here and make a difference. Every single Member who said: I have a difference that I can make on this legislation, the Committee on Rules said: Bring your amendment to the floor, and we will have a vote.

Let's succeed together on the little things, Mr. Speaker. If the hard things were easy, we would have done them already. The hard things are hard, and that is the problem. Let's get together on these things that are common sense. Let's get together on these things that bring us together. Let's get together on these things where every single voice in the Chamber is being heard. Let's succeed, let's make a difference, and then let's come back tomorrow and do it again.

The material previously referred to by Mr. POLIS is as follows:

AN AMENDMENT TO H. RES. 803 OFFERED BY MR. POLIS

At the end of the resolution, add the following new sections:

SEC. 3. Immediately upon adoption of this resolution the Speaker shall, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 1076) to increase public safety by permitting the Attorney General to deny the transfer of a firearm or the issuance of firearms or explosives licenses to a known or suspected dangerous terrorist. The first reading of the bill shall be dispensed with. All points of order against consideration of the bill are waived. General debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chair and ranking minority member of the Committee on the Judiciary. After general debate the bill shall be considered for amendment under the five-minute rule. All points of order against provisions in the bill are waived. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions. If the Committee of the Whole rises and reports that it has come to no resolution on the bill, then on the next legislative day the House shall, immediately after the third daily order of business under clause 1 of rule XIV, resolve into the Committee of the Whole for further consideration of the bill.

SEC. 4. Clause 1(c) of rule XIX shall not apply to the consideration of H.R. 1076.

THE VOTE ON THE PREVIOUS QUESTION: WHAT IT REALLY MEANS

This vote, the vote on whether to order the previous question on a special rule, is not merely a procedural vote. A vote against ordering the previous question is a vote against the Republican majority agenda and a vote to allow the Democratic minority to offer an alternative plan. It is a vote about what the House should be debating.

Mr. Clarence Cannon's Precedents of the House of Representatives (VI, 308–311), describes the vote on the previous question on the rule as ''a motion to direct or control the consideration of the subject before the House being made by the Member in charge.'' To defeat the previous question is to give the opposition a chance to decide the subject before the House. Cannon cites the Speaker's ruling of January 13, 1920, to the effect that ''the refusal of the House to sustain the demand for the previous question passes the control of the resolution to the opposition'' in order to offer an amendment. On March 15, 1909, a member of the majority party offered a rule resolution. The House defeated the previous question and a member of the opposition rose to a parliamentary inquiry, asking who was entitled to recognition. Speaker Joseph G. Cannon (R–Illinois) said: ''The previous question having been refused, the gentleman from New York, Mr. Fitzgerald, who had asked the gentleman to yield to him for an amendment, is entitled to the first recognition.''

The Republican majority may say ''the vote on the previous question is simply a vote on whether to proceed to an immediate vote on adopting the resolution . . . [and] has no substantive legislative or policy implications whatsoever.'' But that is not what they have always said. Listen to the Republican Leadership Manual on the Legislative Process in the United States House of Representatives, (6th edition, page 135). Here's how the Republicans describe the previous question vote in their own manual: ''Although it is generally not possible to amend the rule because the majority Member controlling the time will not yield for the purpose of offering an amendment, the same result may be achieved by voting down the previous question on the rule. . . . When the motion for the previous question is defeated, control of the time passes to the Member who led the opposition to ordering the previous question. That Member, because he then controls the time, may offer an amendment to the rule, or yield for the purpose of amendment.''

In Deschler's Procedure in the U.S. House of Representatives, the subchapter titled ''Amending Special Rules'' states: ''a refusal to order the previous question on such a rule [a special rule reported from the Committee on Rules] opens the resolution to amendment and further debate.'' (Chapter 21, section 21.2) Section 21.3 continues: ''Upon rejection of the motion for the previous question on a resolution reported from the Committee on Rules, control shifts to the Member leading the opposition to the previous question, who may offer a proper amendment or motion and who controls the time for debate thereon.''

Clearly, the vote on the previous question on a rule does have substantive policy implications. It is one of the only available tools for those who oppose the Republican majority's agenda and allows those with alternative views the opportunity to offer an alternative plan.

Mr. WOODALL. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The SPEAKER pro tempore (Mr. GRAVES of Louisiana). The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. POLIS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on the motion to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote incurs objection under clause 6 of rule XX.

Any record vote on the postponed question will be taken later.

HELPING FAMILIES IN MENTAL HEALTH CRISIS ACT OF 2016

Mr. MURPHY of Pennsylvania. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 2646) to make available needed psychiatric, psychological, and supportive services for individuals with mental illness and families in mental health crisis, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 2646

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

TITLE I—ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE

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

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

''(c) ASSISTANT SECRETARY AND DEPUTY ASSISTANT SECRETARY.—

''(1) ASSISTANT SECRETARY.—

''(A) APPOINTMENT.—The Administration shall be headed by an official to be known as the Assistant Secretary for Mental Health and Substance Use (hereinafter in this title referred to as the 'Assistant Secretary') who shall be appointed by the President, by and with the advice and consent of the Senate.

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

''(i) a doctoral degree in medicine, osteopathic medicine, or psychology;

''(ii) clinical and research experience regarding mental health and substance use disorders; and

''(iii) an understanding of biological, psychosocial, and pharmaceutical treatments of mental illness and substance use disorders.

''(2) DEPUTY ASSISTANT SECRETARY.—The Assistant Secretary, with the approval of the Secretary, may appoint a Deputy Assistant Secretary and may employ and prescribe the functions of such officers and employees, including attorneys, as are necessary to administer the activities to be carried out through the Administration.''.

(b) TRANSFER OF AUTHORITIES.—The Secretary of Health and Human Services shall delegate to the Assistant Secretary for Mental Health and Substance Use all duties and authorities that—

(1) as of the day before the date of enactment of this Act, were vested in the Administrator of the Substance Abuse and Mental Health Services Administration; and

(2) are not terminated by this Act.

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

(1) in paragraph (17), by striking ''and'' at the end;

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

(3) by adding at the end the following:

''(19) evaluate, in consultation with the Assistant Secretary for Financial Resources, the information used for oversight of grants under programs related to mental illness and substance use disorders, including co-occurring illness or disorders, administered by the Center for Mental Health Services;

''(20) periodically review Federal programs and activities relating to the diagnosis or prevention of, or treatment or rehabilitation for, mental illness and substance use disorders to identify any such programs or activities that have proven to be effective or efficient in improving outcomes or increasing access to evidence-based programs;

''(21) establish standards for the appointment of peer-review panels to evaluate grant applications and recommend standards for mental health grant programs; and''.

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

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

''(A) the capacity of the grantee to implement the award;

''(B) requirements for the description of the program implementation approach;

''(C) the extent to which the grant plan submitted by the grantee as part of its application must explain how the grantee will reach the population of focus and provide a statement of need, including to what extent the grantee will increase the number of clients served and the estimated percentage of clients receiving services who report positive functioning after 6 months or no past-month substance use, as applicable;

''(D) the extent to which the grantee must collect and report on required performance measures; and

''(E) the extent to which the grantee is proposing evidence-based practices and the extent to which—

''(i) those evidence-based practices must be used with respect to a population similar to the population for which the evidence-based practices were shown to be effective; or

''(ii) if no evidence-based practice exists for a population of focus, the way in which the grantee will implement adaptations of evidence-based practices, promising practices, or cultural practices.''.

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

''(4) AVAILABILITY OF FUNDS THROUGH FOLLOWING FISCAL YEAR.—Amounts made available for carrying out this subsection shall remain available through the end of the fiscal year following the fiscal year for which such amounts are appropriated.''.

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

(1) in subsection (b)—

(A) by redesignating paragraphs (4), (5), and (6) as paragraphs (5), (6), and (7), respectively; and

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

''(4) the Assistant Secretary for Mental Health and Substance Use;''; and

(2) in subsection (c), by striking ''(4), (5), and (6)'' each place it appears and inserting ''(5), (6), and (7)''.

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

(1) by striking ''Administrator of the Substance Abuse and Mental Health Services Administration'' each place it appears and inserting ''Assistant Secretary for Mental Health and Substance Use''; and

(2) by striking ''Administrator'' each place it appears (including in any headings) and inserting ''Assistant Secretary'', except where the term ''Administrator'' appears—

(A) in each of subsections (e) and (f) of section 501 of such Act (42 U.S.C. 290aa), including the headings of such subsections, within the term ''Associate Administrator'';

(B) in section 507(b)(6) of such Act (42 U.S.C. 290bb(b)(6)), within the term ''Administrator of the Health Resources and Services Administration'';

(C) in section 507(b)(6) of such Act (42 U.S.C. 290bb(b)(6)), within the term ''Administrator of the Centers for Medicare & Medicaid Services'';

(D) in section 519B(c)(1)(B) of such Act (42 U.S.C. 290bb-25b(c)(1)(B)), within the term ''Administrator of the National Highway Traffic Safety Administration''; or

(E) in each of sections 519B(c)(1)(B), 520C(a), and 520D(a) of such Act (42 U.S.C. 290bb-25b(c)(1)(B), 290bb-34(a), 290bb-35(a)), within the term ''Administrator of the Office of Juvenile Justice and Delinquency Prevention''.

(h) REFERENCES.—After executing subsections (a), (b), and (f), any reference in statute, regulation, or guidance to the Administrator of the Substance Abuse and Mental Health Services Administration shall be construed to be a reference to the Assistant Secretary for Mental Health and Substance Use.

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

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

''SEC. 501A. IMPROVING OVERSIGHT OF MENTAL HEALTH AND SUBSTANCE USE PROGRAMS.

''(a) ACTIVITIES.—For the purpose of ensuring efficient and effective planning and evaluation of mental illness and substance use disorder programs and related activities, the Assistant Secretary for Planning and Evaluation, in consultation with the Assistant Secretary for Mental Health and Substance Use, shall—

''(1) collect and organize relevant data on homelessness, involvement with the criminal justice system, hospitalizations, mortality outcomes, and other measures the Secretary deems appropriate from across Federal departments and agencies;

''(2) evaluate programs related to mental illness and substance use disorders, including co-occurring illness or disorders, across Federal departments and agencies, as appropriate, including programs related to—

''(A) prevention, intervention, treatment, and recovery support services, including such services for individuals with a serious mental illness or serious emotional disturbance;

''(B) the reduction of homelessness and involvement with the criminal justice system among individuals with a mental illness or substance use disorder; and

''(C) public health and health services; and

''(3) consult, as appropriate, with the Assistant Secretary, the Behavioral Health Coordinating Council of the Department of Health and Human Services, other agencies within the Department of Health and Human Services, and other relevant Federal departments.

''(b) RECOMMENDATIONS.—The Assistant Secretary for Planning and Evaluation shall develop an evaluation strategy that identifies priority programs to be evaluated by the Assistant Secretary and priority programs to be evaluated by other relevant agencies within the Department of Health and Human Services. The Assistant Secretary for Planning and Evaluation shall provide recommendations on improving programs and activities based on the evaluation described in subsection (a)(2) as needing improvement.''.

SEC. 103. NATIONAL MENTAL HEALTH AND SUBSTANCE USE POLICY LABORATORY.

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

''SEC. 501B. NATIONAL MENTAL HEALTH AND SUBSTANCE USE POLICY LABORATORY.

''(a) IN GENERAL.—There shall be established within the Administration a National Mental Health and Substance Use Policy Laboratory (referred to in this section as the 'Laboratory').

''(b) RESPONSIBILITIES.—The Laboratory shall—

''(1) continue to carry out the authorities and activities that were in effect for the Office of Policy, Planning, and Innovation as such Office existed prior to the date of enactment of the Helping Families in Mental Health Crisis Act of 2016;

''(2) identify, coordinate, and facilitate the implementation of policy changes likely to have a significant effect on mental health, mental illness, and the prevention and treatment of substance use disorder services;

''(3) collect, as appropriate, information from grantees under programs operated by the Administration in order to evaluate and disseminate information on evidence-based practices, including culturally and linguistically appropriate services, as appropriate, and service delivery models;

''(4) provide leadership in identifying and coordinating policies and programs, including evidence-based programs, related to mental illness and substance use disorders;

''(5) recommend ways in which payers may implement program and policy findings of the Administration and the Laboratory to improve outcomes and reduce per capita program costs;

''(6) in consultation with the Assistant Secretary for Planning and Evaluation, as appropriate, periodically review Federal programs and activities relating to the diagnosis or prevention of, or treatment or rehabilitation for, mental illness and substance use disorders, including by—

''(A) identifying any such programs or activities that are duplicative;

''(B) identifying any such programs or activities that are not evidence-based, effective, or efficient; and

''(C) formulating recommendations for coordinating, eliminating, or improving programs or activities identified under subparagraph (A) or (B) and merging such programs or activities into other successful programs or activities; and

''(7) carry out other activities as deemed necessary to continue to encourage innovation and disseminate evidence-based programs and practices, including programs and practices with scientific merit.

''(c) EVIDENCE-BASED PRACTICES AND SERVICE DELIVERY MODELS.—

''(1) IN GENERAL.—In selecting evidence-based best practices and service delivery models for evaluation and dissemination, the Laboratory—

''(A) shall give preference to models that improve—

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

''(ii) the coordination among such providers and the justice and corrections system; and

''(iii) the cost effectiveness, quality, effectiveness, and efficiency of health care services furnished to individuals with serious mental illness or serious emotional disturbance, in mental health crisis, or at risk to themselves, their families, and the general public; and

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

''(2) DEADLINE FOR BEGINNING IMPLEMENTATION.—The Laboratory shall begin implementation of the duties described in this section not later than January 1, 2018.

''(3) CONSULTATION.—In carrying out the duties under this section, the Laboratory shall consult with—

''(A) representatives of the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism, on an ongoing basis;

''(B) other appropriate Federal agencies;

''(C) clinical and analytical experts with expertise in psychiatric medical care and clinical psychological care, health care management, education, corrections health care, and mental health court systems, as appropriate; and

''(D) other individuals and agencies as determined appropriate by the Assistant Secretary.''.

SEC. 104. PEER-SUPPORT SPECIALIST PROGRAMS.

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

(b) CONTENTS OF STUDY.—In conducting the study under subsection (a), the Comptroller General of the United States shall examine and identify best practices in the selected States related to training and credential requirements for peer-support specialist programs, such as—

(1) hours of formal work or volunteer experience related to mental illness and substance use disorders conducted through such programs;

(2) types of peer-support specialist exams required for such programs in the States;

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

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

(5) requirements for continuing education.

SEC. 105. PROHIBITION AGAINST LOBBYING USING FEDERAL FUNDS BY SYSTEMS ACCEPTING FEDERAL FUNDS TO PROTECT AND ADVOCATE THE RIGHTS OF INDIVIDUALS WITH MENTAL ILLNESS.

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

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

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

(3) by adding at the end the following:

''(11) agree to refrain, during any period for which funding is provided to the system under this part, from using Federal funds to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to

influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State or local government, including any legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local, or tribal government in policymaking and administrative processes within the executive branch of that government.''.

SEC. 106. REPORTING FOR PROTECTION AND ADVOCACY ORGANIZATIONS.

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

(b) DETAILED ACCOUNTING.—Section 114(a) of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10824(a)) is amended—

(1) in paragraph (3), by striking ''and'' at the end;

(2) in paragraph (4), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(5) using data from the existing required annual program progress reports submitted by each system funded under this title, a detailed accounting for each such system of how funds are spent, disaggregated according to whether the funds were received from the Federal Government, the State government, a local government, or a private entity.''.

SEC. 107. GRIEVANCE PROCEDURE.

Section 105 of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10805), as amended, is further amended by adding at the end the following:

''(d) GRIEVANCE PROCEDURE.—The Secretary shall establish an independent grievance procedure for persons described in subsection (a)(9).''.

SEC. 108. CENTER FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY.

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

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

''(4) The Center for Behavioral Health Statistics and Quality.'';

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

(A) in subparagraph (C), by striking ''and'' at the end;

(B) in subparagraph (D), by striking the period at the end and inserting ''; and''; and

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

''(E) the Center for Behavioral Health Statistics and Quality.''; and

(3) in part B (42 U.S.C. 290bb et seq.) by adding at the end the following new subpart:

''Subpart 4—Center for Behavioral Health Statistics and Quality

''SEC. 520L. CENTER FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY.

''(a) ESTABLISHMENT.—There is established in the Administration a Center for Behavioral Health Statistics and Quality (in this section referred to as the 'Center'). The Center shall be headed by a Director (in this section referred to as the 'Director') appointed by the Secretary from among individuals with extensive experience and academic qualifications in research and analysis in behavioral health care or related fields.

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

''(1) coordinate the Administration's integrated data strategy by coordinating—

''(A) surveillance and data collection (including that authorized by section 505);

''(B) evaluation;

''(C) statistical and analytic support;

''(D) service systems research; and

''(E) performance and quality information systems;

''(2) recommend a core set of measurement standards for grant programs administered by the Administration; and

''(3) coordinate evaluation efforts for the grant programs, contracts, and collaborative agreements of the Administration.

''(c) BIANNUAL REPORT TO CONGRESS.—Not later than 2 years after the date of enactment of this section, and every 2 years thereafter, the Director of the Center shall submit to Congress a report on the quality of services furnished through grant programs of the Administration, including applicable measures of outcomes for individuals and public outcomes such as—

''(1) the number of patients screened positive for unhealthy alcohol use who receive brief counseling as appropriate; the number of patients screened positive for tobacco use and receiving smoking cessation interventions; the number of patients with a new diagnosis of major depressive episode who are assessed for suicide risk; the number of patients screened positive for clinical depression with a documented followup plan; and the number of patients with a documented pain assessment that have a followup treatment plan when pain is present; and satisfaction with care;

''(2) the incidence and prevalence of mental illness and substance use disorders; the number of suicide attempts and suicide completions; overdoses seen in emergency rooms resulting from alcohol and drug use; emergency room boarding; overdose deaths; emergency psychiatric hospitalizations; new criminal justice involvement while in treatment; stable housing; and rates of involvement in employment, education, and training; and

''(3) such other measures for outcomes of services as the Director may determine.

''(d) STAFFING COMPOSITION.—The staff of the Center may include individuals with advanced degrees and field expertise as well as clinical and research experience in mental illness and substance use disorders such as—

''(1) professionals with clinical and research expertise in the prevention and treatment of, and recovery from, mental illness and substance use disorders;

''(2) professionals with training and expertise in statistics or research and survey design and methodologies; and

''(3) other related fields in the social and behavioral sciences, as specified by relevant position descriptions.

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

''(f) DEFINITION.—In this section, the term 'emergency room boarding' means the practice of admitting patients to an emergency department and holding such patients in the department until inpatient psychiatric beds become available.''.

SEC. 109. STRATEGIC PLAN.

