

114TH CONGRESS  
2D SESSION

# H. R. 2646

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## AN ACT

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

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

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

2 (a) SHORT TITLE.—This Act may be cited as the  
3 “Helping Families in Mental Health Crisis Act of 2016”.

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

Sec. 1. Short title; table of contents.

TITLE I—ASSISTANT SECRETARY FOR MENTAL HEALTH AND  
SUBSTANCE USE

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

TITLE II—MEDICAID MENTAL HEALTH COVERAGE

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

TITLE III—INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS  
COORDINATING COMMITTEE

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

TITLE IV—COMPASSIONATE COMMUNICATION ON HIPAA

- Sec. 401. Sense of Congress.
- Sec. 402. Confidentiality of records.
- Sec. 403. Clarification of circumstances under which disclosure of protected  
health information is permitted.

Sec. 404. Development and dissemination of model training programs.

TITLE V—INCREASING ACCESS TO TREATMENT FOR SERIOUS  
MENTAL ILLNESS

Sec. 501. Assertive community treatment grant program for individuals with serious mental illness.

Sec. 502. Strengthening community crisis response systems.

Sec. 503. Increased and extended funding for assisted outpatient grant program for individuals with serious mental illness.

Sec. 504. Liability protections for health professional volunteers at community health centers.

TITLE VI—SUPPORTING INNOVATIVE AND EVIDENCE-BASED  
PROGRAMS

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

Sec. 601. Encouraging innovation and evidence-based programs.

Sec. 602. Promoting access to information on evidence-based programs and practices.

Sec. 603. Sense of Congress.

Subtitle B—Supporting the State Response to Mental Health Needs

Sec. 611. Community Mental Health Services Block Grant.

Subtitle C—Strengthening Mental Health Care for Children and Adolescents

Sec. 621. Tele-mental health care access grants.

Sec. 622. Infant and early childhood mental health promotion, intervention, and treatment.

Sec. 623. National Child Traumatic Stress Initiative.

TITLE VII—GRANT PROGRAMS AND PROGRAM REAUTHORIZATION

Subtitle A—Garrett Lee Smith Memorial Act Reauthorization

Sec. 701. Youth interagency research, training, and technical assistance centers.

Sec. 702. Youth suicide early intervention and prevention strategies.

Sec. 703. Mental health and substance use disorder services on campus.

Subtitle B—Other Provisions

Sec. 711. National Suicide Prevention Lifeline Program.

Sec. 712. Workforce development studies and reports.

Sec. 713. Minority Fellowship Program.

Sec. 714. Center and program repeals.

Sec. 715. National violent death reporting system.

Sec. 716. Sense of Congress on prioritizing Native American youth and suicide prevention programs.

Sec. 717. Peer professional workforce development grant program.

Sec. 718. National Health Service Corps.

Sec. 719. Adult suicide prevention.

Sec. 720. Crisis intervention grants for police officers and first responders.

- Sec. 721. Demonstration grant program to train health service psychologists in community-based mental health.
- Sec. 722. Investment in tomorrow's pediatric health care workforce.
- Sec. 723. CUTGO compliance.

TITLE VIII—MENTAL HEALTH PARITY

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

1 **TITLE I—ASSISTANT SECRETARY**  
 2 **FOR MENTAL HEALTH AND**  
 3 **SUBSTANCE USE**

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

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

9 “(c) ASSISTANT SECRETARY AND DEPUTY ASSIST-  
 10 ANT SECRETARY.—

11 “(1) ASSISTANT SECRETARY.—

12 “(A) APPOINTMENT.—The Administration  
 13 shall be headed by an official to be known as  
 14 the Assistant Secretary for Mental Health and  
 15 Substance Use (hereinafter in this title referred  
 16 to as the ‘Assistant Secretary’) who shall be ap-

1 pointed by the President, by and with the ad-  
2 vice and consent of the Senate.

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

6 “(i) a doctoral degree in medicine, os-  
7 teopathic medicine, or psychology;

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

11 “(iii) an understanding of biological,  
12 psychosocial, and pharmaceutical treat-  
13 ments of mental illness and substance use  
14 disorders.

15 “(2) DEPUTY ASSISTANT SECRETARY.—The As-  
16 sistant Secretary, with the approval of the Secretary,  
17 may appoint a Deputy Assistant Secretary and may  
18 employ and prescribe the functions of such officers  
19 and employees, including attorneys, as are necessary  
20 to administer the activities to be carried out through  
21 the Administration.”.

22 (b) TRANSFER OF AUTHORITIES.—The Secretary of  
23 Health and Human Services shall delegate to the Assist-  
24 ant Secretary for Mental Health and Substance Use all  
25 duties and authorities that—

1           (1) as of the day before the date of enactment  
2 of this Act, were vested in the Administrator of the  
3 Substance Abuse and Mental Health Services Ad-  
4 ministration; and

5           (2) are not terminated by this Act.

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

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

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

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

13           “(19) evaluate, in consultation with the Assist-  
14 ant Secretary for Financial Resources, the informa-  
15 tion used for oversight of grants under programs re-  
16 lated to mental illness and substance use disorders,  
17 including co-occurring illness or disorders, adminis-  
18 tered by the Center for Mental Health Services;

19           “(20) periodically review Federal programs and  
20 activities relating to the diagnosis or prevention of,  
21 or treatment or rehabilitation for, mental illness and  
22 substance use disorders to identify any such pro-  
23 grams or activities that have proven to be effective  
24 or efficient in improving outcomes or increasing ac-  
25 cess to evidence-based programs;

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

5           (d) STANDARDS FOR GRANT PROGRAMS.—Section  
6 501(d) of the Public Health Service Act (42 U.S.C.  
7 290aa(d)), as amended by subsection (c), is further  
8 amended by adding at the end the following:

9           “(22) in consultation with the National Mental  
10          Health and Substance Use Policy Laboratory, and  
11          after providing an opportunity for public input, set  
12          standards for grant programs under this title for  
13          mental health and substance use services, which may  
14          address—

15                 “(A) the capacity of the grantee to imple-  
16                 ment the award;

17                 “(B) requirements for the description of  
18                 the program implementation approach;

19                 “(C) the extent to which the grant plan  
20                 submitted by the grantee as part of its applica-  
21                 tion must explain how the grantee will reach  
22                 the population of focus and provide a statement  
23                 of need, including to what extent the grantee  
24                 will increase the number of clients served and  
25                 the estimated percentage of clients receiving

1 services who report positive functioning after 6  
2 months or no past-month substance use, as ap-  
3 plicable;

4 “(D) the extent to which the grantee must  
5 collect and report on required performance  
6 measures; and

7 “(E) the extent to which the grantee is  
8 proposing evidence-based practices and the ex-  
9 tent to which—

10 “(i) those evidence-based practices  
11 must be used with respect to a population  
12 similar to the population for which the evi-  
13 dence-based practices were shown to be ef-  
14 fective; or

15 “(ii) if no evidence-based practice ex-  
16 ists for a population of focus, the way in  
17 which the grantee will implement adapta-  
18 tions of evidence-based practices, prom-  
19 ising practices, or cultural practices.”.

20 (e) EMERGENCY RESPONSE.—Section 501(m) of the  
21 Public Health Service Act (42 U.S.C. 290aa(m)) is  
22 amended by adding at the end the following:

23 “(4) AVAILABILITY OF FUNDS THROUGH FOL-  
24 LOWING FISCAL YEAR.—Amounts made available for  
25 carrying out this subsection shall remain available

1 through the end of the fiscal year following the fiscal  
2 year for which such amounts are appropriated.”.

3 (f) MEMBER OF COUNCIL ON GRADUATE MEDICAL  
4 EDUCATION.—Section 762 of the Public Health Service  
5 Act (42 U.S.C. 290o) is amended—

6 (1) in subsection (b)—

7 (A) by redesignating paragraphs (4), (5),  
8 and (6) as paragraphs (5), (6), and (7), respec-  
9 tively; and

10 (B) by inserting after paragraph (3) the  
11 following:

12 “(4) the Assistant Secretary for Mental Health  
13 and Substance Use;”; and

14 (2) in subsection (c), by striking “(4), (5), and  
15 (6)” each place it appears and inserting “(5), (6),  
16 and (7)”.

17 (g) CONFORMING AMENDMENTS.—Title V of the  
18 Public Health Service Act (42 U.S.C. 290aa et seq.), as  
19 amended by the previous provisions of this section, is fur-  
20 ther amended—

21 (1) by striking “Administrator of the Substance  
22 Abuse and Mental Health Services Administration”  
23 each place it appears and inserting “Assistant Sec-  
24 retary for Mental Health and Substance Use”; and

1           (2) by striking “Administrator” each place it  
2 appears (including in any headings) and inserting  
3 “Assistant Secretary”, except where the term “Ad-  
4 ministrator” appears—

5           (A) in each of subsections (e) and (f) of  
6 section 501 of such Act (42 U.S.C. 290aa), in-  
7 cluding the headings of such subsections, within  
8 the term “Associate Administrator”;

9           (B) in section 507(b)(6) of such Act (42  
10 U.S.C. 290bb(b)(6)), within the term “Adminis-  
11 trator of the Health Resources and Services Ad-  
12 ministration”;

13           (C) in section 507(b)(6) of such Act (42  
14 U.S.C. 290bb(b)(6)), within the term “Adminis-  
15 trator of the Centers for Medicare & Medicaid  
16 Services”;

17           (D) in section 519B(c)(1)(B) of such Act  
18 (42 U.S.C. 290bb–25b(c)(1)(B)), within the  
19 term “Administrator of the National Highway  
20 Traffic Safety Administration”; or

21           (E) in each of sections 519B(c)(1)(B),  
22 520C(a), and 520D(a) of such Act (42 U.S.C.  
23 290bb–25b(c)(1)(B), 290bb–34(a), 290bb–  
24 35(a)), within the term “Administrator of the

1 Office of Juvenile Justice and Delinquency Pre-  
2 vention”.

3 (h) REFERENCES.—After executing subsections (a),  
4 (b), and (f), any reference in statute, regulation, or guid-  
5 ance to the Administrator of the Substance Abuse and  
6 Mental Health Services Administration shall be construed  
7 to be a reference to the Assistant Secretary for Mental  
8 Health and Substance Use.

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

11 Title V of the Public Health Service Act is amended  
12 by inserting after section 501 of such Act (42 U.S.C.  
13 290aa) the following:

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

16 “(a) ACTIVITIES.—For the purpose of ensuring effi-  
17 cient and effective planning and evaluation of mental ill-  
18 ness and substance use disorder programs and related ac-  
19 tivities, the Assistant Secretary for Planning and Evalua-  
20 tion, in consultation with the Assistant Secretary for Men-  
21 tal Health and Substance Use, shall—

22 “(1) collect and organize relevant data on  
23 homelessness, involvement with the criminal justice  
24 system, hospitalizations, mortality outcomes, and

1 other measures the Secretary deems appropriate  
2 from across Federal departments and agencies;

3 “(2) evaluate programs related to mental illness  
4 and substance use disorders, including co-occurring  
5 illness or disorders, across Federal departments and  
6 agencies, as appropriate, including programs related  
7 to—

8 “(A) prevention, intervention, treatment,  
9 and recovery support services, including such  
10 services for individuals with a serious mental ill-  
11 ness or serious emotional disturbance;

12 “(B) the reduction of homelessness and in-  
13 volvement with the criminal justice system  
14 among individuals with a mental illness or sub-  
15 stance use disorder; and

16 “(C) public health and health services; and

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

23 “(b) RECOMMENDATIONS.—The Assistant Secretary  
24 for Planning and Evaluation shall develop an evaluation  
25 strategy that identifies priority programs to be evaluated

1 by the Assistant Secretary and priority programs to be  
2 evaluated by other relevant agencies within the Depart-  
3 ment of Health and Human Services. The Assistant Sec-  
4 retary for Planning and Evaluation shall provide rec-  
5 ommendations on improving programs and activities based  
6 on the evaluation described in subsection (a)(2) as needing  
7 improvement.”.

8 **SEC. 103. NATIONAL MENTAL HEALTH AND SUBSTANCE**  
9 **USE POLICY LABORATORY.**

10 Title V of the Public Health Service Act (42 U.S.C.  
11 290aa et seq.) is amended by inserting after section 501A,  
12 as added by section 102 of this Act, the following:

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

15 “(a) IN GENERAL.—There shall be established within  
16 the Administration a National Mental Health and Sub-  
17 stance Use Policy Laboratory (referred to in this section  
18 as the ‘Laboratory’).

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

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

1           “(2) identify, coordinate, and facilitate the im-  
2           plementation of policy changes likely to have a sig-  
3           nificant effect on mental health, mental illness, and  
4           the prevention and treatment of substance use dis-  
5           order services;

6           “(3) collect, as appropriate, information from  
7           grantees under programs operated by the Adminis-  
8           tration in order to evaluate and disseminate infor-  
9           mation on evidence-based practices, including cul-  
10          turally and linguistically appropriate services, as ap-  
11          propriate, and service delivery models;

12          “(4) provide leadership in identifying and co-  
13          ordinating policies and programs, including evidence-  
14          based programs, related to mental illness and sub-  
15          stance use disorders;

16          “(5) recommend ways in which payers may im-  
17          plement program and policy findings of the Adminis-  
18          tration and the Laboratory to improve outcomes and  
19          reduce per capita program costs;

20          “(6) in consultation with the Assistant Sec-  
21          retary for Planning and Evaluation, as appropriate,  
22          periodically review Federal programs and activities  
23          relating to the diagnosis or prevention of, or treat-  
24          ment or rehabilitation for, mental illness and sub-  
25          stance use disorders, including by—

1           “(A) identifying any such programs or ac-  
2           tivities that are duplicative;

3           “(B) identifying any such programs or ac-  
4           tivities that are not evidence-based, effective, or  
5           efficient; and

6           “(C) formulating recommendations for co-  
7           ordinating, eliminating, or improving programs  
8           or activities identified under subparagraph (A)  
9           or (B) and merging such programs or activities  
10          into other successful programs or activities; and

11          “(7) carry out other activities as deemed nec-  
12          essary to continue to encourage innovation and dis-  
13          seminate evidence-based programs and practices, in-  
14          cluding programs and practices with scientific merit.

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

17                 “(1) IN GENERAL.—In selecting evidence-based  
18                 best practices and service delivery models for evalua-  
19                 tion and dissemination, the Laboratory—

20                         “(A) shall give preference to models that  
21                         improve—

22                                 “(i) the coordination between mental  
23                                 health and physical health providers;

1           “(ii) the coordination among such pro-  
2           viders and the justice and corrections sys-  
3           tem; and

4           “(iii) the cost effectiveness, quality,  
5           effectiveness, and efficiency of health care  
6           services furnished to individuals with seri-  
7           ous mental illness or serious emotional dis-  
8           turbance, in mental health crisis, or at risk  
9           to themselves, their families, and the gen-  
10          eral public; and

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

17          “(2) DEADLINE FOR BEGINNING IMPLEMENTA-  
18          TION.—The Laboratory shall begin implementation  
19          of the duties described in this section not later than  
20          January 1, 2018.

21          “(3) CONSULTATION.—In carrying out the du-  
22          ties under this section, the Laboratory shall consult  
23          with—

24                 “(A) representatives of the National Insti-  
25                 tute of Mental Health, the National Institute

1 on Drug Abuse, and the National Institute on  
2 Alcohol Abuse and Alcoholism, on an ongoing  
3 basis;

4 “(B) other appropriate Federal agencies;

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

10 “(D) other individuals and agencies as de-  
11 termined appropriate by the Assistant Sec-  
12 retary.”.

13 **SEC. 104. PEER-SUPPORT SPECIALIST PROGRAMS.**

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

24 (b) CONTENTS OF STUDY.—In conducting the study  
25 under subsection (a), the Comptroller General of the

1 United States shall examine and identify best practices in  
2 the selected States related to training and credential re-  
3 quirements for peer-support specialist programs, such  
4 as—

5 (1) hours of formal work or volunteer experi-  
6 ence related to mental illness and substance use dis-  
7 orders conducted through such programs;

8 (2) types of peer-support specialist exams re-  
9 quired for such programs in the States;

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

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

14 (5) requirements for continuing education.

15 **SEC. 105. PROHIBITION AGAINST LOBBYING USING FED-**  
16 **ERAL FUNDS BY SYSTEMS ACCEPTING FED-**  
17 **ERAL FUNDS TO PROTECT AND ADVOCATE**  
18 **THE RIGHTS OF INDIVIDUALS WITH MENTAL**  
19 **ILLNESS.**

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

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

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

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

4           “(11) agree to refrain, during any period for  
5           which funding is provided to the system under this  
6           part, from using Federal funds to pay the salary or  
7           expenses of any grant or contract recipient, or agent  
8           acting for such recipient, related to any activity de-  
9           signed to influence the enactment of legislation, ap-  
10          propriations, regulation, administrative action, or  
11          Executive order proposed or pending before the Con-  
12          gress or any State or local government, including  
13          any legislative body, other than for normal and rec-  
14          ognized executive-legislative relationships or partici-  
15          pation by an agency or officer of a State, local, or  
16          tribal government in policymaking and administra-  
17          tive processes within the executive branch of that  
18          government.”.

