

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

Strike all after the enacting clause and insert the following:

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

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

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

Sec. 1. Short title; table of contents.

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

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

**TITLE II—MEDICAID MENTAL HEALTH COVERAGE**

- Sec. 201. Rule of construction related to Medicaid coverage of mental health services and primary care services furnished on the same day.
- Sec. 202. Optional limited coverage of inpatient services furnished in institutions for mental diseases.
- Sec. 203. Study and report related to Medicaid managed care regulation.
- Sec. 204. Guidance on opportunities for innovation.

- Sec. 205. Study and report on Medicaid emergency psychiatric demonstration project.
- Sec. 206. Providing full-range of EPSDT services to children in IMDs.
- Sec. 207. Electronic visit verification system required for personal care services and home health care services under Medicaid.

TITLE III—INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS  
COORDINATING COMMITTEE

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

TITLE IV—COMPASSIONATE COMMUNICATION ON HIPAA

- Sec. 401. Sense of Congress.
- Sec. 402. Confidentiality of records.
- Sec. 403. Clarification of circumstances under which disclosure of protected health information is permitted.
- Sec. 404. Development and dissemination of model training programs.

TITLE V—INCREASING ACCESS TO TREATMENT FOR SERIOUS  
MENTAL ILLNESS

- Sec. 501. Assertive community treatment grant program for individuals with serious mental illness.
- Sec. 502. Strengthening community crisis response systems.
- Sec. 503. Increased and extended funding for assisted outpatient grant program for individuals with serious mental illness.
- Sec. 504. Liability protections for health professional volunteers at community health centers.

TITLE VI—SUPPORTING INNOVATIVE AND EVIDENCE-BASED  
PROGRAMS

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

- Sec. 601. Encouraging innovation and evidence-based programs.
- Sec. 602. Promoting access to information on evidence-based programs and practices.
- Sec. 603. Sense of Congress.

Subtitle B—Supporting the State Response to Mental Health Needs

- Sec. 611. Community Mental Health Services Block Grant.

Subtitle C—Strengthening Mental Health Care for Children and Adolescents

- Sec. 621. Telehealth child psychiatry access grants.
- Sec. 622. Infant and early childhood mental health promotion, intervention, and treatment.
- Sec. 623. National Child Traumatic Stress Initiative.

TITLE VII—GRANT PROGRAMS AND PROGRAM REAUTHORIZATION

Subtitle A—Garrett Lee Smith Memorial Act Reauthorization

- Sec. 701. Youth interagency research, training, and technical assistance centers.
- Sec. 702. Youth suicide early intervention and prevention strategies.

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

Subtitle B—Other Provisions

- Sec. 711. National Suicide Prevention Lifeline Program.
- Sec. 712. Workforce development studies and reports.
- Sec. 713. Minority Fellowship Program.
- Sec. 714. Center and program repeals.
- Sec. 715. National violent death reporting system.
- Sec. 716. Sense of Congress on prioritizing Native American youth and suicide prevention programs.
- Sec. 717. Peer professional workforce development grant program.
- Sec. 718. National Health Service Corps.
- Sec. 719. Adult suicide prevention.
- Sec. 720. Crisis intervention grants for police officers and first responders.
- Sec. 721. Demonstration grant program to train health service psychologists in community-based mental health.
- Sec. 722. Investment in tomorrow’s pediatric health care workforce.
- Sec. 723. CUTGO compliance.

TITLE VIII—MENTAL HEALTH PARITY

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

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

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

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

1           “(c) ASSISTANT SECRETARY AND DEPUTY ASSIST-  
2   ANT SECRETARY.—

3           “(1) ASSISTANT SECRETARY.—

4                   “(A) APPOINTMENT.—The Administration  
5           shall be headed by an official to be known as  
6           the Assistant Secretary for Mental Health and  
7           Substance Use (hereinafter in this title referred  
8           to as the ‘Assistant Secretary’) who shall be ap-  
9           pointed by the President, by and with the ad-  
10          vice and consent of the Senate.

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

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

16                           “(ii) clinical and research experience  
17                           regarding mental health and substance use  
18                           disorders; and

19                           “(iii) an understanding of biological,  
20                           psychosocial, and pharmaceutical treat-  
21                           ments of mental illness and substance use  
22                           disorders.

23                   “(2) DEPUTY ASSISTANT SECRETARY.—The As-  
24          sistant Secretary, with the approval of the Secretary,  
25          may appoint a Deputy Assistant Secretary and may

1 employ and prescribe the functions of such officers  
2 and employees, including attorneys, as are necessary  
3 to administer the activities to be carried out through  
4 the Administration.”.

5 (b) TRANSFER OF AUTHORITIES.—The Secretary of  
6 Health and Human Services shall delegate to the Assist-  
7 ant Secretary for Mental Health and Substance Use all  
8 duties and authorities that—

9 (1) as of the day before the date of enactment  
10 of this Act, were vested in the Administrator of the  
11 Substance Abuse and Mental Health Services Ad-  
12 ministration; and

13 (2) are not terminated by this Act.

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

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

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

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

21 “(19) evaluate, in consultation with the Assist-  
22 ant Secretary for Financial Resources, the informa-  
23 tion used for oversight of grants under programs re-  
24 lated to mental and substance use disorders, includ-

1       ing co-occurring disorders, administered by the Cen-  
2       ter for Mental Health Services;

3           “(20) periodically review Federal programs and  
4       activities relating to the diagnosis or prevention of,  
5       or treatment or rehabilitation for, mental illness and  
6       substance use disorders to identify any such pro-  
7       grams or activities that have proven to be effective  
8       or efficient in improving outcomes or increasing ac-  
9       cess to evidence-based programs;

10          “(21) establish standards for the appointment  
11       of peer-review panels to evaluate grant applications  
12       and recommend standards for mental health grant  
13       programs; and”.

14       (d) STANDARDS FOR GRANT PROGRAMS.—Section  
15       501(d) of the Public Health Service Act (42 U.S.C.  
16       290aa(d)), as amended by subsection (c), is amended by  
17       adding at the end the following:

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

24           “(A) the capacity of the grantee to imple-  
25       ment the award;

1           “(B) requirements for the description of  
2           the program implementation approach;

3           “(C) the extent to which the grant plan  
4           submitted by the grantee as part of its applica-  
5           tion must explain how the grantee will reach  
6           the population of focus and provide a statement  
7           of need, including to what extent the grantee  
8           will increase the number of clients served and  
9           the estimated percentage of clients receiving  
10          services who report positive functioning after 6  
11          months or no past-month substance use, as ap-  
12          plicable;

13          “(D) the extent to which the grantee must  
14          collect and report on required performance  
15          measures; and

16          “(E) the extent to which the grantee is  
17          proposing evidence-based practices and the ex-  
18          tent to which—

19                 “(i) those evidence-based practices  
20                 must be used with respect to a population  
21                 similar to the population for which the evi-  
22                 dence-based practices were shown to be ef-  
23                 fective; or

24                 “(ii) if no evidence-based practice ex-  
25                 ists for a population of focus, the way in

1           which the grantee will implement adapta-  
2           tions of evidence-based practices, prom-  
3           ising practices, or cultural practices.”.

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

7           (1) in subsection (b)—

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

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

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

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

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

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



1           (2) by striking “Administrator” each place it  
2           appears and inserting “Assistant Secretary”, except  
3           where the term “Administrator” appears within the  
4           term—

5                   (A) Associate Administrator;

6                   (B) Administrator of the Health Resources  
7                   and Services Administration;

8                   (C) Administrator of the Centers for Medi-  
9                   care & Medicaid Services; or

10                  (D) Administrator of the Office of Juvenile  
11                  Justice and Delinquency Prevention.

12           (g) REFERENCES.—After executing subsections (a),  
13 (b), and (e), any reference in statute, regulation, or guid-  
14 ance to the Administrator of the Substance Abuse and  
15 Mental Health Services Administration shall be construed  
16 to be a reference to the Assistant Secretary for Mental  
17 Health and Substance Use.

18 **SEC. 102. IMPROVING OVERSIGHT OF MENTAL HEALTH**

19 **AND SUBSTANCE USE PROGRAMS.**

20           Title V of the Public Health Service Act is amended  
21 by inserting after section 501 of such Act (42 U.S.C.  
22 290aa) the following:

1 **“SEC. 501A. IMPROVING OVERSIGHT OF MENTAL HEALTH**  
2 **AND SUBSTANCE USE PROGRAMS.**

3 “(a) ACTIVITIES.—For the purpose of ensuring effi-  
4 cient and effective planning and evaluation of mental and  
5 substance use disorder programs and related activities, the  
6 Assistant Secretary for Planning and Evaluation, in con-  
7 sultation with the Assistant Secretary for Mental Health  
8 and Substance Use, shall—

9 “(1) collect and organize relevant data on  
10 homelessness, involvement with the criminal justice  
11 system, hospitalizations, mortality outcomes, and  
12 other measures the Secretary deems appropriated  
13 from across Federal departments and agencies;

14 “(2) evaluate programs related to mental and  
15 substance use disorders, including co-occurring dis-  
16 orders, across Federal departments and agencies, as  
17 appropriate, including programs related to—

18 “(A) prevention, intervention, treatment,  
19 and recovery support services, including such  
20 services for individuals with a serious mental ill-  
21 ness or serious emotional disturbance;

22 “(B) the reduction of homelessness and in-  
23 volvement with the criminal justice system  
24 among individuals with a mental or substance  
25 use disorder; and

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

1           “(3) consult, as appropriate, with the Assistant  
2           Secretary, the Behavioral Health Coordinating  
3           Council of the Department of Health and Human  
4           Services, other agencies within the Department of  
5           Health and Human Services, and other relevant  
6           Federal departments.

7           “(b) RECOMMENDATIONS.—The Assistant Secretary  
8           for Planning and Evaluation shall develop an evaluation  
9           strategy that identifies priority programs to be evaluated  
10          by the Assistant Secretary and priority programs to be  
11          evaluated by other relevant agencies within the Depart-  
12          ment of Health and Human Services. The Assistant Sec-  
13          retary shall provide recommendations on improving pro-  
14          grams and activities based on the evaluation described in  
15          subsection (a)(2) as needing improvement.”.