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

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

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

''(l) STRATEGIC PLAN.—

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

''(2) COORDINATION.—In developing and carrying out the strategic plan under this section, the Assistant Secretary shall take into consideration the report of the Interdepartmental Serious Mental Illness Coordinating Committee under section 301 of the Helping Families in Mental Health Crisis Act of 2016.

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

''(A) submit the strategic plan developed under paragraph (1) to the appropriate committees of Congress; and

''(B) post such plan on the Internet website of the Administration.

''(4) CONTENTS.—The strategic plan developed under paragraph (1) shall—

''(A) identify strategic priorities, goals, and measurable objectives for mental illness and substance use disorder activities and programs operated and supported by the Administration, including priorities to prevent or eliminate the burden of mental illness and substance use disorders;

''(B) identify ways to improve services for individuals with a mental illness or substance use disorder, including services related to the prevention of, diagnosis of, intervention in, treatment of, and recovery from, mental illness or substance use disorders, including serious mental illness or serious emotional disturbance, and access to services and supports for individuals with a serious mental illness or serious emotional disturbance;

''(C) ensure that programs provide, as appropriate, access to effective and evidence-based prevention, diagnosis, intervention, treatment, and recovery services, including culturally and linguistically appropriate services, as appropriate, for individuals with a mental illness or substance use disorder;

''(D) identify opportunities to collaborate with the Health Resources and Services Administration to develop or improve—

''(i) initiatives to encourage individuals to pursue careers (especially in rural and underserved areas and populations) as psychiatrists, psychologists, psychiatric nurse practitioners, physician assistants, occupational therapists, clinical social workers, certified peer-support specialists, licensed professional counselors, or other licensed or certified mental health professionals, including such professionals specializing in the diagnosis, evaluation, or treatment of individuals with a serious mental illness or serious emotional disturbance; and

''(ii) a strategy to improve the recruitment, training, and retention of a workforce for the treatment of individuals with mental illness or substance use disorders, or co-occurring illness or disorders;

''(E) identify opportunities to improve collaboration with States, local governments, communities, and Indian tribes and tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)); and

''(F) specify a strategy to disseminate evidenced-based and promising best practices related to prevention, diagnosis, early intervention, treatment, and recovery services related to mental illness, particularly for individuals with a serious mental illness and children and adolescents with a serious emotional disturbance, and substance use disorders.''.

SEC. 110. AUTHORITIES OF CENTERS FOR MENTAL HEALTH SERVICES AND SUBSTANCE ABUSE TREATMENT.

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

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

(2) by inserting after paragraph (2) the following:

''(3) collaborate with the Director of the National Institute of Mental Health to ensure that, as appropriate, programs related to the prevention and treatment of mental illness and the promotion of mental health are carried out in a manner that reflects the best available science and evidence-based practices, including culturally and linguistically appropriate services;'';

(3) in paragraph (5), as so redesignated, by inserting ''through policies and programs that reduce risk and promote resiliency'' before the semicolon;

(4) in paragraph (6), as so redesignated, by inserting ''in collaboration with the Director of the National Institute of Mental Health,'' before ''develop'';

(5) in paragraph (8), as so redesignated, by inserting '', increase meaningful participation of individuals with mental illness in programs and activities of the Administration,'' before ''and protect the legal'';

(6) in paragraph (10), as so redesignated, by striking ''professional and paraprofessional personnel pursuant to section 303'' and inserting ''paraprofessional personnel and health professionals'';

(7) in paragraph (11), as so redesignated, by inserting ''and telemental health,'' after ''rural mental health,'';

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

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

(10) in paragraph (16), as so redesignated, by striking the period and inserting ''; and''; and

(11) by adding at the end the following:

''(17) consult with other agencies and offices of the Department of Health and Human Services to ensure, with respect to each grant awarded by the Center for Mental Health Services, the consistent documentation of the application of criteria when awarding grants and the ongoing oversight of grantees after such grants are awarded.''.

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

(1) in subsection (a)—

(A) by striking ''treatment of substance abuse'' and inserting ''treatment of substance use disorders''; and

(B) by striking ''abuse treatment systems'' and inserting ''use disorder treatment systems''; and

(2) in subsection (b)—

(A) in paragraph (3), by striking ''abuse'' and inserting ''use disorder'';

(B) in paragraph (4), by striking ''individuals who abuse drugs'' and inserting ''individuals who use drugs'';

(C) in paragraph (9), by striking ''carried out by the Director'';

(D) by striking paragraph (10);

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

(F) in paragraph (12), as so redesignated, by striking ''; and'' and inserting a semicolon; and

(G) by striking paragraph (13), as so redesignated, and inserting the following:

''(13) ensure the consistent documentation of the application of criteria when awarding grants and the ongoing oversight of grantees after such grants are awarded; and

''(14) work with States, providers, and individuals in recovery, and their families, to promote the expansion of recovery support services and systems of care oriented towards recovery.''.

SEC. 111. ADVISORY COUNCILS.

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

(1) in paragraph (2)—

(A) in subparagraph (E), by striking ''and'' after the semicolon;

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

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

''(F) for the advisory councils appointed under subsections (a)(1)(A) and (a)(1)(D), the Director of the National Institute of Mental Health;

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

''(H) for the advisory councils appointed under subsections (a)(1)(A), (a)(1)(B), and (a)(1)(C), the Director of the National Institute on Alcohol Abuse and Alcoholism; and''; and

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

''(C) Not less than half of the members of the advisory council appointed under subsection (a)(1)(D)—

''(i) shall have—

''(I) a medical degree;

''(II) a doctoral degree in psychology; or

''(III) an advanced degree in nursing or social work from an accredited graduate school or be a certified physician assistant; and

''(ii) shall specialize in the mental health field.''.

SEC. 112. PEER REVIEW.

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

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.

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

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

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

SEC. 202. OPTIONAL LIMITED COVERAGE OF INPATIENT SERVICES FURNISHED IN INSTITUTIONS FOR MENTAL DISEASES.

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

''(I)(i) Notwithstanding the limitation specified in the subdivision (B) following paragraph (29) of section 1905(a) and subject to clause (ii), a State may, under a risk contract entered into by the State under this title (or under section 1115) with a medicaid managed care organization or a prepaid inpatient health plan (as defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation)), make a monthly capitation payment to such organization or plan for enrollees with the organization or plan who are over 21 years of age and under 65 years of age and are receiving inpatient treatment in an institution for mental diseases (as defined in section 1905(i)), so long as each of the following conditions is met:

''(I) The institution is a hospital providing inpatient psychiatric or substance use disorder services or a sub-acute facility providing psychiatric or substance use disorder crisis residential services.

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

''(III) The provision of such treatment meets the following criteria for consideration as services or settings that are provided in lieu of services or settings covered under the State plan:

''(aa) The State determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the service or setting covered under the State plan.

''(bb) The enrollee is not required by the managed care organization or prepaid inpatient health plan to use the alternative service or setting.

''(cc) Such treatment is authorized and identified in such contract, and will be offered to such enrollees at the option of the managed care organization or prepaid inpatient health plan.

''(ii) For purposes of setting the amount of such a monthly capitation payment, a State may use the utilization of services provided to an individual under this subparagraph when developing the inpatient psychiatric or substance use disorder component of such payment, but the amount of such payment for such services may not exceed the cost of the same services furnished through providers included under the State plan.''.

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

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

(a) STUDY.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall conduct a study on coverage under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) of services provided through a medicaid managed care organization (as defined in section 1903(m) of such Act (42 U.S.C. 1396b(m)) or a prepaid inpatient health plan (as defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation)) with respect to individuals over the age of 21 and under the age of 65 for the treatment of a mental health disorder in institutions for mental diseases (as defined in section 1905(i) of such Act (42 U.S.C. 1396d(i))). Such study shall include information on the following:

(1) The extent to which States, including the District of Columbia and each territory or possession of the United States, are providing capitated payments to such organizations or plans for enrollees who are receiving services in institutions for mental diseases.

(2) The number of individuals receiving medical assistance under a State plan under such title XIX, or a waiver of such plan, who receive services in institutions for mental diseases through such organizations and plans.

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

(4) How such organizations or plans determine when to provide for the furnishing of such services through an institution for mental diseases in lieu of other benefits (including the full range of community-based services) under their contract with the State agency administering the State plan under such title XIX, or a waiver of such plan, to address psychiatric or substance use disorder treatment.

(5) The extent to which the provision of services within such institutions has affected the capitated payments for such organizations or plans.

(b) REPORT.—Not later than three years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a).

SEC. 204. GUIDANCE ON OPPORTUNITIES FOR INNOVATION.

Not later than one year after the date of the enactment of this Act, the Administrator of the Centers for Medicare & Medicaid Services shall issue a State Medicaid Director letter regarding opportunities to design innovative service delivery systems, including systems for providing community-based services, for individuals with serious mental illness or serious emotional disturbance who are receiving medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.). The letter shall include opportunities for demonstration projects under section 1115 of such Act (42 U.S.C. 1315), to improve care for such individuals.

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

(a) COLLECTION OF INFORMATION.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall, with respect to each State that has participated in the demonstration project established under section 2707 of the Patient Protection and Affordable Care Act (42 U.S.C. 1396a note), collect from each such State information on the following:

(1) The number of institutions for mental diseases (as defined in section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i))) and beds in such institutions that received payment for the provision of services to individuals who receive medical assistance under a State plan under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or under a waiver of such plan) through the demonstration project in each such State as compared to the total number of institutions for mental diseases and beds in the State.

(2) The extent to which there is a reduction in expenditures under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) or other spending on the full continuum of physical or mental health care for individuals who receive treatment in an institution for mental diseases under the demonstration project, including outpatient, inpatient, emergency, and ambulatory care, that is attributable to such individuals receiving treatment in institutions for mental diseases under the demonstration project.

(3) The number of forensic psychiatric hospitals, the number of beds in such hospitals, and the number of forensic psychiatric beds in other hospitals in such State, based on the most recent data available, to the extent practical, as determined by such Administrator.

(4) The amount of any disproportionate share hospital payments under section 1923 of the Social Security Act (42 U.S.C. 1396r–4) that institutions for mental diseases in the State received during the period beginning on July 1, 2012, and ending on June 30, 2015, and the extent to which the demonstration project reduced the amount of such payments.

(5) The most recent data regarding all facilities or sites in the State in which any individuals with serious mental illness who are receiving medical assistance under a State plan under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or under a waiver of such plan) are treated during the period referred to in paragraph (4), to the extent practical, as determined by the Administrator, including—

(A) the types of such facilities or sites (such as an institution for mental diseases, a hospital emergency department, or other inpatient hospital);

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

(C) the payment rate under the State plan (or a waivers of such plan) for services furnished to such an individual for that treatment, disaggregated by facility type, during the period in which the demonstration project is in operation.

(6) The extent to which the utilization of hospital emergency departments during the period in which the demonstration project was is in operation differed, with respect to individuals who are receiving medical assistance under a State plan under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or under a waiver of such plan), between—

(A) those individuals who received treatment in an institution for mental diseases under the demonstration project;

(B) those individuals who met the eligibility requirements for the demonstration project but who did not receive treatment in an institution for mental diseases under the demonstration project; and

(C) those individuals with serious mental illness who did not meet such eligibility requirements and did not receive treatment for such illness in an institution for mental diseases.

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

SEC. 206. PROVIDING EPSDT SERVICES TO CHILDREN IN IMDS.

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

(1) by striking ''effective January 1, 1973'' and inserting ''(A) effective January 1, 1973''; and

(2) by inserting before the semicolon at the end the following: '', and, (B) for individuals receiving services described in subparagraph (A), early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)), whether or not such screening, diagnostic, and treatment services are furnished by the provider of the services described in such subparagraph''.

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

SEC. 207. ELECTRONIC VISIT VERIFICATION SYSTEM REQUIRED FOR PERSONAL CARE SERVICES AND HOME HEALTH CARE SERVICES UNDER MEDICAID.

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

''(l)(1) Subject to paragraphs (3) and (4), with respect to any amount expended for personal care services or home health care services requiring an in-home visit by a provider that are provided under a State plan under this title (or under a waiver of the plan) and furnished in a calendar quarter beginning on or after January 1, 2019 (or, in the case of home health care services, on or after January 1, 2023), unless a State requires the use of an electronic visit verification system for such services furnished in such quarter under the plan or such waiver, the Federal medical assistance percentage shall be reduced—

''(A) in the case of personal care services—

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

''(ii) for calendar quarters in 2021, by .5 percentage points;

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

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

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

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

''(ii) for calendar quarters in 2025, by .5 percentage points;

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

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

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

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

''(i) is minimally burdensome;

''(ii) takes into account existing best practices and electronic visit verification systems in use in the State; and

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

''(B) take into account a stakeholder process that includes input from beneficiaries, family caregivers, individuals who furnish personal care services or home health care services, and other stakeholders, as determined by the State in accordance with guidance from the Secretary; and

''(C) ensure that individuals who furnish personal care services, home health care services, or both under the State plan (or under a waiver of the plan) are provided the opportunity for training on the use of such system.

''(3) Paragraphs (1) and (2) shall not apply in the case of a State that, as of the date of the enactment of this subsection, requires the use of any system for the electronic verification of visits conducted as part of both personal care services and home health care services, so long as the State continues to require the use of such system with respect to the electronic verification of such visits.

''(4)(A) In the case of a State described in subparagraph (B), the reduction under paragraph (1) shall not apply—

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

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

''(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that demonstrates to the Secretary that the State—

''(i) has made a good faith effort to comply with the requirements of paragraphs (1) and (2) (including by taking steps to adopt the technology used for an electronic visit verification system); or

''(ii) in implementing such a system, has encountered unavoidable system delays.

''(5) In this subsection:

''(A) The term 'electronic visit verification system' means, with respect to personal care services or home health care services, a system under which visits conducted as part of such services are electronically verified with respect to—

''(i) the type of service performed;

''(ii) the individual receiving the service;

''(iii) the date of the service;

''(iv) the location of service delivery;

''(v) the individual providing the service; and

''(vi) the time the service begins and ends.

''(B) The term 'home health care services' means services described in section 1905(a)(7) provided under a State plan under this title (or under a waiver of the plan).

''(C) The term 'personal care services' means personal care services provided under a State plan under this title (or under a waiver of the plan), including services provided under section 1905(a)(24), 1915(c), 1915(i), 1915(j), or 1915(k) or under a wavier under section 1115.

''(6)(A) In the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system operated by the State or a contractor on behalf of the State, the Secretary shall pay to the State, for each quarter, an amount equal to 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such system, and 75 per centum of so much of the sums for the operation and maintenance of such system.

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

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

(1) training individuals who furnish personal care services, home health care services, or both under the State plan under title XIX of such Act (or under a waiver of the plan) on such systems and the operation of such systems and the prevention of fraud with respect to the provision of personal care services or home health care services (as defined in such subsection (l)(5)); and

(2) the provision of notice and educational materials to family caregivers and beneficiaries with respect to the use of such electronic visit verification systems and other means to prevent such fraud.

(c) RULES OF CONSTRUCTION.—

(1) NO EMPLOYER-EMPLOYEE RELATIONSHIP ESTABLISHED.—Nothing in the amendment made by this section may be construed as establishing an employer-employee relationship between the agency or entity that provides for personal care services or home health care services and the individuals who, under a contract with such an agency or entity, furnish such services for purposes of part 552 of title 29, Code of Federal Regulations (or any successor regulations).

(2) NO PARTICULAR OR UNIFORM ELECTRONIC VISIT VERIFICATION SYSTEM REQUIRED.—Nothing in the amendment made by this section shall be construed to require the use of a particular or uniform electronic visit verification system (as defined in subsection (l)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)) by all agencies or entities that provide personal care services or home health care under a State plan under title XIX of the Social Security Act (or under a waiver of the plan) (42 U.S.C. 1396 et seq.).

(3) NO LIMITS ON PROVISION OF CARE.—Nothing in the amendment made by this section may be construed to limit, with respect to personal care services or home health care services provided under a State plan under title XIX of the Social Security Act (or under a waiver of the plan) (42 U.S.C. 1396 et seq.), provider selection, constrain beneficiaries' selection of a caregiver, or impede the manner in which care is delivered.

(4) NO PROHIBITION ON STATE QUALITY MEASURES REQUIREMENTS.—Nothing in the amendment made by this section shall be construed as prohibiting a State, in implementing an electronic visit verification system (as defined in subsection (l)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), from establishing requirements related to quality measures for such system.

TITLE III—INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE

SEC. 301. INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 3 months after the date of enactment of this Act, the Secretary of Health and Human Services, or the designee of the Secretary, shall establish a committee to be known as the ''Interdepartmental Serious Mental Illness Coordinating Committee'' (in this section referred to as the ''Committee'').

(2) FEDERAL ADVISORY COMMITTEE ACT.—Except as provided in this section, the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Committee.

(b) MEETINGS.—The Committee shall meet not fewer than 2 times each year.

(c) RESPONSIBILITIES.—Not later than 1 year after the date of enactment of this Act, and 5 years after such date of enactment, the Committee shall submit to Congress a report including—

(1) a summary of advances in serious mental illness and serious emotional disturbance research related to the prevention of, diagnosis of, intervention in, and treatment and recovery of, serious mental illnesses, serious emotional disturbances, and advances in access to services and support for individuals with a serious mental illness or serious emotional disturbance;

(2) an evaluation of the effect on public health of Federal programs related to serious mental illness or serious emotional disturbance, including measurements of public health outcomes such as—

(A) rates of suicide, suicide attempts, prevalence of serious mental illness, serious emotional disturbances, and substance use disorders, overdose, overdose deaths, emergency hospitalizations, emergency room boarding, preventable emergency room visits, involvement with the criminal justice system, crime, homelessness, and unemployment;

(B) increased rates of employment and enrollment in educational and vocational programs;

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

(D) any other criteria as may be determined by the Secretary;

(3) a plan to improve outcomes for individuals with serious mental illness or serious emotional disturbances, including reducing incarceration for such individuals, reducing homelessness, and increasing employment; and

(4) specific recommendations for actions that agencies can take to better coordinate the administration of mental health services for people with serious mental illness or serious emotional disturbances.

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

(e) MEMBERSHIP.—

(1) FEDERAL MEMBERS.—The Committee shall be composed of the following Federal representatives, or their designees:

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

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

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

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

(E) The Attorney General of the United States.

(F) The Secretary of Veterans Affairs.

(G) The Secretary of Defense.

(H) The Secretary of Housing and Urban Development.

(I) The Secretary of Education.

(J) The Secretary of Labor.

(K) The Commissioner of Social Security.