19 **SEC. 106. REPORTING FOR PROTECTION AND ADVOCACY**  
20 **ORGANIZATIONS.**

21           (a) **PUBLIC AVAILABILITY OF REPORTS.**—Section  
22 105(a)(7) of the Protection and Advocacy for Individuals  
23 with Mental Illness Act (42 U.S.C. 10805(a)(7)) is  
24 amended by striking “is located a report” and inserting  
25 “is located, and make publicly available, a report”.

1 (b) DETAILED ACCOUNTING.—Section 114(a) of the  
2 Protection and Advocacy for Individuals with Mental Ill-  
3 ness Act (42 U.S.C. 10824(a)) is amended—

4 (1) in paragraph (3), by striking “and” at the  
5 end;

6 (2) in paragraph (4), by striking the period at  
7 the end and inserting “; and”; and

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

9 “(5) using data from the existing required an-  
10 nual program progress reports submitted by each  
11 system funded under this title, a detailed accounting  
12 for each such system of how funds are spent,  
13 disaggregated according to whether the funds were  
14 received from the Federal Government, the State  
15 government, a local government, or a private enti-  
16 ty.”.

17 **SEC. 107. GRIEVANCE PROCEDURE.**

18 Section 105 of the Protection and Advocacy for Indi-  
19 viduals with Mental Illness Act (42 U.S.C. 10805), as  
20 amended, is further amended by adding at the end the  
21 following:

22 “(d) GRIEVANCE PROCEDURE.—The Secretary shall  
23 establish an independent grievance procedure for persons  
24 described in subsection (a)(9).”.

1 **SEC. 108. CENTER FOR BEHAVIORAL HEALTH STATISTICS**  
2 **AND QUALITY.**

3 Title V of the Public Health Service Act (42 U.S.C.  
4 290aa et seq.) is amended—

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

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

9 (2) in section 502(a)(1) (42 U.S.C. 290aa-  
10 1(a)(1))—

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

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

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

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

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

21 **“Subpart 4—Center for Behavioral Health Statistics**  
22 **and Quality**

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

25 “(a) ESTABLISHMENT.—There is established in the  
26 Administration a Center for Behavioral Health Statistics

1 and Quality (in this section referred to as the ‘Center’).  
2 The Center shall be headed by a Director (in this section  
3 referred to as the ‘Director’) appointed by the Secretary  
4 from among individuals with extensive experience and aca-  
5 demic qualifications in research and analysis in behavioral  
6 health care or related fields.

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

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

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

12 “(B) evaluation;

13 “(C) statistical and analytic support;

14 “(D) service systems research; and

15 “(E) performance and quality information  
16 systems;

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

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

23 “(c) BIENNIAL REPORT TO CONGRESS.—Not later  
24 than 2 years after the date of enactment of this section,  
25 and every 2 years thereafter, the Director of the Center

1 shall submit to Congress a report on the quality of services  
2 furnished through grant programs of the Administration,  
3 including applicable measures of outcomes for individuals  
4 and public outcomes such as—

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

17           “(2) the incidence and prevalence of mental ill-  
18 ness and substance use disorders; the number of sui-  
19 cide attempts and suicide completions; overdoses  
20 seen in emergency rooms resulting from alcohol and  
21 drug use; emergency room boarding; overdose  
22 deaths; emergency psychiatric hospitalizations; new  
23 criminal justice involvement while in treatment; sta-  
24 ble housing; and rates of involvement in employ-  
25 ment, education, and training; and

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

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

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

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

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

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

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

1 **SEC. 109. STRATEGIC PLAN.**

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

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

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

8 “(l) STRATEGIC PLAN.—

9 “(1) IN GENERAL.—Not later than December 1,  
10 2017, and every 5 years thereafter, the Assistant  
11 Secretary shall develop and carry out a strategic  
12 plan in accordance with this subsection for the plan-  
13 ning and operation of evidence-based programs and  
14 grants carried out by the Administration.

15 “(2) COORDINATION.—In developing and car-  
16 rying out the strategic plan under this section, the  
17 Assistant Secretary shall take into consideration the  
18 report of the Interdepartmental Serious Mental Ill-  
19 ness Coordinating Committee under section 301 of  
20 the Helping Families in Mental Health Crisis Act of  
21 2016.

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

1           “(A) submit the strategic plan developed  
2           under paragraph (1) to the appropriate commit-  
3           tees of Congress; and

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

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

8           “(A) identify strategic priorities, goals, and  
9           measurable objectives for mental illness and  
10          substance use disorder activities and programs  
11          operated and supported by the Administration,  
12          including priorities to prevent or eliminate the  
13          burden of mental illness and substance use dis-  
14          orders;

15          “(B) identify ways to improve services for  
16          individuals with a mental illness or substance  
17          use disorder, including services related to the  
18          prevention of, diagnosis of, intervention in,  
19          treatment of, and recovery from, mental illness  
20          or substance use disorders, including serious  
21          mental illness or serious emotional disturbance,  
22          and access to services and supports for individ-  
23          uals with a serious mental illness or serious  
24          emotional disturbance;

1           “(C) ensure that programs provide, as ap-  
2           propriate, access to effective and evidence-based  
3           prevention, diagnosis, intervention, treatment,  
4           and recovery services, including culturally and  
5           linguistically appropriate services, as appro-  
6           priate, for individuals with a mental illness or  
7           substance use disorder;

8           “(D) identify opportunities to collaborate  
9           with the Health Resources and Services Admin-  
10          istration to develop or improve—

11           “(i) initiatives to encourage individ-  
12          uals to pursue careers (especially in rural  
13          and underserved areas and populations) as  
14          psychiatrists, psychologists, psychiatric  
15          nurse practitioners, physician assistants,  
16          occupational therapists, clinical social  
17          workers, certified peer-support specialists,  
18          licensed professional counselors, or other  
19          licensed or certified mental health profes-  
20          sionals, including such professionals spe-  
21          cializing in the diagnosis, evaluation, or  
22          treatment of individuals with a serious  
23          mental illness or serious emotional disturb-  
24          ance; and

1           “(ii) a strategy to improve the recruit-  
2           ment, training, and retention of a work-  
3           force for the treatment of individuals with  
4           mental illness or substance use disorders,  
5           or co-occurring illness or disorders;

6           “(E) identify opportunities to improve col-  
7           laboration with States, local governments, com-  
8           munities, and Indian tribes and tribal organiza-  
9           tions (as such terms are defined in section 4 of  
10          the Indian Self-Determination and Education  
11          Assistance Act (25 U.S.C. 450b)); and

12          “(F) specify a strategy to disseminate evi-  
13          denced-based and promising best practices re-  
14          lated to prevention, diagnosis, early interven-  
15          tion, treatment, and recovery services related to  
16          mental illness, particularly for individuals with  
17          a serious mental illness and children and ado-  
18          lescents with a serious emotional disturbance,  
19          and substance use disorders.”.

20 **SEC. 110. AUTHORITIES OF CENTERS FOR MENTAL HEALTH**  
21 **SERVICES AND SUBSTANCE ABUSE TREAT-**  
22 **MENT.**

23          (a) CENTER FOR MENTAL HEALTH SERVICES.—Sec-  
24          tion 520(b) of the Public Health Service Act (42 U.S.C.  
25          290bb–31(b)) is amended—

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

3           (2) by inserting after paragraph (2) the fol-  
4           lowing:

5           “(3) collaborate with the Director of the Na-  
6           tional Institute of Mental Health to ensure that, as  
7           appropriate, programs related to the prevention and  
8           treatment of mental illness and the promotion of  
9           mental health are carried out in a manner that re-  
10          flects the best available science and evidence-based  
11          practices, including culturally and linguistically ap-  
12          propriate services;”;

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

16          (4) in paragraph (6), as so redesignated, by in-  
17          serting “in collaboration with the Director of the  
18          National Institute of Mental Health,” before “de-  
19          velop”;

20          (5) in paragraph (8), as so redesignated, by in-  
21          serting “, increase meaningful participation of indi-  
22          viduals with mental illness in programs and activi-  
23          ties of the Administration,” before “and protect the  
24          legal”;

1           (6) in paragraph (10), as so redesignated, by  
2 striking “professional and paraprofessional per-  
3 sonnel pursuant to section 303” and inserting  
4 “paraprofessional personnel and health profes-  
5 sionals”;

6           (7) in paragraph (11), as so redesignated, by  
7 inserting “and telemental health,” after “rural men-  
8 tal health,”;

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

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

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

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

20           “(17) consult with other agencies and offices of  
21 the Department of Health and Human Services to  
22 ensure, with respect to each grant awarded by the  
23 Center for Mental Health Services, the consistent  
24 documentation of the application of criteria when

1       awarding grants and the ongoing oversight of grant-  
2       ees after such grants are awarded.”.

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

6           (1) in subsection (a)—

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

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

13           (2) in subsection (b)—

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

16               (B) in paragraph (4), by striking “individ-  
17               uals who abuse drugs” and inserting “individ-  
18               uals who use drugs”;

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

21               (D) by striking paragraph (10);

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

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

4 (G) by striking paragraph (13), as so re-  
5 designated, and inserting the following:

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

10 “(14) work with States, providers, and individ-  
11 uals in recovery, and their families, to promote the  
12 expansion of recovery support services and systems  
13 of care oriented towards recovery.”

14 **SEC. 111. ADVISORY COUNCILS.**

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

17 (1) in paragraph (2)—

18 (A) in subparagraph (E), by striking  
19 “and” after the semicolon;

20 (B) by redesignating subparagraph (F) as  
21 subparagraph (I); and

22 (C) by inserting after subparagraph (E),  
23 the following:

24 “(F) for the advisory councils appointed  
25 under subsections (a)(1)(A) and (a)(1)(D), the

1 Director of the National Institute of Mental  
2 Health;

3 “(G) for the advisory councils appointed  
4 under subsections (a)(1)(A), (a)(1)(B), and  
5 (a)(1)(C), the Director of the National Institute  
6 on Drug Abuse;

7 “(H) for the advisory councils appointed  
8 under subsections (a)(1)(A), (a)(1)(B), and  
9 (a)(1)(C), the Director of the National Institute  
10 on Alcohol Abuse and Alcoholism; and”;

11 (2) in paragraph (3), by adding at the end the  
12 following:

13 “(C) Not less than half of the members of  
14 the advisory council appointed under subsection  
15 (a)(1)(D)—

16 “(i) shall have—

17 “(I) a medical degree;

18 “(II) a doctoral degree in psy-  
19 chology; or

20 “(III) an advanced degree in  
21 nursing or social work from an ac-  
22 credited graduate school or be a cer-  
23 tified physician assistant; and

24 “(ii) shall specialize in the mental  
25 health field.”.

1 **SEC. 112. PEER REVIEW.**

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

13 **TITLE II—MEDICAID MENTAL**  
14 **HEALTH COVERAGE**

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

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

25 (1) a primary care service furnished to the indi-  
26 vidual by a provider at a facility on the same day

1 a mental health service is furnished to such indi-  
2 vidual by such provider (or another provider) at the  
3 facility; or

4 (2) a mental health service furnished to the in-  
5 dividual by a provider at a facility on the same day  
6 a primary care service is furnished to such individual  
7 by such provider (or another provider) at the facil-  
8 ity.

9 **SEC. 202. OPTIONAL LIMITED COVERAGE OF INPATIENT**  
10 **SERVICES FURNISHED IN INSTITUTIONS FOR**  
11 **MENTAL DISEASES.**

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

15 “(I)(i) Notwithstanding the limitation specified in the  
16 subdivision (B) following paragraph (29) of section  
17 1905(a) and subject to clause (ii), a State may, under a  
18 risk contract entered into by the State under this title (or  
19 under section 1115) with a medicaid managed care organi-  
20 zation or a prepaid inpatient health plan (as defined in  
21 section 438.2 of title 42, Code of Federal Regulations (or  
22 any successor regulation)), make a monthly capitation  
23 payment to such organization or plan for enrollees with  
24 the organization or plan who are over 21 years of age and  
25 under 65 years of age and are receiving inpatient treat-

1 ment in an institution for mental diseases (as defined in  
2 section 1905(i)), so long as each of the following condi-  
3 tions is met:

4           “(I) The institution is a hospital providing in-  
5           patient psychiatric or substance use disorder services  
6           or a sub-acute facility providing psychiatric or sub-  
7           stance use disorder crisis residential services.

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

12          “(III) The provision of such treatment meets  
13          the following criteria for consideration as services or  
14          settings that are provided in lieu of services or set-  
15          tings covered under the State plan:

16               “(aa) The State determines that the alter-  
17               native service or setting is a medically appro-  
18               priate and cost-effective substitute for the serv-  
19               ice or setting covered under the State plan.

20               “(bb) The enrollee is not required by the  
21               managed care organization or prepaid inpatient  
22               health plan to use the alternative service or set-  
23               ting.

24               “(cc) Such treatment is authorized and  
25               identified in such contract, and will be offered

1 to such enrollees at the option of the managed  
2 care organization or prepaid inpatient health  
3 plan.

4 “(ii) For purposes of setting the amount of such a  
5 monthly capitation payment, a State may use the utiliza-  
6 tion of services provided to an individual under this sub-  
7 paragraph when developing the inpatient psychiatric or  
8 substance use disorder component of such payment, but  
9 the amount of such payment for such services may not  
10 exceed the cost of the same services furnished through  
11 providers included under the State plan.”.

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

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

17 (a) STUDY.—The Secretary of Health and Human  
18 Services, acting through the Administrator of the Centers  
19 for Medicare & Medicaid Services, shall conduct a study  
20 on coverage under the Medicaid program under title XIX  
21 of the Social Security Act (42 U.S.C. 1396 et seq.) of serv-  
22 ices provided through a medicaid managed care organiza-  
23 tion (as defined in section 1903(m) of such Act (42 U.S.C.  
24 1396b(m)) or a prepaid inpatient health plan (as defined  
25 in section 438.2 of title 42, Code of Federal Regulations

1 (or any successor regulation)) with respect to individuals  
2 over the age of 21 and under the age of 65 for the treat-  
3 ment of a mental health disorder in institutions for mental  
4 diseases (as defined in section 1905(i) of such Act (42  
5 U.S.C. 1396d(i))). Such study shall include information  
6 on the following:

7           (1) The extent to which States, including the  
8           District of Columbia and each territory or possession  
9           of the United States, are providing capitated pay-  
10          ments to such organizations or plans for enrollees  
11          who are receiving services in institutions for mental  
12          diseases.

13          (2) The number of individuals receiving medical  
14          assistance under a State plan under such title XIX,  
15          or a waiver of such plan, who receive services in in-  
16          stitutions for mental diseases through such organiza-  
17          tions and plans.

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

22          (4) How such organizations or plans determine  
23          when to provide for the furnishing of such services  
24          through an institution for mental diseases in lieu of  
25          other benefits (including the full range of commu-

1 nity-based services) under their contract with the  
2 State agency administering the State plan under  
3 such title XIX, or a waiver of such plan, to address  
4 psychiatric or substance use disorder treatment.

5 (5) The extent to which the provision of serv-  
6 ices within such institutions has affected the  
7 capitated payments for such organizations or plans.

8 (b) REPORT.—Not later than 3 years after the date  
9 of the enactment of this Act, the Secretary shall submit  
10 to Congress a report on the study conducted under sub-  
11 section (a).

12 **SEC. 204. GUIDANCE ON OPPORTUNITIES FOR INNOVATION.**

13 Not later than 1 year after the date of the enactment  
14 of this Act, the Administrator of the Centers for Medicare  
15 & Medicaid Services shall issue a State Medicaid Director  
16 letter regarding opportunities to design innovative service  
17 delivery systems, including systems for providing commu-  
18 nity-based services, for individuals with serious mental ill-  
19 ness or serious emotional disturbance who are receiving  
20 medical assistance under title XIX of the Social Security  
21 Act (42 U.S.C. 1396 et seq.). The letter shall include op-  
22 portunities for demonstration projects under section 1115  
23 of such Act (42 U.S.C. 1315), to improve care for such  
24 individuals.

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

3 (a) COLLECTION OF INFORMATION.—The Secretary  
4 of Health and Human Services, acting through the Ad-  
5 ministrator of the Centers for Medicare & Medicaid Serv-  
6 ices, shall, with respect to each State that has participated  
7 in the demonstration project established under section  
8 2707 of the Patient Protection and Affordable Care Act  
9 (42 U.S.C. 1396a note), collect from each such State in-  
10 formation on the following:

11 (1) The number of institutions for mental dis-  
12 eases (as defined in section 1905(i) of the Social Se-  
13 curity Act (42 U.S.C. 1396d(i))) and beds in such  
14 institutions that received payment for the provision  
15 of services to individuals who receive medical assist-  
16 ance under a State plan under the Medicaid pro-  
17 gram under title XIX of the Social Security Act (42  
18 U.S.C. 1396 et seq.) (or under a waiver of such  
19 plan) through the demonstration project in each  
20 such State as compared to the total number of insti-  
21 tutions for mental diseases and beds in the State.

