section:

(1) Eligible entity

The term ''eligible entity'' means a State, or an appropriate State agency, in collaboration with—

(A) 1 or more qualified community programs as described in section 300x–2(b)(1) of this title; or

(B) 1 or more health centers (as defined in section 254b(a) of this title), rural health clinics (as defined in section 1395x(aa) of this title), or Federally qualified health centers (as defined in such section), or primary care

practices serving adult or pediatric patients or both.

(2) Integrated care; bidirectional integrated care

(A) The term ''integrated care'' means collaborative models, including the psychiatric collaborative care model and other evidence-based or evidence-informed models, or practices for coordinating and jointly delivering behavioral and physical health services, which may include practices that share the same space in the same facility.

(B) The term ''bidirectional integrated care'' means the integration of behavioral health care and specialty physical health care, and the integration of primary and physical health care within specialty behavioral health settings, including within primary health care settings.

(3) Psychiatric collaborative care model

The term ''psychiatric collaborative care model'' means the evidence-based, integrated behavioral health service delivery method that includes—

(A) care directed by the primary care team;

(B) structured care management;

(C) regular assessments of clinical status using developmentally appropriate, validated tools; and

(D) modification of treatment as appropriate.

(4) Special population

The term ''special population'' means—

(A) adults with a serious mental illness or adults who have co-occurring mental illness and physical health conditions or chronic disease;

(B) children and adolescents with a serious emotional disturbance who have a co-occurring physical health condition or chronic disease;

(C) individuals with a substance use disorder; or

(D) individuals with a mental illness who have a co-occurring substance use disorder.

(b) Grants and cooperative agreements

(1) In general

The Secretary may award grants and cooperative agreements to eligible entities to support the improvement of integrated care for physical and behavioral health care in accordance with paragraph (2).

(2) Use of funds

A grant or cooperative agreement awarded under this section shall be used—

(A) to promote full integration and collaboration in clinical practices between physical and behavioral health care, including for special populations;

(B) to support the improvement of integrated care models for physical and behavioral health care to improve overall wellness and physical health status, including for special populations;

(C) to promote the implementation and improvement of bidirectional integrated care services provided at entities described in subsection (a)(1), including evidence-based or evidence-informed screening, assessment, diagnosis, prevention, treatment, and recovery services for mental and substance use disorders, and co-occurring physical health conditions and chronic diseases; and

(D) in the case of an eligible entity that is collaborating with a primary care practice, to support the implementation of evidence-based or evidence-informed integrated care models, including the psychiatric collaborative care model, including—

(i) by hiring staff;

(ii) by identifying and formalizing contractual relationships with other health care providers or other relevant entities offering care management and behavioral health consultation to facilitate the adoption of integrated care, including, as applicable, providers who will function as psychiatric consultants and behavioral health care managers in providing behavioral health integration services through the collaborative care model;

(iii) by purchasing or upgrading software and other resources, as applicable, needed to appropriately provide behavioral health integration, including resources needed to establish a patient registry and implement measurement-based care; and

(iv) for such other purposes as the Secretary determines to be applicable and appropriate.

(c) Applications

(1) In general

An eligible entity that is seeking a grant or cooperative agreement under this section shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require, including the contents described in paragraph (2).

(2) Contents for awards

Any such application of an eligible entity seeking a grant or cooperative agreement under this section shall include, as applicable—

(A) a description of a plan to achieve fully collaborative agreements to provide bidirectional integrated care to special populations;

(B) a summary of the policies, if any, that are barriers to the provision of integrated care, and the specific steps, if applicable, that will be taken to address such barriers;

(C) a description of partnerships or other arrangements with local health care providers to provide services to special populations and, as applicable, in areas with demonstrated need, such as Tribal, rural, or other medically underserved communities, such as those with a workforce shortage of mental health and substance use disorder, pediatric mental health, or other related professionals;

(D) an agreement and plan to report to the Secretary performance measures necessary to evaluate patient outcomes and facilitate

evaluations across participating projects; and

(E) a description of the plan or progress in implementing the psychiatric collaborative care model, as applicable and appropriate;

(F) a description of the plan or progress of evidence-based or evidence-informed integrated care models other than the psychiatric collaborative care model implemented by primary care practices, as applicable and appropriate; and

(G) a plan for sustainability beyond the grant or cooperative agreement period under subsection (e).