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

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

(A) at least 2 members shall be individuals with lived experience with serious mental illness or serious emotional disturbance;

(B) at least 1 member shall be a parent or legal guardian of an individual with a history of a serious mental illness or serious emotional disturbance;

(C) at least 1 member shall be a representative of a leading research, advocacy, or service organization for individuals with serious mental illness or serious emotional disturbance;

(D) at least 2 members shall be—

(i) a licensed psychiatrist with experience treating serious mental illnesses or serious emotional disturbances;

(ii) a licensed psychologist with experience treating serious mental illnesses or serious emotional disturbances;

(iii) a licensed clinical social worker with experience treating serious mental illness or serious emotional disturbances; or

(iv) a licensed psychiatric nurse, nurse practitioner, or physician assistant with experience treating serious mental illnesses or serious emotional disturbances;

(E) at least 1 member shall be a licensed mental health professional with a specialty in treating children and adolescents with serious emotional disturbances;

(F) at least 1 member shall be a mental health professional who has research or clinical mental health experience working with minorities;

(G) at least 1 member shall be a mental health professional who has research or clinical mental health experience working with medically underserved populations;

(H) at least 1 member shall be a State certified mental health peer-support specialist;

(I) at least 1 member shall be a judge with experience adjudicating cases within a mental health court;

(J) at least 1 member shall be a law enforcement officer or corrections officer with extensive experience in interfacing with individuals with a serious mental illness or serious emotional disturbance, or in a mental health crisis; and

(K) at least 1 member shall be a homeless services provider with experience working with individuals with serious mental illness, with serious emotional disturbance, or having mental health crisis.

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

(f) WORKING GROUPS.—In carrying out its functions, the Committee may establish working groups. Such working groups shall be composed of Committee members, or their designees, and may hold such meetings as are necessary.

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

TITLE IV—COMPASSIONATE COMMUNICATION ON HIPAA

SEC. 401. SENSE OF CONGRESS.

(a) FINDINGS.—Congress finds the following:

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

(2) Persons with serious mental illness (in this section referred to as ''SMI''), including schizophrenia spectrum, bipolar disorders, and major depressive disorder, may be significantly impaired in their ability to understand or make sound decisions for their care and needs. By nature of their illness, cognitive impairments in reasoning and judgment, as well as the presence of hallucinations, delusions, and severe emotional distortions, they may lack the awareness they even have a mental illness (a condition known as anosognosia), and thus may be unable to make sound decisions regarding their care, nor follow through consistently and effectively on their care needs.

(3) Persons with mental illness or SMI may require and benefit from mental health treatment in order to recover to the fullest extent of their ability; these beneficial interventions may include psychiatric care, psychological care, medication, peer support, educational support, employment support, and housing support.

(4) Persons with SMI who are provided with professional and supportive services may still experience times when their symptoms may greatly impair their abilities to make sound decisions for their personal care or may discontinue their care as a result of this impaired decisionmaking resulting in a further deterioration of their condition. They may experience a temporary or prolonged impairment as a result of their diminished capacity to care for themselves.

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

(6) Persons with SMI—

(A) are at high risk for other chronic physical illnesses, with approximately 50 percent having two or more co-occurring chronic physical illnesses such as cardiac, pulmonary, cancer, and endocrine disorders; and

(B) have three times the odds of having chronic bronchitis, five times the odds of having emphysema, and four times the odds of having COPD, are more than four times as likely to have fluid and electrolyte disorders, and are nearly three times as likely to be nicotine dependent.

(7) Some psychotropic medications, such as second generation antipsychotics, significantly increase risk for chronic illnesses such as diabetes and cardiovascular disease.

(8) When the individual fails to seek or maintain treatment for these physical conditions over a long term, it can result in the individual becoming gravely disabled, or developing life-threatening illnesses. Early and consistent treatment can ameliorate or reduce symptoms or cure the disease.

(9) Persons with SMI die 7 to 24 years earlier than their age cohorts primarily because of complications from their chronic physical illness and failure to seek or maintain treatment resulting from emotional and cognitive impairments from their SMI.

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

(11) When the individual with SMI is significantly diminished in their capacity to care for themselves long term or acutely, other supportive interventions to assist their care may be necessary to protect their health and safety.

(12) Prognosis for the physical and psychiatric health of those with SMI may improve when responsible caregivers facilitate and participate in care.

(13) When an individual with SMI is chronically incapacitated in their ability to care for themselves, caregivers can pursue legal guardianship to facilitate care in appropriate areas while being mindful to allow the individual to make decisions for themselves in areas where they are capable.

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

(15) All professional and support efforts should be made to help the individual with SMI and acute or chronic physical illnesses to understand and follow through on treatment.

(16) When individuals with SMI, even after efforts to help them understand, have failed to care for themselves, there exists confusion in the health care community around what is currently permissible under HIPAA rules. This confusion may hinder communication with responsible caregivers who may be able to facilitate care for the patient with SMI in instances when the individual does not give permission for disclosure.

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

SEC. 402. CONFIDENTIALITY OF RECORDS.

Not later than one year after the date on which the Secretary of Health and Human Services first finalizes regulations updating part 2 of title 42, Code of Federal Regulations (relating to confidentiality of alcohol and drug abuse patient records) after the date of enactment of this Act, the Secretary shall convene relevant stakeholders to determine the effect of such regulations on patient care, health outcomes, and patient privacy. The Secretary shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate, and make publicly available, a report on the findings of such stakeholders.

SEC. 403. CLARIFICATION OF CIRCUMSTANCES UNDER WHICH DISCLOSURE OF PROTECTED HEALTH INFORMATION IS PERMITTED.

(a) IN GENERAL.—Not later than one year after the date of enactment of this section, the Secretary of Health and Human Services shall promulgate final regulations clarifying the circumstances under which, consistent with the provisions of subpart C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.) and regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), a health care provider or covered entity may disclose the protected health information of a patient with a mental illness, including for purposes of—

(1) communicating (including with respect to treatment, side effects, risk factors, and the availability of community resources) with a family member of such patient, caregiver of such patient, or other individual to the extent that such family member, caregiver, or individual is involved in the care of the patient;

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

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

(4) considering the patient's capacity to agree or object to the sharing of the protected health information of the patient;

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

(A) the patient consents;

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

(C) the patient does not consent and the patient is not incapacitated or in an emergency circumstance, but the ability of the patient to make rational health care decisions is significantly diminished by reason of the physical or mental health condition of the patient; and

(D) the patient does not consent, but such communication and sharing of information is necessary to prevent impending and serious deterioration of the patient's mental or physical health;

(6) involving a patient's family members, caregivers, or others involved in the patient's care or care plan, including facilitating treatment and medication adherence,

in dealing with patient failures to adhere to medication or other therapy;

(7) listening to or receiving information with respect to the patient from the family or caregiver of such patient receiving mental illness treatment;

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

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

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

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

SEC. 404. DEVELOPMENT AND DISSEMINATION OF MODEL TRAINING PROGRAMS.

(a) INITIAL PROGRAMS AND MATERIALS.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop and disseminate—

(1) a model program and materials for training health care providers (including physicians, emergency medical personnel, psychologists, counselors, therapists, behavioral health facilities and clinics, care managers, and hospitals) regarding the circumstances under which, consistent with the standards governing the privacy and security of individually identifiable health information promulgated by the Secretary under subpart C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.) and regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), the protected health information of patients with a mental illness may be disclosed with and without patient consent;

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

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

(b) PERIODIC UPDATES.—The Secretary shall—

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

(2) disseminate the updated model programs and materials.

(c) CONTENTS.—The programs and materials developed under subsection (a) shall address the guidance entitled ''HIPAA Privacy Rule and Sharing Information Related to Mental Health'', issued by the Department of Health and Human Services on February 20, 2014.

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

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

(f) FUNDING.—There are authorized to be appropriated to carry out this section $4,000,000 for fiscal year 2018, $2,000,000 for each of fiscal years 2019 and 2020, and $1,000,000 for each of fiscal years 2021 and 2022.

TITLE V—INCREASING ACCESS TO TREATMENT FOR SERIOUS MENTAL ILLNESS

SEC. 501. ASSERTIVE COMMUNITY TREATMENT GRANT PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

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

''SEC. 520M. ASSERTIVE COMMUNITY TREATMENT GRANT PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

''(a) IN GENERAL.—The Assistant Secretary shall award grants to eligible entities—

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

''(2) to maintain or expand such programs.

''(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall be a State, county, city, tribe, tribal organization, mental health system, health care facility, or any other entity the Assistant Secretary deems appropriate.

''(c) SPECIAL CONSIDERATION.—In selecting among applicants for a grant under this section, the Assistant Secretary may give special consideration to the potential of the applicant's program to reduce hospitalization, homelessness, and involvement with the criminal justice system while improving the health and social outcomes of the patient.

''(d) ADDITIONAL ACTIVITIES.—The Assistant Secretary shall—

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

''(A) cost savings and public health outcomes such as mortality, suicide, substance abuse, hospitalization, and use of services;

''(B) rates of involvement with the criminal justice system of patients;

''(C) rates of homelessness among patients; and

''(D) patient and family satisfaction with program participation; and

''(2) provide appropriate information, training, and technical assistance to grant recipients under this section to help such recipients to establish, maintain, or expand their assertive community treatment programs.

''(e) AUTHORIZATION OF APPROPRIATIONS.—

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

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

SEC. 502. STRENGTHENING COMMUNITY CRISIS RESPONSE SYSTEMS.

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

''SEC. 520F. STRENGTHENING COMMUNITY CRISIS RESPONSE SYSTEMS.

''(a) IN GENERAL.—The Secretary shall award competitive grants—

''(1) to State and local governments and Indian tribes and tribal organizations to enhance community-based crisis response systems; or

''(2) to States to develop, maintain, or enhance a database of beds at inpatient psychiatric facilities, crisis stabilization units, and residential community mental health and residential substance use disorder treatment facilities, for individuals with serious mental illness, serious emotional disturbance, or substance use disorders.

''(b) APPLICATION.—

''(1) IN GENERAL.—To receive a grant or cooperative agreement under subsection (a), an entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

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

''(A) promoting integration and coordination between local public and private entities engaged in crisis response, including first responders, emergency health care providers, primary care providers, law enforcement, court systems, health care payers, social service providers, and behavioral health providers;

''(B) developing a plan for entering into memoranda of understanding with public and private entities to implement crisis response services;

''(C) expanding the continuum of community-based services to address crisis intervention and prevention; and

''(D) developing models for minimizing hospital readmissions, including through appropriate discharge planning.

''(3) BEDS DATABASE PLAN.—An application for a grant under subsection (a)(2) shall include a plan for developing, maintaining, or enhancing a real-time Internet-based bed database to collect, aggregate, and display information about beds in inpatient psychiatric facilities and crisis stabilization units, and residential community mental health and residential substance use disorder treatment facilities, to facilitate the identification and designation of facilities for the temporary treatment of individuals in mental or substance use disorder crisis.

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

''(1) includes information on inpatient psychiatric facilities, crisis stabilization units, and residential community mental health and residential substance use disorder facilities in the State involved, including contact information for the facility or unit;

''(2) provides real-time information about the number of beds available at each facility or unit and, for each available bed, the type of patient that may be admitted, the level of security provided, and any other information that may be necessary to allow for the proper identification of appropriate facilities for treatment of individuals in mental or substance use disorder crisis; and

''(3) enables searches of the database to identify available beds that are appropriate for the treatment of individuals in mental or substance use disorder crisis.

''(d) EVALUATION.—An entity receiving a grant under subsection (a)(1) shall submit to the Secretary, at such time, in such manner, and containing such information as the Secretary may reasonably require, a report, including an evaluation of the effect of such grant on—

''(1) local crisis response services and measures of individuals receiving crisis planning and early intervention supports;

''(2) individuals reporting improved functional outcomes; and

''(3) individuals receiving regular followup care following a crisis.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to

carry out this section, $5,000,000 for the period of fiscal years 2018 through 2022.''.

SEC. 503. INCREASED AND EXTENDED FUNDING FOR ASSISTED OUTPATIENT GRANT PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

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

(1) in paragraph (1), by striking ''2018'' and inserting ''2022''; and

(2) in paragraph (2), by striking ''is authorized to be appropriated to carry out this section $15,000,000 for each of fiscal years 2015 through 2018'' and inserting ''are authorized to be appropriated to carry out this section $15,000,000 for each of fiscal years 2015 through 2017, $20,000,000 for fiscal year 2018, $19,000,000 for each of fiscal years 2019 and 2020, and $18,000,000 for each of fiscal years 2021 and 2022''.

SEC. 504. LIABILITY PROTECTIONS FOR HEALTH PROFESSIONAL VOLUNTEERS AT COMMUNITY HEALTH CENTERS.

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

''(q)(1) For purposes of this section, a health professional volunteer at an entity described in subsection (g)(4) shall, in providing a health professional service eligible for funding under section 330 to an individual, be deemed to be an employee of the Public Health Service for a calendar year that begins during a fiscal year for which a transfer was made under paragraph (4)(C). The preceding sentence is subject to the provisions of this subsection.

''(2) In providing a health service to an individual, a health care practitioner shall for purposes of this subsection be considered to be a health professional volunteer at an entity described in subsection (g)(4) if the following conditions are met:

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

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

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

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

''(E) At the time the service is provided, the health care practitioner is licensed or certified in accordance with applicable law regarding the provision of the service.

''(3) Subsection (g) (other than paragraphs (3) and (5)) and subsections (h), (i), and (l) apply to a health care practitioner for purposes of this subsection to the same extent and in the same manner as such subsections apply to an officer, governing board member, employee, or contractor of an entity described in subsection (g)(4), subject to paragraph (4) and subject to the following:

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

''(B) With respect to an entity described in subsection (g)(4), a health care practitioner is not a health professional volunteer at such entity unless the entity sponsors the health care practitioner. For purposes of this subsection, the entity shall be considered to be sponsoring the health care practitioner if—

''(i) with respect to the health care practitioner, the entity submits to the Secretary an application meeting the requirements of subsection (g)(1)(D); and

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

''(C) In the case of a health care practitioner who is determined by the Secretary pursuant to subsection (g)(1)(E) to be a health professional volunteer at such entity, this subsection applies to the health care practitioner (with respect to services performed on behalf of the entity sponsoring the health care practitioner pursuant to subparagraph (B)) for any cause of action arising from an act or omission of the health care practitioner occurring on or after the date on which the Secretary makes such determination.

''(D) Subsection (g)(1)(F) applies to a health care practitioner for purposes of this subsection only to the extent that, in providing health services to an individual, each of the conditions specified in paragraph (2) is met.

''(4)(A) Amounts in the fund established under subsection (k)(2) shall be available for transfer under subparagraph (C) for purposes of carrying out this subsection.

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

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

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

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

''(i) the Secretary may issue regulations for carrying out this subsection, and the Secretary may accept and consider applications submitted pursuant to paragraph (3)(B); and

''(ii) reports under paragraph (4)(B) may be submitted to the Congress.''.

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.

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

''(d) PROMOTING INNOVATION.—

''(1) IN GENERAL.—The Assistant Secretary, in coordination with the Laboratory, may award grants to States, local governments, Indian tribes or tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act), educational institutions, and nonprofit organizations to develop evidence-based interventions, including culturally and linguistically appropriate services, as appropriate, for—

''(A) evaluating a model that has been scientifically demonstrated to show promise, but would benefit from further applied development, for—

''(i) enhancing the prevention, diagnosis, intervention, treatment, and recovery of mental illness, serious emotional disturbance, substance use disorders, and co-occurring illness or disorders; or

''(ii) integrating or coordinating physical health services and mental illness and substance use disorder services; and

''(B) expanding, replicating, or scaling evidence-based programs across a wider area to enhance effective screening, early diagnosis, intervention, and treatment with respect to mental illness, serious mental illness, and serious emotional disturbance, primarily by—

''(i) applying delivery of care, including training staff in effective evidence-based treatment; or

''(ii) integrating models of care across specialties and jurisdictions.

''(2) CONSULTATION.—In awarding grants under this paragraph, the Assistant Secretary shall, as appropriate, consult with the advisory councils described in section 502, the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism, as appropriate.

''(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated—

''(A) to carry out paragraph (1)(A), $7,000,000 for the period of fiscal years 2018 through 2020; and

''(B) to carry out paragraph (1)(B), $7,000,000 for the period of fiscal years 2018 through 2020.''.

SEC. 602. PROMOTING ACCESS TO INFORMATION ON EVIDENCE-BASED PROGRAMS AND PRACTICES.

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

''SEC. 544. PROMOTING ACCESS TO INFORMATION ON EVIDENCE-BASED PROGRAMS AND PRACTICES.

''(a) IN GENERAL.—The Assistant Secretary shall improve access to reliable and valid information on evidence-based programs and practices, including information on the strength of evidence associated with such programs and practices, related to mental illness and substance use disorders for States, local communities, nonprofit entities, and other stakeholders by posting on the website of the National Registry of Evidence-Based Programs and Practices evidence-based programs and practices that have been reviewed by the Assistant Secretary pursuant to the requirements of this section.

''(b) NOTICE.—

''(1) PERIODS.—In carrying out subsection (a), the Assistant Secretary may establish an initial period for the submission of applications for evidence-based programs and practices to be posted publicly in accordance with subsection (a) (and may establish subsequent such periods). The Assistant Secretary shall publish notice of such application periods in the Federal Register.

''(2) ADDRESSING GAPS.—Such notice may solicit applications for evidence-based practices and programs to address gaps in information identified by the Assistant Secretary, the Assistant Secretary for Planning

and Evaluation, the Assistant Secretary for Financial Resources, or the National Mental Health and Substance Use Policy Laboratory, including pursuant to priorities identified in the strategic plan established under section 501(l).

''(c) REQUIREMENTS.—The Assistant Secretary shall establish minimum requirements for applications referred to in this section, including applications related to the submission of research and evaluation.

''(d) REVIEW AND RATING.—The Assistant Secretary shall review applications prior to public posting, and may prioritize the review of applications for evidence-based practices and programs that are related to topics included in the notice established under subsection (b). The Assistant Secretary shall utilize a rating and review system, which shall include information on the strength of evidence associated with such programs and practices and a rating of the methodological rigor of the research supporting the application. The Assistant Secretary shall make the metrics used to evaluate applications and the resulting ratings publicly available.''.

SEC. 603. SENSE OF CONGRESS.

It is the sense of the Congress that the National Institute of Mental Health should conduct or support research on the determinants of self-directed and other violence connected to mental illness.

Subtitle B—Supporting the State Response to Mental Health Needs

SEC. 611. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT.

(a) FORMULA GRANTS.—Section 1911(b) of the Public Health Service Act (42 U.S.C. 300x(b)) is amended—

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

(2) by inserting before paragraph (2) (as so redesignated), the following:

''(1) providing community mental health services for adults with a serious mental illness and children with a serious emotional disturbance as defined in accordance with section 1912(c);''.