22 (2) The extent to which there is a reduction in  
23 expenditures under the Medicaid program under title  
24 XIX of the Social Security Act (42 U.S.C. 1396 et  
25 seq.) or other spending on the full continuum of  
26 physical or mental health care for individuals who

1 receive treatment in an institution for mental dis-  
2 eases under the demonstration project, including  
3 outpatient, inpatient, emergency, and ambulatory  
4 care, that is attributable to such individuals receiv-  
5 ing treatment in institutions for mental diseases  
6 under the demonstration project.

7 (3) The number of forensic psychiatric hos-  
8 pitals, the number of beds in such hospitals, and the  
9 number of forensic psychiatric beds in other hos-  
10 pitals in such State, based on the most recent data  
11 available, to the extent practical, as determined by  
12 such Administrator.

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

21 (5) The most recent data regarding all facilities  
22 or sites in the State in which any individuals with  
23 serious mental illness who are receiving medical as-  
24 sistance under a State plan under the Medicaid pro-  
25 gram under title XIX of the Social Security Act (42

1 U.S.C. 1396 et seq.) (or under a waiver of such  
2 plan) are treated during the period referred to in  
3 paragraph (4), to the extent practical, as determined  
4 by the Administrator, including—

5 (A) the types of such facilities or sites  
6 (such as an institution for mental diseases, a  
7 hospital emergency department, or other inpa-  
8 tient hospital);

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

12 (C) the payment rate under the State plan  
13 (or a waivers of such plan) for services fur-  
14 nished to such an individual for that treatment,  
15 disaggregated by facility type, during the period  
16 in which the demonstration project is in oper-  
17 ation.

18 (6) The extent to which the utilization of hos-  
19 pital emergency departments during the period in  
20 which the demonstration project was is in operation  
21 differed, with respect to individuals who are receiv-  
22 ing medical assistance under a State plan under the  
23 Medicaid program under title XIX of the Social Se-  
24 curity Act (42 U.S.C. 1396 et seq.) (or under a  
25 waiver of such plan), between—

1 (A) those individuals who received treat-  
2 ment in an institution for mental diseases  
3 under the demonstration project;

4 (B) those individuals who met the eligi-  
5 bility requirements for the demonstration  
6 project but who did not receive treatment in an  
7 institution for mental diseases under the dem-  
8 onstration project; and

9 (C) those individuals with serious mental  
10 illness who did not meet such eligibility require-  
11 ments and did not receive treatment for such  
12 illness in an institution for mental diseases.

13 (b) REPORT.—Not later than 2 years after the date  
14 of the enactment of this Act, the Secretary of Health and  
15 Human Services shall submit to Congress a report that  
16 summarizes and analyzes the information collected under  
17 subsection (a). Such report may be submitted as part of  
18 the report required under section 2707(f) of the Patient  
19 Protection and Affordable Care Act (42 U.S.C. 1396a  
20 note) or separately.

21 **SEC. 206. PROVIDING EPSDT SERVICES TO CHILDREN IN**  
22 **IMDS.**

23 (a) IN GENERAL.—Section 1905(a)(16) of the Social  
24 Security Act (42 U.S.C. 1396d(a)(16)) is amended—

1 (1) by striking “effective January 1, 1973” and  
2 inserting “(A) effective January 1, 1973”; and

3 (2) by inserting before the semicolon at the end  
4 the following: “, and, (B) for individuals receiving  
5 services described in subparagraph (A), early and  
6 periodic screening, diagnostic, and treatment serv-  
7 ices (as defined in subsection (r)), whether or not  
8 such screening, diagnostic, and treatment services  
9 are furnished by the provider of the services de-  
10 scribed in such subparagraph”.

11 (b) EFFECTIVE DATE.—The amendment made by  
12 subsection (a) shall apply with respect to items and serv-  
13 ices furnished in calendar quarters beginning on or after  
14 January 1, 2019.

15 **SEC. 207. ELECTRONIC VISIT VERIFICATION SYSTEM RE-**  
16 **QUIRED FOR PERSONAL CARE SERVICES AND**  
17 **HOME HEALTH CARE SERVICES UNDER MED-**  
18 **ICAID.**

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

22 “(l)(1) Subject to paragraphs (3) and (4), with re-  
23 spect to any amount expended for personal care services  
24 or home health care services requiring an in-home visit  
25 by a provider that are provided under a State plan under

1 this title (or under a waiver of the plan) and furnished  
2 in a calendar quarter beginning on or after January 1,  
3 2019 (or, in the case of home health care services, on or  
4 after January 1, 2023), unless a State requires the use  
5 of an electronic visit verification system for such services  
6 furnished in such quarter under the plan or such waiver,  
7 the Federal medical assistance percentage shall be re-  
8 duced—

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

10 “(i) for calendar quarters in 2019 and  
11 2020, by .25 percentage points;

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

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

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

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

19 “(i) for calendar quarters in 2023 and  
20 2024, by .25 percentage points;

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

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

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

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

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

10                           “(i) is minimally burdensome;

11                           “(ii) takes into account existing best prac-  
12                           tices and electronic visit verification systems in  
13                           use in the State; and

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

18                   “(B) take into account a stakeholder process  
19                   that includes input from beneficiaries, family care-  
20                   givers, individuals who furnish personal care services  
21                   or home health care services, and other stakeholders,  
22                   as determined by the State in accordance with guid-  
23                   ance from the Secretary; and

24                   “(C) ensure that individuals who furnish per-  
25                   sonal care services, home health care services, or

1 both under the State plan (or under a waiver of the  
2 plan) are provided the opportunity for training on  
3 the use of such system.

4 “(3) Paragraphs (1) and (2) shall not apply in the  
5 case of a State that, as of the date of the enactment of  
6 this subsection, requires the use of any system for the elec-  
7 tronic verification of visits conducted as part of both per-  
8 sonal care services and home health care services, so long  
9 as the State continues to require the use of such system  
10 with respect to the electronic verification of such visits.

11 “(4)(A) In the case of a State described in subpara-  
12 graph (B), the reduction under paragraph (1) shall not  
13 apply—

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

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

18 “(B) For purposes of subparagraph (A), a State de-  
19 scribed in this subparagraph is a State that demonstrates  
20 to the Secretary that the State—

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

1           “(ii) in implementing such a system, has en-  
2           countered unavoidable system delays.

3           “(5) In this subsection:

4           “(A) The term ‘electronic visit verification sys-  
5           tem’ means, with respect to personal care services or  
6           home health care services, a system under which vis-  
7           its conducted as part of such services are electroni-  
8           cally verified with respect to—

9                   “(i) the type of service performed;

10                   “(ii) the individual receiving the service;

11                   “(iii) the date of the service;

12                   “(iv) the location of service delivery;

13                   “(v) the individual providing the service;

14                   and

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

16           “(B) The term ‘home health care services’  
17           means services described in section 1905(a)(7) pro-  
18           vided under a State plan under this title (or under  
19           a waiver of the plan).

20           “(C) The term ‘personal care services’ means  
21           personal care services provided under a State plan  
22           under this title (or under a waiver of the plan), in-  
23           cluding services provided under section 1905(a)(24),  
24           1915(c), 1915(i), 1915(j), or 1915(k) or under a  
25           wavier under section 1115.

1           “(6)(A) In the case in which a State requires personal  
2 care service and home health care service providers to uti-  
3 lize an electronic visit verification system operated by the  
4 State or a contractor on behalf of the State, the Secretary  
5 shall pay to the State, for each quarter, an amount equal  
6 to 90 per centum of so much of the sums expended during  
7 such quarter as are attributable to the design, develop-  
8 ment, or installation of such system, and 75 per centum  
9 of so much of the sums for the operation and maintenance  
10 of such system.

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

16           (b) COLLECTION AND DISSEMINATION OF BEST  
17 PRACTICES.—Not later than January 1, 2018, the Sec-  
18 retary of Health and Human Services shall, with respect  
19 to electronic visit verification systems (as defined in sub-  
20 section (l)(5) of section 1903 of the Social Security Act  
21 (42 U.S.C. 1396b), as inserted by subsection (a)), collect  
22 and disseminate best practices to State Medicaid Directors  
23 with respect to—

24           (1) training individuals who furnish personal  
25 care services, home health care services, or both

1 under the State plan under title XIX of such Act (or  
2 under a waiver of the plan) on such systems and the  
3 operation of such systems and the prevention of  
4 fraud with respect to the provision of personal care  
5 services or home health care services (as defined in  
6 such subsection (1)(5)); and

7 (2) the provision of notice and educational ma-  
8 terials to family caregivers and beneficiaries with re-  
9 spect to the use of such electronic visit verification  
10 systems and other means to prevent such fraud.

11 (c) RULES OF CONSTRUCTION.—

12 (1) NO EMPLOYER-EMPLOYEE RELATIONSHIP  
13 ESTABLISHED.—Nothing in the amendment made by  
14 this section may be construed as establishing an em-  
15 ployer-employee relationship between the agency or  
16 entity that provides for personal care services or  
17 home health care services and the individuals who,  
18 under a contract with such an agency or entity, fur-  
19 nish such services for purposes of part 552 of title  
20 29, Code of Federal Regulations (or any successor  
21 regulations).

22 (2) NO PARTICULAR OR UNIFORM ELECTRONIC  
23 VISIT VERIFICATION SYSTEM REQUIRED.—Nothing  
24 in the amendment made by this section shall be con-  
25 strued to require the use of a particular or uniform

1 electronic visit verification system (as defined in sub-  
2 section (l)(5) of section 1903 of the Social Security  
3 Act (42 U.S.C. 1396b), as inserted by subsection  
4 (a)) by all agencies or entities that provide personal  
5 care services or home health care under a State plan  
6 under title XIX of the Social Security Act (or under  
7 a waiver of the plan) (42 U.S.C. 1396 et seq.).

8 (3) NO LIMITS ON PROVISION OF CARE.—Noth-  
9 ing in the amendment made by this section may be  
10 construed to limit, with respect to personal care  
11 services or home health care services provided under  
12 a State plan under title XIX of the Social Security  
13 Act (or under a waiver of the plan) (42 U.S.C. 1396  
14 et seq.), provider selection, constrain beneficiaries'  
15 selection of a caregiver, or impede the manner in  
16 which care is delivered.

17 (4) NO PROHIBITION ON STATE QUALITY MEAS-  
18 URES REQUIREMENTS.—Nothing in the amendment  
19 made by this section shall be construed as prohib-  
20 iting a State, in implementing an electronic visit  
21 verification system (as defined in subsection (l)(5) of  
22 section 1903 of the Social Security Act (42 U.S.C.  
23 1396b), as inserted by subsection (a)), from estab-  
24 lishing requirements related to quality measures for  
25 such system.

1 **TITLE III—INTERDEPART-**  
2 **MENTAL SERIOUS MENTAL**  
3 **ILLNESS COORDINATING**  
4 **COMMITTEE**

5 **SEC. 301. INTERDEPARTMENTAL SERIOUS MENTAL ILL-**  
6 **NESS COORDINATING COMMITTEE.**

7 (a) ESTABLISHMENT.—

8 (1) IN GENERAL.—Not later than 3 months  
9 after the date of enactment of this Act, the Sec-  
10 retary of Health and Human Services, or the des-  
11 ignee of the Secretary, shall establish a committee to  
12 be known as the “Interdepartmental Serious Mental  
13 Illness Coordinating Committee” (in this section re-  
14 ferred to as the “Committee”).

15 (2) FEDERAL ADVISORY COMMITTEE ACT.—Ex-  
16 cept as provided in this section, the provisions of the  
17 Federal Advisory Committee Act (5 U.S.C. App.)  
18 shall apply to the Committee.

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

21 (c) RESPONSIBILITIES.—Not later than 1 year after  
22 the date of enactment of this Act, and 5 years after such  
23 date of enactment, the Committee shall submit to Con-  
24 gress a report including—

1           (1) a summary of advances in serious mental  
2 illness and serious emotional disturbance research  
3 related to the prevention of, diagnosis of, interven-  
4 tion in, and treatment and recovery of, serious men-  
5 tal illnesses, serious emotional disturbances, and ad-  
6 vances in access to services and support for individ-  
7 uals with a serious mental illness or serious emo-  
8 tional disturbance;

9           (2) an evaluation of the effect on public health  
10 of Federal programs related to serious mental illness  
11 or serious emotional disturbance, including measure-  
12 ments of public health outcomes such as—

13                 (A) rates of suicide, suicide attempts, prev-  
14 alence of serious mental illness, serious emo-  
15 tional disturbances, and substance use dis-  
16 orders, overdose, overdose deaths, emergency  
17 hospitalizations, emergency room boarding, pre-  
18 ventable emergency room visits, involvement  
19 with the criminal justice system, crime, home-  
20 lessness, and unemployment;

21                 (B) increased rates of employment and en-  
22 rollment in educational and vocational pro-  
23 grams;

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

1           (D) any other criteria as may be deter-  
2           mined by the Secretary;

3           (3) a plan to improve outcomes for individuals  
4           with serious mental illness or serious emotional dis-  
5           turbances, including reducing incarceration for such  
6           individuals, reducing homelessness, and increasing  
7           employment; and

8           (4) specific recommendations for actions that  
9           agencies can take to better coordinate the adminis-  
10          tration of mental health services for people with seri-  
11          ous mental illness or serious emotional disturbances.

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

16          (e) MEMBERSHIP.—

17               (1) FEDERAL MEMBERS.—The Committee shall  
18               be composed of the following Federal representa-  
19               tives, or their designees:

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

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

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

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

5 (E) The Attorney General of the United  
6 States.

7 (F) The Secretary of Veterans Affairs.

8 (G) The Secretary of Defense.

9 (H) The Secretary of Housing and Urban  
10 Development.

11 (I) The Secretary of Education.

12 (J) The Secretary of Labor.

13 (K) The Commissioner of Social Security.

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

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

20 (A) at least two members shall be individ-  
21 uals with lived experience with serious mental  
22 illness or serious emotional disturbance;

23 (B) at least one member shall be a parent  
24 or legal guardian of an individual with a history

1 of a serious mental illness or serious emotional  
2 disturbance;

3 (C) at least one member shall be a rep-  
4 resentative of a leading research, advocacy, or  
5 service organization for individuals with serious  
6 mental illness or serious emotional disturbance;

7 (D) at least two members shall be—

8 (i) a licensed psychiatrist with experi-  
9 ence treating serious mental illnesses or se-  
10 rious emotional disturbances;

11 (ii) a licensed psychologist with expe-  
12 rience treating serious mental illnesses or  
13 serious emotional disturbances;

14 (iii) a licensed clinical social worker  
15 with experience treating serious mental ill-  
16 ness or serious emotional disturbances; or

17 (iv) a licensed psychiatric nurse, nurse  
18 practitioner, or physician assistant with ex-  
19 perience treating serious mental illnesses  
20 or serious emotional disturbances;

21 (E) at least one member shall be a licensed  
22 mental health professional with a specialty in  
23 treating children and adolescents with serious  
24 emotional disturbances;

1 (F) at least one member shall be a mental  
2 health professional who has research or clinical  
3 mental health experience working with minori-  
4 ties;

5 (G) at least one member shall be a mental  
6 health professional who has research or clinical  
7 mental health experience working with medi-  
8 cally underserved populations;

9 (H) at least one member shall be a State  
10 certified mental health peer-support specialist;

11 (I) at least one member shall be a judge  
12 with experience adjudicating cases within a  
13 mental health court;

14 (J) at least one member shall be a law en-  
15 forcement officer or corrections officer with ex-  
16 tensive experience in interfacing with individ-  
17 uals with a serious mental illness or serious  
18 emotional disturbance, or in a mental health  
19 crisis; and

20 (K) at least one member shall be a home-  
21 less services provider with experience working  
22 with individuals with serious mental illness,  
23 with serious emotional disturbance, or having  
24 mental health crisis.

1           (3) TERMS.—A member of the Committee ap-  
2           pointed under paragraph (2) shall serve for a term  
3           of 3 years, and may be reappointed for one or more  
4           additional 3-year terms. Any member appointed to  
5           fill a vacancy for an unexpired term shall be ap-  
6           pointed for the remainder of such term. A member  
7           may serve after the expiration of the member’s term  
8           until a successor has been appointed.

9           (f) WORKING GROUPS.—In carrying out its func-  
10          tions, the Committee may establish working groups. Such  
11          working groups shall be composed of Committee members,  
12          or their designees, and may hold such meetings as are nec-  
13          essary.

14          (g) SUNSET.—The Committee shall terminate on the  
15          date that is 6 years after the date on which the Committee  
16          is established under subsection (a)(1).

17           **TITLE IV—COMPASSIONATE**  
18           **COMMUNICATION ON HIPAA**

19   **SEC. 401. SENSE OF CONGRESS.**

20          (a) FINDINGS.—Congress finds the following:

21           (1) The vast majority of individuals with mental  
22           illness are capable of understanding their illness and  
23           caring for themselves.