16   **SEC. 103. NATIONAL MENTAL HEALTH AND SUBSTANCE**  
17                           **USE POLICY LABORATORY.**

18          Title V of the Public Health Service Act (42 U.S.C.  
19    290aa et seq.) is amended by inserting after section 501A,  
20    as added by section 102 of this Act the following:

21   **“SEC. 501B. NATIONAL MENTAL HEALTH AND SUBSTANCE**  
22                           **USE POLICY LABORATORY.**

23          “(a) IN GENERAL.—There shall be established within  
24    the Administration a National Mental Health and Sub-

1 stance Use Policy Laboratory (referred to in this section  
2 as the ‘Laboratory’).

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

4 “(1) continue to carry out the authorities and  
5 activities that were in effect for the Office of Policy,  
6 Planning, and Innovation as such Office existed  
7 prior to the date of enactment of the Helping Fami-  
8 lies in Mental Health Crisis Act of 2016;

9 “(2) identify, coordinate, and facilitate the im-  
10 plementation of policy changes likely to have a sig-  
11 nificant effect on mental health, mental illness, and  
12 the prevention and treatment of substance use dis-  
13 order services;

14 “(3) collect, as appropriate, information from  
15 grantees under programs operated by the Adminis-  
16 tration in order to evaluate and disseminate infor-  
17 mation on evidence-based practices, including cul-  
18 turally and linguistically appropriate services, as ap-  
19 propriate, and service delivery models;

20 “(4) provide leadership in identifying and co-  
21 ordinating policies and programs, including evidence-  
22 based programs, related to mental and substance use  
23 disorders;

24 “(5) recommend ways in which payers may im-  
25 plement program and policy findings of the Adminis-

1 tration and the Laboratory to improve outcomes and  
2 reduce per capita program costs;

3 “(6) in consultation with the Assistant Sec-  
4 retary for Planning and Evaluation, as appropriate,  
5 periodically review Federal programs and activities  
6 relating to the diagnosis or prevention of, or treat-  
7 ment or rehabilitation for, mental illness and sub-  
8 stance use disorders, including by—

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

11 “(B) identifying any such programs or ac-  
12 tivities that are not evidence-based, effective, or  
13 efficient; and

14 “(C) formulating recommendations for co-  
15 ordinating, eliminating, or improving programs  
16 or activities identified under subparagraph (A),  
17 (B), or (C), and merging such programs or ac-  
18 tivities into other successful programs or activi-  
19 ties; and

20 “(7) carry out other activities as deemed nec-  
21 essary to continue to encourage innovation and dis-  
22 seminate evidence-based programs and practices, in-  
23 cluding programs and practices with scientific merit.

24 “(c) EVIDENCE-BASED PRACTICES AND SERVICE  
25 DELIVERY MODELS.—

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

4                   “(A) shall give preference to models that  
5           improve—

6                           “(i) the coordination between mental  
7                           health and physical health providers;

8                           “(ii) the coordination among such pro-  
9                           viders and the justice and corrections sys-  
10                          tem; and

11                          “(iii) the cost effectiveness, quality,  
12                          effectiveness, and efficiency of health care  
13                          services furnished to individuals with seri-  
14                          ous mental illness or serious emotional dis-  
15                          turbance, in mental health crisis, or at risk  
16                          to themselves, their families, and the gen-  
17                          eral public; and

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

24                          “(2) DEADLINE FOR BEGINNING IMPLEMENTA-  
25           TION.—The Laboratory shall begin implementation

1 of the duties described in this subsection not later  
2 than January 1, 2018.

3 “(3) CONSULTATION.—In carrying out the du-  
4 ties under this subsection, the Laboratory shall con-  
5 sult with—

6 “(A) representatives of the National Insti-  
7 tute of Mental Health, the National Institute  
8 on Drug Abuse, and the National Institute on  
9 Alcohol Abuse and Alcoholism, on an ongoing  
10 basis;

11 “(B) other appropriate Federal agencies;

12 “(C) clinical and analytical experts with  
13 expertise in psychiatric medical care and clinical  
14 psychological care, health care management,  
15 education, corrections health care, and mental  
16 health court systems, as appropriate; and

17 “(D) other individuals and agencies as de-  
18 termined appropriate by the Assistant Sec-  
19 retary.”.

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

21 (a) IN GENERAL.—Not later than 2 years after the  
22 date of enactment of this Act, the Comptroller General  
23 of the United States shall conduct a study on peer-support  
24 specialist programs in up to 10 States (to be selected by  
25 the Comptroller General) that receive funding from the

1 Substance Abuse and Mental Health Services Administra-  
2 tion and submit to the Committee on Health, Education,  
3 Labor, and Pensions of the Senate and the Committee on  
4 Energy and Commerce of the House of Representatives  
5 a report containing the results of such study.

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

11 (1) hours of formal work or volunteer experi-  
12 ence related to mental and substance use disorders  
13 conducted through such programs;

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

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

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

20 (5) requirements for continuing education.



1 **SEC. 105. PROHIBITION AGAINST LOBBYING USING FED-**  
2 **ERAL FUNDS BY SYSTEMS ACCEPTING FED-**  
3 **ERAL FUNDS TO PROTECT AND ADVOCATE**  
4 **THE RIGHTS OF INDIVIDUALS WITH MENTAL**  
5 **ILLNESS.**

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

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

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

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

14 “(11) agree to refrain, during any period for  
15 which funding is provided to the system under this  
16 part, from using Federal funds to pay the salary or  
17 expenses of any grant or contract recipient, or agent  
18 acting for such recipient, related to any activity de-  
19 signed to influence the enactment of legislation, ap-  
20 propriations, regulation, administrative action, or  
21 Executive order proposed or pending before the Con-  
22 gress or any State government, State legislature or  
23 local legislature or legislative body, other than for  
24 normal and recognized executive-legislative relation-  
25 ships or participation by an agency or officer of a  
26 State, local, or tribal government in policymaking

1 and administrative processes within the executive  
2 branch of that government;”.

3 **SEC. 106. REPORTING FOR PROTECTION AND ADVOCACY**  
4 **ORGANIZATIONS.**

5 (a) PUBLIC AVAILABILITY OF REPORTS.—Section  
6 105(a)(7) of the Protection and Advocacy for Individuals  
7 with Mental Illness Act (42 U.S.C. 10805(a)(7)) is  
8 amended by striking “is located a report” and inserting  
9 “is located, and make publicly available, a report”.

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

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

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

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

18 “(5) using data from the existing required an-  
19 nual program progress reports submitted by each  
20 system funded under this title, a detailed accounting  
21 for each such system of how funds are spent,  
22 disaggregated according to whether the funds were  
23 received from the Federal Government, the State  
24 government, a local government, or a private enti-  
25 ty.”.

1 **SEC. 107. GRIEVANCE PROCEDURE.**

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

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

9 **SEC. 108. CENTER FOR BEHAVIORAL HEALTH STATISTICS**  
10 **AND QUALITY.**

11 Title V of the Public Health Service Act (42 U.S.C.  
12 290aa et seq.) is amended—

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

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

17 (2) in section 502(a)(1) (42 U.S.C. 290aa-  
18 1(a)(1))—

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

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

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

25 “(E) the Center for Behavioral Health  
26 Statistics and Quality.”; and

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

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

5 **“SEC. 520L. CENTER FOR BEHAVIORAL HEALTH STATISTICS**  
6 **AND QUALITY.**

7 “(a) ESTABLISHMENT.—There is established in the  
8 Administration a Center for Behavioral Health Statistics  
9 and Quality (in this section referred to as the ‘Center’).  
10 The Center shall be headed by a Director (in this section  
11 referred to as the ‘Director’) appointed by the Secretary  
12 from among individuals with extensive experience and aca-  
13 demic qualifications in research and analysis in behavioral  
14 health care or related fields.

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

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

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

20 “(B) evaluation;

21 “(C) statistical and analytic support;

22 “(D) service systems research; and

23 “(E) performance and quality information  
24 systems;

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

4           “(3) coordinate evaluation efforts for the grant  
5 programs, contracts, and collaborative agreements of  
6 the Administration.

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

14           “(1) the number of patients screened positive  
15 for unhealthy alcohol use who receive brief coun-  
16 seling as appropriate; the number of patients  
17 screened positive for tobacco use and receiving  
18 smoking cessation interventions; the number of pa-  
19 tients with a new diagnosis of major depressive epi-  
20 sode who are assessed for suicide risk; the number  
21 of patients screened positive for clinical depression  
22 with a documented followup plan; and the number of  
23 patients with a documented pain assessment that  
24 have a followup treatment plan when pain is present;  
25 and satisfaction with care;

1           “(2) the incidence and prevalence of substance  
2           use and mental disorders; the number of suicide at-  
3           tempts and suicide completions; overdoses seen in  
4           emergency rooms resulting from alcohol and drug  
5           use; emergency room boarding; overdose deaths;  
6           emergency psychiatric hospitalizations; new criminal  
7           justice involvement while in treatment; stable hous-  
8           ing; and rates of involvement in employment, edu-  
9           cation, and training; and

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

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

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

19           “(2) professionals with training and expertise in  
20           statistics or research and survey design and meth-  
21           odologies; and

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

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

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

10 **SEC. 109. STRATEGIC PLAN.**

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

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

15           (2) by inserting after subsection (k) the fol-  
16 lowing:

17       “(1) STRATEGIC PLAN.—

18           “(1) IN GENERAL.—Not later than December 1,  
19 2017, and every 5 years thereafter, the Assistant  
20 Secretary shall develop and carry out a strategic  
21 plan in accordance with this subsection for the plan-  
22 ning and operation of evidence-based programs and  
23 grants carried out by the Administration.

24           “(2) COORDINATION.—In developing and car-  
25 rying out the strategic plan under this section, the

1 Assistant Secretary shall take into consideration the  
2 report of the Interdepartmental Serious Mental Ill-  
3 ness Coordinating Committee under section 301 of  
4 such Act.

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

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

11 “(B) post such plan on the Internet  
12 website of the Administration.