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

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

''(1) SYSTEM OF CARE.—The plan provides a description of the system of care of the State, including as follows:

''(A) COMPREHENSIVE COMMUNITY-BASED HEALTH SYSTEMS.—The plan shall—

''(i) identify the single State agency to be responsible for the administration of the program under the grant and any third party with whom the agency will contract (subject to such third party complying with the requirements of this part) for administering mental health services through such program;

''(ii) provide for an organized community-based system of care for individuals with mental illness, and describe available services and resources in a comprehensive system of care, including services for individuals with mental health and behavioral health co-occurring illness or disorders;

''(iii) include a description of the manner in which the State and local entities will coordinate services to maximize the efficiency, effectiveness, quality, and cost effectiveness of services and programs to produce the best possible outcomes (including health services, rehabilitation services, employment services, housing services, educational services, substance use disorder services, legal services, law enforcement services, social services, child welfare services, medical and dental care services, and other support services to be provided with Federal, State, and local public and private resources) with other agencies to enable individuals receiving services to function outside of inpatient or residential institutions, to the maximum extent of their capabilities, including services to be provided by local school systems under the Individuals with Disabilities Education Act;

''(iv) include a description of how the State—

''(I) promotes evidence-based practices, including those evidence-based programs that address the needs of individuals with early serious mental illness regardless of the age of the individual at onset;

''(II) provides comprehensive individualized treatment; or

''(III) integrates mental and physical health services;

''(v) include a description of case management services in the State;

''(vi) include a description of activities that seek to engage individuals with serious mental illness or serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication between individuals, families, caregivers, and treatment providers; and

''(vii) as appropriate to and reflective of the uses the State proposes for the block grant monies—

''(I) a description of the activities intended to reduce hospitalizations and hospital stays using the block grant monies;

''(II) a description of the activities intended to reduce incidents of suicide using the block grant monies; and

''(III) a description of how the State integrates mental health and primary care using the block grant monies.

''(B) MENTAL HEALTH SYSTEM DATA AND EPIDEMIOLOGY.—The plan shall contain an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children and presents quantitative targets and outcome measures for programs and services provided under this subpart.

''(C) CHILDREN'S SERVICES.—In the case of children with serious emotional disturbance (as defined in accordance with subsection (c)), the plan shall provide for a system of integrated social services, educational services, child welfare services, juvenile justice services, law enforcement services, and substance use disorder services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (such system to include services provided under the Individuals with Disabilities Education Act).

''(D) TARGETED SERVICES TO RURAL AND HOMELESS POPULATIONS.—The plan shall describe the State's outreach to and services for individuals who are homeless and how community-based services will be provided to individuals residing in rural areas.

''(E) MANAGEMENT SERVICES.—The plan shall—

''(i) describe the financial resources available, the existing mental health workforce, and the workforce trained in treating individuals with co-occurring mental illness and substance use disorders;

''(ii) provide for the training of providers of emergency health services regarding mental health;

''(iii) describe the manner in which the State intends to expend the grant under section 1911 for the fiscal year involved; and

''(iv) describe the manner in which the State intends to comply with each of the funding agreements in this subpart and subpart III.

''(2) GOALS AND OBJECTIVES.—The plan establishes goals and objectives for the period of the plan, including targets and milestones that are intended to be met, and the activities that will be undertaken to achieve those goals and objectives.''.

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

''(c) BEST PRACTICES IN CLINICAL CARE MODELS.—A State shall expend not less than 10 percent of the amount the State receives for carrying out this subpart in each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at the onset of such illness.''.

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

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

''(1) IN GENERAL.—A funding agreement for a grant under section 1911 is that the State involved will maintain State expenditures for community mental health services at a level that is not less than the average of the amounts prescribed by this paragraph (prior to any waiver under paragraph (3)) for such expenditures by such State for each of the two fiscal years immediately preceding the fiscal year for which the State is applying for the grant.'';

(2) in paragraph (2)—

(A) by striking ''under subsection (a)'' and inserting ''specified in paragraph (1)''; and

(B) by striking ''principle'' and inserting ''principal'';

(3) by amending paragraph (3) to read as follows:

''(3) WAIVER.—

''(A) IN GENERAL.—The Secretary may, upon the request of a State, waive the requirement established in paragraph (1) in whole or in part, if the Secretary determines that extraordinary economic conditions in the State in the fiscal year involved or in the previous fiscal year justify the waiver.

''(B) DATE CERTAIN FOR ACTION UPON REQUEST.—The Secretary shall approve or deny a request for a waiver under this paragraph not later than 120 days after the date on which the request is made.

''(C) APPLICABILITY OF WAIVER.—A waiver provided by the Secretary under this paragraph shall be applicable only to the fiscal year involved.''; and

(4) in paragraph (4)—

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

''(A) IN GENERAL.—

''(i) DETERMINATION AND REDUCTION.—The Secretary shall determine, in the case of each State, and for each fiscal year, whether the State maintained material compliance with the agreement made under paragraph (1). If the Secretary determines that a State has failed to maintain such compliance for a fiscal year, the Secretary shall reduce the amount of the allotment under section 1911 for the State, for the first fiscal year beginning after such determination is final, by an amount equal to the amount constituting such failure for the previous fiscal year about which the determination was made.

''(ii) ALTERNATIVE SANCTION.—The Secretary may by regulation provide for an alternative method of imposing a sanction for a failure by a State to maintain material compliance with the agreement under paragraph (1) if the Secretary determines that such alternative method would be more equitable and would be a more effective incentive for States to maintain such material compliance.''; and

(B) in subparagraph (B)—

(i) by inserting after the subparagraph designation the following: ''SUBMISSION OF INFORMATION TO THE SECRETARY.—''; and

(ii) by striking ''subparagraph (A)'' and inserting ''subparagraph (A)(i)''.

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

(1) in paragraph (1), by striking ''1941'' and inserting ''1942(a)''; and

(2) in paragraph (5), by striking ''1915(b)(3)(B)'' and inserting ''1915(b)''.

Subtitle C—Strengthening Mental Health Care for Children and Adolescents

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

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

''SEC. 330M. TELE-MENTAL HEALTH CARE ACCESS GRANTS.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in coordination with other relevant Federal agencies, shall award grants to States, political subdivisions of States, Indian tribes, and tribal organizations (for purposes of this section, as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)) to promote behavioral health integration in pediatric primary care by—

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

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

''(b) PROGRAM REQUIREMENTS.—

''(1) IN GENERAL.—A child mental health care access program referred to in subsection (a), with respect to which a grant under such subsection may be used, shall—

''(A) be a statewide network of pediatric mental health teams that provide support to pediatric primary care sites as an integrated team;

''(B) support and further develop organized State networks of child and adolescent psychiatrists and psychologists to provide consultative support to pediatric primary care sites;

''(C) conduct an assessment of critical behavioral consultation needs among pediatric providers and such providers' preferred mechanisms for receiving consultation and training and technical assistance;

''(D) develop an online database and communication mechanisms, including telehealth, to facilitate consultation support to pediatric practices;

''(E) provide rapid statewide clinical telephone or telehealth consultations when requested between the pediatric mental health teams and pediatric primary care providers;

''(F) conduct training and provide technical assistance to pediatric primary care providers to support the early identification, diagnosis, treatment, and referral of children with behavioral health conditions or co-occurring intellectual and other developmental disabilities;

''(G) provide information to pediatric providers about, and assist pediatric providers in accessing, child psychiatry and psychology consultations and in scheduling and conducting technical assistance;

''(H) assist with referrals to specialty care and community or behavioral health resources; and

''(I) establish mechanisms for measuring and monitoring increased access to child and adolescent psychiatric and psychology services by pediatric primary care providers and expanded capacity of pediatric primary care providers to identify, treat, and refer children with mental health problems.

''(2) PEDIATRIC MENTAL HEALTH TEAMS.—In this subsection, the term 'pediatric mental health team' means a team of case coordinators, child and adolescent psychiatrists, and licensed clinical mental health professionals, such as a psychologist, social worker, or mental health counselor.

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

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

''(e) MATCHING REQUIREMENT.—The Secretary may not award a grant under this section unless the State, political subdivision of a State, Indian tribe, or tribal organization involved agrees, with respect to the costs to be incurred by the State, political subdivision of a State, Indian tribe, or tribal organization in carrying out the purpose described in this section, to make available non-Federal contributions (in cash or in kind) toward such costs in an amount that is not less than 20 percent of Federal funds provided in the grant.

''(f) AUTHORIZATION OF APPROPRIATIONS.—To carry this section, there are authorized to be appropriated $9,000,000 for the period of fiscal years 2018 through 2020.''.

SEC. 622. INFANT AND EARLY CHILDHOOD MENTAL HEALTH PROMOTION, INTERVENTION, AND TREATMENT.

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

''SEC. 399Z–2. INFANT AND EARLY CHILDHOOD MENTAL HEALTH PROMOTION, INTERVENTION, AND TREATMENT.

''(a) GRANTS.—The Secretary shall—

''(1) award grants to eligible entities, including human services agencies, to develop, maintain, or enhance infant and early childhood mental health promotion, intervention, and treatment programs, including—

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

''(B) multigenerational therapy and other services that support the caregiving relationship; and

''(2) ensure that programs funded through grants under this section are evidence-informed or evidence-based models, practices, and methods that are, as appropriate, culturally and linguistically appropriate, and can be replicated in other appropriate settings.

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

''(1) ELIGIBLE CHILD.—The term 'eligible child' means a child from birth to not more than 5 years of age who—

''(A) is at risk for, shows early signs of, or has been diagnosed with a mental illness, including serious emotional disturbance; and

''(B) may benefit from infant and early childhood intervention or treatment programs or specialized preschool or elementary school programs that are evidence-based or that have been scientifically demonstrated to show promise but would benefit from further applied development.

''(2) ELIGIBLE ENTITY.—The term 'eligible entity' means a nonprofit institution that—

''(A) is accredited or approved by a State mental health or education agency, as applicable, to provide for children from infancy to 5 years of age mental health promotion, intervention, or treatment services that are evidence-based or that have been scientifically demonstrated to show promise but would benefit from further applied development; and

''(B) provides programs described in subsection (a) that are evidence-based or that have been scientifically demonstrated to show promise but would benefit from further applied development.

''(c) APPLICATION.—An eligible entity seeking a grant under subsection (a) shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

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

''(1) Provide age-appropriate mental health promotion and early intervention services or mental illness treatment services, which may include specialized programs, for eligible children at significant risk of developing, showing early signs of, or having been diagnosed with a mental illness, including serious emotional disturbance. Such services may include social and behavioral services as well as multigenerational therapy and other services ?that support the caregiving relationship.

''(2) Provide training for health care professionals with expertise in infant and early childhood mental health care with respect to appropriate and relevant integration with other disciplines such as primary care clinicians, early intervention specialists, child welfare staff, home visitors, early care and education providers, and others who work with young children and families.

''(3) Provide mental health consultation to personnel of early care and education programs (including licensed or regulated center-based and home-based child care, home visiting, preschool special education, and early intervention programs) who work with children and families.

''(4) Provide training for mental health clinicians in infant and early childhood in promising and evidence-based practices and models for infant and early childhood mental health treatment and early intervention, including with regard to practices for identifying and treating mental illness and behavioral disorders of infants and children resulting from exposure or repeated exposure to adverse childhood experiences or childhood trauma.

''(5) Provide age-appropriate assessment, diagnostic, and intervention services for eligible children, including early mental health promotion, intervention, and treatment services.

''(e) MATCHING FUNDS.—The Secretary may not award a grant under this section to an eligible entity unless the eligible entity agrees, with respect to the costs to be incurred by the eligible entity in carrying out the activities described in subsection (d), to make available non-Federal contributions (in cash or in kind) toward such costs in an amount that is not less than 10 percent of the total amount of Federal funds provided in the grant.

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

SEC. 623. NATIONAL CHILD TRAUMATIC STRESS INITIATIVE.

Section 582 of the Public Health Service Act (42 U.S.C. 290hh–1; relating to grants to address the problems of persons who experience violence related stress) is amended—

(1) in subsection (a), by striking ''developing programs'' and all that follows and inserting the following: ''developing and maintaining programs that provide for—

''(1) the continued operation of the National Child Traumatic Stress Initiative (referred to in this section as the 'NCTSI'), which includes a coordinating center that focuses on the mental, behavioral, and biological aspects of psychological trauma response; and

''(2) the development of knowledge with regard to evidence-based practices for identifying and treating mental illness, behavioral disorders, and physical health conditions of children and youth resulting from witnessing or experiencing a traumatic event.'';

(2) in subsection (b)—

(A) by striking ''subsection (a) related'' and inserting ''subsection (a)(2) (related'';

(B) by striking ''treating disorders associated with psychological trauma'' and inserting ''treating mental illness and behavioral and biological disorders associated with psychological trauma)''; and

(C) by striking ''mental health agencies and programs that have established clinical and basic research'' and inserting ''universities, hospitals, mental health agencies, and other programs that have established clinical expertise and research'';

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

(4) by inserting after subsection (b), the following:

''(c) CHILD OUTCOME DATA.—The NCTSI coordinating center shall collect, analyze, report, and make publicly available NCTSI-wide child treatment process and outcome data regarding the early identification and delivery of evidence-based treatment and services for children and families served by the NCTSI grantees.

''(d) TRAINING.—The NCTSI coordinating center shall facilitate the coordination of training initiatives in evidence-based and trauma-informed treatments, interventions, and practices offered to NCTSI grantees, providers, and partners.

''(e) DISSEMINATION.—The NCTSI coordinating center shall, as appropriate, collaborate with the Secretary in the dissemination of evidence-based and trauma-informed interventions, treatments, products, and other resources to appropriate stakeholders.

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

(5) in subsection (g) (as so redesignated), by striking ''with respect to centers of excellence are distributed equitably among the regions of the country'' and inserting ''are distributed equitably among the regions of the United States'';

(6) in subsection (i) (as so redesignated), by striking ''recipient may not exceed 5 years'' and inserting ''recipient shall not be less than 4 years, but shall not exceed 5 years''; and

(7) in subsection (j) (as so redesignated), by striking ''$50,000,000'' and all that follows through ''2006'' and inserting ''$46,887,000 for each of fiscal years 2017 through 2021''.

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.

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

(1) by striking the section heading and inserting ''**SUICIDE PREVENTION TECHNICAL ASSISTANCE CENTER.**'';

(2) in subsection (a), by striking ''and in consultation with'' and all that follows through the period at the end of paragraph (2) and inserting ''shall establish a research, training, and technical assistance resource center to provide appropriate information, training, and technical assistance to States, political subdivisions of States, federally recognized Indian tribes, tribal organizations, institutions of higher education, public organizations, or private nonprofit organizations regarding the prevention of suicide among all ages, particularly among groups that are at high risk for suicide.'';

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

(4) by redesignating subsection (d) as subsection (b);

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

(A) by striking the subsection heading and inserting ''RESPONSIBILITIES OF THE CENTER.—'';

(B) in the matter preceding paragraph (1), by striking ''The additional research'' and all that follows through ''nonprofit organizations for'' and inserting ''The center established under subsection (a) shall conduct activities for the purpose of'';

(C) by striking ''youth suicide'' each place such term appears and inserting ''suicide'';

(D) in paragraph (1)—

(i) by striking ''the development or continuation of'' and inserting ''developing and continuing''; and

(ii) by inserting ''for all ages, particularly among groups that are at high risk for suicide'' before the semicolon at the end;

(E) in paragraph (2), by inserting ''for all ages, particularly among groups that are at high risk for suicide'' before the semicolon at the end;

(F) in paragraph (3), by inserting ''and tribal'' after ''statewide'';

(G) in paragraph (5), by inserting ''and prevention'' after ''intervention'';

(H) in paragraph (8), by striking ''in youth'';

(I) in paragraph (9), by striking ''and behavioral health'' and inserting ''health and substance use disorder''; and

(J) in paragraph (10), by inserting ''conducting'' before ''other''; and

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

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

''(d) REPORT.—Not later than 2 years after the date of enactment of the Helping Families in Mental Health Crisis Act of 2016, the Secretary shall submit to Congress a report on the activities carried out by the center established under subsection (a) during the year involved, including the potential effects of such activities, and the States, organizations, and institutions that have worked with the center.''.

SEC. 702. YOUTH SUICIDE EARLY INTERVENTION AND PREVENTION STRATEGIES.

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

(1) in paragraph (1) of subsection (a) and in subsection (c), by striking ''substance abuse'' each place such term appears and inserting ''substance use disorder'';

(2) in subsection (b)(2)—

(A) by striking ''each State is awarded only 1 grant or cooperative agreement under this section'' and inserting ''a State does not receive more than 1 grant or cooperative agreement under this section at any 1 time''; and

(B) by striking ''been awarded'' and inserting ''received''; and

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

''(m) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $35,427,000 for each of fiscal years 2017 through 2021.''.

SEC. 703. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES ON CAMPUS.

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

(1) in the section heading, by striking ''**AND BEHAVIORAL HEALTH**'' and inserting ''**HEALTH AND SUBSTANCE USE DISORDER**'';

(2) in subsection (a)—

(A) by striking ''Services,'' and inserting ''Services and'';

(B) by striking ''and behavioral health problems'' and inserting ''health or substance use disorders''; and

(C) by striking ''substance abuse'' and inserting ''substance use disorders'';

(3) in subsection (b)—

(A) in the matter preceding paragraph (1), by striking ''for—'' and inserting ''for one or more of the following:''; and

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

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

''(2) The operation of hotlines.

''(3) Preparing informational material.

''(4) Providing outreach services to notify students about available mental health and substance use disorder services.

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

''(6) Supporting the training of students, faculty, and staff to respond effectively to students with mental health and substance use disorders.

''(7) Creating a network infrastructure to link colleges and universities with health care providers who treat mental health and substance use disorders.'';

(4) in subsection (c)(5), by striking ''substance abuse'' and inserting ''substance use disorder'';

(5) in subsection (d)—

(A) in the matter preceding paragraph (1), by striking ''An institution of higher education desiring a grant under this section'' and inserting ''To be eligible to receive a grant under this section, an institution of higher education'';

(B) in paragraph (1)—

(i) by striking ''and behavioral health'' and inserting ''health and substance use disorder''; and

(ii) by inserting '', including veterans whenever possible and appropriate,'' after ''students''; and

(C) in paragraph (2), by inserting '', which may include, as appropriate and in accordance with subsection (b)(7), a plan to seek input from relevant stakeholders in the community, including appropriate public and private entities, in order to carry out the program under the grant'' before the period at the end;

(6) in subsection (e)(1), by striking ''and behavioral health problems'' and inserting ''health and substance use disorders'';

(7) in subsection (f)(2)—

(A) by striking ''and behavioral health'' and inserting ''health and substance use disorder''; and

(B) by striking ''suicide and substance abuse'' and inserting ''suicide and substance use disorders''; and

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

Subtitle B—Other Provisions

SEC. 711. NATIONAL SUICIDE PREVENTION LIFELINE PROGRAM.