24           (2) Persons with serious mental illness (in this  
25           section referred to as “SMI”), including schizo-

1        phrenia spectrum, bipolar disorders, and major de-  
2        pressive disorder, may be significantly impaired in  
3        their ability to understand or make sound decisions  
4        for their care and needs. By nature of their illness,  
5        cognitive impairments in reasoning and judgment, as  
6        well as the presence of hallucinations, delusions, and  
7        severe emotional distortions, they may lack the  
8        awareness they even have a mental illness (a condi-  
9        tion known as anosognosia), and thus may be unable  
10       to make sound decisions regarding their care, nor  
11       follow through consistently and effectively on their  
12       care needs.

13                (3) Persons with mental illness or SMI may re-  
14       require and benefit from mental health treatment in  
15       order to recover to the fullest extent of their ability;  
16       these beneficial interventions may include psychiatric  
17       care, psychological care, medication, peer support,  
18       educational support, employment support, and hous-  
19       ing support.

20                (4) Persons with SMI who are provided with  
21       professional and supportive services may still experi-  
22       ence times when their symptoms may greatly impair  
23       their abilities to make sound decisions for their per-  
24       sonal care or may discontinue their care as a result  
25       of this impaired decisionmaking resulting in a fur-

1       ther deterioration of their condition. They may expe-  
2       rience a temporary or prolonged impairment as a re-  
3       sult of their diminished capacity to care for them-  
4       selves.

5           (5) Episodes of psychiatric crises among those  
6       with SMI can result in neurological harm to the in-  
7       dividual's brain.

8           (6) Persons with SMI—

9           (A) are at high risk for other chronic phys-  
10       ical illnesses, with approximately 50 percent  
11       having two or more co-occurring chronic phys-  
12       ical illnesses such as cardiac, pulmonary, can-  
13       cer, and endocrine disorders; and

14          (B) have three times the odds of having  
15       chronic bronchitis, five times the odds of having  
16       emphysema, and four times the odds of having  
17       COPD, are more than four times as likely to  
18       have fluid and electrolyte disorders, and are  
19       nearly three times as likely to be nicotine de-  
20       pendent.

21          (7) Some psychotropic medications, such as sec-  
22       ond generation antipsychotics, significantly increase  
23       risk for chronic illnesses such as diabetes and car-  
24       diovascular disease.

1           (8) When the individual fails to seek or main-  
2           tain treatment for these physical conditions over a  
3           long term, it can result in the individual becoming  
4           gravely disabled, or developing life-threatening ill-  
5           nesses. Early and consistent treatment can amelio-  
6           rate or reduce symptoms or cure the disease.

7           (9) Persons with SMI die 7 to 24 years earlier  
8           than their age cohorts primarily because of com-  
9           plications from their chronic physical illness and fail-  
10          ure to seek or maintain treatment resulting from  
11          emotional and cognitive impairments from their  
12          SMI.

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

18          (11) When the individual with SMI is signifi-  
19          cantly diminished in their capacity to care for them-  
20          selves long term or acutely, other supportive inter-  
21          ventions to assist their care may be necessary to  
22          protect their health and safety.

23          (12) Prognosis for the physical and psychiatric  
24          health of those with SMI may improve when respon-  
25          sible caregivers facilitate and participate in care.

1           (13) When an individual with SMI is chron-  
2 ically incapacitated in their ability to care for them-  
3 selves, caregivers can pursue legal guardianship to  
4 facilitate care in appropriate areas while being mind-  
5 ful to allow the individual to make decisions for  
6 themselves in areas where they are capable.

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

18           (15) All professional and support efforts should  
19 be made to help the individual with SMI and acute  
20 or chronic physical illnesses to understand and fol-  
21 low through on treatment.

22           (16) When individuals with SMI, even after ef-  
23 forts to help them understand, have failed to care  
24 for themselves, there exists confusion in the health  
25 care community around what is currently permis-

1       sible under HIPAA rules. This confusion may hinder  
2       communication with responsible caregivers who may  
3       be able to facilitate care for the patient with SMI in  
4       instances when the individual does not give permis-  
5       sion for disclosure.

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

17 **SEC. 402. CONFIDENTIALITY OF RECORDS.**

18       Not later than 1 year after the date on which the  
19 Secretary of Health and Human Services first finalizes  
20 regulations updating part 2 of title 42, Code of Federal  
21 Regulations (relating to confidentiality of alcohol and drug  
22 abuse patient records) after the date of enactment of this  
23 Act, the Secretary shall convene relevant stakeholders to  
24 determine the effect of such regulations on patient care,  
25 health outcomes, and patient privacy. The Secretary shall

1 submit to the Committee on Energy and Commerce of the  
2 House of Representatives and the Committee on Health,  
3 Education, Labor, and Pensions of the Senate, and make  
4 publicly available, a report on the findings of such stake-  
5 holders.

6 **SEC. 403. CLARIFICATION OF CIRCUMSTANCES UNDER**  
7 **WHICH DISCLOSURE OF PROTECTED HEALTH**  
8 **INFORMATION IS PERMITTED.**

9 (a) IN GENERAL.—Not later than 1 year after the  
10 date of enactment of this section, the Secretary of Health  
11 and Human Services shall promulgate final regulations  
12 clarifying the circumstances under which, consistent with  
13 the provisions of subpart C of title XI of the Social Secu-  
14 rity Act (42 U.S.C. 1320d et seq.) and regulations pro-  
15 mulgated pursuant to section 264(e) of the Health Insur-  
16 ance Portability and Accountability Act of 1996 (42  
17 U.S.C. 1320d–2 note), a health care provider or covered  
18 entity may disclose the protected health information of a  
19 patient with a mental illness, including for purposes of—

20 (1) communicating (including with respect to  
21 treatment, side effects, risk factors, and the avail-  
22 ability of community resources) with a family mem-  
23 ber of such patient, caregiver of such patient, or  
24 other individual to the extent that such family mem-

1 ber, caregiver, or individual is involved in the care  
2 of the patient;

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

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

9 (4) considering the patient's capacity to agree  
10 or object to the sharing of the protected health in-  
11 formation of the patient;

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

14 (A) the patient consents;

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

19 (C) the patient does not consent and the  
20 patient is not incapacitated or in an emergency  
21 circumstance, but the ability of the patient to  
22 make rational health care decisions is signifi-  
23 cantly diminished by reason of the physical or  
24 mental health condition of the patient; and

1 (D) the patient does not consent, but such  
2 communication and sharing of information is  
3 necessary to prevent impending and serious de-  
4 terioration of the patient's mental or physical  
5 health;

6 (6) involving a patient's family members, care-  
7 givers, or others involved in the patient's care or  
8 care plan, including facilitating treatment and medi-  
9 cation adherence, in dealing with patient failures to  
10 adhere to medication or other therapy;

11 (7) listening to or receiving information with re-  
12 spect to the patient from the family or caregiver of  
13 such patient receiving mental illness treatment;

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

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

24 (b) COORDINATION.—The Secretary of Health and  
25 Human Services shall carry out this section in coordina-

1 tion with the Director of the Office for Civil Rights within  
2 the Department of Health and Human Services.

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

9 **SEC. 404. DEVELOPMENT AND DISSEMINATION OF MODEL**  
10 **TRAINING PROGRAMS.**

11 (a) INITIAL PROGRAMS AND MATERIALS.—Not later  
12 than 1 year after the date of the enactment of this Act,  
13 the Secretary of Health and Human Services (in this sec-  
14 tion referred to as the “Secretary”) shall develop and dis-  
15 seminate—

16 (1) a model program and materials for training  
17 health care providers (including physicians, emer-  
18 gency medical personnel, psychologists, counselors,  
19 therapists, behavioral health facilities and clinics,  
20 care managers, and hospitals) regarding the cir-  
21 cumstances under which, consistent with the stand-  
22 ards governing the privacy and security of individ-  
23 ually identifiable health information promulgated by  
24 the Secretary under subpart C of title XI of the So-  
25 cial Security Act (42 U.S.C. 1320d et seq.) and reg-

1       ulations promulgated pursuant to section 264(e) of  
2       the Health Insurance Portability and Accountability  
3       Act of 1996 (42 U.S.C. 1320d–2 note), the pro-  
4       tected health information of patients with a mental  
5       illness may be disclosed with and without patient  
6       consent;

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

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

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

15              (1) periodically review and update the model  
16       programs and materials developed under subsection  
17       (a); and

18              (2) disseminate the updated model programs  
19       and materials.

20       (c) CONTENTS.—The programs and materials devel-  
21       oped under subsection (a) shall address the guidance enti-  
22       tled “HIPAA Privacy Rule and Sharing Information Re-  
23       lated to Mental Health”, issued by the Department of  
24       Health and Human Services on February 20, 2014.

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

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

14           (f) FUNDING.—There are authorized to be appro-  
15 priated to carry out this section \$4,000,000 for fiscal year  
16 2018, \$2,000,000 for each of fiscal years 2019 and 2020,  
17 and \$1,000,000 for each of fiscal years 2021 and 2022.

1 **TITLE V—INCREASING ACCESS**  
2 **TO TREATMENT FOR SERIOUS**  
3 **MENTAL ILLNESS**

4 **SEC. 501. ASSERTIVE COMMUNITY TREATMENT GRANT**  
5 **PROGRAM FOR INDIVIDUALS WITH SERIOUS**  
6 **MENTAL ILLNESS.**

7 Part B of title V of the Public Health Service Act  
8 (42 U.S.C. 290bb et seq.) is amended by inserting after  
9 section 520L the following:

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

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

15 “(1) to establish assertive community treatment  
16 programs for individuals with serious mental illness;  
17 or

18 “(2) to maintain or expand such programs.

19 “(b) **ELIGIBLE ENTITIES.**—To be eligible to receive  
20 a grant under this section, an entity shall be a State, coun-  
21 ty, city, tribe, tribal organization, mental health system,  
22 health care facility, or any other entity the Assistant Sec-  
23 retary deems appropriate.

24 “(c) **SPECIAL CONSIDERATION.**—In selecting among  
25 applicants for a grant under this section, the Assistant

1 Secretary may give special consideration to the potential  
2 of the applicant’s program to reduce hospitalization,  
3 homelessness, and involvement with the criminal justice  
4 system while improving the health and social outcomes of  
5 the patient.

6 “(d) ADDITIONAL ACTIVITIES.—The Assistant Sec-  
7 retary shall—

8 “(1) not later than the end of fiscal year 2021,  
9 submit a report to the appropriate congressional  
10 committees on the grant program under this section,  
11 including an evaluation of—

12 “(A) cost savings and public health out-  
13 comes such as mortality, suicide, substance  
14 abuse, hospitalization, and use of services;

15 “(B) rates of involvement with the criminal  
16 justice system of patients;

17 “(C) rates of homelessness among patients;

18 and

19 “(D) patient and family satisfaction with  
20 program participation; and

21 “(2) provide appropriate information, training,  
22 and technical assistance to grant recipients under  
23 this section to help such recipients to establish,  
24 maintain, or expand their assertive community treat-  
25 ment programs.

1 “(e) AUTHORIZATION OF APPROPRIATIONS.—

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

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

10 **SEC. 502. STRENGTHENING COMMUNITY CRISIS RESPONSE**  
11 **SYSTEMS.**

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

14 **“SEC. 520F. STRENGTHENING COMMUNITY CRISIS RE-**  
15 **SPONSE SYSTEMS.**

16 “(a) IN GENERAL.—The Secretary shall award com-  
17 petitive grants—

18 “(1) to State and local governments and Indian  
19 tribes and tribal organizations to enhance commu-  
20 nity-based crisis response systems; or

21 “(2) to States to develop, maintain, or enhance  
22 a database of beds at inpatient psychiatric facilities,  
23 crisis stabilization units, and residential community  
24 mental health and residential substance use disorder  
25 treatment facilities, for individuals with serious men-

1       tal illness, serious emotional disturbance, or sub-  
2       stance use disorders.

3       “(b) APPLICATION.—

4             “(1) IN GENERAL.—To receive a grant or coop-  
5       erative agreement under subsection (a), an entity  
6       shall submit to the Secretary an application, at such  
7       time, in such manner, and containing such informa-  
8       tion as the Secretary may require.

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

12             “(A) promoting integration and coordina-  
13       tion between local public and private entities  
14       engaged in crisis response, including first re-  
15       sponders, emergency health care providers, pri-  
16       mary care providers, law enforcement, court  
17       systems, health care payers, social service pro-  
18       viders, and behavioral health providers;

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

23             “(C) expanding the continuum of commu-  
24       nity-based services to address crisis intervention  
25       and prevention; and

1           “(D) developing models for minimizing  
2           hospital readmissions, including through appro-  
3           priate discharge planning.

4           “(3) BEDS DATABASE PLAN.—An application  
5           for a grant under subsection (a)(2) shall include a  
6           plan for developing, maintaining, or enhancing a  
7           real-time Internet-based bed database to collect, ag-  
8           gregate, and display information about beds in inpa-  
9           tient psychiatric facilities and crisis stabilization  
10          units, and residential community mental health and  
11          residential substance use disorder treatment facili-  
12          ties, to facilitate the identification and designation of  
13          facilities for the temporary treatment of individuals  
14          in mental or substance use disorder crisis.

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

17               “(1) includes information on inpatient psy-  
18               chiatric facilities, crisis stabilization units, and resi-  
19               dential community mental health and residential  
20               substance use disorder facilities in the State in-  
21               volved, including contact information for the facility  
22               or unit;

23               “(2) provides real-time information about the  
24               number of beds available at each facility or unit and,  
25               for each available bed, the type of patient that may

1 be admitted, the level of security provided, and any  
2 other information that may be necessary to allow for  
3 the proper identification of appropriate facilities for  
4 treatment of individuals in mental or substance use  
5 disorder crisis; and

6 “(3) enables searches of the database to iden-  
7 tify available beds that are appropriate for the treat-  
8 ment of individuals in mental or substance use dis-  
9 order crisis.

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

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

18 “(2) individuals reporting improved functional  
19 outcomes; and

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

22 “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
23 is authorized to be appropriated to carry out this section,  
24 \$5,000,000 for the period of fiscal years 2018 through  
25 2022.”.

1 **SEC. 503. INCREASED AND EXTENDED FUNDING FOR AS-**  
2 **SISTED OUTPATIENT GRANT PROGRAM FOR**  
3 **INDIVIDUALS WITH SERIOUS MENTAL ILL-**  
4 **NESS.**

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

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

9 (2) in paragraph (2), by striking “is authorized  
10 to be appropriated to carry out this section  
11 \$15,000,000 for each of fiscal years 2015 through  
12 2018” and inserting “are authorized to be appro-  
13 priated to carry out this section \$15,000,000 for  
14 each of fiscal years 2015 through 2017,  
15 \$20,000,000 for fiscal year 2018, \$19,000,000 for  
16 each of fiscal years 2019 and 2020, and  
17 \$18,000,000 for each of fiscal years 2021 and  
18 2022”.

19 **SEC. 504. LIABILITY PROTECTIONS FOR HEALTH PROFES-**  
20 **SIONAL VOLUNTEERS AT COMMUNITY**  
21 **HEALTH CENTERS.**

22 Section 224 of the Public Health Service Act (42  
23 U.S.C. 233) is amended by adding at the end the fol-  
24 lowing:

25 “(q)(1) For purposes of this section, a health profes-  
26 sional volunteer at an entity described in subsection (g)(4)

1 shall, in providing a health professional service eligible for  
2 funding under section 330 to an individual, be deemed to  
3 be an employee of the Public Health Service for a calendar  
4 year that begins during a fiscal year for which a transfer  
5 was made under paragraph (4)(C). The preceding sen-  
6 tence is subject to the provisions of this subsection.

7 “(2) In providing a health service to an individual,  
8 a health care practitioner shall for purposes of this sub-  
9 section be considered to be a health professional volunteer  
10 at an entity described in subsection (g)(4) if the following  
11 conditions are met:

12 “(A) The service is provided to the individual at  
13 the facilities of an entity described in subsection  
14 (g)(4), or through offsite programs or events carried  
15 out by the entity.

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

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

1 by the health care practitioner in the provision of  
2 the service to the individual.

3 “(D) Before the service is provided, the health  
4 care practitioner or the entity described in sub-  
5 section (g)(4) posts a clear and conspicuous notice  
6 at the site where the service is provided of the extent  
7 to which the legal liability of the health care practi-  
8 tioner is limited pursuant to this subsection.

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

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

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

23 “(B) With respect to an entity described in sub-  
24 section (g)(4), a health care practitioner is not a  
25 health professional volunteer at such entity unless

1 the entity sponsors the health care practitioner. For  
2 purposes of this subsection, the entity shall be con-  
3 sidered to be sponsoring the health care practitioner  
4 if—

5 “(i) with respect to the health care practi-  
6 tioner, the entity submits to the Secretary an  
7 application meeting the requirements of sub-  
8 section (g)(1)(D); and

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

13 “(C) In the case of a health care practitioner  
14 who is determined by the Secretary pursuant to sub-  
15 section (g)(1)(E) to be a health professional volun-  
16 teer at such entity, this subsection applies to the  
17 health care practitioner (with respect to services per-  
18 formed on behalf of the entity sponsoring the health  
19 care practitioner pursuant to subparagraph (B)) for  
20 any cause of action arising from an act or omission  
21 of the health care practitioner occurring on or after  
22 the date on which the Secretary makes such deter-  
23 mination.