13 “(4) CONTENTS.—The strategic plan developed  
14 under paragraph (1) shall—

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

21 “(B) identify ways to improve services for  
22 individuals with a mental or substance use dis-  
23 order, including services related to the preven-  
24 tion of, diagnosis of, intervention in, treatment  
25 of, and recovery from, mental or substance use



1 disorders, including serious mental illness or se-  
2 rious emotional disturbance, and access to serv-  
3 ices and supports for individuals with a serious  
4 mental illness or serious emotional disturbance;

5 “(C) ensure that programs provide, as ap-  
6 propriate, access to effective and evidence-based  
7 prevention, diagnosis, intervention, treatment,  
8 and recovery services, including culturally and  
9 linguistically appropriate services, as appro-  
10 priate, for individuals with a mental or sub-  
11 stance use disorder;

12 “(D) identify opportunities to collaborate  
13 with the Health Resources and Services Admin-  
14 istration to develop or improve—

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

1 treatment of individuals with a serious  
2 mental illness or serious emotional disturb-  
3 ance; and

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

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

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

1 **SEC. 110. AUTHORITIES OF CENTERS FOR MENTAL HEALTH**  
2 **SERVICES AND SUBSTANCE ABUSE TREAT-**  
3 **MENT.**

4 (a) CENTER FOR MENTAL HEALTH SERVICES.—Sec-  
5 tion 520(b) of the Public Health Service Act (42 U.S.C.  
6 290bb–31(b)) is amended—

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

9 (2) by inserting after paragraph (2) the fol-  
10 lowing:

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

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

22 (4) in paragraph (6), as so redesignated, by in-  
23 serting “in collaboration with the Director of the  
24 National Institute of Mental Health,” before “de-  
25 velop”;

1           (5) in paragraph (8), as so redesignated, by in-  
2           serting “, increase meaningful participation of indi-  
3           viduals with mental illness in programs and activi-  
4           ties of the Administration,” before “and protect the  
5           legal”;

6           (6) in paragraph (10), as so redesignated, by  
7           striking “professional and paraprofessional per-  
8           sonnel pursuant to section 303” and inserting  
9           “paraprofessional personnel and health profes-  
10          sionals”;

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

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

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

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

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

1           “(17) consult with other agencies and offices of  
2           the Department of Health and Human Services to  
3           ensure, with respect to each grant awarded by the  
4           Center for Mental Health Services, the consistent  
5           documentation of the application of criteria when  
6           awarding grants and the ongoing oversight of grant-  
7           ees after such grants are awarded.”.

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

11           (1) in subsection (a)—

12                   (A) by striking “treatment of substance  
13                   abuse” and inserting “treatment of substance  
14                   use disorders”; and

15                   (B) by striking “abuse treatment systems”  
16                   and inserting “use disorder treatment systems”;  
17                   and

18           (2) in subsection (b)—

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

21                   (B) in paragraph (4), by striking “individ-  
22                   uals who abuse drugs” and inserting “individ-  
23                   uals who use drugs”;

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

1 (D) by striking paragraph (10);

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

5 (F) in paragraph (12), as so redesignated,  
6 by striking “; and” and inserting a semicolon;  
7 and

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

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

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

18 **SEC. 111. ADVISORY COUNCILS.**

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

21 (1) in paragraph (2)—

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

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

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

3 “(F) for the advisory councils appointed  
4 under subsections (a)(1)(A) and (a)(1)(D), the  
5 Director of the National Institute of Mental  
6 Health;

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

11 “(H) for the advisory councils appointed  
12 under subsections (a)(1)(A), (a)(1)(B), and  
13 (a)(1)(C), the Director of the National Institute  
14 on Alcohol Abuse and Alcoholism; and”;

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

17 “(C) Not less than half of the members of  
18 the advisory council appointed under subsection  
19 (a)(1)(D)—

20 “(i) shall have—

21 “(I) a medical degree;

22 “(II) a doctoral degree in psy-  
23 chology; or

24 “(III) an advanced degree in  
25 nursing or social work from an ac-

1 credited graduate school or be a cer-  
2 tified physician assistant; and  
3 “(ii) shall specialize in the mental  
4 health field.”.

5 **SEC. 112. PEER REVIEW.**

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

17 **TITLE II—MEDICAID MENTAL**  
18 **HEALTH COVERAGE**

19 **SEC. 201. RULE OF CONSTRUCTION RELATED TO MEDICAID**  
20 **COVERAGE OF MENTAL HEALTH SERVICES**  
21 **AND PRIMARY CARE SERVICES FURNISHED**  
22 **ON THE SAME DAY.**

23 Nothing in title XIX of the Social Security Act (42  
24 U.S.C. 1396 et seq.) shall be construed as prohibiting sep-  
25 arate payment under the State plan under such title (or



1 under a waiver of the plan) for the provision of a mental  
2 health service or primary care service under such plan,  
3 with respect to an individual, because such service is—

4 (1) a primary care service furnished to the indi-  
5 vidual by a provider at a facility on the same day  
6 a mental health service is furnished to such indi-  
7 vidual by such provider (or another provider) at the  
8 facility; or

9 (2) a mental health service furnished to the in-  
10 dividual by a provider at a facility on the same day  
11 a primary care service is furnished to such individual  
12 by such provider (or another provider) at the facil-  
13 ity.

14 **SEC. 202. OPTIONAL LIMITED COVERAGE OF INPATIENT**  
15 **SERVICES FURNISHED IN INSTITUTIONS FOR**  
16 **MENTAL DISEASES.**

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

20 “(I)(i) Notwithstanding the limitation specified in the  
21 subdivision (B) following paragraph (29) of section  
22 1905(a) and subject to clause (ii), a State may, under a  
23 risk contract entered into by the State under this title (or  
24 under section 1115) with a medicaid managed care organi-  
25 zation or a prepaid inpatient health plan (as defined in

1 section 438.2 of title 42, Code of Federal Regulations (or  
2 any successor regulation)), make a monthly capitation  
3 payment to such organization or plan for enrollees with  
4 the organization or plan who are over 21 years of age and  
5 under 65 years of age and are receiving inpatient treat-  
6 ment in an institution for mental diseases (as defined in  
7 section 1905(i)), so long as each of the following condi-  
8 tions is met:

9           “(I) The institution is a hospital providing  
10           inpatient psychiatric or substance use disorder  
11           services or a sub-acute facility providing psy-  
12           chiatric or substance use disorder crisis residen-  
13           tial services.

14           “(II) The length of stay in such an institu-  
15           tion for such treatment is for a short-term stay  
16           of no more than 15 days during the period of  
17           the monthly capitation payment.

18           “(III) The provision of such treatment  
19           meets the following criteria for consideration as  
20           services or settings that are in lieu of services  
21           or settings covered under the State plan:

22           “(aa) The State determines that the  
23           alternative service or setting is a medically  
24           appropriate and cost-effective substitute

1 for the covered service or setting under the  
2 State plan.

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

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

12 “(ii) For purposes of setting the amount of such a  
13 monthly capitation payment, a State may use the utiliza-  
14 tion of services provided to an individual under this sub-  
15 paragraph when developing the inpatient psychiatric or  
16 substance use disorder component of such payment, but  
17 the amount of such payment for such services may not  
18 exceed the cost of the same services furnished through  
19 providers included under the State plan.”.

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

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

3 (a) STUDY.—The Secretary of Health and Human  
4 Services, acting through the Administrator of the Centers  
5 for Medicare & Medicaid Services, shall conduct a study  
6 on coverage under the Medicaid program under title XIX  
7 of the Social Security Act (42 U.S.C. 1396 et seq.) of serv-  
8 ices provided through a medicaid managed care organiza-  
9 tion (as defined in section 1903(m) of such Act (42 U.S.C.  
10 1396b(m)) or a prepaid inpatient health plan (as defined  
11 in section 438.2 of title 42, Code of Federal Regulations  
12 (or any successor regulation)) with respect to individuals  
13 over the age of 21 and under the age of 65 for the treat-  
14 ment of a mental health disorder in institutions for mental  
15 diseases (as defined in section 1905(i) of such Act (42  
16 U.S.C. 1396d(i))). Such study shall include information  
17 on the following:

18 (1) The extent to which States, including the  
19 District of Columbia and each territory or possession  
20 of the United States, are providing capitated pay-  
21 ments to such organizations or plans for enrollees  
22 who are receiving services in institutions for mental  
23 diseases.

24 (2) The number of individuals receiving medical  
25 assistance under a State plan under such title XIX,  
26 or a waiver of such plan, who receive services in in-

1       stitutions for mental diseases through such organiza-  
2       tions and plans.

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

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

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

18      (b) REPORT.—Not later than three years after the  
19      date of the enactment of this Act, the Secretary shall sub-  
20      mit to Congress a report on the study conducted under  
21      subsection (a).

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

23      Not later than one year after the date of the enact-  
24      ment of this Act, the Administrator of the Centers for  
25      Medicare & Medicaid Services shall issue a State Medicaid

1 Director letter regarding opportunities to design innova-  
2 tive service delivery systems, including systems for pro-  
3 viding community-based services, for individuals with seri-  
4 ous mental illness or serious emotional disturbance who  
5 are receiving medical assistance under title XIX of the So-  
6 cial Security Act (42 U.S.C. 1396 et seq.). The letter shall  
7 include opportunities for demonstration projects under  
8 section 1115 of such Act (42 U.S.C. 1315), to improve  
9 care for such individuals.

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

12 (a) COLLECTION OF INFORMATION.—The Secretary  
13 of Health and Human Services, acting through the Ad-  
14 ministrator of the Centers for Medicare & Medicaid Serv-  
15 ices, shall, with respect to each State that has participated  
16 in the demonstration project established under section  
17 2707 of the Patient Protection and Affordable Care Act  
18 (42 U.S.C. 1396a note), collect from each such State in-  
19 formation on the following:

20 (1) The number of institutions for mental dis-  
21 eases (as defined in section 1905(i) of the Social Se-  
22 curity Act (42 U.S.C. 1396d(i))) and beds in such  
23 institutions that received payment for the provision  
24 of services to individuals who receive medical assist-  
25 ance under a State plan under the Medicaid pro-

1       gram under title XIX of the Social Security Act (42  
2       U.S.C. 1396 et seq.) (or under a waiver of such  
3       plan) through the demonstration project in each  
4       such State as compared to the total number of insti-  
5       tutions for mental diseases and beds in the State.