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

''SEC. 520E–3. NATIONAL SUICIDE PREVENTION LIFELINE PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall maintain the National Suicide Prevention Lifeline Program (referred to in this section as the 'Program'), authorized under section 520A and in effect prior to the date of enactment of the Helping Families in Mental Health Crisis Act of 2016.

''(b) ACTIVITIES.—In maintaining the Program, the activities of the Secretary shall include—

''(1) coordinating a network of crisis centers across the United States for providing suicide prevention and crisis intervention services to individuals seeking help at any time, day or night;

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

''(3) consulting with the Secretary of Veterans Affairs to ensure that veterans calling the suicide prevention hotline have access to a specialized veterans' suicide prevention hotline.

''(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $7,198,000 for each of fiscal years 2017 through 2021.''.

SEC. 712. WORKFORCE DEVELOPMENT STUDIES AND REPORTS.

(a) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Assistant Secretary for Mental Health and Substance Use, in consultation with the Administrator of the Health Resources and Services Administration, shall conduct a study, and publicly post on the appropriate Internet website of the Department of Health and Human Services a report, on the mental health and substance use disorder workforce in order to inform Federal, State, and local efforts related to workforce enhancement.

(b) CONTENTS.—The report under this section shall contain—

(1) national and State-level projections of the supply and demand of mental health and substance use disorder health workers, including the number of individuals practicing in fields deemed relevant by the Secretary;

(2) an assessment of the mental health and substance use disorder workforce capacity, strengths, and weaknesses as of the date of the report, including the capacity of primary care to prevent, screen, treat, or refer for mental health and substance use disorders;

(3) information on trends within the mental health and substance use disorder provider workforce, including the number of individuals entering the mental health workforce over the next five years;

(4) information on the gaps in workforce development for mental health providers and professionals, including those who serve pediatric, adult, and geriatric patients; and

(5) any additional information determined by the Assistant Secretary for Mental Health and Substance Use, in consultation with the Administrator of the Health Resources and Services Administration, to be relevant to the mental health and substance use disorder provider workforce.

SEC. 713. MINORITY FELLOWSHIP PROGRAM.

Title V of the Public Health Service Act (42 U.S.C. 290aa et seq.) is amended by adding at the end the following:

''PART K—MINORITY FELLOWSHIP PROGRAM

''SEC. 597. FELLOWSHIPS.

''(a) IN GENERAL.—The Secretary shall maintain a program, to be known as the Minority Fellowship Program, under which the Secretary awards fellowships, which may include stipends, for the purposes of—

''(1) increasing behavioral health practitioners' knowledge of issues related to prevention, treatment, and recovery support for mental illness and substance use disorders among racial and ethnic minority populations;

''(2) improving the quality of mental illness and substance use disorder prevention and treatment delivered to racial and ethnic minorities; and

''(3) increasing the number of culturally competent behavioral health professionals and school personnel who teach, administer, conduct services research, and provide direct mental health or substance use services to racial and ethnic minority populations.

''(b) TRAINING COVERED.—The fellowships under subsection (a) shall be for postbaccalaureate training (including for master's and doctoral degrees) for mental health professionals, including in the fields of psychiatry, nursing, social work, psychology, marriage and family therapy, mental health counseling, and substance use and addiction counseling.

''(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $12,669,000 for each of fiscal years 2017, 2018, and 2019 and $13,669,000 for each of fiscal years 2020 and 2021.''.

SEC. 714. CENTER AND PROGRAM REPEALS.

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

SEC. 715. NATIONAL VIOLENT DEATH REPORTING SYSTEM.

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

SEC. 716. SENSE OF CONGRESS ON PRIORITIZING NATIVE AMERICAN YOUTH AND SUICIDE PREVENTION PROGRAMS.

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

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

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

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

(b) SENSE OF CONGRESS.—It is the sense of Congress that the Secretary of Health and Human Services, in carrying out programs for Native American youth and suicide prevention programs for youth suicide intervention, should prioritize programs and activities for individuals who have a high risk or disproportional burden of suicide, such as Native Americans.

SEC. 717. PEER PROFESSIONAL WORKFORCE DEVELOPMENT GRANT PROGRAM.

(a) IN GENERAL.—For the purposes described in subsection (b), the Secretary of Health and Human Services shall award grants to develop and sustain behavioral health paraprofessional training and education programs, including through tuition support.

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

(1) to increase the number of behavioral health paraprofessionals, including trained peers, recovery coaches, mental health and addiction specialists, prevention specialists, and pre-masters-level addiction counselors; and

(2) to help communities develop the infrastructure to train and certify peers as behavioral health paraprofessionals.

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

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

(e) SPECIAL CONSIDERATION.—In awarding grants under this section, the Secretary may give special consideration to proposed and existing programs targeting peer professionals serving youth ages 16 to 25.

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

SEC. 718. NATIONAL HEALTH SERVICE CORPS.

(a) DEFINITIONS.—

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

(2) BEHAVIORAL AND MENTAL HEALTH PROFESSIONALS.—Clause (i) of section 331(a)(3)(E) of the Public Health Service Act (42 U.S.C. 254d(a)(3)(E)) is amended by inserting ''(and pediatric subspecialists thereof)'' before the period at the end.

(b) ELIGIBILITY TO PARTICIPATE IN LOAN REPAYMENT PROGRAM.—Section 338B(b)(1)(B) of the Public Health Service Act (42 U.S.C. 254l–1(b)(1)(B)) is amended by inserting '', including any physician child and adolescent psychiatry residency or fellowship training program'' after ''be enrolled in an approved graduate training program in medicine, osteopathic medicine, dentistry, behavioral and mental health, or other health profession''.

SEC. 719. ADULT SUICIDE PREVENTION.

(a) GRANTS.—

(1) AUTHORITY.—The Assistant Secretary for Mental Health and Substance Use (referred to in this section as the ''Assistant Secretary'') may award grants to eligible entities in order to implement suicide prevention efforts amongst adults 25 and older.

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

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

(4) NATURE OF ACTIVITIES.—The grants awarded under paragraph (1) shall be used to implement programs that—

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

(B) implement evidence-based practices to treat individuals who are at suicide risk, including appropriate followup services; and

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

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

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

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

(3) provide appropriate information, training, and technical assistance to eligible entities that receive a grant under this section, in order to help such entities to meet the requirements of this section, including assistance with—

(A) selection and implementation of evidence-based interventions and frameworks to prevent suicide, such as the Zero Suicide framework; and

(B) other activities as the Assistant Secretary determines appropriate.

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

(d) AUTHORIZATION OF APPROPRIATIONS.—

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

(2) USE OF CERTAIN FUNDS.—Of the funds appropriated to carry out this section in any fiscal year, the lesser of 5 percent of such funds or $500,000 shall be available to the Assistant Secretary for purposes of carrying out subsection (b).

SEC. 720. CRISIS INTERVENTION GRANTS FOR POLICE OFFICERS AND FIRST RESPONDERS.

(a) IN GENERAL.—The Assistant Secretary for Mental Health and Substance Use may award grants to entities such as law enforcement agencies and first responders—

(1) to provide specialized training to law enforcement officers, corrections officers, paramedics, emergency medical services workers, and other first responders (including village public safety officers (as defined in section 247 of the Indian Arts and Crafts Amendments Act of 2010 (42 U.S.C. 3796dd note)))—

(A) to recognize individuals who have mental illness and how to properly intervene with individuals with mental illness; and

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

(2) to establish collaborative law enforcement and mental health programs, including behavioral health response teams and mental health crisis intervention teams comprised of mental health professionals, law enforcement officers, and other first responders, as appropriate, to provide on-site, face-to-face, mental and behavioral health care services during a mental health crisis, and to connect the individual in crisis to appropriate community-based treatment services in lieu of unnecessary hospitalization or further involvement with the criminal justice system.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $9,000,000 for the period of fiscal years 2018 through 2020.

SEC. 721. DEMONSTRATION GRANT PROGRAM TO TRAIN HEALTH SERVICE PSYCHOLOGISTS IN COMMUNITY-BASED MENTAL HEALTH.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a grant program under which the Assistant Secretary of Mental Health and Substance Use Disorders may award grants to eligible institutions to support the recruitment, education, and clinical training experiences of health services psychology students, interns, and postdoctoral residents for education and clinical experience in community mental health settings.

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

(1) are focused on the development and implementation of interdisciplinary training of psychology graduate students and postdoctoral fellows in providing mental and behavioral health services to address substance use disorders, serious emotional disturbance, and serious illness, as well as developing faculty and implementing curriculum to prepare psychologists to work with underserved populations; and

(2) demonstrate an ability to train health service psychologists in psychiatric hospitals, forensic hospitals, community mental health centers, community health centers, federally qualified health centers, or adult and juvenile correctional facilities.

(c) PRIORITIES.—In selecting grant recipients under this section, the Secretary shall give priority to eligible institutions in which training focuses on the needs of individuals with serious mental illness, serious emotional disturbance, justice-involved youth, and individuals with or at high risk for substance use disorders.

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

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

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

''(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $12,000,000 for the period of fiscal years 2018 through 2022.''.

SEC. 723. CUTGO COMPLIANCE.

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

TITLE VIII—MENTAL HEALTH PARITY

SEC. 801. ENHANCED COMPLIANCE WITH MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE REQUIREMENTS.

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

''(6) COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—

''(A) IN GENERAL.—Not later than 12 months after the date of enactment of the Helping Families in Mental Health Crisis Act of 2016, the Secretary, the Secretary of Labor, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, shall issue a compliance program guidance document to help improve compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, and section 9812 of the Internal Revenue Code of 1986, as applicable.

''(B) EXAMPLES ILLUSTRATING COMPLIANCE AND NONCOMPLIANCE.—

''(i) IN GENERAL.—The compliance program guidance document required under this paragraph shall provide illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, based on investigations of violations of such sections, including—

''(I) examples illustrating requirements for information disclosures and nonquantitative treatment limitations; and

''(II) descriptions of the violations uncovered during the course of such investigations.

''(ii) NONQUANTITATIVE TREATMENT LIMITATIONS.—To the extent that any example described in clause (i) involves a finding of compliance or noncompliance with regard to any requirement for nonquantitative treatment limitations, the example shall provide sufficient detail to fully explain such finding, including a full description of the criteria involved for medical and surgical benefits and the criteria involved for mental health and substance use disorder benefits.

''(iii) ACCESS TO ADDITIONAL INFORMATION REGARDING COMPLIANCE.—In developing and issuing the compliance program guidance document required under this paragraph, the Secretaries specified in subparagraph (A)—

''(I) shall enter into interagency agreements with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury to share findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable; and

''(II) shall seek to enter into an agreement with a State to share information on findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable.

''(C) RECOMMENDATIONS.—The compliance program guidance document shall include recommendations to comply with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, and encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. Such internal controls may include a compliance checklist with illustrative examples of nonquantitative treatment limitations on mental health and substance use disorder benefits, which may fail to comply with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, in relation to nonquantitative treatment limitations on medical and surgical benefits.

''(D) UPDATING THE COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—The compliance program guidance document shall be updated every 2 years to include illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable.''.

(b) ADDITIONAL GUIDANCE.—Section 2726(a) of the Public Health Service Act (42 U.S.C. 300gg–26(a)), as amended by subsection (a), is further amended by adding at the end the following:

''(7) ADDITIONAL GUIDANCE.—

''(A) IN GENERAL.—Not later than 1 year after the date of enactment of the Helping Families in Mental Health Crisis Act of 2016,

the Secretary, in coordination with the Secretary of Labor and the Secretary of the Treasury, shall issue guidance to group health plans and health insurance issuers offering group or individual health insurance coverage to assist such plans and issuers in satisfying the requirements of this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable,.

''(B) DISCLOSURE.—

''(i) GUIDANCE FOR PLANS AND ISSUERS.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use for disclosing information to ensure compliance with the requirements under this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, (and any regulations promulgated pursuant to such sections, as applicable).

''(ii) DOCUMENTS FOR PARTICIPANTS, BENEFICIARIES, CONTRACTING PROVIDERS, OR AUTHORIZED REPRESENTATIVES.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use to provide any participant, beneficiary, contracting provider, or authorized representative, as applicable, with documents containing information that the health plans or issuers are required to disclose to participants, beneficiaries, contracting providers, or authorized representatives to ensure compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable; any regulation issued pursuant to such respective section, or any other applicable law or regulation, including information that is comparative in nature with respect to—

''(I) nonquantitative treatment limitations for both medical and surgical benefits and mental health and substance use disorder benefits;

''(II) the processes, strategies, evidentiary standards, and other factors used to apply the limitations described in subclause (I); and

''(III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and mental health and substance use disorder benefits.

''(C) NONQUANTITATIVE TREATMENT LIMITATIONS.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that group health plans and health insurance issuers offering group or individual health insurance coverage may use regarding the development and application of nonquantitative treatment limitations to ensure compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, (and any regulations promulgated pursuant to such respective section), including—

''(i) examples of methods of determining appropriate types of nonquantitative treatment limitations with respect to both medical and surgical benefits and mental health and substance use disorder benefits, including nonquantitative treatment limitations pertaining to—

''(I) medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;

''(II) limitations with respect to prescription drug formulary design; and

''(III) use of fail-first or step therapy protocols;

''(ii) examples of methods of determining—

''(I) network admission standards (such as credentialing); and

''(II) factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;

''(iii) examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of nonquantitative treatment limitations;

''(iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans or issuers in performing a nonquantitative treatment limitation analysis;

''(v) examples of how specific evidentiary standards may be used to determine whether treatments are considered experimental or investigative;

''(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;

''(vii) examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for individuals with a serious mental illness and types of medical management techniques;

''(viii) examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship between the covered mental health or substance use disorder benefit and a traditional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment; and

''(ix) additional illustrative examples of methods, processes, strategies, evidentiary standards, and other factors for which the Secretary determines that additional guidance is necessary to improve compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable.

''(D) PUBLIC COMMENT.—Prior to issuing any final guidance under this paragraph, the Secretary shall provide a public comment period of not less than 60 days during which any member of the public may provide comments on a draft of the guidance.''.

(c) AVAILABILITY OF PLAN INFORMATION.—

(1) PHSA AMENDMENT.—Paragraph (4) of section 2726(a) of the Public Health Service Act (42 U.S.C. 300gg–26(a)) is amended to read as follows:

''(4) AVAILABILITY OF PLAN INFORMATION.—The criteria for medical necessity determinations made under the plan or health insurance coverage with respect to mental health or substance use disorder benefits or medical or surgical benefits, the reason for denial of any such benefits, and any other information appropriate to demonstrate compliance under this section (including any such medical and surgical information) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with applicable regulations to the current or potential participant, beneficiary, or contracting provider involved upon request. The Secretary may promulgate any such regulations, including interim final regulations or temporary regulations, as may be appropriate to carry out this paragraph.''.

(2) ERISA AMENDMENT.—Paragraph (4) of section 712(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a(a)) is amended to read as follows:

''(4) AVAILABILITY OF PLAN INFORMATION.—The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits or medical or surgical benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits), the reason for denial of any such benefits, and any other information appropriate to demonstrate compliance under this section (including any such medical and surgical information) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with applicable regulations to the current or potential participant, beneficiary, or contracting provider involved upon request. The Secretary may promulgate any such regulations, including interim final regulations or temporary regulations, as may be appropriate to carry out this paragraph.''.

(3) IRC AMENDMENT.—Paragraph (4) of section 9812(a) of the Internal Revenue Code of 1986 is amended to read as follows:

''(4) AVAILABILITY OF PLAN INFORMATION.—The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits or medical or surgical benefits, the reason for denial of any such benefits, and any other information appropriate to demonstrate compliance under this section (including any such medical and surgical information) shall be made available by the plan administrator in accordance with applicable regulations to the current or potential participant, beneficiary, or contracting provider involved upon request. The Secretary may promulgate any such regulations, including interim final regulations or temporary regulations, as may be appropriate to carry out this paragraph.''.

(d) IMPROVING COMPLIANCE.—

(1) IN GENERAL.—In the case that the Secretary of Health and Human Services, the Secretary of Labor, or the Secretary of the Treasury determines that a group health plan or health insurance issuer offering group or individual health insurance coverage has violated, at least 5 times, section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), or section 9812 of the Internal Revenue Code of 1986, respectively, the appropriate Secretary shall audit plan documents for such health plan or issuer in the plan year following the Secretary's determination in order to help improve compliance with such section.

(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to limit the authority, as in effect on the day before the date of enactment of this Act, of the Secretary of Health and Human Services, the Secretary of Labor, or the Secretary of the Treasury to audit documents of health plans or health insurance issuers.

SEC. 802. ACTION PLAN FOR ENHANCED ENFORCEMENT OF MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE.

(a) PUBLIC MEETING.—

(1) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall convene a public meeting of stakeholders described in paragraph (2) to produce an action plan for improved Federal and State coordination related to the enforcement of section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section

9812 of the Internal Revenue Code of 1986, and any comparable provisions of State law (in this section collectively referred to as ''mental health parity and addiction equity requirements'').

(2) STAKEHOLDERS.—The stakeholders described in this paragraph shall include each of the following:

(A) The Federal Government, including representatives from—

(i) the Department of Health and Human Services;

(ii) the Department of the Treasury;

(iii) the Department of Labor; and

(iv) the Department of Justice.

(B) State governments, including—

(i) State health insurance commissioners;

(ii) appropriate State agencies, including agencies on public health or mental health; and

(iii) State attorneys general or other representatives of State entities involved in the enforcement of mental health parity and addiction equity requirements.

(C) Representatives from key stakeholder groups, including—

(i) the National Association of Insurance Commissioners;

(ii) health insurance providers;

(iii) providers of mental health and substance use disorder treatment;

(iv) employers; and

(v) patients or their advocates.

(b) ACTION PLAN.—Not later than 6 months after the conclusion of the public meeting under subsection (a), the Secretary of Health and Human Services shall finalize the action plan described in such subsection and make it plainly available on the Internet website of the Department of Health and Human Services.

(c) CONTENT.—The action plan under this section shall—

(1) reflect the input of the stakeholders participating in the public meeting under subsection (a);

(2) identify specific strategic objectives regarding how the various Federal and State agencies charged with enforcement of mental health parity and addiction equity requirements will collaborate to improve enforcement of such requirements;

(3) provide a timeline for implementing the action plan; and

(4) provide specific examples of how such objectives may be met, which may include—

(A) providing common educational information and documents to patients about their rights under mental health parity and addiction equity requirements;

(B) facilitating the centralized collection of, monitoring of, and response to patient complaints or inquiries relating to mental health parity and addiction equity requirements, which may be through the development and administration of a single, toll-free telephone number and an Internet website portal;

(C) Federal and State law enforcement agencies entering into memoranda of understanding to better coordinate enforcement responsibilities and information sharing, including whether such agencies should make the results of enforcement actions related to mental health parity and addiction equity requirements publicly available; and

(D) recommendations to the Congress regarding the need for additional legal authority to improve enforcement of mental health parity and addiction equity requirements, including the need for additional legal authority to ensure that nonquantitative treatment limitations are applied, and the extent and frequency of the applications of such limitations, both to medical and surgical benefits and to mental health and substance use disorder benefits in a comparable manner.