24 “(D) Subsection (g)(1)(F) applies to a health  
25 care practitioner for purposes of this subsection only

1 to the extent that, in providing health services to an  
2 individual, each of the conditions specified in para-  
3 graph (2) is met.

4 “(4)(A) Amounts in the fund established under sub-  
5 section (k)(2) shall be available for transfer under sub-  
6 paragraph (C) for purposes of carrying out this sub-  
7 section.

8 “(B) Not later May 1 of each fiscal year, the Attor-  
9 ney General, in consultation with the Secretary, shall sub-  
10 mit to the Congress a report providing an estimate of the  
11 amount of claims (together with related fees and expenses  
12 of witnesses) that, by reason of the acts or omissions of  
13 health professional volunteers, will be paid pursuant to  
14 this section during the calendar year that begins in the  
15 following fiscal year. Subsection (k)(1)(B) applies to the  
16 estimate under the preceding sentence regarding health  
17 professional volunteers to the same extent and in the same  
18 manner as such subsection applies to the estimate under  
19 such subsection regarding officers, governing board mem-  
20 bers, employees, and contractors of entities described in  
21 subsection (g)(4).

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

1 graph (B) for the calendar year beginning in such fiscal  
2 year, subject to the extent of amounts in the fund.

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

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

7 “(i) the Secretary may issue regulations for car-  
8 rying out this subsection, and the Secretary may ac-  
9 cept and consider applications submitted pursuant to  
10 paragraph (3)(B); and

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

13 **TITLE VI—SUPPORTING INNOVA-**  
14 **TIVE AND EVIDENCE-BASED**  
15 **PROGRAMS**

16 **Subtitle A—Encouraging the Ad-**  
17 **vancement, Incorporation, and**  
18 **Development of Evidence-Based**  
19 **Practices**

20 **SEC. 601. ENCOURAGING INNOVATION AND EVIDENCE-**  
21 **BASED PROGRAMS.**

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

25 “(d) PROMOTING INNOVATION.—

1           “(1) IN GENERAL.—The Assistant Secretary, in  
2           coordination with the Laboratory, may award grants  
3           to States, local governments, Indian tribes or tribal  
4           organizations (as such terms are defined in section  
5           4 of the Indian Self-Determination and Education  
6           Assistance Act), educational institutions, and non-  
7           profit organizations to develop evidence-based inter-  
8           ventions, including culturally and linguistically ap-  
9           propriate services, as appropriate, for—

10                   “(A) evaluating a model that has been sci-  
11                   entifically demonstrated to show promise, but  
12                   would benefit from further applied development,  
13                   for—

14                           “(i) enhancing the prevention, diag-  
15                           nosis, intervention, treatment, and recovery  
16                           of mental illness, serious emotional dis-  
17                           turbance, substance use disorders, and co-  
18                           occurring illness or disorders; or

19                           “(ii) integrating or coordinating phys-  
20                           ical health services and mental illness and  
21                           substance use disorder services; and

22                   “(B) expanding, replicating, or scaling evi-  
23                   dence-based programs across a wider area to  
24                   enhance effective screening, early diagnosis,  
25                   intervention, and treatment with respect to

1           mental illness, serious mental illness, and seri-  
2           ous emotional disturbance, primarily by—

3                   “(i) applying delivery of care, includ-  
4                   ing training staff in effective evidence-  
5                   based treatment; or

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

8           “(2) CONSULTATION.—In awarding grants  
9           under this paragraph, the Assistant Secretary shall,  
10          as appropriate, consult with the advisory councils de-  
11          scribed in section 502, the National Institute of  
12          Mental Health, the National Institute on Drug  
13          Abuse, and the National Institute on Alcohol Abuse  
14          and Alcoholism, as appropriate.

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

17                   “(A) to carry out paragraph (1)(A),  
18                   \$7,000,000 for the period of fiscal years 2018  
19                   through 2020; and

20                   “(B) to carry out paragraph (1)(B),  
21                   \$7,000,000 for the period of fiscal years 2018  
22                   through 2020.”.

1 **SEC. 602. PROMOTING ACCESS TO INFORMATION ON EVI-**  
2 **DENCE-BASED PROGRAMS AND PRACTICES.**

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

6 **“SEC. 544. PROMOTING ACCESS TO INFORMATION ON EVI-**  
7 **DENCE-BASED PROGRAMS AND PRACTICES.**

8 “(a) IN GENERAL.—The Assistant Secretary shall  
9 improve access to reliable and valid information on evi-  
10 dence-based programs and practices, including informa-  
11 tion on the strength of evidence associated with such pro-  
12 grams and practices, related to mental illness and sub-  
13 stance use disorders for States, local communities, non-  
14 profit entities, and other stakeholders by posting on the  
15 website of the National Registry of Evidence-Based Pro-  
16 grams and Practices evidence-based programs and prac-  
17 tices that have been reviewed by the Assistant Secretary  
18 pursuant to the requirements of this section.

19 “(b) NOTICE.—

20 “(1) PERIODS.—In carrying out subsection (a),  
21 the Assistant Secretary may establish an initial pe-  
22 riod for the submission of applications for evidence-  
23 based programs and practices to be posted publicly  
24 in accordance with subsection (a) (and may establish  
25 subsequent such periods). The Assistant Secretary

1 shall publish notice of such application periods in  
2 the Federal Register.

3 “(2) ADDRESSING GAPS.—Such notice may so-  
4 licit applications for evidence-based practices and  
5 programs to address gaps in information identified  
6 by the Assistant Secretary, the Assistant Secretary  
7 for Planning and Evaluation, the Assistant Sec-  
8 retary for Financial Resources, or the National Men-  
9 tal Health and Substance Use Policy Laboratory, in-  
10 cluding pursuant to priorities identified in the stra-  
11 tegic plan established under section 501(l).

12 “(c) REQUIREMENTS.—The Assistant Secretary shall  
13 establish minimum requirements for applications referred  
14 to in this section, including applications related to the sub-  
15 mission of research and evaluation.

16 “(d) REVIEW AND RATING.—The Assistant Secretary  
17 shall review applications prior to public posting, and may  
18 prioritize the review of applications for evidence-based  
19 practices and programs that are related to topics included  
20 in the notice established under subsection (b). The Assist-  
21 ant Secretary shall utilize a rating and review system,  
22 which shall include information on the strength of evidence  
23 associated with such programs and practices and a rating  
24 of the methodological rigor of the research supporting the  
25 application. The Assistant Secretary shall make the

1 metrics used to evaluate applications and the resulting rat-  
2 ings publicly available.”.

3 **SEC. 603. SENSE OF CONGRESS.**

4 It is the sense of the Congress that the National In-  
5 stitute of Mental Health should conduct or support re-  
6 search on the determinants of self-directed and other vio-  
7 lence connected to mental illness.

8 **Subtitle B—Supporting the State**  
9 **Response to Mental Health Needs**

10 **SEC. 611. COMMUNITY MENTAL HEALTH SERVICES BLOCK**  
11 **GRANT.**

12 (a) FORMULA GRANTS.—Section 1911(b) of the Pub-  
13 lic Health Service Act (42 U.S.C. 300x(b)) is amended—

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

16 (2) by inserting before paragraph (2) (as so re-  
17 designated), the following:

18 “(1) providing community mental health serv-  
19 ices for adults with a serious mental illness and chil-  
20 dren with a serious emotional disturbance as defined  
21 in accordance with section 1912(c);”.

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

1       “(b) CRITERIA FOR PLAN.—The criteria specified in  
2 this subsection are as follows:

3               “(1) SYSTEM OF CARE.—The plan provides a  
4 description of the system of care of the State, in-  
5 cluding as follows:

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

8                               “(i) identify the single State agency to  
9 be responsible for the administration of the  
10 program under the grant and any third  
11 party with whom the agency will contract  
12 (subject to such third party complying with  
13 the requirements of this part) for admin-  
14 istering mental health services through  
15 such program;

16                               “(ii) provide for an organized commu-  
17 nity-based system of care for individuals  
18 with mental illness, and describe available  
19 services and resources in a comprehensive  
20 system of care, including services for indi-  
21 viduals with mental health and behavioral  
22 health co-occurring illness or disorders;

23                               “(iii) include a description of the  
24 manner in which the State and local enti-  
25 ties will coordinate services to maximize

1 the efficiency, effectiveness, quality, and  
2 cost effectiveness of services and programs  
3 to produce the best possible outcomes (in-  
4 cluding health services, rehabilitation serv-  
5 ices, employment services, housing services,  
6 educational services, substance use dis-  
7 order services, legal services, law enforce-  
8 ment services, social services, child welfare  
9 services, medical and dental care services,  
10 and other support services to be provided  
11 with Federal, State, and local public and  
12 private resources) with other agencies to  
13 enable individuals receiving services to  
14 function outside of inpatient or residential  
15 institutions, to the maximum extent of  
16 their capabilities, including services to be  
17 provided by local school systems under the  
18 Individuals with Disabilities Education  
19 Act;

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

22 “(I) promotes evidence-based  
23 practices, including those evidence-  
24 based programs that address the  
25 needs of individuals with early serious

1                   mental illness regardless of the age of  
2                   the individual at onset;

3                   “(II) provides comprehensive in-  
4                   dividualized treatment; or

5                   “(III) integrates mental and  
6                   physical health services;

7                   “(v) include a description of case  
8                   management services in the State;

9                   “(vi) include a description of activities  
10                  that seek to engage individuals with seri-  
11                  ous mental illness or serious emotional dis-  
12                  turbance and their caregivers where appro-  
13                  priate in making health care decisions, in-  
14                  cluding activities that enhance communica-  
15                  tion between individuals, families, care-  
16                  givers, and treatment providers; and

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

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

24                  “(II) a description of the activi-  
25                  ties intended to reduce incidents of

1 suicide using the block grant monies;  
2 and

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

7 “(B) MENTAL HEALTH SYSTEM DATA AND  
8 EPIDEMIOLOGY.—The plan shall contain an es-  
9 timate of the incidence and prevalence in the  
10 State of serious mental illness among adults  
11 and serious emotional disturbance among chil-  
12 dren and presents quantitative targets and out-  
13 come measures for programs and services pro-  
14 vided under this subpart.

15 “(C) CHILDREN’S SERVICES.—In the case  
16 of children with serious emotional disturbance  
17 (as defined in accordance with subsection (c)),  
18 the plan shall provide for a system of integrated  
19 social services, educational services, child wel-  
20 fare services, juvenile justice services, law en-  
21 forcement services, and substance use disorder  
22 services that, together with health and mental  
23 health services, will be provided in order for  
24 such children to receive care appropriate for  
25 their multiple needs (such system to include

1 services provided under the Individuals with  
2 Disabilities Education Act).

3 “(D) TARGETED SERVICES TO RURAL AND  
4 HOMELESS POPULATIONS.—The plan shall de-  
5 scribe the State’s outreach to and services for  
6 individuals who are homeless and how commu-  
7 nity-based services will be provided to individ-  
8 uals residing in rural areas.

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

11 “(i) describe the financial resources  
12 available, the existing mental health work-  
13 force, and the workforce trained in treating  
14 individuals with co-occurring mental illness  
15 and substance use disorders;

16 “(ii) provide for the training of pro-  
17 viders of emergency health services regard-  
18 ing mental health;

19 “(iii) describe the manner in which  
20 the State intends to expend the grant  
21 under section 1911 for the fiscal year in-  
22 volved; and

23 “(iv) describe the manner in which  
24 the State intends to comply with each of

1           the funding agreements in this subpart  
2           and subpart III.

3           “(2) GOALS AND OBJECTIVES.—The plan estab-  
4           lishes goals and objectives for the period of the plan,  
5           including targets and milestones that are intended to  
6           be met, and the activities that will be undertaken to  
7           achieve those goals and objectives.”.

8           (c) BEST PRACTICES IN CLINICAL CARE MODELS.—  
9           Section 1920 of the Public Health Service Act (42 U.S.C.  
10          300x–9) is amended by adding at the end the following:

11          “(c) BEST PRACTICES IN CLINICAL CARE MOD-  
12          ELS.—A State shall expend not less than 10 percent of  
13          the amount the State receives for carrying out this sub-  
14          part in each fiscal year to support evidence-based pro-  
15          grams that address the needs of individuals with early se-  
16          rious mental illness, including psychotic disorders, regard-  
17          less of the age of the individual at the onset of such ill-  
18          ness.”.

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

22                 (1) by amending paragraph (1) to read as fol-  
23          lows:

24                 “(1) IN GENERAL.—A funding agreement for a  
25          grant under section 1911 is that the State involved

1 will maintain State expenditures for community  
2 mental health services at a level that is not less than  
3 the average of the amounts prescribed by this para-  
4 graph (prior to any waiver under paragraph (3)) for  
5 such expenditures by such State for each of the 2  
6 fiscal years immediately preceding the fiscal year for  
7 which the State is applying for the grant.”;

8 (2) in paragraph (2)—

9 (A) by striking “under subsection (a)” and  
10 inserting “specified in paragraph (1)”; and

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

13 (3) by amending paragraph (3) to read as fol-  
14 lows:

15 “(3) WAIVER.—

16 “(A) IN GENERAL.—The Secretary may,  
17 upon the request of a State, waive the require-  
18 ment established in paragraph (1) in whole or  
19 in part, if the Secretary determines that ex-  
20 traordinary economic conditions in the State in  
21 the fiscal year involved or in the previous fiscal  
22 year justify the waiver.

23 “(B) DATE CERTAIN FOR ACTION UPON  
24 REQUEST.—The Secretary shall approve or  
25 deny a request for a waiver under this para-

1 graph not later than 120 days after the date on  
2 which the request is made.

3 “(C) APPLICABILITY OF WAIVER.—A waiv-  
4 er provided by the Secretary under this para-  
5 graph shall be applicable only to the fiscal year  
6 involved.”; and

7 (4) in paragraph (4)—

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

10 “(A) IN GENERAL.—

11 “(i) DETERMINATION AND REDUC-  
12 TION.—The Secretary shall determine, in  
13 the case of each State, and for each fiscal  
14 year, whether the State maintained mate-  
15 rial compliance with the agreement made  
16 under paragraph (1). If the Secretary de-  
17 termines that a State has failed to main-  
18 tain such compliance for a fiscal year, the  
19 Secretary shall reduce the amount of the  
20 allotment under section 1911 for the State,  
21 for the first fiscal year beginning after  
22 such determination is final, by an amount  
23 equal to the amount constituting such fail-  
24 ure for the previous fiscal year about  
25 which the determination was made.

1                   “(ii) ALTERNATIVE SANCTION.—The  
2                   Secretary may by regulation provide for an  
3                   alternative method of imposing a sanction  
4                   for a failure by a State to maintain mate-  
5                   rial compliance with the agreement under  
6                   paragraph (1) if the Secretary determines  
7                   that such alternative method would be  
8                   more equitable and would be a more effec-  
9                   tive incentive for States to maintain such  
10                  material compliance.”; and

11                  (B) in subparagraph (B)—

12                   (i) by inserting after the subpara-  
13                   graph designation the following: “SUBMIS-  
14                   SION OF INFORMATION TO THE SEC-  
15                   RETARY.—”; and

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

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

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

23                   (2) in paragraph (5), by striking  
24                   “1915(b)(3)(B)” and inserting “1915(b)”.

1 **Subtitle C—Strengthening Mental**  
2 **Health Care for Children and**  
3 **Adolescents**

4 **SEC. 621. TELE-MENTAL HEALTH CARE ACCESS GRANTS.**

5 Title III of the Public Health Service Act is amended  
6 by inserting after section 330L of such Act (42 U.S.C.  
7 254e–18) the following new section:

8 **“SEC. 330M. TELE-MENTAL HEALTH CARE ACCESS GRANTS.**

9 “(a) IN GENERAL.—The Secretary, acting through  
10 the Administrator of the Health Resources and Services  
11 Administration and in coordination with other relevant  
12 Federal agencies, shall award grants to States, political  
13 subdivisions of States, Indian tribes, and tribal organiza-  
14 tions (for purposes of this section, as such terms are de-  
15 fined in section 4 of the Indian Self-Determination and  
16 Education Assistance Act (25 U.S.C. 450b)) to promote  
17 behavioral health integration in pediatric primary care  
18 by—

19 “(1) supporting the development of statewide  
20 child mental health care access programs; and

21 “(2) supporting the improvement of existing  
22 statewide child mental health care access programs.