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

17          (3) The number of forensic psychiatric hos-  
18      pitals, the number of beds in such hospitals, and the  
19      number of forensic psychiatric beds in other hos-  
20      pitals in such State, based on the most recent data  
21      available, to the extent practical, as determined by  
22      such Administrator.

23          (4) The amount of any disproportionate share  
24      hospital payments under section 1923 of the Social  
25      Security Act (42 U.S.C. 1396r-4) that institutions

1 for mental diseases in the State received during the  
2 period beginning on July 1, 2012, and ending on  
3 June 30, 2015, and the extent to which the dem-  
4 onstration project reduced the amount of such pay-  
5 ments.

6 (5) The most recent data regarding all facilities  
7 or sites in the State in which any individuals with  
8 serious mental illness who are receiving medical as-  
9 sistance under a State plan under the Medicaid pro-  
10 gram under title XIX of the Social Security Act (42  
11 U.S.C. 1396 et seq.) (or under a waiver of such  
12 plan) are treated during the period referred to in  
13 paragraph (4), to the extent practical, as determined  
14 by the Administrator—

15 (A) the types of such facilities or sites  
16 (such as an institution for mental diseases, a  
17 hospital emergency department, or other inpa-  
18 tient hospital);

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

22 (C) the payment rate under the State plan  
23 (or a waivers of such plan) for services fur-  
24 nished to such an individual for that treatment,  
25 disaggregated by facility type, during the period



1           in which the demonstration project is in oper-  
2           ation.

3           (6) The extent to which the utilization of hos-  
4           pital emergency departments during the period in  
5           which the demonstration project was is in operation  
6           differed, with respect to individuals who are receiv-  
7           ing medical assistance under a State plan under the  
8           Medicaid program under title XIX of the Social Se-  
9           curity Act (42 U.S.C. 1396 et seq.) (or under a  
10          waiver of such plan), between—

11           (A) those individuals who received treat-  
12          ment in an institution for mental diseases  
13          under the demonstration project;

14           (B) those individuals who met the eligi-  
15          bility requirements for the demonstration  
16          project but who did not receive treatment in an  
17          institution for mental diseases under the dem-  
18          onstration project; and

19           (C) those individuals with serious mental  
20          illness who did not meet such eligibility require-  
21          ments and did not receive treatment for such  
22          illness in an institution for mental diseases.

23          (b) REPORT.—Not later than two years after the date  
24          of the enactment of this Act, the Secretary of Health and  
25          Human Services shall submit to Congress a report that

1 summarizes and analyzes the information collected under  
2 subsection (a). Such report may be submitted as part of  
3 the report required under section 2707(f) of the Patient  
4 Protection and Affordable Care Act (42 U.S.C. 1396a  
5 note) or separately.

6 **SEC. 206. PROVIDING FULL-RANGE OF EPSDT SERVICES TO**  
7 **CHILDREN IN IMDS.**

8 Section 1905(a)(16) of the Social Security Act (42  
9 U.S.C. 1396d(a)(16)) is amended by inserting before the  
10 semicolon at the end the following: “, and, effective Janu-  
11 ary 1, 2019, the full-range of early and periodic screening,  
12 diagnostic, and treatment services (as defined in sub-  
13 section (r)) for such individuals whether or not such  
14 screening, diagnostic, and treatment services are furnished  
15 by the provider of inpatient psychiatric hospital services  
16 for individuals under age 21”.

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

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

24 “(l)(1) Subject to paragraphs (3) and (4), with re-  
25 spect to any amount expended for personal care services

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

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

12                   “(i) for calendar quarters in 2019 and  
13                   2020, by .25 percentage points;

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

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

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

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

21                   “(i) for calendar quarters in 2023 and  
22                   2024, by .25 percentage points;

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

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

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

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

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

12           “(i) is minimally burdensome;

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

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

20          “(B) take into account a stakeholder process  
21          that includes input from beneficiaries, family care-  
22          givers, personal care or home health care services  
23          workers, and other stakeholders, as determined by  
24          the State in accordance with guidance from the Sec-  
25          retary; and

1           “(C) ensure that individuals who furnish per-  
2           sonal care services, home health care services, or  
3           both under the State plan (or under a waiver of the  
4           plan) are provided the opportunity for training on  
5           the use of such system.

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

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

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

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

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

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

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

3           “(5) In this subsection:

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

9                   “(i) the type of service performed;

10                   “(ii) the individual receiving the service;

11                   “(iii) the date of the service;

12                   “(iv) the location of service delivery;

13                   “(v) the individual providing the service;

14                   and

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

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

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

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

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

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

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

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

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

11 (c) RULES OF CONSTRUCTION.—

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

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



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

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

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

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

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

7 (a) ESTABLISHMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

16 (e) MEMBERSHIP.—

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

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

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

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

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

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

7 (F) The Secretary of Veterans Affairs.

8 (G) The Secretary of Defense.

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

11 (I) The Secretary of Education.

12 (J) The Secretary of Labor.

13 (K) The Commissioner of Social Security.

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

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

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

23 (B) at least 1 member shall be a parent or  
24 legal guardian of an individual with a history of

1 a serious mental illness or serious emotional  
2 disturbance;

3 (C) at least 1 member shall be a represent-  
4 ative of a leading research, advocacy, or service  
5 organization for individuals with serious mental  
6 illness or serious emotional disturbance;

7 (D) at least 2 members shall be—

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

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

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

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

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

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

5 (G) at least 1 member shall be a mental  
6 health professional who has research or clinical  
7 mental health experience working with medi-  
8 cally underserved populations;

9 (H) at least 1 member shall be a State cer-  
10 tified mental health peer specialist;

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

14 (J) at least 1 member shall be a law en-  
15 forcement officer or corrections officer with ex-  
16 tensive experience in interfacing with individ-  
17 uals with a serious mental illness or serious  
18 emotional disturbance, or in a mental health  
19 crisis; and

20 (K) at least 1 member shall be a homeless  
21 services provider with experience working with  
22 individuals with serious mental illness, with se-  
23 rious emotional disturbance, or having mental  
24 health crisis.

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

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

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

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

19   **SEC. 401. SENSE OF CONGRESS.**

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

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

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



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

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

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

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

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

8           (6) Persons with SMI—

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

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

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

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

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

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

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

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

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

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

18          (15) All professional and support efforts should  
19          be made to help the individual with SMI and experi-  
20          ence acute or chronic physical illnesses to under-  
21          stand and follow through on treatment.

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

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

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

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

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

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

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

9 (a) IN GENERAL.—Not later than one year after the  
10 date of enactment of this section, the Secretary of Health  
11 and Human Services shall promulgate final regulations  
12 clarifying the circumstances under which, consistent with  
13 the provisions of subpart C of title XI of the Social Secu-  
14 rity Act and regulations promulgated pursuant to section  
15 264(e) of the Health Insurance Portability and Account-  
16 ability Act of 1996, a health care provider or covered enti-  
17 ty may disclose the protected health information of a pa-  
18 tient with a mental illness, including for purposes of—

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

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

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

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

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

12                 (A) the patient consents;

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

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

23                 (D) the patient does not consent, but such  
24                 communication and sharing of information is  
25                 necessary to prevent impending and serious de-

1           terioration of the patient's mental or physical  
2           health;

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

8           (7) listening to or receiving information with re-  
9           spect to the patient from the family or caregiver of  
10          such patient receiving mental illness treatment;

11          (8) communicating with family members of the  
12          patient, caregivers of patient, law enforcement, or  
13          others when the patient presents a serious and im-  
14          minent threat of harm to self or others; and

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

21          (b) COORDINATION.—The Secretary of Health and  
22          Human Services shall carry out this section in coordina-  
23          tion with the Director of the Office for Civil Rights within  
24          the Department of Health and Human Services.



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

7 **SEC. 404. DEVELOPMENT AND DISSEMINATION OF MODEL**  
8 **TRAINING PROGRAMS.**

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

14           (1) a model program and materials for training  
15 health care providers (including physicians, emer-  
16 gency medical personnel, psychologists, counselors,  
17 therapists, behavioral health facilities and clinics,  
18 care managers, and hospitals) regarding the cir-  
19 cumstances under which, consistent with the stand-  
20 ards governing the privacy and security of individ-  
21 ually identifiable health information promulgated by  
22 the Secretary under sections 262(a) and 264 of the  
23 Health Insurance Portability and Accountability Act  
24 of 1996, the protected health information of patients

1 with a mental illness may be disclosed with and  
2 without patient consent;

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

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

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

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

14 (2) disseminate the updated model programs  
15 and materials.

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

21 (d) COORDINATION.—The Secretary shall carry out  
22 this section in coordination with the Director of the Office  
23 for Civil Rights within the Department of Health and  
24 Human Services, the Assistant Secretary for Mental  
25 Health and Substance Use, the Administrator of the

1 Health Resources and Services Administration, and the  
2 heads of other relevant agencies within the Department  
3 of Health and Human Services.

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

9 (f) FUNDING.—There are authorized to be appro-  
10 priated to carry out this section \$4,000,000 for fiscal year  
11 2018, \$2,000,000 for each of fiscal years 2019 and 2020,  
12 and \$1,000,000 for each of fiscal years 2021 and 2022.