SEC. 803. REPORT ON INVESTIGATIONS REGARDING PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, and annually thereafter for the subsequent 5 years, the Administrator of the Centers for Medicare & Medicaid Services, in collaboration with the Assistant Secretary of Labor of the Employee Benefits Security Administration and the Secretary of the Treasury, shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report summarizing the results of all closed Federal investigations completed during the preceding 12-month period with findings of any serious violation regarding compliance with mental health and substance use disorder coverage requirements under section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section 9812 of the Internal Revenue Code of 1986.

(b) CONTENTS.—Subject to subsection (c), a report under subsection (a) shall, with respect to investigations described in such subsection, include each of the following:

(1) The number of closed Federal investigations conducted during the covered reporting period.

(2) Each benefit classification examined by any such investigation conducted during the covered reporting period.

(3) Each subject matter, including compliance with requirements for quantitative and nonquantitative treatment limitations, of any such investigation conducted during the covered reporting period.

(4) A summary of the basis of the final decision rendered for each closed investigation conducted during the covered reporting period that resulted in a finding of a serious violation.

(c) LIMITATION.—Any individually identifiable information shall be excluded from reports under subsection (a) consistent with protections under the health privacy and security rules promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

SEC. 804. GAO STUDY ON PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

Not later than 3 years after the date of enactment of this Act, the Comptroller General of the United States, in consultation with the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury, shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report detailing the extent to which group health plans or health insurance issuers offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, medicaid managed care organizations with a contract under section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)), and health plans provided under the State Children's Health Insurance Program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) comply with section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section 9812 of the Internal Revenue Code of 1986, including—

(1) how nonquantitative treatment limitations, including medical necessity criteria, of such plans or issuers comply with such sections;

(2) how the responsible Federal departments and agencies ensure that such plans or issuers comply with such sections, including an assessment of how the Secretary of Health and Human Services has used its authority to conduct audits of such plans to ensure compliance;

(3) a review of how the various Federal and State agencies responsible for enforcing mental health parity requirements have improved enforcement of such requirements in accordance with the objectives and timeline described in the action plan under section 802; and

(4) recommendations for how additional enforcement, education, and coordination activities by responsible Federal and State departments and agencies could better ensure compliance with such sections, including recommendations regarding the need for additional legal authority.

SEC. 805. INFORMATION AND AWARENESS ON EATING DISORDERS.

(a) INFORMATION.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') may—

(1) update information, related fact sheets, and resource lists related to eating disorders that are available on the public Internet website of the National Women's Health Information Center sponsored by the Office on Women's Health, to include—

(A) updated findings and current research related to eating disorders, as appropriate; and

(B) information about eating disorders, including information related to males and females;

(2) incorporate, as appropriate, and in coordination with the Secretary of Education, information from publicly available resources into appropriate obesity prevention programs developed by the Office on Women's Health; and

(3) make publicly available (through a public Internet website or other method) information, related fact sheets and resource lists, as updated under paragraph (1), and the information incorporated into appropriate obesity prevention programs, as updated under paragraph (2).

(b) AWARENESS.—The Secretary may advance public awareness on—

(1) the types of eating disorders;

(2) the seriousness of eating disorders, including prevalence, comorbidities, and physical and mental health consequences;

(3) methods to identify, intervene, refer for treatment, and prevent behaviors that may lead to the development of eating disorders;

(4) discrimination and bullying based on body size;

(5) the effects of media on self-esteem and body image; and

(6) the signs and symptoms of eating disorders.

SEC. 806. EDUCATION AND TRAINING ON EATING DISORDERS.

The Secretary of Health and Human Services may facilitate the identification of programs to educate and train health professionals and school personnel in effective strategies to—

(1) identify individuals with eating disorders;

(2) provide early intervention services for individuals with eating disorders;

(3) refer patients with eating disorders for appropriate treatment;

(4) prevent the development of eating disorders; or

(5) provide appropriate treatment services for individuals with eating disorders.

SEC. 807. GAO STUDY ON PREVENTING DISCRIMINATORY COVERAGE LIMITATIONS FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS AND SUBSTANCE USE DISORDERS.

Not later than 2 years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress and make publicly available a report detailing Federal oversight of group health plans and health insurance coverage offered in the individual or group market (as such terms are defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)), including Medicaid managed care plans under section 1903 of the Social Security Act (42 U.S.C. 1396b), to ensure compliance of such plans and coverage with sections 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and 9812 of the Internal Revenue Code of 1986 (in this section collectively referred to as the ''parity law''), including—

(1) a description of how Federal regulations and guidance consider nonquantitative treatment limitations, including medical necessity criteria and application of such criteria to medical, surgical, and primary care, of such plans and coverage in ensuring compliance by such plans and coverage with the parity law;

(2) a description of actions that Federal departments and agencies are taking to ensure that such plans and coverage comply with the parity law; and

(3) the identification of enforcement, education, and coordination activities within Federal departments and agencies, including educational activities directed to State insurance commissioners, and a description of how such proper activities can be used to ensure full compliance with the parity law.

SEC. 808. CLARIFICATION OF EXISTING PARITY RULES.

If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage for eating disorder benefits, including residential treatment, such group health plan or health insurance issuer shall provide such benefits consistent with the requirements of section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section 9812 of the Internal Revenue Code of 1986.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Pennsylvania (Mr. MURPHY) and the gentleman from New Jersey (Mr. PALLONE) each will control 20 minutes.

The Chair recognizes the gentleman from Pennsylvania.

GENERAL LEAVE

Mr. MURPHY of Pennsylvania. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks and insert extraneous materials in the RECORD on the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Pennsylvania?

There was no objection.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, our mental health system in this country is a failure. This is one of those times where we are not gathered for a moment of silence, but a time of action. We are here finally to speak up for the last, the lost, the least, and the lonely, that is those who suffer from mental illness which is untreated.

Mental illness affects one in five Americans. About 10 million Americans have serious mental illness. About 4 million of those go without any treatment. There are 100,000 new cases each year. Half of psychosis cases emerge by age 14, 75 percent by age 24. We have a need for 30,000 child psychiatrists. We only have 9,000. We have great shortages of psychologists.

The time between the emergence of the first symptoms of serious mental illness and the first appointment is about 80 weeks. We need about 100,000 hospital beds in this country, but we only have 40,000 for psychiatric crises. A person is 10 times more likely, therefore, to be in jail than in a hospital if they are mentally ill.

And these statistics, too: 43,000 suicides last year, 47,000 drug overdose deaths, 1,000 homicides, 250 mentally ill violently killed in a police encounter where they attacked a policeman. We have hundreds of thousands of homeless and mentally ill who die the slow-motion death of chronic illness, and that comes to more than the number who die of breast cancer, perhaps 350,000 or more a year.

The Helping Families in Mental Health Crisis Act, a bipartisan bill with over 205 cosponsors, which came out of the Committee on Energy and Commerce with a unanimous vote, fixes this. It allows parents and caregivers to help with care. It increases the number of crisis mental health beds. It drives evidence-based care. It builds on existing mental health and substance abuse parity laws. It brings accountability to Federal grant programs, which two GAO reports say were disastrous. It focuses on innovation and reaches underserved and rural populations, expands the mental health workforce, advances early intervention and prevention programs, develops alternatives to institutionalization, focuses on suicide prevention, increases program coordination across the 112 Federal programs and agencies, reforms protection and advocacy, provides training grants to train police officers and first responders, and saves the Federal Government money. It is wide ranging, it is impactful, and it is something that we are going to have to pass today if we really, truly want to make a difference.

Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield myself such time as I may consume.

I rise in support of H.R. 2646, the Helping Families in Mental Health Crisis Act.

Today's mental health system can hardly be described as a system at all. While some States are undertaking promising improvements, the system is fragmented, overwhelmed, and underresourced. Far too many people with mental illnesses can't get the treatment they need to live long, healthy, and productive lives, so I am pleased that this bill takes an important step toward improving mental health care in this country.

The bill under consideration today, Mr. Speaker, is a significant improvement over the original version introduced a year ago. It is no secret that many of us had substantial concerns with some of the provisions in the original text of the bill, and I am sure that my fellow Members of the Committee on Energy and Commerce remember the extensive debate we had on this bill during our subcommittee markup last November.

Since that time, we have found common ground. We removed many provisions that would have done more harm than good, in my opinion, and replaced them with policies that strengthen the bill. I am proud that H.R. 2646 now includes several policies championed by Democrats.

The bill requires that States provide the full range of early and periodic screening, diagnostic, and treatment—EPSDT—services to children in the Medicaid program who receive inpatient psychiatric care at so-called institutions of mental disease. It creates a new assertive community treatment grant program and a peer professional workforce grant program. The legislation also creates new grant programs to address adult suicide, expands access to community crisis response services, and creates and disseminates model HIPAA training programs.

A great deal of work went into crafting this agreement, and I want to thank my Republican colleagues for continuing to meet with us throughout this process so that we could bring a bipartisan product to the floor.

That said, the bill before us today is not transformative reform nor is it a panacea to the many problems now facing our mental health system. I encourage my colleagues to see this legislation as a necessary step rather than a solution, and I want to be very clear on this point. If we are truly serious about fixing our broken mental health system, we have to expand access and make sustained investment, and that means we must work to encourage all States to expand Medicaid and provide more Federal resources to support the growth of community-based prevention, treatment, and recovery services.

This legislation is not comprehensive. It by no means contains enough funding to make the mental health system whole. I hope that, in the near future, we can work together again on additional legislation to increase treatment options and further strengthen mental health parity enforcement.

I once again want to thank my colleagues who stood with me throughout this long process, fiercely voicing their concerns and advocating for major improvements to the bill. I want to thank Chairman UPTON for his leadership, and the bill's sponsors, Representatives TIM MURPHY and EDDIE BERNICE JOHNSON, for championing this issue for so many years.

I urge my colleagues to support this important bipartisan bill, and I look forward to the Senate's action on this issue.

Mr. Speaker, I reserve the balance of my time.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield 1 minute to the gentleman from New Jersey (Mr. LANCE), a member of the Committee on Energy and Commerce, who has been supporting this from the onset.

Mr. LANCE. Mr. Speaker, today marks a very important moment in the long and tortuous road to reform a mental health system that is broken and must be fixed.

I joined the gentleman from Pennsylvania (Mr. MURPHY), a psychologist and my friend and colleague, and our former colleague, now U.S. Senator from Louisiana, Dr. BILL CASSIDY, in a conference room in the basement of the U.S. Capitol in December 2013, where the three of us stood together and called on Congress to address a mental healthcare system in crisis, a system where millions of Americans suffer every year and are all too often pushed into the shadows by archaic regulations and an outdated Federal bureaucracy. 2½ years later, I am proud that the House stands poised today to pass the most significant reform to our Nation's mental health programs in decades.

This bill includes provisions I have championed to help provide early detection of eating disorders and improve access to treatment coverage. This is an historic achievement, as it marks the first time Congress has addressed eating disorders specifically through legislation.

I thank Subcommittee Chairman MURPHY, Chairman UPTON, and the entire Committee on Energy and Commerce for working together to pass this landmark mental healthcare reform bill and move us one step closer to providing millions of Americans and their families a chance at treatment before tragedy strikes.

Mr. PALLONE. Mr. Speaker, I yield 1½ minutes to the gentleman from Texas (Mr. GENE GREEN), the ranking member of the Health Subcommittee.

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Mr. GENE GREEN of Texas. Mr. Speaker, I rise in support of H.R. 2646, legislation to improve our mental health system.

This bill is a positive step forward. I want to thank my colleagues on both sides of the aisle for their work to improve access, prevention, and treatment for those with mental and behavioral conditions. We worked extensively and collaboratively to craft the legislation.

I want to particularly thank Energy and Commerce Committee Chairman UPTON; Ranking Member PALLONE; Representatives KENNEDY, MATSUI, LOEBSACK, TONKO, and DEGETTE for their contributions; and Congressman TIM MURPHY for elevating the conversation about mental health.

H.R. 2646 includes new grant programs that expand access to critical mental health services, such as community crisis response systems and adult suicide prevention. It provides new tools to improve compliance with mental health parity, HIPAA training programs for patients and providers to better understand their protections and rights, and a peer professional workforce development grant.

I am pleased that this legislation extends the Federal Tort Claims Act to help professional volunteers at community health centers. It also affords the full range of Early and Periodic Screening, Diagnostic, and Treatment services to Medicaid children who receive care in Institutes of Mental Diseases.

While not comprehensive and lacking key resources, today's vote marks a significant step forward to strengthening our Nation's mental health system.

Again, I want to thank my colleagues on the Energy and Commerce Committee and their staffs, and I urge Members to vote in favor of this legislation.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield 1 minute to the gentleman from Louisiana (Mr. SCALISE) the majority whip.

Mr. SCALISE. Mr. Speaker, I thank my colleague from Pennsylvania for yielding, but especially for taking the lead on this issue.

Mr. Speaker, it has been decades since Congress has reformed our mental health laws. Unfortunately, we have seen so many negative aspects since then. Suicide rates are through the roof. There are so many other problems throughout our country. It has touched every community in this Nation. We see a growing problem with mental health.

This bill really refocuses efforts, but it also puts a different priority on Federal grants and Federal agencies to force them to do a better job of addressing these problems. It also helps families to get more involved in the mental health problems that their own children face. Right now, some Federal laws make it harder for parents to help their own children. These kinds of serious problems have been complicated to work through.

Mr. Speaker, when you look at the fact that it has been decades, there is a reason why. This is hard work. It is complicated work. This bill has been at least 3 years in the making, and so it is very important that we bring this bill to the floor today and pass it over to the Senate. This is not only reform that can pass the House, but reform that actually get signed by the President and make a real difference and impact in improving people's lives.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Ms. MATSUI).

Ms. MATSUI. Mr. Speaker, I thank the gentleman for yielding.

For far too long, those with mental illness have been left in the shadows, and mental health prevention and treatment have been left out of our health systems.

The mental health crisis in this country is very personal to me, and I have been fighting for patients and their loved ones for many years. I believe there is a lot we can do better to stop or slow down the hurt and pain that patients and families feel when mental health is left unaddressed.

The bill before us today is a good bill. It is a first step toward mental health reform, offering policies that help move us in the direction of better parity between mental and physical illness, a stronger workforce trained to address mental illness, and promotion of evidence-based services and supports.

Especially important to me are the provisions that will help clarify when and how providers are able to share information with families and caregivers in order to better serve the patients in times of need.

There is more left to be done, more to do, and our reform efforts will not be complete or comprehensive until we make real investments in our mental health system. I will continue working for the comprehensive mental health reforms that our families need and deserve.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield 1 minute to the gentleman from Michigan (Mr. UPTON), chairman of the full committee and who we owe a great debt of gratitude for moving forward this bill.

Mr. UPTON. Mr. Speaker, today marks an important milestone in the multiyear, multi-Congress effort to deliver meaningful reforms to the Nation's mental health system.

Last month, the Energy and Commerce Committee passed this bill 53–0 in committee. It has been bipartisan. We know that this is an issue that impacts every community and so many families in one way or another. We continue to hear tales of great loss where intervention was lacking or nonexistent. So we got to work. We spent hundreds and hundreds of hours—I am not kidding—in staff work and work by Members.

For way too long, mental health was a subject that was left in the shadows. Thankfully, that is no longer the case. Today we have developed a thoughtful solution. Throughout the process, we have achieved many important reforms. Today we build upon that momentum.

Our current system of siloed grants, prevention, and treatment simply doesn't work the way it should. This bill changes that with real reforms to provide SAMHSA new tools, under the leadership of a new Assistant Secretary, and we have done it the way that we should.

This bipartisan bill will save lives, aid families, and provide comfort and relief to those who are struggling.

Mr. Speaker, today marks an important milestone in the multi-year, multi-Congress effort to deliver meaningful reforms to the nation's mental health system. Last month, the

Energy and Commerce Committee unanimously approved H.R. 2646 by a vote of 53 to zero to help families in mental health crisis.

This is an issue that impacts every community, and so many families, in one way or another. We continue to hear tales of great loss where intervention was lacking or nonexistent.

But you know what? Congressman Tim MURPHY got to work. For way too long, mental health was a subject left for the shadows. Thankfully, that's no longer the case. Today, we have developed a thoughtful legislative solution. Throughout this process, we have achieved important reforms and today we build upon that momentum.

Our current system of siloed grants, prevention, and treatment simply does not work as well as it should. The "Helping Families in Mental Health Crisis Act" includes new reforms to make sure the federal government is leveraging their dollars with investments in evidence-based programs. The bill includes reforms to provide SAMHSA new tools, under the leadership of an Assistant Secretary for Mental Health and Substance Use, to do its job better.

Thoughtful legislating takes time and dedication. This Congress we have seen multi-year landmark committee efforts finally make it across the finish line in SGR reform, pipeline safety and chemical safety reforms, which were both signed into law late last month. 21st Century Cures has taken years, and we continue to make progress. And I am hopeful these mental health reforms that we have long pursued are on the same path to being signed into law, building upon our proud bipartisan record of success.

This bipartisan bill will save lives, aid families, and provide comfort and relief to those struggling. This strong bill is something that both Republicans and Democrats can be proud of. I thank Dr. MURPHY, Health Subcommittee Chairman PITTS, full committee Ranking Member FRANK PALLONE and the staff, who worked hundreds of hours to bring us to where we are today.

This bill will truly make a real difference and deliver meaningful reforms to families in mental health crisis all across America.

Mr. PALLONE. Mr. Speaker, I yield 1½ minutes to the gentleman from New York (Mr. TONKO).

Mr. TONKO. Mr. Speaker, I thank the gentleman from New Jersey for yielding.

Mr. Speaker, I rise today in support of H.R. 2646, the Helping Families in Mental Health Crisis Act. While this bill is not perfect and necessarily represents a compromise from all sides, it is a good first step in making the improvement to our Nation's mental health system. It has been a long road to get here, and the passionate debate we have had has only served to strengthen the bill and produce legislation that we can all support.

In particular, I would like to highlight section 502, which is based on my Coordinating Crisis Care Act, which I sponsored. This provision would authorize a new grant program at SAMHSA to fund the development of real-time bed registry systems that will help get individuals in crisis the appropriate care they need in a timely fashion. By ensuring better coordination of crisis care systems, we can save lives and support individuals and families in their time of need.