23 “(b) PROGRAM REQUIREMENTS.—

24 “(1) IN GENERAL.—A child mental health care  
25 access program referred to in subsection (a), with

1       respect to which a grant under such subsection may  
2       be used, shall—

3               “(A) be a statewide network of pediatric  
4               mental health teams that provide support to pe-  
5               diatric primary care sites as an integrated  
6               team;

7               “(B) support and further develop orga-  
8               nized State networks of child and adolescent  
9               psychiatrists and psychologists to provide con-  
10              sultative support to pediatric primary care sites;

11              “(C) conduct an assessment of critical be-  
12              havioral consultation needs among pediatric  
13              providers and such providers’ preferred mecha-  
14              nisms for receiving consultation and training  
15              and technical assistance;

16              “(D) develop an online database and com-  
17              munication mechanisms, including telehealth, to  
18              facilitate consultation support to pediatric prac-  
19              tices;

20              “(E) provide rapid statewide clinical tele-  
21              phone or telehealth consultations when re-  
22              quested between the pediatric mental health  
23              teams and pediatric primary care providers;

24              “(F) conduct training and provide tech-  
25              nical assistance to pediatric primary care pro-

1           viders to support the early identification, diag-  
2           nosis, treatment, and referral of children with  
3           behavioral health conditions or co-occurring in-  
4           tellectual and other developmental disabilities;

5           “(G) provide information to pediatric pro-  
6           viders about, and assist pediatric providers in  
7           accessing, child psychiatry and psychology con-  
8           sultations and in scheduling and conducting  
9           technical assistance;

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

13           “(I) establish mechanisms for measuring  
14           and monitoring increased access to child and  
15           adolescent psychiatric and psychology services  
16           by pediatric primary care providers and ex-  
17           panded capacity of pediatric primary care pro-  
18           viders to identify, treat, and refer children with  
19           mental health problems.

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

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

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

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

1       “(f) AUTHORIZATION OF APPROPRIATIONS.—To  
2 carry this section, there are authorized to be appropriated  
3 \$9,000,000 for the period of fiscal years 2018 through  
4 2020.”.

5 **SEC. 622. INFANT AND EARLY CHILDHOOD MENTAL**  
6                   **HEALTH PROMOTION, INTERVENTION, AND**  
7                   **TREATMENT.**

8       Part Q of title III of the Public Health Service Act  
9 (42 U.S.C. 290h et seq.) is amended by adding at the end  
10 the following:

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

14       “(a) GRANTS.—The Secretary shall—

15               “(1) award grants to eligible entities, including  
16 human services agencies, to develop, maintain, or en-  
17 hance infant and early childhood mental health pro-  
18 motion, intervention, and treatment programs, in-  
19 cluding—

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

1           “(B) multigenerational therapy and other  
2           services that support the caregiving relation-  
3           ship; and

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

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

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

15                   “(A) is at risk for, shows early signs of, or  
16                   has been diagnosed with a mental illness, in-  
17                   cluding serious emotional disturbance; and

18                   “(B) may benefit from infant and early  
19                   childhood intervention or treatment programs  
20                   or specialized preschool or elementary school  
21                   programs that are evidence-based or that have  
22                   been scientifically demonstrated to show prom-  
23                   ise but would benefit from further applied de-  
24                   velopment.

1           “(2) ELIGIBLE ENTITY.—The term ‘eligible en-  
2           tity’ means a nonprofit institution that—

3                   “(A) is accredited or approved by a State  
4                   mental health or education agency, as applica-  
5                   ble, to provide for children from infancy to 5  
6                   years of age mental health promotion, interven-  
7                   tion, or treatment services that are evidence-  
8                   based or that have been scientifically dem-  
9                   onstrated to show promise but would benefit  
10                  from further applied development; and

11                  “(B) provides programs described in sub-  
12                  section (a) that are evidence-based or that have  
13                  been scientifically demonstrated to show prom-  
14                  ise but would benefit from further applied de-  
15                  velopment.

16           “(c) APPLICATION.—An eligible entity seeking a  
17           grant under subsection (a) shall submit to the Secretary  
18           an application at such time, in such manner, and con-  
19           taining such information as the Secretary may require.

20           “(d) USE OF FUNDS FOR EARLY INTERVENTION AND  
21           TREATMENT PROGRAMS.—An eligible entity may use  
22           amounts awarded under a grant under subsection (a)(1)  
23           to carry out the following:

24                   “(1) Provide age-appropriate mental health pro-  
25                   motion and early intervention services or mental ill-

1       ness treatment services, which may include special-  
2       ized programs, for eligible children at significant  
3       risk of developing, showing early signs of, or having  
4       been diagnosed with a mental illness, including seri-  
5       ous emotional disturbance. Such services may in-  
6       clude social and behavioral services as well as  
7       multigenerational therapy and other services that  
8       support the caregiving relationship.

9               “(2) Provide training for health care profes-  
10       sionals with expertise in infant and early childhood  
11       mental health care with respect to appropriate and  
12       relevant integration with other disciplines such as  
13       primary care clinicians, early intervention specialists,  
14       child welfare staff, home visitors, early care and edu-  
15       cation providers, and others who work with young  
16       children and families.

17               “(3) Provide mental health consultation to per-  
18       sonnel of early care and education programs (includ-  
19       ing licensed or regulated center-based and home-  
20       based child care, home visiting, preschool special  
21       education, and early intervention programs) who  
22       work with children and families.

23               “(4) Provide training for mental health clini-  
24       cians in infant and early childhood in promising and  
25       evidence-based practices and models for infant and

1 early childhood mental health treatment and early  
2 intervention, including with regard to practices for  
3 identifying and treating mental illness and behav-  
4 ioral disorders of infants and children resulting from  
5 exposure or repeated exposure to adverse childhood  
6 experiences or childhood trauma.

7 “(5) Provide age-appropriate assessment, diag-  
8 nostic, and intervention services for eligible children,  
9 including early mental health promotion, interven-  
10 tion, and treatment services.

11 “(e) MATCHING FUNDS.—The Secretary may not  
12 award a grant under this section to an eligible entity un-  
13 less the eligible entity agrees, with respect to the costs to  
14 be incurred by the eligible entity in carrying out the activi-  
15 ties described in subsection (d), to make available non-  
16 Federal contributions (in cash or in kind) toward such  
17 costs in an amount that is not less than 10 percent of  
18 the total amount of Federal funds provided in the grant.

19 “(f) AUTHORIZATION OF APPROPRIATIONS.—To  
20 carry this section, there are authorized to be appropriated  
21 \$20,000,000 for the period of fiscal years 2018 through  
22 2022.”.

1 **SEC. 623. NATIONAL CHILD TRAUMATIC STRESS INITIA-**  
2 **TIVE.**

3 Section 582 of the Public Health Service Act (42  
4 U.S.C. 290hh-1; relating to grants to address the prob-  
5 lems of persons who experience violence related stress) is  
6 amended—

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

11 “(1) the continued operation of the National  
12 Child Traumatic Stress Initiative (referred to in this  
13 section as the ‘NCTSI’), which includes a coordi-  
14 nating center that focuses on the mental, behavioral,  
15 and biological aspects of psychological trauma re-  
16 sponse; and

17 “(2) the development of knowledge with regard  
18 to evidence-based practices for identifying and treat-  
19 ing mental illness, behavioral disorders, and physical  
20 health conditions of children and youth resulting  
21 from witnessing or experiencing a traumatic event.”;

22 (2) in subsection (b)—

23 (A) by striking “subsection (a) related”  
24 and inserting “subsection (a)(2) (related”;

25 (B) by striking “treating disorders associ-  
26 ated with psychological trauma” and inserting

1 “treating mental illness and behavioral and bio-  
2 logical disorders associated with psychological  
3 trauma)””; and

4 (C) by striking “mental health agencies  
5 and programs that have established clinical and  
6 basic research” and inserting “universities, hos-  
7 pitals, mental health agencies, and other pro-  
8 grams that have established clinical expertise  
9 and research”;

10 (3) by redesignating subsections (c) through (g)  
11 as subsections (g) through (k), respectively;

12 (4) by inserting after subsection (b), the fol-  
13 lowing:

14 “(c) CHILD OUTCOME DATA.—The NCTSI coordi-  
15 nating center shall collect, analyze, report, and make pub-  
16 licly available NCTSI-wide child treatment process and  
17 outcome data regarding the early identification and deliv-  
18 ery of evidence-based treatment and services for children  
19 and families served by the NCTSI grantees.

20 “(d) TRAINING.—The NCTSI coordinating center  
21 shall facilitate the coordination of training initiatives in  
22 evidence-based and trauma-informed treatments, interven-  
23 tions, and practices offered to NCTSI grantees, providers,  
24 and partners.

1       “(e) DISSEMINATION.—The NCTSI coordinating  
2 center shall, as appropriate, collaborate with the Secretary  
3 in the dissemination of evidence-based and trauma-in-  
4 formed interventions, treatments, products, and other re-  
5 sources to appropriate stakeholders.

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

12           (5) in subsection (g) (as so redesignated), by  
13 striking “with respect to centers of excellence are  
14 distributed equitably among the regions of the coun-  
15 try” and inserting “are distributed equitably among  
16 the regions of the United States”;

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

21           (7) in subsection (j) (as so redesignated), by  
22 striking “\$50,000,000” and all that follows through  
23 “2006” and inserting “\$46,887,000 for each of fis-  
24 cal years 2017 through 2021”.

1 **TITLE VII—GRANT PROGRAMS**  
2 **AND PROGRAM REAUTHOR-**  
3 **IZATION**

4 **Subtitle A—Garrett Lee Smith**  
5 **Memorial Act Reauthorization**

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

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

10 (1) by striking the section heading and insert-  
11 ing “**SUICIDE PREVENTION TECHNICAL ASSIST-**  
12 **ANCE CENTER.**”;

13 (2) in subsection (a), by striking “and in con-  
14 sultation with” and all that follows through the pe-  
15 riod at the end of paragraph (2) and inserting “shall  
16 establish a research, training, and technical assist-  
17 ance resource center to provide appropriate informa-  
18 tion, training, and technical assistance to States, po-  
19 litical subdivisions of States, federally recognized In-  
20 dian tribes, tribal organizations, institutions of high-  
21 er education, public organizations, or private non-  
22 profit organizations regarding the prevention of sui-  
23 cide among all ages, particularly among groups that  
24 are at high risk for suicide.”;

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

1           (4) by redesignating subsection (d) as sub-  
2           section (b);

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

4           (A) by striking the subsection heading and  
5           inserting “RESPONSIBILITIES OF THE CEN-  
6           TER.—”;

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

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

15          (D) in paragraph (1)—

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

19               (ii) by inserting “for all ages, particu-  
20               larly among groups that are at high risk  
21               for suicide” before the semicolon at the  
22               end;

23          (E) in paragraph (2), by inserting “for all  
24          ages, particularly among groups that are at

1 high risk for suicide” before the semicolon at  
2 the end;

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

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

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

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

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

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

16 “(c) AUTHORIZATION OF APPROPRIATIONS.—For the  
17 purpose of carrying out this section, there are authorized  
18 to be appropriated \$5,988,000 for each of fiscal years  
19 2017 through 2021.

20 “(d) REPORT.—Not later than 2 years after the date  
21 of enactment of the Helping Families in Mental Health  
22 Crisis Act of 2016, the Secretary shall submit to Congress  
23 a report on the activities carried out by the center estab-  
24 lished under subsection (a) during the year involved, in-  
25 cluding the potential effects of such activities, and the

1 States, organizations, and institutions that have worked  
2 with the center.”.

3 **SEC. 702. YOUTH SUICIDE EARLY INTERVENTION AND PRE-**  
4 **VENTION STRATEGIES.**

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

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

11 (2) in subsection (b)(2)—

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

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

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

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

1 **SEC. 703. MENTAL HEALTH AND SUBSTANCE USE DIS-**  
2 **ORDER SERVICES ON CAMPUS.**

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

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

8 (2) in subsection (a)—

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

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

14 (C) by striking “substance abuse” and in-  
15 serting “substance use disorders”;

16 (3) in subsection (b)—

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

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

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

25 “(2) The operation of hotlines.

26 “(3) Preparing informational material.

1           “(4) Providing outreach services to notify stu-  
2 dents about available mental health and substance  
3 use disorder services.

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

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

9           “(7) Creating a network infrastructure to link  
10 colleges and universities with health care providers  
11 who treat mental health and substance use dis-  
12 orders.”;

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

15           (5) in subsection (d)—

16                 (A) in the matter preceding paragraph (1),  
17 by striking “An institution of higher education  
18 desiring a grant under this section” and insert-  
19 ing “To be eligible to receive a grant under this  
20 section, an institution of higher education”;

21                 (B) in paragraph (1)—

22                         (i) by striking “and behavioral  
23 health” and inserting “health and sub-  
24 stance use disorder”; and

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

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

11 (6) in subsection (e)(1), by striking “and behav-  
12 ioral health problems” and inserting “health and  
13 substance use disorders”;

14 (7) in subsection (f)(2)—

15 (A) by striking “and behavioral health”  
16 and inserting “health and substance use dis-  
17 order”; and

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

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

1           **Subtitle B—Other Provisions**

2   **SEC. 711. NATIONAL SUICIDE PREVENTION LIFELINE PRO-**  
3                   **GRAM.**

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

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

10          “(a) **IN GENERAL.**—The Secretary, acting through  
11   the Assistant Secretary, shall maintain the National Sui-  
12   cide Prevention Lifeline Program (referred to in this sec-  
13   tion as the ‘Program’), authorized under section 520A and  
14   in effect prior to the date of enactment of the Helping  
15   Families in Mental Health Crisis Act of 2016.

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

18               “(1) coordinating a network of crisis centers  
19               across the United States for providing suicide pre-  
20               vention and crisis intervention services to individuals  
21               seeking help at any time, day or night;

22               “(2) maintaining a suicide prevention hotline to  
23               link callers to local emergency, mental health, and  
24               social services resources; and



1 individuals practicing in fields deemed relevant by  
2 the Secretary;

3 (2) an assessment of the mental health and  
4 substance use disorder workforce capacity, strengths,  
5 and weaknesses as of the date of the report, includ-  
6 ing the capacity of primary care to prevent, screen,  
7 treat, or refer for mental health and substance use  
8 disorders;

9 (3) information on trends within the mental  
10 health and substance use disorder provider work-  
11 force, including the number of individuals entering  
12 the mental health workforce over the next 5 years;

13 (4) information on the gaps in workforce devel-  
14 opment for mental health providers and profes-  
15 sionals, including those who serve pediatric, adult,  
16 and geriatric patients; and

17 (5) any additional information determined by  
18 the Assistant Secretary for Mental Health and Sub-  
19 stance Use, in consultation with the Administrator  
20 of the Health Resources and Services Administra-  
21 tion, to be relevant to the mental health and sub-  
22 stance use disorder provider workforce.

1 **SEC. 713. MINORITY FELLOWSHIP PROGRAM.**

2 Title V of the Public Health Service Act (42 U.S.C.  
3 290aa et seq.) is amended by adding at the end the fol-  
4 lowing:

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

6 **“SEC. 597. FELLOWSHIPS.**

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

11 “(1) increasing behavioral health practitioners’  
12 knowledge of issues related to prevention, treatment,  
13 and recovery support for mental illness and sub-  
14 stance use disorders among racial and ethnic minor-  
15 ity populations;

16 “(2) improving the quality of mental illness and  
17 substance use disorder prevention and treatment de-  
18 livered to racial and ethnic minorities; and

19 “(3) increasing the number of culturally com-  
20 petent behavioral health professionals and school  
21 personnel who teach, administer, conduct services re-  
22 search, and provide direct mental health or sub-  
23 stance use services to racial and ethnic minority  
24 populations.

25 “(b) TRAINING COVERED.—The fellowships under  
26 subsection (a) shall be for postbaccalaureate training (in-

1 cluding for master’s and doctoral degrees) for mental  
2 health professionals, including in the fields of psychiatry,  
3 nursing, social work, psychology, marriage and family  
4 therapy, mental health counseling, and substance use and  
5 addiction counseling.

6 “(c) AUTHORIZATION OF APPROPRIATIONS.—To  
7 carry out this section, there are authorized to be appro-  
8 priated \$12,669,000 for each of fiscal years 2017, 2018,  
9 and 2019 and \$13,669,000 for each of fiscal years 2020  
10 and 2021.”.

11 **SEC. 714. CENTER AND PROGRAM REPEALS.**

12 Part B of title V of the Public Health Service Act  
13 (42 U.S.C. 290bb et seq.) is amended by striking the sec-  
14 ond section 514 (42 U.S.C. 290bb–9), relating to meth-  
15 amphetamine and amphetamine treatment initiatives, and  
16 sections 514A, 517, 519A, 519C, 519E, 520D, and 520H  
17 (42 U.S.C. 290bb–8, 290bb–23, 290bb–25a, 290bb–25c,  
18 290bb–25e, 290bb–35, and 290bb–39).

19 **SEC. 715. NATIONAL VIOLENT DEATH REPORTING SYSTEM.**

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

1 Participation in the system by the States shall be vol-  
2 untary.

3 **SEC. 716. SENSE OF CONGRESS ON PRIORITIZING NATIVE**  
4 **AMERICAN YOUTH AND SUICIDE PREVEN-**  
5 **TION PROGRAMS.**

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

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

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

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

18 (b) SENSE OF CONGRESS.—It is the sense of Con-  
19 gress that the Secretary of Health and Human Services,  
20 in carrying out programs for Native American youth and  
21 suicide prevention programs for youth suicide interven-  
22 tion, should prioritize programs and activities for individ-  
23 uals who have a high risk or disproportional burden of  
24 suicide, such as Native Americans.