13 **TITLE V—INCREASING ACCESS**  
14 **TO TREATMENT FOR SERIOUS**  
15 **MENTAL ILLNESS**

16 **SEC. 501. ASSERTIVE COMMUNITY TREATMENT GRANT**  
17 **PROGRAM FOR INDIVIDUALS WITH SERIOUS**  
18 **MENTAL ILLNESS.**

19 Part B of title V of the Public Health Service Act  
20 (42 U.S.C. 290bb et seq.) is amended by inserting after  
21 section 520L the following:

1 **“SEC. 520M. ASSERTIVE COMMUNITY TREATMENT GRANT**  
2 **PROGRAM FOR INDIVIDUALS WITH SERIOUS**  
3 **MENTAL ILLNESS.**

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

6 “(1) to establish assertive community treatment  
7 programs for individuals with serious mental illness;  
8 or

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

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

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

22 “(d) ADDITIONAL ACTIVITIES.—The Assistant Sec-  
23 retary shall—

24 “(1) not later than the end of fiscal year 2021,  
25 submit a report to the appropriate congressional

1 committees on the grant program under this section,  
2 including an evaluation of—

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

6 “(B) rates of involvement with the criminal  
7 justice system of patients;

8 “(C) rates of homelessness among patients;  
9 and

10 “(D) patient and family satisfaction with  
11 program participation; and

12 “(2) provide appropriate information, training,  
13 and technical assistance to grant recipients under  
14 this section to help such recipients to establish,  
15 maintain, or expand their assertive community treat-  
16 ment programs.

17 “(e) AUTHORIZATION OF APPROPRIATIONS.—

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

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

1 **SEC. 502. STRENGTHENING COMMUNITY CRISIS RESPONSE**  
2 **SYSTEMS.**

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

5 **“SEC. 520F. STRENGTHENING COMMUNITY CRISIS RE-**  
6 **SPONSE SYSTEMS.**

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

9 “(1) to State and local governments and Indian  
10 tribes and tribal organizations to enhance commu-  
11 nity-based crisis response systems; or

12 “(2) to States to develop, maintain, or enhance  
13 a database of beds at inpatient psychiatric facilities,  
14 crisis stabilization units, and residential community  
15 mental health and residential substance use disorder  
16 treatment facilities, for individuals with serious men-  
17 tal illness, serious emotional disturbance, or sub-  
18 stance use disorders.

19 “(b) APPLICATION.—

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

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

4                   “(A) promoting integration and coordina-  
5 tion between local public and private entities  
6 engaged in crisis response, including first re-  
7 sponders, emergency health care providers, pri-  
8 mary care providers, law enforcement, court  
9 systems, health care payers, social service pro-  
10 viders, and behavioral health providers;

11                   “(B) developing a plan for entering into  
12 memoranda of understanding with public and  
13 private entities to implement crisis response  
14 services;

15                   “(C) expanding the continuum of commu-  
16 nity-based services to address crisis intervention  
17 and prevention; and

18                   “(D) developing models for minimizing  
19 hospital readmissions, including through appro-  
20 priate discharge planning.

21           “(3) BEDS DATABASE PLAN.—An application  
22 for a grant under subsection (a)(2) shall include a  
23 plan for developing, maintaining, or enhancing a  
24 real-time Internet-based bed database to collect, ag-  
25 gregate, and display information about beds in inpa-

1       tient psychiatric facilities and crisis stabilization  
2       units, and residential community mental health and  
3       residential substance use disorder treatment facili-  
4       ties to facilitate the identification and designation of  
5       facilities for the temporary treatment of individuals  
6       in mental or substance use disorder crisis.

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

9               “(1) includes information on inpatient psy-  
10       chiatric facilities, crisis stabilization units, and resi-  
11       dential community mental health and residential  
12       substance use disorder facilities in the State in-  
13       volved, including contact information for the facility  
14       or unit;

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

23              “(3) enables searches of the database to iden-  
24       tify available beds that are appropriate for the treat-



1       ment of individuals in mental or substance use dis-  
2       order crisis.

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

8               “(1) local crisis response services and measures  
9               of individuals receiving crisis planning and early  
10              intervention supports;

11             “(2) individuals reporting improved functional  
12             outcomes; and

13             “(3) individuals receiving regular followup care  
14             following a crisis.

15       “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
16       is authorized to be appropriated to carry out this section,  
17       \$5,000,000 for the period of fiscal years 2018 through  
18       2022.”.

19       **SEC. 503. INCREASED AND EXTENDED FUNDING FOR AS-**  
20                               **SISTED OUTPATIENT GRANT PROGRAM FOR**  
21                               **INDIVIDUALS WITH SERIOUS MENTAL ILL-**  
22                               **NESS.**

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

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

3 (2) in paragraph (2), by striking “is authorized  
4 to be appropriated to carry out this section  
5 \$15,000,000 for each of fiscal years 2015 through  
6 2018” and inserting “are authorized to be appro-  
7 priated to carry out this section \$15,000,000 for  
8 each of fiscal years 2015 through 2017,  
9 \$20,000,000 for fiscal year 2018, \$19,000,000 for  
10 each of fiscal years 2019 and 2020, and  
11 \$18,000,000 for each of fiscal years 2021 and  
12 2022”.

13 **SEC. 504. LIABILITY PROTECTIONS FOR HEALTH PROFES-**  
14 **SIONAL VOLUNTEERS AT COMMUNITY**  
15 **HEALTH CENTERS.**

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

19 “(q)(1) For purposes of this section, a health profes-  
20 sional volunteer at an entity described in subsection (g)(4)  
21 shall, in providing a health professional service eligible for  
22 funding under section 330 to an individual, be deemed to  
23 be an employee of the Public Health Service for a calendar  
24 year that begins during a fiscal year for which a transfer

1 was made under paragraph (4)(C). The preceding sen-  
2 tence is subject to the provisions of this subsection.

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

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

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

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

24 “(D) Before the service is provided, the health  
25 care practitioner or the entity described in sub-

1 section (g)(4) posts a clear and conspicuous notice  
2 at the site where the service is provided of the extent  
3 to which the legal liability of the health care practi-  
4 tioner is limited pursuant to this subsection.

5 “(E) At the time the service is provided, the  
6 health care practitioner is licensed or certified in ac-  
7 cordance with applicable law regarding the provision  
8 of the service.

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

16 “(A) The first sentence of paragraph (1) ap-  
17 plies in lieu of the first sentence of subsection  
18 (g)(1)(A).

19 “(B) With respect to an entity described in sub-  
20 section (g)(4), a health care practitioner is not a  
21 health professional volunteer at such entity unless  
22 the entity sponsors the health care practitioner. For  
23 purposes of this subsection, the entity shall be con-  
24 sidered to be sponsoring the health care practitioner  
25 if—

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

5           “(ii) the Secretary, pursuant to subsection  
6           (g)(1)(E), determines that the health care prac-  
7           titioner is deemed to be an employee of the  
8           Public Health Service.

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

20          “(D) Subsection (g)(1)(F) applies to a health  
21          care practitioner for purposes of this subsection only  
22          to the extent that, in providing health services to an  
23          individual, each of the conditions specified in para-  
24          graph (2) is met.

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

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

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

1 “(5)(A) This subsection takes effect on October 1,  
2 2017, except as provided in subparagraph (B).

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

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

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

11 **TITLE VI—SUPPORTING INNOVA-**  
12 **TIVE AND EVIDENCE-BASED**  
13 **PROGRAMS**

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

18 **SEC. 601. ENCOURAGING INNOVATION AND EVIDENCE-**  
19 **BASED PROGRAMS.**

20 Section 501B of the Public Health Service Act, as  
21 inserted by section 103, is amended—

22 (1) by redesignating subsection (d) as sub-  
23 section (e); and

24 (2) by inserting after subsection (e) the fol-  
25 lowing new subsection:

1 “(d) PROMOTING INNOVATION.—

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

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

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

20 “(ii) integrating or coordinating phys-  
21 ical health services and mental and sub-  
22 stance use disorder services; and

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



1 intervention, and treatment with respect to  
2 mental illness, serious mental illness, and seri-  
3 ous emotional disturbance, primarily by—

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

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

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

16 “(3) AUTHORIZATION OF APPROPRIATIONS.—  
17 There is authorized to be appropriated—

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

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

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

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

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

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

19 “(b) NOTICE.—

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

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

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

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

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

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

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

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

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

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

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

14 (1) by redesignating paragraphs (1) through

15 (3) as paragraphs (2) through (4), respectively; and

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

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

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

1           “(b) CRITERIA FOR PLAN.—In accordance with sub-  
2 section (a), a State shall submit to the Secretary a plan  
3 that, at a minimum, satisfies the following criteria:

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

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

9           “(i) identify the single State agency to  
10 be responsible for the administration of the  
11 program under the grant, including any  
12 third party who administers mental health  
13 services and is responsible for complying  
14 with the requirements of this part with re-  
15 spect to the grant;

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

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

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

20 “(iv) include a description of how the  
21 State promotes evidence-based practices,  
22 including those evidence-based programs  
23 that address the needs of individuals with  
24 early serious mental illness regardless of  
25 the age of the individual at onset or pro-

1           viding comprehensive individualized treat-  
2           ment, or integrating mental and physical  
3           health services;

4           “ (v) include a description of case  
5           management services;

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

14          “ (vii) as appropriate to and reflective  
15          of the uses the State proposes for the block  
16          grant monies—

17                 “ (I) a description of the activities  
18                 intended to reduce hospitalizations  
19                 and hospital stays using the block  
20                 grant monies;

21                 “ (II) a description of the activi-  
22                 ties intended to reduce incidents of  
23                 suicide using the block grant monies;  
24                 and

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

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

13                  “(C) CHILDREN’S SERVICES.—In the case  
14                  of children with serious emotional disturbance  
15                  (as defined in subsection (c)), the plan shall  
16                  provide for a system of integrated social serv-  
17                  ices, educational services, child welfare services,  
18                  juvenile justice services, law enforcement serv-  
19                  ices, and substance use disorder services that,  
20                  together with health and mental health services,  
21                  will be provided in order for such children to re-  
22                  ceive care appropriate for their multiple needs  
23                  (such system to include services provided under  
24                  the Individuals with Disabilities Education  
25                  Act).



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

7           “(E) MANAGEMENT SERVICES.—The plan  
8 shall—

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

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

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

21           “(iv) describe the manner in which  
22 the State intends to comply with each of  
23 the funding agreements in this subpart  
24 and subpart III.