(d) Grant and cooperative agreement amounts

(1) Target amount

The target amount that an eligible entity may receive for a year through a grant or cooperative agreement under this section shall be no more than $2,000,000.

(2) Adjustment permitted

The Secretary, taking into consideration the quality of an eligible entity's application and the number of eligible entities that received grants under this section prior to December 29, 2022, may adjust the target amount that an eligible entity may receive for a year through a grant or cooperative agreement under this section.

(3) Limitation

An eligible entity that is receiving funding under subsection (b)—

(A) may not allocate more than 10 percent of the funds awarded to such eligible entity under this section to administrative functions; and

(B) shall allocate the remainder of such funding to health facilities that provide integrated care.

(e) Duration

A grant or cooperative agreement under this section shall be for a period not to exceed 5 years.

(f) Report on program outcomes

An eligible entity receiving a grant or cooperative agreement under this section shall submit an annual report to the Secretary. Such annual report shall include—

(1) the progress made to reduce barriers to integrated care as described in the entity's application under subsection (c);

(2) a description of outcomes with respect to each special population listed in subsection (a)(4), including outcomes related to education, employment, and housing, or, as applicable and appropriate, outcomes for such populations receiving behavioral health care through the psychiatric collaborative care model in primary care practices; and

(3) progress in meeting performance metrics and other relevant benchmarks; and

(4) such other information that the Secretary may require.

(g) Technical assistance for primary-behavioral health care integration

(1) Certain recipients

The Secretary may provide appropriate information, training, and technical assistance to eligible entities that receive a grant or cooperative agreement under subsection (b)(2), in order to help such entities meet the requirements of this section, including assistance with—

(A) development and selection of integrated care models;

(B) dissemination of evidence-based interventions in integrated care;

(C) establishment of organizational practices to support operational and administrative success; and

(D) as appropriate, appropriate information, training, and technical assistance in implementing the psychiatric collaborative care model when an eligible entity is collaborating with 1 or more primary care practices for the purposes of implementing the psychiatric collaborative care model.

(2) Additional dissemination of technical information

In addition to providing the assistance described in paragraph (1) to recipients of a grant or cooperative agreement under this section, the Secretary may also provide such assistance to other States and political subdivisions of States, Indian Tribes and Tribal organizations, as those terms are defined in section 5304 of title 25, outpatient mental health and addiction treatment centers, community mental health centers that meet the criteria under section 300x–2(c) of this title, certified community behavioral health clinics described in section 223 of the Protecting Access to Medicare Act of 2014, primary care organizations such as Federally qualified health centers or rural health clinics as defined in section 1395x(aa) of this title, primary health care practices, the community-based organizations, and other entities engaging in integrated care activities, as the Secretary determines appropriate.

(h) Report to Congress

Not later than 18 months after December 29, 2022, and annually thereafter, the Secretary shall submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives summarizing the information submitted in reports to the Secretary under subsection (f), including progress made in meeting performance metrics and the uptake of integrated care models, any adjustments made to target amounts pursuant to subsection (d)(2), and any other relevant information.

(i) Funding

(1) Authorization of appropriations

To carry out this section, there is authorized to be appropriated $60,000,000 for each of fiscal years 2023 through 2027.

(2) Increasing uptake of the psychiatric collaborative care model by primary care practices

Not less than 10 percent of funds appropriated to carry out this section shall be for the purposes of implementing the psychiatric collaborative care model implemented by primary care practices under subsection (b).

(3) Funding contingency

Paragraph (2) shall not apply to a fiscal year unless the amount made available to carry out this section for such fiscal year exceeds the amount appropriated to carry out this section (as in effect before December 29, 2022) for fiscal year 2022.

(July 1, 1944, ch.373, title V, § 520K, as added Pub. L. 111–148, title V, § 5604, Mar. 23, 2010, 124 Stat. 679; amended Pub. L. 114–255, div. B, title IX, § 9003, Dec. 13, 2016, 130 Stat. 1235; Pub. L. 117–328, div. FF, title I, § 1301, Dec. 29, 2022, 136 Stat. 5692.)