Looking forward, Congress needs to do more to heal a broken mental health system. We should pass additional legislation that would ensure vigorous enforcement of our mental health parity laws and to strengthen mental health and substance use coverage for Medicaid and Medicare beneficiaries. That is ultimately the key to quality performance here for the mental health community.

Finally, we have to acknowledge that the current dysfunction in our mental health systems stems, in part, from decades of broken promises and a chronic underinvestment in community-based mental health services that simply cannot be solved by one single bill like this.

We must do better, and I stand ready to help in that fight.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield 1 minute to the gentleman from Oregon (Mr. WALDEN).

Mr. WALDEN. Mr. Speaker, today I rise in support of Representative MURPHY's Helping Families in Mental Health Crisis Act.

Ten million Americans suffer from serious mental illness, Mr. Speaker. If they get care, they are 16 times less likely to harm themselves or others. Right now, too many patients fall through the cracks.

At a recent roundtable in Medford, Oregon, and on a tele-townhall I just completed, I heard from parents about their children who experienced homelessness and violence due to their illness, from caregivers about the difficulty of getting timely care, and from law enforcement about how the default place for the mentally ill is often a jail.

The consensus among all of them was that the healthcare system, the government, and society are failing those who need help the most. They overwhelmingly support the provisions in this legislation.

We can improve treatment, we can and do boost resources, and we will get care to people in need, especially in our rural communities.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from Massachusetts (Mr. KENNEDY).

Mr. KENNEDY. Mr. Speaker, I want to thank Ranking Member PALLONE, Chairman UPTON, and Congressman MURPHY for, once again, the bipartisan leadership that has guided this bill through our committee and onto the floor.

Mr. Speaker, you cannot listen to the constant stories from patients and families who have been denied access to mental health care and believe that there are not tragic gaps in our mental health system. This bill is a bipartisan, incremental step forward in our efforts to address those gaps.

I am especially pleased by the inclusion of my bill to remove the discriminatory barrier to care for children in certain inpatient psychiatric facilities, yet we have to acknowledge that, unless this is just the first step, we have failed to fix a broken system. Unless we increase Medicaid reimbursements rates, providers will still be forced to turn away our most vulnerable patient populations. Unless we inspire and encourage a new generation to pursue careers as psychologists, psychiatrists, and social workers, there will still be a shortage of professionals to care for our patients. Unless we can guarantee parity, insurance companies will continue to construct barriers to care, leaving patients without access to the mental health system no matter how strong that system may be.

And that is where our eyes should be focused tomorrow after this bill is passed.

Whether in conference or in our future committee hearings, we cannot accept this bill as a full, comprehensive fix to a fully broken system. If we do, patients suffering from mental illness will continue to fall through the same gaps that exist today.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. BILIRAKIS), a member of the Energy and Commerce Committee.

Mr. BILIRAKIS. Mr. Speaker, I rise today in support of H.R. 2646, the Helping Families in Mental Health Crisis Act, of which I am a cosponsor.

I want to thank Chairman MURPHY for the extensive amount of time and attention he has put into addressing mental health and substance abuse disorders. He even joined me in my district to hear directly from my constituents about this particular bill. I thank Chairman MURPHY again for that.

We discussed the struggles that individuals with mental illness face and how Congress can best address the need of those we serve. With their input, we worked to address every aspect of this overall problem.

This legislation will help countless individuals and families in my district in Florida and in communities across our country. I urge my colleagues to support this great piece of legislation.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON), the Democratic sponsor of the bill.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise today in support of H.R. 2646, the Helping Families in Mental Health Crisis Act. As the original Democratic cosponsor of this piece of legislation and the one that preceded it, I am proud to see it come to the floor today.

H.R. 2646 is a demonstration of more than 3 years of collaboration between not only myself and Congressman TIM MURPHY, but the many other Members and organizations that came to the table to offer feedback, suggestions, and, at times, criticism. At no time did Congressman MURPHY turn anyone's input down.

The end result is a bill that remains focused on enabling the most severely and mentally ill to access the treatment they desperately deserve, while allowing their families and caregivers to help them along the way.

This piece of legislation contains several necessary provisions, including the establishment of an Assistant Secretary for Mental Health and Substance Use Disorder, easing our Nation's chronic shortage of psychiatric beds, requiring the Secretary of Health and Human Services to clarify confusing HIPAA rules surrounding mental health patients, and increasing grant programs with results proven to help individuals with serious mental health illness gain access to treatment like Assisted Outpatient Treatment and Assertive Community Treatment.

As two of the few mental health providers serving in Congress—another over here to my left, Dr. MCDERMOTT, a psychiatrist—Congressman MURPHY and I have always been focused on the needs of the severely mentally ill. Many that we read about daily in our many cities across the Nation end up in jail or prison.

□ 1415

While the homeless and prison population are particularly vulnerable to mental illness, these are the individuals that get the least amount of attention and access to mental health services. Through our work, we have a deep understanding of patient need, and this need is not being met.

The SPEAKER pro tempore. The time of the gentlewoman has expired.

Mr. PALLONE. Mr. Speaker, I yield the gentlewoman an additional 1 minute.

Ms. EDDIE BERNICE JOHNSON of Texas. Unfortunately, we have found that many of our fellow Members lack the understanding of patients in crisis, making this process more difficult.

I am hopeful, however, that this bill will be a framework to help us move the needle forward on mental health treatment in America.

I would like to thank Congressman MURPHY for his steadfast commitment to mental health. I would also like to thank the chairman, FRED UPTON, and our ranking member, Mr. PALLONE, for their hard work on this measure. While we still have a long ways to go, this is certainly a step forward.

Mr. MURPHY of Pennsylvania. Mr. Speaker, how much time do I have remaining?

The SPEAKER pro tempore (Mr. LOUDERMILK). The gentleman from Pennsylvania has 12½ minutes remaining.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Indiana (Mrs. BROOKS), who has been a real champion of this bill.

Mrs. BROOKS of Indiana. Mr. Speaker, 1 in 4 adults, a total of 61.5 million Americans, will experience mental illness within a given year. The numbers alone don't tell the stories behind the deeply personal pain that this disease inflicts on our friends, neighbors, and, most importantly, their families.

Today, I am proud to stand with the gentleman from Pennsylvania in support of this strong bipartisan bill. He has truly championed the first major mental health reform in this country in 50 years.

Right now, our healthcare system does not allow families of those suffering from mental illness to become partners in their health care, and this bill ensures that adult patients struggling with mental illness will receive the healthcare treatment they need, while allowing their families to become close partners in their care. It expands the mental health workforce and increases the number of psychiatric hospital beds for those experiencing an acute mental health crisis.

This legislation is a significant, important step toward comprehensive, community-based care that will work better for people and, most importantly, their families. I urge my colleagues to vote ''yes'' on this bill.

Mr. PALLONE. Mr. Speaker, how much time do I have remaining?

The SPEAKER pro tempore. The gentleman from New Jersey has 8½ minutes remaining.

Mr. PALLONE. Mr. Speaker, I yield 1½ minutes to the gentlewoman from Ohio (Ms. KAPTUR).

Ms. KAPTUR. Mr. Speaker, I rise today in support of the Helping Families in Mental Health Crisis Act, H.R. 2646, and wish to thank Chairman UPTON, Ranking Member PALLONE, and the two driving sponsors of this measure, Congressman TIM MURPHY and Congresswoman EDDIE BERNICE JOHNSON, who have adeptly navigated this bill through very choppy legislative waters.

The bill takes head-on one of the most compelling and unaddressed health challenges of our society: the suffering, the anguish, the travails, the plight of the seriously mentally ill. The bill will empower parents and caregivers, drive innovation, advance early-intervention and prevention programs, and offer alternatives to institutionalization, and provide the first step in a long time to show respect and real treatment alternatives to Americans living with mental illness.

It is no secret our prisons have become the domiciles for the mentally ill. This bill rings out: ''No more, no more.''

Sadly, psychiatric care has become the responsibility of our prison system. Three of the largest mental health ''hospitals'' in our country are incarceration facilities. Speak to any local sheriff. They will tell you their jails are overcrowded with the mentally ill.

What too often happens is that the ill person in an adult incarceration facility actually began their journey in a child correction facility, and as they matured, essentially, graduated to the adult facility without their underlying mental illness being properly diagnosed, much less treated. What an indictment of our Nation, not just our health and corrections system, this is, but our entire country.

Today's bill calls for a complete overhaul of the current mental health system. It has been needed since the de-institutionalization that sent millions, some to their death when they were sent to the streets.

I want to congratulate, as I conclude, Representatives MURPHY and JOHNSON for bringing this bill to the floor and addressing a crying human need for too long ignored in our country. They are doing something noble for the Nation. The severely mentally ill must be humanely treated.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania (Mr. PITTS), the chairman of the Health Subcommittee of the Committee on Energy and Commerce.

Mr. PITTS. Mr. Speaker, I thank Mr. MURPHY for his leadership and his persistence in getting this historic legislation to the floor.

When a person struggles with mental illness, he or she may lose her job, her friends, even her family, which can make the mental illness worse. And help for this person may be available, but she may not be able to navigate available resources alone or drive to her doctor's appointments regularly without help.

Therefore, organizations providing mental health assistance must not only provide resources, they must make sure they actually connect people with people in need.

When the Federal Government distributes mental health funding, it needs to go to programs that are doing this, and Congressman MURPHY's bill is a step in the right direction. His bill will increase accountability so that we can better understand how Federal mental health and substance abuse treatment funds are used in each State. It would summarize best practice models in the States and do many other things, and this way we can highlight mental health programs that are most effective.

I urge my colleagues to support the bill.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from Washington (Mr. MCDERMOTT), the chairman of the Ways and Means Health Subcommittee.

Mr. MCDERMOTT. Mr. Speaker, first of all, I want to say congratulations to Congressman MURPHY. His persistence brought this bill to the floor, and it is important that this issue be discussed.

We are all going to vote for this bill. It will go out of here unanimously. We are all going to vote for it. But it is a hollow promise if there is not some money in it.

Now, I was in my training in Chicago, in 1964, when the first mental health money came from the Federal Government to Chicago, and it went all

over the country. And if the Federal Government doesn't put money into this program that we are outlining in this very carefully constructed bill, we will be sending out a blank check. There will be nothing. It won't be worth anything. To think that State legislatures or somebody is going to find the money somewhere is simply not real.

Now, this morning, Mr. PALLONE and I sat on a conference committee on opioids. We are doing the same thing there. We know there is addiction, we know there are all kinds of problems all over the place, and we are passing a wonderful bill out with some nice words in it, but no money. And if you are not willing to put some money into a program like this, you are simply consigning the mental health people to the jail.

I was the King County Jail psychiatrist in 1979 and I ran the second-largest mental hospital in the State of Washington. I had more patients every night in that jail than anybody except the guy running the State mental hospital down in Tacoma. And that is where the mentally ill are today.

If you want to get them out of that situation and get them into treatment, you are going to have to put some money out into the community in a variety of these programs. Good programs. I like what is in them. But you have got to put some money where your mouth is.

I will support the bill, and I want to hear the appropriations process next.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield 1 minute to the gentleman from Texas (Mr. BURGESS).

Mr. BURGESS. I thank the gentleman for the recognition.

Mr. Speaker, passage of this bill represents a major milestone for individuals affected by mental illness across the country, and, of course, I want to congratulate Chairman and Congressman TIM MURPHY and Congresswoman EDDIE BERNICE JOHNSON on the progress they have made on this front. Many of us have worked in committee for a long time to achieve this day.

And while we are in the business of congratulating ourselves as a routine matter, I also want to take a moment to acknowledge the participation of staff, both in our personal offices, as well as the professional committee staff that helped bring this bill to the point we are today. In particular, an alumnus of my office, Adrianna Simonelli, worked hard to get this bill to a place where both sides could expect and accept the results that we are achieving today.

Thank you, Mr. Chairman, for the recognition. Thanks for bringing this bill to the floor of the House.

Mr. PALLONE. Mr. Speaker, could I inquire again about the time remaining on each side, and ask whether Mr. MURPHY, how many additional speakers he has?

The SPEAKER pro tempore. The gentleman from New Jersey has 5 minutes remaining.

Mr. PALLONE. Does the gentleman have a number of additional speakers?

Mr. MURPHY of Pennsylvania. I have about 10 more speakers who would like to speak.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from Colorado (Ms. DEGETTE), who is the ranking member of the Oversight and Investigations Subcommittee.

Ms. DEGETTE. Mr. Speaker, today's vote on this wonderful bill is the result of longstanding efforts in the Energy and Commerce Committee to come to a bipartisan compromise on mental health legislation. I particularly want to thank my compadre, my chairman, Mr. MURPHY, for his hard work on this. I have spent many, many hours talking to him about this bill over the last few years, and I am happy to have it come together.

This bill really incorporates a number of our positive changes that included key provisions from the Comprehensive Behavioral Health Reform and Recovery Act, which I am an original cosponsor, and other bills.

But as Mr. MCDERMOTT and others on this side of the aisle have said, we still have a lot more work to do. This bill is really just the first step towards true reform. And if we want to make a difference, Congress really does need to provide the resources needed.

We have heard people talking about overfilled jails. We have heard people talking about parents who can't find beds for their tremendously mentally ill children. We have heard about the lack of truly educated professionals.

These things can only be achieved with resources and money. And so I truly see this bill as the first step towards a very robust mental health system in this country.

The last thing I want to say is, action on mental health legislation does not excuse inaction on gun violence prevention legislation. We must do something as well as passing comprehensive mental health legislation to respond to the gun violence epidemic.

Americans, my constituents, want us to take these steps. They have made this abundantly clear in the last few weeks, and I am urging that we have a vote separately on those issues.

But for today, let's all vote ''yes'' on this piece of legislation, and then let's move forward for the important steps we need to take.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield 45 seconds to the gentleman from Michigan (Mr. BENISHEK).

Mr. BENISHEK. Mr. Speaker, we are here today to vote on long overdue bipartisan mental health legislation. This bill will finally take concrete steps toward improving the quality of care available to those suffering from mental illness.

For too long, the most desperate among us have not had access to proper mental health care. Patients, along with their families and loved ones, have had nowhere to turn.

As a doctor taking care of patients in northern Michigan for 30 years, I am all too familiar with the lack of resources and attention devoted to providing quality mental health care for our Nation. There are many communities in my district there are no psychiatric beds available. Local agencies don't have the staff or the resources to provide answers for those seeking help, let alone treatment. This bill represents a major step forward in turning all that around.

I hope all my colleagues will join me in supporting this commonsense step to help deliver better mental health care.

Mr. PALLONE. Mr. Speaker, I reserve the balance of my time.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield 45 seconds to the gentleman from New York (Mr. GIBSON).

Mr. GIBSON. Mr. Speaker, I want to congratulate Dr. MURPHY and Ms. JOHNSON for this landmark mental health legislation. I believe it builds on earlier legislation we enacted in this Congress, like the Clay Hunt suicide awareness and prevention bill, improving the mental health for our veterans. And it fills a void that has existed for decades now since we de-institutionalized in the 1970s, a decision I support, but we never put Federal policy in behind it until today, Mr. Speaker, resources for the local level for inpatient care for Americans and families in mental health crisis.

□ 1430

It improves coordination across the agencies to deliver better suicide awareness and prevention in mental health.

I want to thank my wife, Mary Jo, a licensed clinical social worker, for her advice and inspiration.

Mr. Speaker, I urge my colleagues to support this legislation.

Mr. PALLONE. I continue to reserve the balance of my time, Mr. Speaker.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield 45 seconds to the gentleman from Pennsylvania (Mr. ROTHFUS), my friend and colleague.

Mr. ROTHFUS. Mr. Speaker, I want to thank my colleague and neighbor from Pennsylvania, Congressman MURPHY, for his unrelenting leadership on this legislation and for calling attention to a problem that affects millions of families across the country.

Nearly 10 million Americans have serious mental illness, including schizophrenia, substance abuse disorder, and major depression. I think today of the many families in my district who tell me about the heartbreak they have had after losing loved ones to drug addiction or suicide.

This legislation will improve the oversight of mental health and substance abuse programs by ensuring we are using the most relevant data and most effective, evidence-based programs to address our mental health crisis.

I urge my colleagues to support this legislation, and I thank the gentleman for his leadership.

Mr. PALLONE. Mr. Speaker, I will continue to reserve the balance of my time until we get to closing remarks.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield 45 seconds to the gentleman from Georgia (Mr. ALLEN).

Mr. ALLEN. Mr. Speaker, I thank Chairman MURPHY for this great piece of legislation.

I rise today in support of H.R. 2646, the Helping Families in Mental Health Crisis Act. Too many families across America have experienced a loved one who is living with or has been diagnosed with a mental illness. Sadly, one in five children ages 13 to 18 have or will battle a mental illness.

As a proud member of the House Education and the Workforce Committee, I had the privilege of visiting schools across Georgia's 12th Congressional District and visiting with educators and staff members. School leaders from elementary school to college all say that mental health is one of their top concerns for the students.

These heartbreaking statistics are more than data and numbers on a spreadsheet. They are mothers, fathers, sisters, brothers, students, friends, and children.

Mr. Speaker, I urge my colleagues to vote in favor of H.R. 2646.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield 45 seconds to the gentlewoman from Virginia (Mrs. COMSTOCK).

Mrs. COMSTOCK. Mr. Speaker, I thank the gentleman for yielding and for his tireless work on this important bipartisan legislation which I was proud to cosponsor.

I rise in support of H.R. 2646, the Helping Families in Mental Health Crisis Act.

Every week we hear from constituents concerned about this issue, and, of course, we all no doubt know somebody battling with this issue. I appreciate the input from all stakeholders that has been taken into account here—doctors, healthcare providers, academics, and law enforcement—but, most importantly, the input from the families, the caregivers, and those dealing with the mental health conditions that are in so much need for more care.

So I urge my colleagues to support this bipartisan bill that will allow for more efficient use of the resource allocation, improved responsiveness, and reduced time and energy that is now lost spent navigating a very difficult system that will be improved by this. So I thank the gentleman.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I include in the RECORD this list of over 50 professional organizations in support of this bill and also a list of 65-plus editorials in support of this bill.