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

6           (c) BEST PRACTICES IN CLINICAL CARE MODELS.—  
7           Section 1920 of the Public Health Service Act (42 U.S.C.  
8           300x–9) is amended by adding at the end the following:  
9           “(c) BEST PRACTICES IN CLINICAL CARE MOD-  
10          ELS.—A State shall expend not less than 10 percent of  
11          the amount the State receives for carrying out this sub-  
12          part in each fiscal year to support evidence-based pro-  
13          grams that address the needs of individuals with early se-  
14          rious mental illness, including psychotic disorders, regard-  
15          less of the age of the individual at onset.”.

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

19                 (1) by amending paragraph (1) to read as fol-  
20                 lows:

21                 “(1) IN GENERAL.—A funding agreement for a  
22                 grant under section 1911 is that the State involved  
23                 will maintain State expenditures for community  
24                 mental health services at a level that is not less than  
25                 the average of the amounts prescribed by this para-

1 graph (prior to any waiver under paragraph (3)) for  
2 such expenditures by such State for each of the two  
3 fiscal years immediately preceding the fiscal year for  
4 which the State is applying for the grant.”;

5 (2) in paragraph (2)—

6 (A) by striking “subsection (a)” and in-  
7 serting “paragraph (1)”; and

8 (B) by striking “principle” and inserting  
9 “principal”;

10 (3) by amending paragraph (3) to read as fol-  
11 lows:

12 “(3) WAIVER.—

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

20 “(B) DATE CERTAIN FOR ACTION UPON  
21 REQUEST.—The Secretary shall approve or  
22 deny a request for a waiver under this para-  
23 graph not later than 120 days after the date on  
24 which the request is made.

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

5           (4) in paragraph (4)—

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

8           “(A) IN GENERAL.—

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

24           “(ii) ALTERNATIVE SANCTION.—The  
25 Secretary may by regulation provide for an

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

9 (B) in subparagraph (B)—

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

14 (ii) by striking “subparagraph (A)”  
15 and inserting “subparagraph (A)(i)”.

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

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

21 (2) in paragraph (5), by striking  
22 “1915(b)(3)(B)” and inserting “1915(b)”.

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

4 **SEC. 621. TELEHEALTH CHILD PSYCHIATRY ACCESS**  
5 **GRANTS.**

6 Title III of the Public Health Service Act is amended  
7 by inserting after section 330L of such Act (42 U.S.C.  
8 254c–18) the following new section:

9 **“SEC. 330M. TELEHEALTH CHILD PSYCHIATRY ACCESS**  
10 **GRANTS.**

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

21 “(1) supporting the development of statewide  
22 child psychiatry access programs; and

23 “(2) supporting the improvement of existing  
24 statewide child psychiatry access programs.

25 “(b) PROGRAM REQUIREMENTS.—

1           “(1) IN GENERAL.—A child psychiatry access  
2           program referred to in subsection (a), with respect  
3           to which a grant under such subsection may be used,  
4           shall—

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

9                   “(B) support and further develop orga-  
10                  nized State networks of child and adolescent  
11                  psychiatrists to provide consultative support to  
12                  pediatric primary care sites;

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

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

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

1           “(F) conduct training and provide tech-  
2           nical assistance to pediatric primary care pro-  
3           viders to support the early identification, diag-  
4           nosis, treatment, and referral of children with  
5           behavioral health conditions or co-occurring in-  
6           tellectual and other developmental disabilities;

7           “(G) inform and assist pediatric providers  
8           in accessing child psychiatry consultations and  
9           in scheduling and conducting technical assist-  
10          ance;

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

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

21          “(2) PEDIATRIC MENTAL HEALTH TEAMS.—In  
22          this subsection, the term ‘pediatric mental health  
23          team’ means a team of case coordinators, child and  
24          adolescent psychiatrists, and licensed clinical mental



1 health professionals, such as a psychologist, social  
2 worker, or mental health counselor.

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

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

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

1 an amount that is not less than 20 percent of Federal  
2 funds provided in the grant.

3 “(f) AUTHORIZATION OF APPROPRIATIONS.—To  
4 carry this section, there are authorized to be appropriated  
5 \$9,000,000 for the period of fiscal years 2018 through  
6 2020.”.

7 **SEC. 622. INFANT AND EARLY CHILDHOOD MENTAL**  
8 **HEALTH PROMOTION, INTERVENTION, AND**  
9 **TREATMENT.**

10 Part Q of title III of the Public Health Service Act  
11 (42 U.S.C. 290h et seq.) is amended by adding at the end  
12 the following:

13 **“SEC. 399Z–2. INFANT AND EARLY CHILDHOOD MENTAL**  
14 **HEALTH PROMOTION, INTERVENTION, AND**  
15 **TREATMENT.**

16 “(a) GRANTS.—The Secretary shall—

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

22 “(A) programs for infants and children at  
23 significant risk of developing, showing early  
24 signs of, or having been diagnosed with mental

1 disorders including serious emotional disturb-  
2 ance; and

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

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

12 “(b) ELIGIBLE CHILDREN AND ENTITIES.—In this  
13 section:

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

17 “(A) is at risk for, shows early signs of de-  
18 veloping, or has been diagnosed with a mental  
19 disorder, including serious emotional disturb-  
20 ance; and

21 “(B) may benefit from infant and early  
22 childhood intervention or treatment programs  
23 or specialized preschool or elementary school  
24 programs that are evidence-based or that have  
25 been scientifically demonstrated to show prom-

1           ise but would benefit from further applied de-  
2           velopment.

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

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

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

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

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

1           “(1) Provide age-appropriate mental health pro-  
2           motion and early intervention services or mental dis-  
3           order treatment services, which may include special-  
4           ized programs, for eligible children at significant  
5           risk of developing, showing early signs of, or having  
6           been diagnosed with a mental disorder, including se-  
7           rious emotional disturbance. Such services may in-  
8           clude social and behavioral services as well as  
9           multigenerational therapy and other services that  
10          support the caregiving relationship.

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

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

1           “(4) Provide training for mental health clini-  
2           cians in infant and early childhood promising and  
3           evidence-based practices and models for mental  
4           health treatment and early intervention, including  
5           with regard to practices for identifying and treating  
6           mental and behavioral disorders of infants and chil-  
7           dren resulting from exposure or repeated exposure to  
8           adverse childhood experiences or childhood trauma.

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

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

21          “(f) AUTHORIZATION OF APPROPRIATIONS.—To  
22          carry this section, there are authorized to be appropriated  
23          \$20,000,000 for the period of fiscal years 2018 through  
24          2022.”.

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

3 Section 582 of the Public Health Service Act (42  
4 U.S.C. 290hh-1) is amended—

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

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

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

20 (2) in subsection (b)—

21 (A) by striking “subsection (a) related”  
22 and inserting “subsection (a)(2) (related”;

23 (B) by striking “treating disorders associ-  
24 ated with psychological trauma” and inserting  
25 “treating mental, behavioral, and biological dis-

1 orders associated with psychological trauma)”;  
2 and

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

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

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

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

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

24 “(e) DISSEMINATION.—The NCTSI coordinating  
25 center shall, as appropriate, collaborate with the Secretary



1 in the dissemination of evidence-based and trauma-in-  
2 formed interventions, treatments, products, and other re-  
3 sources to appropriate stakeholders.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 (D) in paragraph (1)—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 (2) in subsection (b)(2)—

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

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

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

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

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

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

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

8 (2) in subsection (a)—

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

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

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

16 (3) in subsection (b)—

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

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

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

25 “(2) The operation of hotlines.

26 “(3) Preparing informational material.

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

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

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

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

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

15          (5) in subsection (d)—

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

21                 (B) in paragraph (1)—

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

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

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

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

14 (7) in subsection (f)(2)—

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

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

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



1           **Subtitle B—Other Provisions**

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

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

8   **“SEC. 520E–4. NATIONAL SUICIDE PREVENTION LIFELINE**  
9                   **PROGRAM.**

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

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

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

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

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

5           “(c) AUTHORIZATION OF APPROPRIATIONS.—To  
6       carry out this section, there are authorized to be appro-  
7       priated \$7,198,000 for each of fiscal years 2017 through  
8       2021.”.

9       **SEC. 712. WORKFORCE DEVELOPMENT STUDIES AND RE-**  
10                                   **PORTS.**

11           (1) IN GENERAL.—Not later than 2 years after  
12       the date of enactment of this Act, the Assistant Sec-  
13       retary for Mental Health and Substance Use, in con-  
14       sultation with the Administrator of the Health Re-  
15       sources and Services Administration, shall conduct a  
16       study and publicly post on the appropriate Internet  
17       website of the Department of Health and Human  
18       Services a report on the mental health and sub-  
19       stance use disorder workforce in order to inform  
20       Federal, State, and local efforts related to workforce  
21       enhancement.

22           (2) CONTENTS.—The report under this section  
23       shall contain—

24                           (A) national and State-level projections of  
25       the supply and demand of mental health and

1 substance use disorder health workers, includ-  
2 ing the number of individuals practicing in  
3 fields deemed relevant by the Secretary;

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

10 (C) information on trends within the men-  
11 tal health and substance use disorder provider  
12 workforce, including the number of individuals  
13 entering the mental health workforce over the  
14 next five years;

15 (D) information on the gaps in workforce  
16 development for mental health providers and  
17 professionals, including those who serve pedi-  
18 atric, adult, and geriatric patients; and

19 (E) any additional information determined  
20 by the Assistant Secretary for Mental Health  
21 and Substance Use, in consultation with the  
22 Administrator of the Health Resources and  
23 Services Administration, to be relevant to the  
24 mental health and substance use disorder pro-  
25 vider workforce.

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

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

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

6 **“SEC. 597. FELLOWSHIPS.**

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

11 “(1) increasing behavioral health practitioners’  
12 knowledge of issues related to prevention, treatment,  
13 and recovery support for mental and substance use  
14 disorders among racial and ethnic minority popu-  
15 lations;

16 “(2) improving the quality of mental and sub-  
17 stance use disorder prevention and treatment deliv-  
18 ered to racial and ethnic minorities; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (a) DEFINITIONS.—

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

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

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



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

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

4 (a) GRANTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (d) AUTHORIZATION OF APPROPRIATIONS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 “(A) IN GENERAL.—Not later than 6  
19 months after the date of enactment of the  
20 Helping Families in Mental Health Crisis Act  
21 of 2016, the Inspector General of the Depart-  
22 ment of Health and Human Services, in coordi-  
23 nation with the Secretary, the Secretary of  
24 Labor, or the Secretary of the Treasury, shall  
25 issue a compliance program guidance document  
26 to help improve compliance with this section.