1 **SEC. 717. PEER PROFESSIONAL WORKFORCE DEVELOP-**  
2 **MENT GRANT PROGRAM.**

3 (a) **IN GENERAL.**—For the purposes described in  
4 subsection (b), the Secretary of Health and Human Serv-  
5 ices shall award grants to develop and sustain behavioral  
6 health paraprofessional training and education programs,  
7 including through tuition support.

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

10 (1) to increase the number of behavioral health  
11 paraprofessionals, including trained peers, recovery  
12 coaches, mental health and addiction specialists, pre-  
13 vention specialists, and pre-masters-level addiction  
14 counselors; and

15 (2) to help communities develop the infrastruc-  
16 ture to train and certify peers as behavioral health  
17 paraprofessionals.

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

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

25 (e) **SPECIAL CONSIDERATION.**—In awarding grants  
26 under this section, the Secretary may give special consid-

1 eration to proposed and existing programs targeting peer  
2 professionals serving youth ages 16 to 25.

3 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry  
4 out this section, there is authorized to be appropriated  
5 \$10,000,000 for the period of fiscal years 2018 through  
6 2022.

7 **SEC. 718. NATIONAL HEALTH SERVICE CORPS.**

8 (a) DEFINITIONS.—

9 (1) PRIMARY HEALTH SERVICES.—Section  
10 331(a)(3)(D) of the Public Health Service Act (42  
11 U.S.C. 254d(a)(3)) is amended by inserting “(in-  
12 cluding pediatric mental health subspecialty serv-  
13 ices)” after “pediatrics”.

14 (2) BEHAVIORAL AND MENTAL HEALTH PRO-  
15 FESSIONALS.—Clause (i) of section 331(a)(3)(E) of  
16 the Public Health Service Act (42 U.S.C.  
17 254d(a)(3)(E)) is amended by inserting “(and pedi-  
18 atric subspecialists thereof)” before the period at the  
19 end.

20 (b) ELIGIBILITY TO PARTICIPATE IN LOAN REPAY-  
21 MENT PROGRAM.—Section 338B(b)(1)(B) of the Public  
22 Health Service Act (42 U.S.C. 254l–1(b)(1)(B)) is amend-  
23 ed by inserting “, including any physician child and ado-  
24 lescent psychiatry residency or fellowship training pro-  
25 gram” after “be enrolled in an approved graduate training

1 program in medicine, osteopathic medicine, dentistry, be-  
2 havioral and mental health, or other health profession”.

3 **SEC. 719. ADULT SUICIDE PREVENTION.**

4 (a) GRANTS.—

5 (1) AUTHORITY.—The Assistant Secretary for  
6 Mental Health and Substance Use (referred to in  
7 this section as the “Assistant Secretary”) may  
8 award grants to eligible entities in order to imple-  
9 ment suicide prevention efforts amongst adults 25  
10 and older.

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

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

23 (4) NATURE OF ACTIVITIES.—The grants  
24 awarded under paragraph (1) shall be used to imple-  
25 ment programs that—

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

3 (B) implement evidence-based practices to  
4 treat individuals who are at suicide risk, includ-  
5 ing appropriate followup services; and

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

8 (b) ADDITIONAL ACTIVITIES.—The Assistant Sec-  
9 retary shall—

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

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

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

22 (A) selection and implementation of evi-  
23 dence-based interventions and frameworks to  
24 prevent suicide, such as the Zero Suicide frame-  
25 work; and

1 (B) other activities as the Assistant Sec-  
2 retary determines appropriate.

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

5 (d) AUTHORIZATION OF APPROPRIATIONS.—

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

9 (2) USE OF CERTAIN FUNDS.—Of the funds ap-  
10 propriated to carry out this section in any fiscal  
11 year, the lesser of 5 percent of such funds or  
12 \$500,000 shall be available to the Assistant Sec-  
13 retary for purposes of carrying out subsection (b).

14 **SEC. 720. CRISIS INTERVENTION GRANTS FOR POLICE OF-**  
15 **FICERS AND FIRST RESPONDERS.**

16 (a) IN GENERAL.—The Assistant Secretary for Men-  
17 tal Health and Substance Use may award grants to enti-  
18 ties such as law enforcement agencies and first respond-  
19 ers—

20 (1) to provide specialized training to law en-  
21 forcement officers, corrections officers, paramedics,  
22 emergency medical services workers, and other first  
23 responders (including village public safety officers  
24 (as defined in section 247 of the Indian Arts and

1 Crafts Amendments Act of 2010 (42 U.S.C. 3796dd  
2 note)))—

3 (A) to recognize individuals who have men-  
4 tal illness and how to properly intervene with  
5 individuals with mental illness; and

6 (B) to establish programs that enhance the  
7 ability of law enforcement agencies to address  
8 the mental health, behavioral, and substance  
9 use problems of individuals encountered in the  
10 line of duty; and

11 (2) to establish collaborative law enforcement  
12 and mental health programs, including behavioral  
13 health response teams and mental health crisis inter-  
14 vention teams comprised of mental health profes-  
15 sionals, law enforcement officers, and other first re-  
16 sponders, as appropriate, to provide on-site, face-to-  
17 face, mental and behavioral health care services dur-  
18 ing a mental health crisis, and to connect the indi-  
19 vidual in crisis to appropriate community-based  
20 treatment services in lieu of unnecessary hospitaliza-  
21 tion or further involvement with the criminal justice  
22 system.

23 (b) AUTHORIZATION OF APPROPRIATIONS.—There  
24 are authorized to be appropriated to carry out this section

1 \$9,000,000 for the period of fiscal years 2018 through  
2 2020.

3 **SEC. 721. DEMONSTRATION GRANT PROGRAM TO TRAIN**  
4 **HEALTH SERVICE PSYCHOLOGISTS IN COM-**  
5 **MUNITY-BASED MENTAL HEALTH.**

6 (a) ESTABLISHMENT.—The Secretary of Health and  
7 Human Services shall establish a grant program under  
8 which the Assistant Secretary of Mental Health and Sub-  
9 stance Use Disorders may award grants to eligible institu-  
10 tions to support the recruitment, education, and clinical  
11 training experiences of health services psychology stu-  
12 dents, interns, and postdoctoral residents for education  
13 and clinical experience in community mental health set-  
14 tings.

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

20 (1) are focused on the development and imple-  
21 mentation of interdisciplinary training of psychology  
22 graduate students and postdoctoral fellows in pro-  
23 viding mental and behavioral health services to ad-  
24 dress substance use disorders, serious emotional dis-  
25 turbance, and serious illness, as well as developing

1 faculty and implementing curriculum to prepare psy-  
2 chologists to work with underserved populations; and

3 (2) demonstrate an ability to train health serv-  
4 ice psychologists in psychiatric hospitals, forensic  
5 hospitals, community mental health centers, commu-  
6 nity health centers, federally qualified health centers,  
7 or adult and juvenile correctional facilities.

8 (c) PRIORITIES.—In selecting grant recipients under  
9 this section, the Secretary shall give priority to eligible in-  
10 stitutions in which training focuses on the needs of indi-  
11 viduals with serious mental illness, serious emotional dis-  
12 turbance, justice-involved youth, and individuals with or  
13 at high risk for substance use disorders.

14 (d) AUTHORIZATION OF APPROPRIATIONS.—There is  
15 authorized to be appropriated to carry out this section  
16 \$12,000,000 for the period of fiscal years 2018 through  
17 2022.

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

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

22 “(e) AUTHORIZATION OF APPROPRIATIONS.—To  
23 carry out this section, there is authorized to be appro-  
24 priated \$12,000,000 for the period of fiscal years 2018  
25 through 2022.”.

1 **SEC. 723. CUTGO COMPLIANCE.**

2 Section 319D(f) of the Public Health Service Act (42  
3 U.S.C. 247d–4(f)) is amended by striking “\$138,300,000  
4 for each of fiscal years 2014 through 2018” and inserting  
5 “\$138,300,000 for each of fiscal years 2014 through 2016  
6 and \$58,000,000 for each of fiscal years 2017 and 2018”.

7 **TITLE VIII—MENTAL HEALTH**  
8 **PARITY**

9 **SEC. 801. ENHANCED COMPLIANCE WITH MENTAL HEALTH**  
10 **AND SUBSTANCE USE DISORDER COVERAGE**  
11 **REQUIREMENTS.**

12 (a) COMPLIANCE PROGRAM GUIDANCE DOCU-  
13 MENT.—Section 2726(a) of the Public Health Service Act  
14 (42 U.S.C. 300gg–26(a)) is amended by adding at the end  
15 the following:

16 “(6) COMPLIANCE PROGRAM GUIDANCE DOCU-  
17 MENT.—

18 “(A) IN GENERAL.—Not later than 12  
19 months after the date of enactment of the  
20 Helping Families in Mental Health Crisis Act  
21 of 2016, the Secretary, the Secretary of Labor,  
22 and the Secretary of the Treasury, in consulta-  
23 tion with the Inspector General of the Depart-  
24 ment of Health and Human Services, shall  
25 issue a compliance program guidance document  
26 to help improve compliance with this section,

1 section 712 of the Employee Retirement Income  
2 Security Act of 1974, and section 9812 of the  
3 Internal Revenue Code of 1986, as applicable.

4 “(B) EXAMPLES ILLUSTRATING COMPLI-  
5 ANCE AND NONCOMPLIANCE.—

6 “(i) IN GENERAL.—The compliance  
7 program guidance document required  
8 under this paragraph shall provide illus-  
9 trative, de-identified examples (that do not  
10 disclose any protected health information  
11 or individually identifiable information) of  
12 previous findings of compliance and non-  
13 compliance with this section, section 712 of  
14 the Employee Retirement Income Security  
15 Act of 1974, or section 9812 of the Inter-  
16 nal Revenue Code of 1986, as applicable,  
17 based on investigations of violations of  
18 such sections, including—

19 “(I) examples illustrating re-  
20 quirements for information disclosures  
21 and nonquantitative treatment limita-  
22 tions; and

23 “(II) descriptions of the viola-  
24 tions uncovered during the course of  
25 such investigations.

1           “(ii) NONQUANTITATIVE TREATMENT  
2           LIMITATIONS.—To the extent that any ex-  
3           ample described in clause (i) involves a  
4           finding of compliance or noncompliance  
5           with regard to any requirement for non-  
6           quantitative treatment limitations, the ex-  
7           ample shall provide sufficient detail to fully  
8           explain such finding, including a full de-  
9           scription of the criteria involved for med-  
10          ical and surgical benefits and the criteria  
11          involved for mental health and substance  
12          use disorder benefits.

13           “(iii) ACCESS TO ADDITIONAL INFOR-  
14          MATION REGARDING COMPLIANCE.—In de-  
15          veloping and issuing the compliance pro-  
16          gram guidance document required under  
17          this paragraph, the Secretaries specified in  
18          subparagraph (A)—

19                   “(I) shall enter into interagency  
20                   agreements with the Inspector Gen-  
21                   eral of the Department of Health and  
22                   Human Services, the Inspector Gen-  
23                   eral of the Department of Labor, and  
24                   the Inspector General of the Depart-  
25                   ment of the Treasury to share find-

1           ings of compliance and noncompliance  
2           with this section, section 712 of the  
3           Employee Retirement Income Security  
4           Act of 1974, or section 9812 of the  
5           Internal Revenue Code of 1986, as  
6           applicable; and

7                       “(II) shall seek to enter into an  
8                       agreement with a State to share infor-  
9                       mation on findings of compliance and  
10                      noncompliance with this section, sec-  
11                      tion 712 of the Employee Retirement  
12                      Income Security Act of 1974, or sec-  
13                      tion 9812 of the Internal Revenue  
14                      Code of 1986, as applicable.

15                   “(C) RECOMMENDATIONS.—The compli-  
16                   ance program guidance document shall include  
17                   recommendations to comply with this section,  
18                   section 712 of the Employee Retirement Income  
19                   Security Act of 1974, or section 9812 of the In-  
20                   ternal Revenue Code of 1986, as applicable, and  
21                   encourage the development and use of internal  
22                   controls to monitor adherence to applicable  
23                   statutes, regulations, and program require-  
24                   ments. Such internal controls may include a  
25                   compliance checklist with illustrative examples

1 of nonquantitative treatment limitations on  
2 mental health and substance use disorder bene-  
3 fits, which may fail to comply with this section,  
4 section 712 of the Employee Retirement Income  
5 Security Act of 1974, or section 9812 of the In-  
6 ternal Revenue Code of 1986, as applicable, in  
7 relation to nonquantitative treatment limita-  
8 tions on medical and surgical benefits.

9 “(D) UPDATING THE COMPLIANCE PRO-  
10 GRAM GUIDANCE DOCUMENT.—The compliance  
11 program guidance document shall be updated  
12 every 2 years to include illustrative, de-identi-  
13 fied examples (that do not disclose any pro-  
14 tected health information or individually identi-  
15 fiable information) of previous findings of com-  
16 pliance and noncompliance with this section,  
17 section 712 of the Employee Retirement Income  
18 Security Act of 1974, or section 9812 of the In-  
19 ternal Revenue Code of 1986, as applicable.”.

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

24 “(7) ADDITIONAL GUIDANCE.—

1           “(A) IN GENERAL.—Not later than 1 year  
2 after the date of enactment of the Helping  
3 Families in Mental Health Crisis Act of 2016,  
4 the Secretary, in coordination with the Sec-  
5 retary of Labor and the Secretary of the Treas-  
6 ury, shall issue guidance to group health plans  
7 and health insurance issuers offering group or  
8 individual health insurance coverage to assist  
9 such plans and issuers in satisfying the require-  
10 ments of this section, section 712 of the Em-  
11 ployee Retirement Income Security Act of 1974,  
12 or section 9812 of the Internal Revenue Code  
13 of 1986, as applicable,.

14           “(B) DISCLOSURE.—

15           “(i) GUIDANCE FOR PLANS AND  
16 ISSUERS.—The guidance issued under this  
17 paragraph shall include clarifying informa-  
18 tion and illustrative examples of methods  
19 that group health plans and health insur-  
20 ance issuers offering group or individual  
21 health insurance coverage may use for dis-  
22 closing information to ensure compliance  
23 with the requirements under this section,  
24 section 712 of the Employee Retirement  
25 Income Security Act of 1974, or section

1 9812 of the Internal Revenue Code of  
2 1986, as applicable, (and any regulations  
3 promulgated pursuant to such sections, as  
4 applicable).

5 “(ii) DOCUMENTS FOR PARTICIPANTS,  
6 BENEFICIARIES, CONTRACTING PROVIDERS,  
7 OR AUTHORIZED REPRESENTATIVES.—The  
8 guidance issued under this paragraph shall  
9 include clarifying information and illus-  
10 trative examples of methods that group  
11 health plans and health insurance issuers  
12 offering group or individual health insur-  
13 ance coverage may use to provide any par-  
14 ticipant, beneficiary, contracting provider,  
15 or authorized representative, as applicable,  
16 with documents containing information  
17 that the health plans or issuers are re-  
18 quired to disclose to participants, bene-  
19 ficiaries, contracting providers, or author-  
20 ized representatives to ensure compliance  
21 with this section, section 712 of the Em-  
22 ployee Retirement Income Security Act of  
23 1974, or section 9812 of the Internal Rev-  
24 enue Code of 1986, as applicable; any reg-  
25 ulation issued pursuant to such respective

1 section, or any other applicable law or reg-  
2 ulation, including information that is com-  
3 parative in nature with respect to—

4 “(I) nonquantitative treatment  
5 limitations for both medical and sur-  
6 gical benefits and mental health and  
7 substance use disorder benefits;

8 “(II) the processes, strategies,  
9 evidentiary standards, and other fac-  
10 tors used to apply the limitations de-  
11 scribed in subclause (I); and

12 “(III) the application of the limi-  
13 tations described in subclause (I) to  
14 ensure that such limitations are ap-  
15 plied in parity with respect to both  
16 medical and surgical benefits and  
17 mental health and substance use dis-  
18 order benefits.