HELPING FAMILIES IN MENTAL HEALTH CRISIS EDITORIAL BOARD ENDORSEMENTS (H.R. 2646)

2015–2016 EDITORIAL ENDORSEMENTS

1. The Florida Times Union, Congress begins to tackle mental illness (April 21, 2015).
2. Observer-Reporter, Reforms to mental-health system neede, (July 21, 2015).
3. The Sacramento Bee, Perhaps Congress will address mental health care (August 1, 2015).
4. The National Review, Congress is Waking Up To Mental health, (August 4, 2015).
5. Reading Record Searchlight, Perhaps Congress will address mental health care (August 9, 2015).
6. U.S. News and World Report, America Wakes Up to Mental Health (August 11, 2015).
7. The Florida Times-Union, Florida's inept system for mental health leads to tragedies (August 20, 2015).
8. The Washington Times, Stopping the shooters (August 27, 2015).
9. KDKA-News, KDKA Urges Congress To Pass Murphy's Helping Families in Mental Health Crisis Act (August 31, 2015).
10. The Connecticut Post, Congress can finally make a difference for mental-health reform (September 17, 2015).
11. The Winona Daily News, Congress can finally make a difference for mental-health reform (September 17, 2015).
12. Dubuque Telegraph Herald, Congress can finally make a difference for mental-health reform (September 17, 2015).
13. Boulder Daily Camera, Congress can finally make a difference for mental-health reform (September 17, 2015).
14. The Rome News-Tribune, Congress can finally make a difference for mental-health reform (September 17, 2015).
15. Carlsbad Current Argus, Congress can finally make a difference for mental-health reform (September 17, 2015).
16. Cecil Whig, Congress can finally make a difference for mental-health reform (September 17, 2015).
17. The Seattle Times, Congress can finally make a difference for mental-health reform (September 17, 2015).
18. Vero Beach Press Journal, Another View: Mental health reform effort deserves support (September 22, 2015).
19. Alamogordo Daily News, Mental health reform effort deserves support (September 25, 2015).
20. Grand Rapids Business Journal, Behavioral Health Care: We Can Do Better Than This (October 2, 2015).
21. The Roanoke Times, Our view: Murphy's (would-be) law (October 7, 2015).
22. The Dallas Morning News, Congress can rewrite mental illness stories by doing this (October 21, 2015).
23. The San Francisco Chronicle, Crime, punishment and mental health (October 22, 2015).
24. The National Review, Editorial: The Week (October 26, 2015).
25. North Dallas Gazette, Dealing with Mental Illness in a Dysfunctional Society (October 28, 2015).
26. The Daily Courier, Seeking to help people before they pull the trigger (October 29, 2015).
27. The Sacramento Bee, We've come to accept the unacceptable (October 30, 2015).
28. The Washington Post, Movement on mental-health care (November 1, 2015).
29. The National Review, Editorial: The Week (November 2, 2015).
30. Kane County Chronicle, Another view: Movement on Mental Health Care (November 2, 2015).
31. Northwest Arkansas Democrat Gazette, Others say: Movement on mental-health care (November 3, 2015).
32. Grand Forks Herald, OUR OPINION: Support US. House's mental health care reform (November 4, 2015).
33. The Oklahoman, A review of state, federal mental health laws is justified (November 9, 2015).
34. Sarasota Herald Tribune, Bill targets mental health crisis (November 22, 2015).
35. The Wall Street Journal, The Next Mad Gunman (November 29, 2015).
36. The Tampa Bay Tribune, Confront Our Mental Health Crisis (December 1, 2015).
37. PennLive, Full U.S. house should get a vote on Rep. Tim Murphy's mental health bill (December 14, 2015).
38. The Scranton Times-Tribune, Retool mental health system (December 16, 2015).
39. The Citizens Voice, Improve access to mental health care (December 16, 2015).
40. New York Daily News, Sane law promises mental health treatment for the dangerously insane (January 28, 2016).
41. Washington Post, A glimmer of hope for reforming mental health care in America (June 25, 2016).

2013–2014 EDITORIAL ENDORSEMENTS

42. The Express-Times, Don't give up on background checks, mental health reform (December 15, 2013).
43. Washington Observer-Reporter, Murphy's bill a step toward mental health reform (December 21, 2013).
44. The Wall Street Journal, A Mental Health Overhaul (December 25, 2013).
45. Houston Chronicle, Dealing with it (January 15, 2014).
46. The Wall Street Journal, The Definition of Insanity (March 31, 2014).
47. Pittsburgh Post-Gazette, Worthy of Support: Murphy's Mental Health Bill Faces the Critics (April 6, 2014).
48. The Toledo Blade, Worth of support (April 9, 2014).
49. Pittsburgh Post-Gazette, Better Care for the Mentally Ill is Crucial for Our Society (April 13, 2014).
50. The Washington Post Mental health care in the U.S. needs a check-up (April 16, 2014).
51. The Orange County Register, A Mental Health Fix That Merits A Chance (April 21, 2014).
52. Mansfield News Journal, How Congress can solve our mental-health crisis (May 19, 2014).
53. The Sacramento Bee, Efforts underway to prevent all-too-often tragic results of untreated severe mental illness (May 20, 2014).
54. The Fresno Bee, Orange County sets example with passage of Laura's Law (May 21, 2014).
55. The Seattle Times, Mental-health reform to consider in light of Santa Barbara shootings (May 28, 2014).
56. Cecil Whig, Rampage spurring new approaches (June 2, 2014).
57. The Arizona Republic, Reforms shouldn't protect 'Big Mental Health' (June 6, 2014).
58. National Review, Don't Go Wobbly on Mental Illness (June 9, 2014).
59. The Sacramento Bee, San Francisco Casts Vote for Compassion for People with Severe Mental Illness (July 9, 2014).
60. San Mateo Journal, A vote for compassion (July 10, 2014).
61. Ocala Star Banner, Mental health issue (August 18, 2014).
62. Bradenton Herald, Bill in Congress a solid overhaul of America's broken mental health system (August 21, 2014).
63. Raleigh News & Observer, Pennsylvania Congressman has Ideas to Address Mental Health Care (August 28, 2014).
64. The Fayetteville Observer, Mental health-care Overhaul Bill Worth Attention (August 29, 2014).
65. The Tampa Tribune, Nation needs to treat mental illness as a crisis (December 21, 2014).

ORGANIZATIONS

Adventist Health Care, American Academy of Child & Adolescent Psychiatry, American Academy of Emergency Medicine, American Academy of Forensic Sciences, American Foundation For Suicide Prevention, American College of Emergency Physicians,

American Occupational Therapy Association, Inc., American Psychiatric Association, American Psychological Association, Behavioral Health IT Coalition, California Psychiatric Association, Center for Substance Abuse Research.

College of Psychiatric and Neurologic Pharmacists, Developmental Disabilities Area Board 10 Los Angeles, Federal Law Enforcement Association of America, International Bipolar Foundation, Mental Health America, Mental Health Association of Essex County, NJ.

Mental Illness FACTS, Mental Illness Policy Organization, National Alliance on Mental Illness (NAMI), National Association of Psychiatric Health Systems, NAMI Harlem, NAMI Kentucky.

NAMI Los Angeles County, NAMI New York State, NAMI Ohio, NAMI San Francisco, NAMI West Side Los Angeles, National Association for the Advancement of Psychoanalysis, National Association of Psychiatric Health Systems, National Council for Behavioral Health, National Sheriffs' Association, No Health Without Mental Health, Pennsylvania Medical Society, Pine Rest Christian Mental Health Services.

Saint Paulus Lutheran Church (San Francisco), Schizophrenia and Related Disorders Alliance of America, Sheppard Pratt Hospital, Society of Hospital Medicine, Sunovian, Treatment Advocacy Cater, Treatment Before Tragedy, University of Pittsburgh, Department of Psychiatry, Washington Psychiatric Society, New York State Association of Chiefs of Police.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield 45 seconds to the gentleman from Georgia (Mr. CARTER).

Mr. CARTER of Georgia. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, I rise today in support of H.R. 2646, the Helping Families in Mental Health Crisis Act of 2015.

Mental health has become a crisis in our country. There is a nationwide shortage of nearly 100,000 psychiatric beds. Three of the largest mental health hospitals are, in fact, criminal incarceration facilities. Only one child psychologist is available for every 2,000 children with a mental disorder.

Our Nation's mental health system is broken. Yet through the hard work of my friend from Pennsylvania (Mr. MURPHY), this bill fixes the deficit that currently exists in our mental health system through refocusing programs, reforming grants, and removing Federal barriers for care. It provides for additional psychiatric hospital beds. It advances telepsychiatry to allow for better coordination. It also incentivizes States to provide community-based alternatives to institutionalization.

This bill takes numerous steps to addressing the deficiencies that our mental health community faces.

I commend Representative TIM MURPHY for his work on this bill, and I encourage my colleagues to support this bill.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield 45 seconds to the gentlewoman from California (Mrs. MIMI WALTERS).

Mrs. MIMI WALTERS of California. Mr. Speaker, I rise today in strong support of the Helping Families in Mental Health Crisis Act.

Across this country, our mental health system is broken. Nearly 10 million Americans suffer from serious mental illness, and for far too many of those individuals the Federal Government stands between them and the care that they so desperately need.

The laws on the books are complicated and outdated, but with this legislation, we have the opportunity to reform our national mental health system. This bipartisan bill will refocus programs, reform grants, and remove the Federal Government as a barrier to lifesaving health care.

I urge my colleagues to support this critical legislation to improve the quality and access to mental health care treatment.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. MCCARTHY), the majority leader of the House of Representatives.

Mr. MCCARTHY. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, it is a testament to Representative TIM MURPHY's expertise, persuasion, and sheer force of will that something so many thought would be impossible is now inevitable.

The House will soon vote to pass Mr. MURPHY's Helping Families in Mental Health Crisis Act under suspension. Though this bill is the most significant reform to our Nation's mental health program in decades, it has such a breadth of bipartisan support that we know it will pass with far more than a majority of votes in this House.

This is a work that Mr. MURPHY of Pennsylvania has done not just for 1 month, not 2, not even 1 year, but I would say a lifetime of his work. You see, each year, the Federal Government has responded with money—$130 billion to be exact. But we cannot and should never conflate the amount we spend with the effectiveness of the spending.

The Federal Government has 112 programs to address mental illness. But coordination is limited and gaps are common. Children with mental health disorders can't get psychiatrists. Criminal facilities are commonly used to house mental health patients. Funding isn't going to support evidence-based breakthroughs that improve people's lives.

We need simplification, coordination, and effectiveness. We need reforms that help those who suffer from mental illness while also making our Nation safer.

This bill is thorough and will deliver. From top to bottom it will improve our fragmented mental health systems, giving new hope to those too often forgotten and support to those truly in need.

It is an honor to be on this floor with Representative TIM MURPHY. He had the passion, but he had the servant's heart to never forget those that he wanted to serve. Many of those did not have a voice, and many of those felt left out, with no one there to speak for them.

Mr. MURPHY of Pennsylvania has never given up, and he has shown that the entire body of this House, and in essence willed it together, that it came out of the Committee on Energy and Commerce unanimously, and I hope on this floor we follow that direction.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield 45 seconds to the gentleman from Illinois (Mr. LAHOOD.)

Mr. LAHOOD. Mr. Speaker, I rise in support of H.R. 2646 and commend Dr. MURPHY for introducing it.

Across the country, over 10 million Americans suffer from severe mental illness. Unfortunately, many are not receiving their proper treatment, including access to inpatient facilities or trained mental health professionals.

In my prior life, I spent about 10 years as a State and Federal prosecutor. In that role, I saw the negative effects of a broken mental health system. It is a system in much need of reform in Illinois and all across this country. I have litigated many cases in which mental health played a significant role in the case, and I can assure you that when it comes to mental illness, incarceration in prison is not the solution.

This bill is a step in the right direction. It is comprehensive, and it will help change the direction of our mental health system. I strongly support it and urge my colleagues to support it.

Mr. PALLONE. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, this bill is an important and positive step towards expanding and improving mental health care services in this country, but it is only a first step. If we are serious about strengthening our national mental health care system, we must expand access and dedicate more resources.

Comprehensive legislation should include dedicating robust resources to ensure access to community-based prevention, treatment, and recovery services in every community across the country. It must provide additional tools to strengthen mental health parity enforcement.

Democrats will stay focused on continuing to expand and improve the continuum care for mental health care services.

That said, I do want my colleagues, and I urge my colleagues, to support this bipartisan legislation, and let us also work together to get the Senate to pass their bipartisan bill, and they need to go to conference or somehow get a bill that would pass both Houses and get to the President. I do pledge to my colleagues on the Republican side that we need to do that between now and the end of year.

I wanted to take a moment to thank the Democratic committee staff who worked so hard on this bill—most of them are on the floor—Tiffany Guarascio, Waverly Gordon to my right, Rachel Pryor, Arielle Woronoff, Una Lee, and, finally, our fellow, Kyle Fischer.

Again, I urge my colleagues to support this bill.

Mr. Speaker, I yield back the balance of my time.

Mr. MURPHY of Pennsylvania. Mr. Speaker, may I inquire how much time I have remaining?

The SPEAKER pro tempore. The gentleman has 2½ minutes remaining.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield myself the balance of my time.

I want to add my thanks also to the ranking member, Mr. PALLONE, for his steadfast work in this and to his staff. I have learned a lot from them. We have had a lot of conversations and hopefully we have learned from each other.

Particularly, I want to thank EDDIE BERNICE JOHNSON of Texas. Her persistence and her role as a psychiatric nurse has been invaluable in this whole process.

In addition, other Members on the other side of the aisle, Mr. GENE GREEN of Texas and Ms. DEGETTE, MARCY KAPTUR and JIM MCDERMOTT, who have been incredible allies in this process, and, of course, the chairman of the full committee, Mr. UPTON.

The staff I want to thank are Gary Andres, Karen Christian, Sam Spector, Paul Edattel, Adrianna Simonelli; my staff, Susan Mosychuk, Scott Dziengelski; my former staff, Brad Grantz; and also Michelle Rosenberg from the committee, for their help.

Publicly, I want to also thank those families who spoke up. Many families came out of their pain—Senator Creigh Deeds, Cathy Costello of Oklahoma, Anthony Hernandez of California and Jennifer Hoff of California, Liza Long from up in Idaho, and Doris Fuller from nearby—all talking about the suffering of their families.

Thousands of other families spoke up, but there are still millions who suffer silently in the shadows trying to deal with mental illness and a Federal Government that has failed them, States that have underfunded it.

I appreciate the comments from my colleagues. Indeed, if we do not fund some of these things we are authorizing here, it is a far cry from what we need to do. But this bill comes a long way in reforming a system.

I ask my colleagues also now, this is one of those moments to put aside any political differences. In the 40 years that I have worked as a psychologist, I have never once asked any of my patients what party they belonged to. We were there to help them. This is our opportunity to speak up for those who have no voice, as I said at the onset, the last, the lost, the least, and the lonely. They depend on us.

I know that Members from both sides of the aisle have told me many times of the stories that they have suffered themselves of their own families and friends.

But now let me take a moment to set aside my title as Congressman or as doctor but to talk as a family member.

I think I was in college at the time when I heard a soft voice call in my house just saying ''help.'' It was my father. I went into the bathroom where he was. He had cut the arteries in his arms and he was bleeding out. I called an ambulance and asked them to come get help for him. He eventually recovered and made peace. But it was that soft voice calling for help that I responded to.

It is decades later and he is long gone. But it is that soft voice that millions of Americans are also calling out for help.

We have a chance here with this bill to make a huge difference. Unlike any other bills we may pass in Congress, this is one where I think Members can really go back and say: Today I voted to save lives.

Let's have treatment before tragedy, because where there is help, there is hope.

Mr. Speaker, I yield back the balance of my time.

Mr. LEVIN. Mr. Speaker, reforming our mental health system has been an active priority of mine. That's why I supported legislation increasing access to the mental health care, including the Mental Health Parity Act of 1996, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, the Excellence in Mental Health Act, and the Affordable Care Act.

Among its provisions, the Affordable Care Act expanded mental health parity protections by including mental health coverage as one of ten Essential Health Benefit categories. The ACA also ended insurers' ability to refuse to cover someone due to a pre-existing condition. Prior to the ACA, insurers often declined to cover someone who had diagnoses of mental health conditions such as bipolar disorder, schizophrenia, and anorexia. This was no accident, and these important mental health reforms were yet another reason I supported the ACA.

The amended version of H.R. 2646, the Helping Families in Mental Health Crisis Act as reported out of Committee on the Energy and Commerce, takes another meaningful step towards reforming our mental health system by strengthening enforcement of mental health parity requirements, increasing access to community-based treatment, and growing the mental health workforce. I am pleased to support this bipartisan legislation, and I look forward to working with my colleagues in Congress to continue to improve the nation's mental health system.

□ 1445

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Pennsylvania (Mr. MURPHY) that the House suspend the rules and pass the bill, H.R. 2646, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. MURPHY of Pennsylvania. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this motion will be postponed.

RESTORING ACCESS TO MEDICATION AND IMPROVING HEALTH SAVINGS ACT OF 2016

Ms. JENKINS of Kansas. Mr. Speaker, pursuant to House Resolution 793, I call up the bill (H.R. 1270) to amend the Internal Revenue Code of 1986 to repeal the amendments made by the Patient Protection and Affordable Care Act which disqualify expenses for over-the-counter drugs under health savings accounts and health flexible spending arrangements, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Pursuant to House Resolution 793, in lieu of the amendment in the nature of a substitute recommended by the Committee on Ways and Means, printed in the bill, an amendment in the nature of a substitute consisting of the text of Rules Committee Print 114–60, is adopted, and the bill, as amended, is considered read.

The text of the bill, as amended, is as follows:

H.R. 1270

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Restoring Access to Medication and Improving Health Savings Act of 2016''.

TITLE I—RESTORING ACCESS TO MEDICATION ACT OF 2016

SEC. 101. SHORT TITLE.

This title may be cited as the ''Restoring Access to Medication Act of 2016''.

SEC. 102. REPEAL OF DISQUALIFICATION OF EXPENSES FOR OVER-THE-COUNTER DRUGS UNDER CERTAIN ACCOUNTS AND ARRANGEMENTS.

(a) HSAS.—Section 223(d)(2)(A) of the Internal Revenue Code of 1986 is amended by striking the last sentence.

(b) ARCHER MSAS.—Section 220(d)(2)(A) of such Code is amended by striking the last sentence.

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of such Code is amended by striking subsection (f).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to expenses incurred after December 31, 2016.

TITLE II—HEALTH CARE SECURITY ACT OF 2016

SEC. 201. SHORT TITLE.

This title may be cited as the ''Health Care Security Act of 2016''.

SEC. 202. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CONTRIBUTIONS TO THE SAME HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223(b)(5) of the Internal Revenue Code of 1986 is amended to read as follows:

''(5) SPECIAL RULE FOR MARRIED INDIVIDUALS WITH FAMILY COVERAGE.—

''(A) IN GENERAL.—In the case of individuals who are married to each other, if both spouses are eligible individuals and either spouse has family coverage under a high deductible health plan as of the first day of any month—

''(i) the limitation under paragraph (1) shall be applied by not taking into account any other high deductible health plan coverage of either spouse (and if such spouses both have family coverage under separate high deductible health plans, only one such coverage shall be taken into account),