1                   “(B) EXAMPLES ILLUSTRATING COMPLI-  
2 ANCE AND NONCOMPLIANCE.—

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

16                   “(I) examples illustrating re-  
17 quirements for information disclosures  
18 and nonquantitative treatment limita-  
19 tions; and

20                   “(II) descriptions of the viola-  
21 tions uncovered during the course of  
22 such investigations.

23                   “(ii) NONQUANTITATIVE TREATMENT  
24 LIMITATIONS.—To the extent that any ex-  
25 ample described in clause (i) involves a



1 finding of compliance or noncompliance  
2 with regard to any requirement for non-  
3 quantitative treatment limitations, the ex-  
4 ample shall provide sufficient detail to fully  
5 explain such finding, including a full de-  
6 scription of the criteria involved for med-  
7 ical and surgical benefits and the criteria  
8 involved for mental health and substance  
9 use disorder benefits.

10 “(iii) ACCESS TO ADDITIONAL INFOR-  
11 MATION REGARDING COMPLIANCE.—In de-  
12 veloping and issuing the compliance pro-  
13 gram guidance document required under  
14 this paragraph, the Inspector General of  
15 the Department of Health and Human  
16 Services may—

17 “(I) enter into interagency agree-  
18 ments with the Inspector General of  
19 the Department of Labor and the In-  
20 spector General of the Department of  
21 the Treasury to share findings of  
22 compliance and noncompliance with  
23 this section, section 712 of the Em-  
24 ployee Retirement Income Security

1 Act of 1974, or section 9812 of the  
2 Internal Revenue Code of 1986; and

3 “(II) enter into an agreement  
4 with a State to share information on  
5 findings of compliance and noncompli-  
6 ance with this section, section 712 of  
7 the Employee Retirement Income Se-  
8 curity Act of 1974, or section 9812 of  
9 the Internal Revenue Code of 1986.

10 “(C) RECOMMENDATIONS.—The compli-  
11 ance program guidance document shall include  
12 recommendations to avoid violations of this sec-  
13 tion and encourage the development and use of  
14 internal controls to monitor adherence to appli-  
15 cable statutes, regulations, and program re-  
16 quirements. Such internal controls may include  
17 a compliance checklist with illustrative examples  
18 of nonquantitative treatment limitations on  
19 mental health and substance use disorder bene-  
20 fits, which may fail to comply with this section  
21 in relation to nonquantitative treatment limita-  
22 tions on medical and surgical benefits.

23 “(D) UPDATING THE COMPLIANCE PRO-  
24 GRAM GUIDANCE DOCUMENT.—The compliance  
25 program guidance document shall be updated

1 every 2 years to include illustrative, de-identi-  
2 fied examples (that do not disclose any pro-  
3 tected health information or individually identi-  
4 fiable information) of previous findings of com-  
5 pliance and noncompliance with this section,  
6 section 712 of the Employee Retirement Income  
7 Security Act of 1974, or section 9812 of the In-  
8 ternal Revenue Code of 1986.”.

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

12 “(7) ADDITIONAL GUIDANCE.—

13 “(A) IN GENERAL.—Not later than 6  
14 months after the date of enactment of the  
15 Helping Families in Mental Health Crisis Act  
16 of 2016, the Secretary, in coordination with the  
17 Secretary of Labor and the Secretary of the  
18 Treasury, shall issue guidance to group health  
19 plans and health insurance issuers offering  
20 group or individual health insurance coverage to  
21 assist such plans and issuers in satisfying the  
22 requirements of this section.

23 “(B) DISCLOSURE.—

24 “(i) GUIDANCE FOR PLANS AND  
25 ISSUERS.—The guidance issued under this

1 paragraph shall include clarifying informa-  
2 tion and illustrative examples of methods  
3 that group health plans and health insur-  
4 ance issuers offering group or individual  
5 health insurance coverage may use for dis-  
6 closing information to ensure compliance  
7 with the requirements under this section  
8 (and any regulations promulgated pursu-  
9 ant to this section).

10 “(ii) DOCUMENTS FOR PARTICIPANTS,  
11 BENEFICIARIES, CONTRACTING PROVIDERS,  
12 OR AUTHORIZED REPRESENTATIVES.—The  
13 guidance issued under this paragraph may  
14 include clarifying information and illus-  
15 trative examples of methods that group  
16 health plans and health insurance issuers  
17 offering group or individual health insur-  
18 ance coverage may use to provide any par-  
19 ticipant, beneficiary, contracting provider,  
20 or authorized representative, as applicable,  
21 with documents containing information  
22 that the health plans or issuers are re-  
23 quired to disclose to participants, bene-  
24 ficiaries, contracting providers, or author-  
25 ized representatives to ensure compliance

1 with this section, any regulation issued  
2 pursuant to this section, or any other ap-  
3 plicable law or regulation, including infor-  
4 mation that is comparative in nature with  
5 respect to—

6 “(I) nonquantitative treatment  
7 limitations for both medical and sur-  
8 gical benefits and mental health and  
9 substance use disorder benefits;

10 “(II) the processes, strategies,  
11 evidentiary standards, and other fac-  
12 tors used to apply the limitations de-  
13 scribed in subclause (I); and

14 “(III) the application of the limi-  
15 tations described in subclause (I) to  
16 ensure that such limitations are ap-  
17 plied in parity with respect to both  
18 medical and surgical benefits and  
19 mental health and substance use dis-  
20 order benefits.

21 “(C) NONQUANTITATIVE TREATMENT LIM-  
22 ITATIONS.—The guidance issued under this  
23 paragraph shall include clarifying information  
24 and illustrative examples of methods, processes,  
25 strategies, evidentiary standards, and other fac-

1           tors that group health plans and health insur-  
2           ance issuers offering group or individual health  
3           insurance coverage may use regarding the de-  
4           velopment and application of nonquantitative  
5           treatment limitations to ensure compliance with  
6           this section (and any regulations promulgated  
7           pursuant to this section), including—

8                   “(i) examples of methods of deter-  
9                   mining appropriate types of nonquantita-  
10                  tive treatment limitations with respect to  
11                  both medical and surgical benefits and  
12                  mental health and substance use disorder  
13                  benefits, including nonquantitative treat-  
14                  ment limitations pertaining to—

15                           “(I) medical management stand-  
16                           ards based on medical necessity or ap-  
17                           propriateness, or whether a treatment  
18                           is experimental or investigative;

19                                   “(II) limitations with respect to  
20                                   prescription drug formulary design;  
21                                   and

22                                           “(III) use of fail-first or step  
23                                           therapy protocols;

24                                                   “(ii) examples of methods of deter-  
25                                                   mining—

1                   “(I) network admission standards  
2                   (such as credentialing); and

3                   “(II) factors used in provider re-  
4                   imbursement methodologies (such as  
5                   service type, geographic market, de-  
6                   mand for services, and provider sup-  
7                   ply, practice size, training, experience,  
8                   and licensure) as such factors apply to  
9                   network adequacy;

10                  “(iii) examples of sources of informa-  
11                  tion that may serve as evidentiary stand-  
12                  ards for the purposes of making deter-  
13                  minations regarding the development and  
14                  application of nonquantitative treatment  
15                  limitations;

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

21                  “(v) examples of how specific evi-  
22                  dentiary standards may be used to deter-  
23                  mine whether treatments are considered  
24                  experimental or investigative;

1           “(vi) examples of how specific evi-  
2           dentiary standards may be applied to each  
3           service category or classification of bene-  
4           fits;

5           “(vii) examples of methods of reach-  
6           ing appropriate coverage determinations  
7           for new mental health or substance use  
8           disorder treatments, such as evidence-  
9           based early intervention programs for indi-  
10          viduals with a serious mental illness and  
11          types of medical management techniques;

12          “(viii) examples of methods of reach-  
13          ing appropriate coverage determinations  
14          for which there is an indirect relationship  
15          between the covered mental health or sub-  
16          stance use disorder benefit and a tradi-  
17          tional covered medical and surgical benefit,  
18          such as residential treatment or hos-  
19          pitalizations involving voluntary or involun-  
20          tary commitment; and

21          “(ix) additional illustrative examples  
22          of methods, processes, strategies, evi-  
23          dentiary standards, and other factors for  
24          which the Secretary determines that addi-



1            tional guidance is necessary to improve  
2            compliance with this section.

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

9            (c) IMPROVING COMPLIANCE.—

10            (1) IN GENERAL.—In the case that the Sec-  
11            retary of Health and Human Services, the Secretary  
12            of Labor, or the Secretary of the Treasury deter-  
13            mines that a group health plan or health insurance  
14            issuer offering group or individual health insurance  
15            coverage has violated, at least 5 times, section 2726  
16            of the Public Health Service Act (42 U.S.C. 300gg–  
17            26), section 712 of the Employee Retirement Income  
18            Security Act of 1974 (29 U.S.C. 1185a), or section  
19            9812 of the Internal Revenue Code, the appropriate  
20            Secretary shall audit plan documents for such health  
21            plan or issuer in the plan year following the Sec-  
22            retary’s determination in order to help improve com-  
23            pliance with such section.

24            (2) RULE OF CONSTRUCTION.—Nothing in this  
25            subsection shall be construed to limit the authority,

1 as in effect on the day before the date of enactment  
2 of this Act, of the Secretary of Health and Human  
3 Services, the Secretary of Labor, or the Secretary of  
4 the Treasury to audit documents of health plans or  
5 health insurance issuers.

6 **SEC. 802. ACTION PLAN FOR ENHANCED ENFORCEMENT OF**  
7 **MENTAL HEALTH AND SUBSTANCE USE DIS-**  
8 **ORDER COVERAGE.**

9 (a) PUBLIC MEETING.—

10 (1) IN GENERAL.—Not later than 6 months  
11 after the date of enactment of this Act, the Sec-  
12 retary of Health and Human Services shall convene  
13 a public meeting of stakeholders described in para-  
14 graph (2) to produce an action plan for improved  
15 Federal and State coordination related to the en-  
16 forcement of mental health parity and addiction eq-  
17 uity requirements.