19 “(C) NONQUANTITATIVE TREATMENT LIM-  
20 ITATIONS.—The guidance issued under this  
21 paragraph shall include clarifying information  
22 and illustrative examples of methods, processes,  
23 strategies, evidentiary standards, and other fac-  
24 tors that group health plans and health insur-  
25 ance issuers offering group or individual health

1 insurance coverage may use regarding the de-  
2 velopment and application of nonquantitative  
3 treatment limitations to ensure compliance with  
4 this section, section 712 of the Employee Re-  
5 tirement Income Security Act of 1974, or sec-  
6 tion 9812 of the Internal Revenue Code of  
7 1986, as applicable, (and any regulations pro-  
8 mulgated pursuant to such respective section),  
9 including—

10 “(i) examples of methods of deter-  
11 mining appropriate types of nonquantita-  
12 tive treatment limitations with respect to  
13 both medical and surgical benefits and  
14 mental health and substance use disorder  
15 benefits, including nonquantitative treat-  
16 ment limitations pertaining to—

17 “(I) medical management stand-  
18 ards based on medical necessity or ap-  
19 propriateness, or whether a treatment  
20 is experimental or investigative;

21 “(II) limitations with respect to  
22 prescription drug formulary design;  
23 and

24 “(III) use of fail-first or step  
25 therapy protocols;

1           “(ii) examples of methods of deter-  
2 mining—

3                   “(I) network admission standards  
4 (such as credentialing); and

5                   “(II) factors used in provider re-  
6 imbursement methodologies (such as  
7 service type, geographic market, de-  
8 mand for services, and provider sup-  
9 ply, practice size, training, experience,  
10 and licensure) as such factors apply to  
11 network adequacy;

12           “(iii) examples of sources of informa-  
13 tion that may serve as evidentiary stand-  
14 ards for the purposes of making deter-  
15 minations regarding the development and  
16 application of nonquantitative treatment  
17 limitations;

18           “(iv) examples of specific factors, and  
19 the evidentiary standards used to evaluate  
20 such factors, used by such plans or issuers  
21 in performing a nonquantitative treatment  
22 limitation analysis;

23           “(v) examples of how specific evi-  
24 dentiary standards may be used to deter-

1 mine whether treatments are considered  
2 experimental or investigative;

3 “(vi) examples of how specific evi-  
4 dentiary standards may be applied to each  
5 service category or classification of bene-  
6 fits;

7 “(vii) examples of methods of reach-  
8 ing appropriate coverage determinations  
9 for new mental health or substance use  
10 disorder treatments, such as evidence-  
11 based early intervention programs for indi-  
12 viduals with a serious mental illness and  
13 types of medical management techniques;

14 “(viii) examples of methods of reach-  
15 ing appropriate coverage determinations  
16 for which there is an indirect relationship  
17 between the covered mental health or sub-  
18 stance use disorder benefit and a tradi-  
19 tional covered medical and surgical benefit,  
20 such as residential treatment or hos-  
21 pitalizations involving voluntary or involun-  
22 tary commitment; and

23 “(ix) additional illustrative examples  
24 of methods, processes, strategies, evi-  
25 dentiary standards, and other factors for

1           which the Secretary determines that addi-  
2           tional guidance is necessary to improve  
3           compliance with this section, section 712 of  
4           the Employee Retirement Income Security  
5           Act of 1974, or section 9812 of the Inter-  
6           nal Revenue Code of 1986, as applicable.

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

13          (c) AVAILABILITY OF PLAN INFORMATION.—

14               (1) PHSA AMENDMENT.—Paragraph (4) of  
15               section 2726(a) of the Public Health Service Act (42  
16               U.S.C. 300gg–26(a)) is amended to read as follows:

17               “(4) AVAILABILITY OF PLAN INFORMATION.—

18               The criteria for medical necessity determinations  
19               made under the plan or health insurance coverage  
20               with respect to mental health or substance use dis-  
21               order benefits or medical or surgical benefits, the  
22               reason for denial of any such benefits, and any other  
23               information appropriate to demonstrate compliance  
24               under this section (including any such medical and  
25               surgical information) shall be made available by the

1 plan administrator (or the health insurance issuer  
2 offering such coverage) in accordance with applicable  
3 regulations to the current or potential participant,  
4 beneficiary, or contracting provider involved upon re-  
5 quest. The Secretary may promulgate any such reg-  
6 ulations, including interim final regulations or tem-  
7 porary regulations, as may be appropriate to carry  
8 out this paragraph.”.

9 (2) ERISA AMENDMENT.—Paragraph (4) of  
10 section 712(a) of the Employee Retirement Income  
11 Security Act of 1974 (29 U.S.C. 1185a(a)) is  
12 amended to read as follows:

13 “(4) AVAILABILITY OF PLAN INFORMATION.—  
14 The criteria for medical necessity determinations  
15 made under the plan with respect to mental health  
16 or substance use disorder benefits or medical or sur-  
17 gical benefits (or the health insurance coverage of-  
18 fered in connection with the plan with respect to  
19 such benefits), the reason for denial of any such  
20 benefits, and any other information appropriate to  
21 demonstrate compliance under this section (includ-  
22 ing any such medical and surgical information) shall  
23 be made available by the plan administrator (or the  
24 health insurance issuer offering such coverage) in  
25 accordance with applicable regulations to the current

1 or potential participant, beneficiary, or contracting  
2 provider involved upon request. The Secretary may  
3 promulgate any such regulations, including interim  
4 final regulations or temporary regulations, as may  
5 be appropriate to carry out this paragraph.”.

6 (3) IRC AMENDMENT.—Paragraph (4) of sec-  
7 tion 9812(a) of the Internal Revenue Code of 1986  
8 is amended to read as follows:

9 “(4) AVAILABILITY OF PLAN INFORMATION.—  
10 The criteria for medical necessity determinations  
11 made under the plan with respect to mental health  
12 or substance use disorder benefits or medical or sur-  
13 gical benefits, the reason for denial of any such ben-  
14 efits, and any other information appropriate to dem-  
15 onstrate compliance under this section (including  
16 any such medical and surgical information) shall be  
17 made available by the plan administrator in accord-  
18 ance with applicable regulations to the current or  
19 potential participant, beneficiary, or contracting pro-  
20 vider involved upon request. The Secretary may pro-  
21 mulgate any such regulations, including interim final  
22 regulations or temporary regulations, as may be ap-  
23 propriate to carry out this paragraph.”.

24 (d) IMPROVING COMPLIANCE.—



1           (1) IN GENERAL.—Not later than 6 months  
2 after the date of enactment of this Act, the Sec-  
3 retary of Health and Human Services shall convene  
4 a public meeting of stakeholders described in para-  
5 graph (2) to produce an action plan for improved  
6 Federal and State coordination related to the en-  
7 forcement of section 2726 of the Public Health Serv-  
8 ice Act (42 U.S.C. 300gg–26), section 712 of the  
9 Employee Retirement Income Security Act of 1974  
10 (29 U.S.C. 1185a), and section 9812 of the Internal  
11 Revenue Code of 1986, and any comparable provi-  
12 sions of State law (in this section collectively re-  
13 ferred to as “mental health parity and addiction eq-  
14 uity requirements”).

15           (2) STAKEHOLDERS.—The stakeholders de-  
16 scribed in this paragraph shall include each of the  
17 following:

18                   (A) The Federal Government, including  
19 representatives from—

20                           (i) the Department of Health and  
21 Human Services;

22                           (ii) the Department of the Treasury;

23                           (iii) the Department of Labor; and

24                           (iv) the Department of Justice.

25                   (B) State governments, including—

1 (i) State health insurance commis-  
2 sioners;

3 (ii) appropriate State agencies, includ-  
4 ing agencies on public health or mental  
5 health; and

6 (iii) State attorneys general or other  
7 representatives of State entities involved in  
8 the enforcement of mental health parity  
9 and addiction equity requirements.

10 (C) Representatives from key stakeholder  
11 groups, including—

12 (i) the National Association of Insur-  
13 ance Commissioners;

14 (ii) health insurance providers;

15 (iii) providers of mental health and  
16 substance use disorder treatment;

17 (iv) employers; and

18 (v) patients or their advocates.

19 (b) ACTION PLAN.—Not later than 6 months after  
20 the conclusion of the public meeting under subsection (a),  
21 the Secretary of Health and Human Services shall finalize  
22 the action plan described in such subsection and make it  
23 plainly available on the Internet website of the Depart-  
24 ment of Health and Human Services.

1 (c) CONTENT.—The action plan under this section  
2 shall—

3 (1) reflect the input of the stakeholders partici-  
4 pating in the public meeting under subsection (a);

5 (2) identify specific strategic objectives regard-  
6 ing how the various Federal and State agencies  
7 charged with enforcement of mental health parity  
8 and addiction equity requirements will collaborate to  
9 improve enforcement of such requirements;

10 (3) provide a timeline for implementing the ac-  
11 tion plan; and

12 (4) provide specific examples of how such objec-  
13 tives may be met, which may include—

14 (A) providing common educational infor-  
15 mation and documents to patients about their  
16 rights under mental health parity and addiction  
17 equity requirements;

18 (B) facilitating the centralized collection  
19 of, monitoring of, and response to patient com-  
20 plaints or inquiries relating to mental health  
21 parity and addiction equity requirements, which  
22 may be through the development and adminis-  
23 tration of a single, toll-free telephone number  
24 and an Internet website portal;

1 (C) Federal and State law enforcement  
2 agencies entering into memoranda of under-  
3 standing to better coordinate enforcement re-  
4 sponsibilities and information sharing, including  
5 whether such agencies should make the results  
6 of enforcement actions related to mental health  
7 parity and addiction equity requirements pub-  
8 licly available; and

9 (D) recommendations to the Congress re-  
10 garding the need for additional legal authority  
11 to improve enforcement of mental health parity  
12 and addiction equity requirements, including  
13 the need for additional legal authority to ensure  
14 that nonquantitative treatment limitations are  
15 applied, and the extent and frequency of the ap-  
16 plications of such limitations, both to medical  
17 and surgical benefits and to mental health and  
18 substance use disorder benefits in a comparable  
19 manner.

20 **SEC. 803. REPORT ON INVESTIGATIONS REGARDING PAR-**  
21 **ITY IN MENTAL HEALTH AND SUBSTANCE**  
22 **USE DISORDER BENEFITS.**

23 (a) IN GENERAL.—Not later than 1 year after the  
24 date of enactment of this Act, and annually thereafter for  
25 the subsequent 5 years, the Administrator of the Centers

1 for Medicare & Medicaid Services, in collaboration with  
2 the Assistant Secretary of Labor of the Employee Benefits  
3 Security Administration and the Secretary of the Treas-  
4 ury, shall submit to the Committee on Energy and Com-  
5 merce of the House of Representatives and the Committee  
6 on Health, Education, Labor, and Pensions of the Senate  
7 a report summarizing the results of all closed Federal in-  
8 vestigations completed during the preceding 12-month pe-  
9 riod with findings of any serious violation regarding com-  
10 pliance with mental health and substance use disorder cov-  
11 erage requirements under section 2726 of the Public  
12 Health Service Act (42 U.S.C. 300gg-26), section 712 of  
13 the Employee Retirement Income Security Act of 1974  
14 (29 U.S.C. 1185a), and section 9812 of the Internal Rev-  
15 enue Code of 1986.

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

19 (1) The number of closed Federal investigations  
20 conducted during the covered reporting period.

21 (2) Each benefit classification examined by any  
22 such investigation conducted during the covered re-  
23 porting period.

24 (3) Each subject matter, including compliance  
25 with requirements for quantitative and nonquantita-

1       tive treatment limitations, of any such investigation  
2       conducted during the covered reporting period.

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

7       (c) LIMITATION.—Any individually identifiable infor-  
8       mation shall be excluded from reports under subsection  
9       (a) consistent with protections under the health privacy  
10      and security rules promulgated under section 264(c) of the  
11      Health Insurance Portability and Accountability Act of  
12      1996 (42 U.S.C. 1320d–2 note).

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

15      Not later than 3 years after the date of enactment  
16      of this Act, the Comptroller General of the United States,  
17      in consultation with the Secretary of Health and Human  
18      Services, the Secretary of Labor, and the Secretary of the  
19      Treasury, shall submit to the Committee on Energy and  
20      Commerce of the House of Representatives and the Com-  
21      mittee on Health, Education, Labor, and Pensions of the  
22      Senate a report detailing the extent to which group health  
23      plans or health insurance issuers offering group or indi-  
24      vidual health insurance coverage that provides both med-  
25      ical and surgical benefits and mental health or substance

1 use disorder benefits, medicaid managed care organiza-  
2 tions with a contract under section 1903(m) of the Social  
3 Security Act (42 U.S.C. 1396b(m)), and health plans pro-  
4 vided under the State Children’s Health Insurance Pro-  
5 gram under title XXI of the Social Security Act (42  
6 U.S.C. 1397aa et seq.) comply with section 2726 of the  
7 Public Health Service Act (42 U.S.C. 300gg–26), section  
8 712 of the Employee Retirement Income Security Act of  
9 1974 (29 U.S.C. 1185a), and section 9812 of the Internal  
10 Revenue Code of 1986, including—

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

14           (2) how the responsible Federal departments  
15           and agencies ensure that such plans or issuers com-  
16           ply with such sections, including an assessment of  
17           how the Secretary of Health and Human Services  
18           has used its authority to conduct audits of such  
19           plans to ensure compliance;

20           (3) a review of how the various Federal and  
21           State agencies responsible for enforcing mental  
22           health parity requirements have improved enforce-  
23           ment of such requirements in accordance with the  
24           objectives and timeline described in the action plan  
25           under section 802; and

1           (4) recommendations for how additional en-  
2           forcement, education, and coordination activities by  
3           responsible Federal and State departments and  
4           agencies could better ensure compliance with such  
5           sections, including recommendations regarding the  
6           need for additional legal authority.

7   **SEC. 805. INFORMATION AND AWARENESS ON EATING DIS-**  
8                           **ORDERS.**

9           (a) INFORMATION.—The Secretary of Health and  
10          Human Services (in this section referred to as the “Sec-  
11          retary”) may—

12           (1) update information, related fact sheets, and  
13           resource lists related to eating disorders that are  
14           available on the public Internet website of the Na-  
15           tional Women’s Health Information Center spon-  
16           sored by the Office on Women’s Health, to include—

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

19                   (B) information about eating disorders, in-  
20                   cluding information related to males and fe-  
21                   males;

22           (2) incorporate, as appropriate, and in coordi-  
23           nation with the Secretary of Education, information  
24           from publicly available resources into appropriate

1 obesity prevention programs developed by the Office  
2 on Women's Health; and

3 (3) make publicly available (through a public  
4 Internet website or other method) information, re-  
5 lated fact sheets and resource lists, as updated  
6 under paragraph (1), and the information incor-  
7 porated into appropriate obesity prevention pro-  
8 grams, as updated under paragraph (2).

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

11 (1) the types of eating disorders;

12 (2) the seriousness of eating disorders, includ-  
13 ing prevalence, comorbidities, and physical and men-  
14 tal health consequences;

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

18 (4) discrimination and bullying based on body  
19 size;

20 (5) the effects of media on self-esteem and body  
21 image; and

22 (6) the signs and symptoms of eating disorders.

1 **SEC. 806. EDUCATION AND TRAINING ON EATING DIS-**  
2 **ORDERS.**

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

7 (1) identify individuals with eating disorders;

8 (2) provide early intervention services for indi-  
9 viduals with eating disorders;

10 (3) refer patients with eating disorders for ap-  
11 propriate treatment;

12 (4) prevent the development of eating disorders;

13 or

14 (5) provide appropriate treatment services for  
15 individuals with eating disorders.

16 **SEC. 807. GAO STUDY ON PREVENTING DISCRIMINATORY**  
17 **COVERAGE LIMITATIONS FOR INDIVIDUALS**  
18 **WITH SERIOUS MENTAL ILLNESS AND SUB-**  
19 **STANCE USE DISORDERS.**

20 Not later than 2 years after the date of the enact-  
21 ment of this Act, the Comptroller General of the United  
22 States shall submit to Congress and make publicly avail-  
23 able a report detailing Federal oversight of group health  
24 plans and health insurance coverage offered in the indi-  
25 vidual or group market (as such terms are defined in sec-  
26 tion 2791 of the Public Health Service Act (42 U.S.C.

1 300gg–91)), including Medicaid managed care plans  
2 under section 1903 of the Social Security Act (42 U.S.C.  
3 1396b), to ensure compliance of such plans and coverage  
4 with sections 2726 of the Public Health Service Act (42  
5 U.S.C. 300gg–26), 712 of the Employee Retirement In-  
6 come Security Act of 1974 (29 U.S.C. 1185a), and 9812  
7 of the Internal Revenue Code of 1986 (in this section col-  
8 lectively referred to as the “parity law”), including—

9           (1) a description of how Federal regulations  
10         and guidance consider nonquantitative treatment  
11         limitations, including medical necessity criteria and  
12         application of such criteria to medical, surgical, and  
13         primary care, of such plans and coverage in ensuring  
14         compliance by such plans and coverage with the par-  
15         ity law;

16           (2) a description of actions that Federal depart-  
17         ments and agencies are taking to ensure that such  
18         plans and coverage comply with the parity law; and

19           (3) the identification of enforcement, education,  
20         and coordination activities within Federal depart-  
21         ments and agencies, including educational activities  
22         directed to State insurance commissioners, and a de-  
23         scription of how such proper activities can be used  
24         to ensure full compliance with the parity law.

1 **SEC. 808. CLARIFICATION OF EXISTING PARITY RULES.**

2       If a group health plan or a health insurance issuer  
3 offering group or individual health insurance coverage pro-  
4 vides coverage for eating disorder benefits, including resi-  
5 dential treatment, such group health plan or health insur-  
6 ance issuer shall provide such benefits consistent with the  
7 requirements of section 2726 of the Public Health Service  
8 Act (42 U.S.C. 300gg-26), section 712 of the Employee  
9 Retirement Income Security Act of 1974 (29 U.S.C.  
10 1185a), and section 9812 of the Internal Revenue Code  
11 of 1986.

Passed the House of Representatives July 6, 2016.

Attest:

*Clerk.*

114<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

**H. R. 2646**

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**AN ACT**

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