Editorial Notes

REFERENCES IN TEXT

Section 223 of the Protecting Access to Medicare Act of 2014, referred to in subsec. (g)(2), is section 223 of Pub. L. 113–93, which is set out as a note under section 1396a of this title.

AMENDMENTS

2022—Pub. L. 117–328 amended section generally. Prior to amendment, section authorized Secretary to award grants and cooperative agreements to eligible entities to support improvement of integrated care for primary care and behavioral health care.

2016—Pub. L. 114–255 amended section generally. Prior to amendment, section related to awards for co-locating primary and specialty care in community-based mental health settings.

§ 290bb–43. Adult suicide prevention

(a) Grants

(1) In general

The Assistant Secretary shall award grants to eligible entities described in paragraph (2) to implement suicide prevention and intervention programs, for adult individuals, that are designed to raise awareness of suicide prevention, establish referral processes, and improve care and outcomes for such individuals who are at risk of suicide.

(2) Eligible entities

To be eligible to receive a grant under this section, an entity shall be a community-based primary care or behavioral health care setting, an emergency department, a State mental health agency (or State health agency with mental or behavioral health functions), public health agency, a territory of the United States, or an Indian Tribe or Tribal organization (as the terms ''Indian Tribe'' and ''Tribal organization'' are defined in section 5304 of title 25).

(3) Use of funds

The grants awarded under paragraph (1) shall be used to implement programs, in accordance with such paragraph, that include one or more of the following components:

(A) Screening for suicide risk, suicide intervention services, and services for referral for treatment for individuals at risk for suicide.

(B) Implementing evidence-based practices to provide treatment for individuals at risk for suicide, including appropriate followup services.

(C) Raising awareness of suicide prevention resources and promoting help seeking among those at risk for suicide.

(b) Evaluations and technical assistance

The Assistant Secretary shall—

(1) evaluate the activities supported by grants awarded under subsection (a), and disseminate, as appropriate, the findings from the evaluation;

(2) provide appropriate information, training, and technical assistance, as appropriate, to eligible entities that receive a grant under this section, in order to help such entities to meet the requirements of this section, including assistance with selection and implementation of evidence-based interventions and frameworks to prevent suicide; and

(3) identify best practices, as applicable, to improve the identification, assessment, treatment, and timely transition, as appropriate, to additional or follow-up care for individuals in emergency departments who are at risk for suicide and enhance the coordination of care for such individuals during and after discharge, in support of activities under subsection (a).

(c) Duration

A grant under this section shall be for a period of not more than 5 years.

(d) Authorization of appropriations

There are authorized to be appropriated to carry out this section $30,000,000 for each of fiscal years 2023 through 2027.

(July 1, 1944, ch. 373, title V, § 520L, as added Pub. L. 114–255, div. B, title IX, § 9009, Dec. 13, 2016, 130 Stat. 1243; amended Pub. L. 117–328, div. FF, title I, § 1122(c), Dec. 29, 2022, 136 Stat. 5652.)

Editorial Notes

AMENDMENTS

2022—Subsec. (a)(1). Pub. L. 117–328, § 1122(c)(1)(A), substituted ''adult individuals'' for ''individuals who are 25 years of age or older'' and inserted ''prevention'' after ''raise awareness of suicide''.

Subsec. (a)(2). Pub. L. 117–328, § 1122(c)(1)(B), in two places, substituted ''Indian Tribe'' for ''Indian tribe'' and ''Tribal organization'' for ''tribal organization''.

Subsec. (a)(3)(C). Pub. L. 117–328, § 1122(c)(1)(C), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: ''Raising awareness and reducing stigma of suicide.''

Subsec. (b)(3). Pub. L. 117–328, § 1122(c)(2), added par. (3).

Subsec. (d). Pub. L. 117–328, § 1122(c)(3), substituted ''$30,000,000 for each of fiscal years 2023 through 2027'' for ''$30,000,000 for the period of fiscal years 2018 through 2022''.

§ 290bb–44. Assertive community treatment grant program

(a) In general

The Assistant Secretary shall award grants to eligible entities—

(1) to establish assertive community treatment programs for adults with a serious mental illness; or

(2) to maintain or expand such programs.

(b) Eligible entities

To be eligible to receive a grant under this section, an entity shall be a State, political sub-