18 (2) STAKEHOLDERS.—The stakeholders de-  
19 scribed in this paragraph shall include each of the  
20 following:

21 (A) The Federal Government, including  
22 representatives from—

23 (i) the Department of Health and  
24 Human Services;

25 (ii) the Department of the Treasury;

1 (iii) the Department of Labor; and

2 (iv) the Department of Justice.

3 (B) State governments, including—

4 (i) State health insurance commis-  
5 sioners;

6 (ii) appropriate State agencies, includ-  
7 ing agencies on public health or mental  
8 health; and

9 (iii) State attorneys general or other  
10 representatives of State entities involved in  
11 the enforcement of mental health parity  
12 laws.

13 (C) Representatives from key stakeholder  
14 groups, including—

15 (i) the National Association of Insur-  
16 ance Commissioners;

17 (ii) health insurance providers;

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

20 (iv) employers; and

21 (v) patients or their advocates.

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

1 on the Internet website of the Department of Health and  
2 Human Services.

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

5 (1) reflect the input of the stakeholders invited  
6 to the public meeting under subsection (a);

7 (2) identify specific strategic objectives regard-  
8 ing how the various Federal and State agencies  
9 charged with enforcement of mental health parity  
10 and addiction equity requirements will collaborate to  
11 improve enforcement of such requirements;

12 (3) provide a timeline for implementing the ac-  
13 tion plan; and

14 (4) provide specific examples of how such objec-  
15 tives may be met, which may include—

16 (A) providing common educational infor-  
17 mation and documents to patients about their  
18 rights under Federal or State mental health  
19 parity and addiction equity requirements;

20 (B) facilitating the centralized collection  
21 of, monitoring of, and response to patient com-  
22 plaints or inquiries relating to Federal or State  
23 mental health parity and addiction equity re-  
24 quirements, which may be through the develop-  
25 ment and administration of a single, toll-free

1 telephone number and an Internet website por-  
2 tal;

3 (C) Federal and State law enforcement  
4 agencies entering into memoranda of under-  
5 standing to better coordinate enforcement re-  
6 sponsibilities and information sharing, including  
7 whether such agencies should make the results  
8 of enforcement actions related to mental health  
9 parity and addiction equity requirements pub-  
10 licly available; and

11 (D) recommendations to the Secretary and  
12 Congress regarding the need for additional legal  
13 authority to improve enforcement of mental  
14 health parity and addiction equity requirements,  
15 including the need for additional legal authority  
16 to ensure that nonquantitative treatment limita-  
17 tions are applied, and the extent and frequency  
18 of the applications of such limitations, both to  
19 medical and surgical benefits and to mental  
20 health and substance use disorder benefits in a  
21 comparable manner.

1 **SEC. 803. REPORT ON INVESTIGATIONS REGARDING PAR-**  
2 **ITY IN MENTAL HEALTH AND SUBSTANCE**  
3 **USE DISORDER BENEFITS.**

4 (a) IN GENERAL.—Not later than 1 year after the  
5 date of enactment of this Act, and annually thereafter for  
6 the subsequent 5 years, the Administrator of the Centers  
7 for Medicare & Medicaid Services, in collaboration with  
8 the Assistant Secretary of Labor of the Employee Benefits  
9 Security Administration and the Secretary of the Treas-  
10 ury, shall submit to the Committee on Energy and Com-  
11 merce of the House of Representatives and the Committee  
12 on Health, Education, Labor, and Pensions of the Senate  
13 a report summarizing the results of all closed Federal in-  
14 vestigations completed during the preceding 12-month pe-  
15 riod with findings of any serious violation regarding com-  
16 pliance with mental health and substance use disorder cov-  
17 erage requirements under section 2726 of the Public  
18 Health Service Act (42 U.S.C. 300gg–26), section 712 of  
19 the Employee Retirement Income Security Act of 1974  
20 (29 U.S.C. 1185a), and section 9812 of the Internal Rev-  
21 enue Code of 1986.

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



1 Services, the Secretary of Labor, and the Secretary of the  
2 Treasury, shall submit to the Committee on Energy and  
3 Commerce of the House of Representatives and the Com-  
4 mittee on Health, Education, Labor, and Pensions of the  
5 Senate a report detailing the extent to which group health  
6 plans or health insurance issuers offering group or indi-  
7 vidual health insurance coverage that provides both med-  
8 ical and surgical benefits and mental health or substance  
9 use disorder benefits, medicaid managed care organiza-  
10 tions with a contract under section 1903(m) of the Social  
11 Security Act (42 U.S.C. 1396b(m)), and health plans pro-  
12 vided under the State Children’s Health Insurance Pro-  
13 gram under title XXI of the Social Security Act (42  
14 U.S.C. 1397aa et seq.) comply with section 2726 of the  
15 Public Health Service Act (42 U.S.C. 300gg–26), section  
16 712 of the Employee Retirement Income Security Act of  
17 1974 (29 U.S.C. 1185a), and section 9812 of the Internal  
18 Revenue Code of 1986, including—

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

22           (2) how the responsible Federal departments  
23           and agencies ensure that such plans or issuers com-  
24           ply with such sections, including an assessment of  
25           how the Secretary of Health and Human Services



1 has used its authority to conduct audits of such  
2 plans to ensure compliance;

3 (3) a review of how the various Federal and  
4 State agencies responsible for enforcing mental  
5 health parity requirements have improved enforce-  
6 ment of such requirements in accordance with the  
7 objectives and timeline described in the action plan  
8 under section 605; and

9 (4) recommendations for how additional en-  
10 forcement, education, and coordination activities by  
11 responsible Federal and State departments and  
12 agencies could better ensure compliance with such  
13 sections, including recommendations regarding the  
14 need for additional legal authority.

15 **SEC. 805. INFORMATION AND AWARENESS ON EATING DIS-**  
16 **ORDERS.**

17 (a) INFORMATION.—The Secretary of Health and  
18 Human Services (in this section referred to as the “Sec-  
19 retary”) may—

20 (1) update information, related fact sheets, and  
21 resource lists related to eating disorders that are  
22 available on the public Internet website of the Na-  
23 tional Women’s Health Information Center spon-  
24 sored by the Office on Women’s Health, to include—

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

3 (B) information about eating disorders, in-  
4 cluding information related to males and fe-  
5 males;

6 (2) incorporate, as appropriate, and in coordi-  
7 nation with the Secretary of Education, information  
8 from publicly available resources into appropriate  
9 obesity prevention programs developed by the Office  
10 on Women's Health; and

11 (3) make publicly available (through a public  
12 Internet website or other method) information, re-  
13 lated fact sheets and resource lists, as updated  
14 under paragraph (1), and the information incor-  
15 porated into appropriate obesity prevention pro-  
16 grams, as updated under paragraph (2).

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

19 (1) the types of eating disorders;

20 (2) the seriousness of eating disorders, includ-  
21 ing prevalence, comorbidities, and physical and men-  
22 tal health consequences;

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

- 1 (4) discrimination and bullying based on body
- 2 size;
- 3 (5) the effects of media on self-esteem and body
- 4 image; and
- 5 (6) the signs and symptoms of eating disorders.

6 **SEC. 806. EDUCATION AND TRAINING ON EATING DIS-**  
7 **ORDERS.**

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

- 12 (1) identify individuals with eating disorders;
- 13 (2) provide early intervention services for indi-
- 14 viduals with eating disorders;
- 15 (3) refer patients with eating disorders for ap-
- 16 propriate treatment;
- 17 (4) prevent the development of eating disorders;
- 18 or
- 19 (5) provide appropriate treatment services for
- 20 individuals with eating disorders.

1 **SEC. 807. GAO STUDY ON PREVENTING DISCRIMINATORY**  
2 **COVERAGE LIMITATIONS FOR INDIVIDUALS**  
3 **WITH SERIOUS MENTAL ILLNESS AND SUB-**  
4 **STANCE USE DISORDERS.**

5 Not later than 2 years after the date of the enact-  
6 ment of this Act, the Comptroller General of the United  
7 States shall submit to Congress and make publicly avail-  
8 able a report detailing Federal oversight of group health  
9 plans and health insurance coverage offered in connection  
10 with such plans (as such terms are defined in section 2791  
11 of the Public Health Service Act (42 U.S.C. 300gg–91),  
12 including Medicaid managed care plans under section  
13 1903 of the Social Security Act (42 U.S.C. 1396b), to en-  
14 sure compliance of such plans and coverage with sections  
15 2726 of the Public Health Service Act (42 U.S.C. 300gg–  
16 26), 712 of the Employee Retirement Income Security Act  
17 of 1974 (29 U.S.C. 1185a), and 9812 of the Internal Rev-  
18 enue Code of 1986 (in this section collectively referred to  
19 as the “parity law”), including—

20 (1) a description of how Federal regulations  
21 and guidance consider nonquantitative treatment  
22 limitations, including medical necessity criteria and  
23 application of such criteria to medical, surgical, and  
24 primary care, of such plans and coverage in ensuring  
25 compliance by such plans and coverage with the par-  
26 ity law;

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

4           (3) the identification of enforcement, education,  
5           and coordination activities within Federal depart-  
6           ments and agencies, including educational activities  
7           directed to State insurance commissioners, and a de-  
8           scription of how such proper activities can be used  
9           to ensure full compliance with the parity law.

10 **SEC. 808. CLARIFICATION OF EXISTING PARITY RULES.**

11         If a group health plan or a health insurance issuer  
12         offering group or individual health insurance coverage pro-  
13         vides coverage for eating disorder benefits, including resi-  
14         dential treatment, such group health plan or health insur-  
15         ance issuer shall provide such benefits consistent with the  
16         requirements of section 2726 of the Public Health Service  
17         Act (42 U.S.C. 300gg-26), section 712 of the Employee  
18         Retirement Income Security Act of 1974 (29 U.S.C.  
19         1185a), and section 9812 of the Internal Revenue Code  
20         of 1986.

