

114TH CONGRESS
1ST SESSION

S. 1945

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

IN THE SENATE OF THE UNITED STATES

AUGUST 5, 2015

Mr. CASSIDY (for himself, Mr. MURPHY, and Ms. COLLINS) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

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

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Mental Health Reform Act of 2015”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Definitions.

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

- Sec. 101. Assistant Secretary for mental health and substance use disorders.
- Sec. 102. Reports.
- Sec. 103. Advisory Council on graduate medical education.

TITLE II—GRANTS

- Sec. 201. National Mental Health Policy Laboratory.
- Sec. 202. Innovation grants.
- Sec. 203. Demonstration grants.
- Sec. 204. Early childhood intervention and treatment.
- Sec. 205. Extension of assisted outpatient treatment grant program for individuals with serious mental illness.
- Sec. 206. Block grants.
- Sec. 207. Telehealth child psychiatry access grants.
- Sec. 208. Liability protections for health care professional volunteers at community health centers and community mental health centers.
- Sec. 209. Minority fellowship program.
- Sec. 210. National health service corps.
- Sec. 211. Reauthorization of mental and behavioral health education training grant.
- Sec. 212. National suicide prevention lifeline program.

TITLE III—INTEGRATION

- Sec. 301. Primary and behavioral health care integration grant programs.

TITLE IV—INTERAGENCY SERIOUS MENTAL ILLNESS
COORDINATING COMMITTEE

- Sec. 401. Interagency Serious Mental Illness Coordinating Committee.

TITLE V—HIPAA CLARIFICATION

- Sec. 501. Findings.
- Sec. 502. Modifications to HIPAA.
- Sec. 503. Development and dissemination of model training programs.
- Sec. 504. Confidentiality of records.

TITLE VI—MEDICARE AND MEDICAID REFORMS

- Sec. 601. Enhanced Medicaid coverage relating to certain mental health services.
- Sec. 602. Modifications to Medicare discharge planning requirements.

TITLE VII—RESEARCH BY NATIONAL INSTITUTE OF MENTAL
HEALTH

- Sec. 701. Increase in funding for certain research.

TITLE VIII—SAMHSA REAUTHORIZATION AND REFORMS

Subtitle A—Organization and General Authorities

- Sec. 801. Peer review.
- Sec. 802. Advisory councils.
- Sec. 803. Grants for jail diversion programs reauthorization.

- Sec. 804. Projects for assistance in transition from homelessness.
- Sec. 805. Comprehensive community mental health services for children with serious emotional disturbances.
- Sec. 806. Reauthorization of priority mental health needs of regional and national significance.

TITLE IX—MENTAL HEALTH PARITY

- Sec. 901. GAO study on preventing discriminatory coverage limitations for individuals with serious mental illness and substance use disorders.
- Sec. 902. Report on investigations regarding parity in mental health and substance use disorder benefits.
- Sec. 903. Strengthening parity in mental health and substance use disorder benefits.

1 **SEC. 2. DEFINITIONS.**

2 In this Act:

3 (1) ASSISTANT SECRETARY.—Except as other-
 4 wise specified, the term “Assistant Secretary”
 5 means the Assistant Secretary for Mental Health
 6 and Substance Use Disorders.

7 (2) EVIDENCE-BASED.—The term “evidence-
 8 based” means the conscientious, systematic, explicit,
 9 and judicious appraisal and use of external, current,
 10 reliable, and valid research findings as the basis for
 11 making decisions about the effectiveness and efficacy
 12 of a program, intervention, or treatment.

13 **TITLE I—ASSISTANT SECRETARY** 14 **FOR MENTAL HEALTH AND** 15 **SUBSTANCE USE DISORDERS**

16 **SEC. 101. ASSISTANT SECRETARY FOR MENTAL HEALTH** 17 **AND SUBSTANCE USE DISORDERS.**

18 (a) IN GENERAL.—There shall be in the Department
 19 of Health and Human Services an official to be known

1 as the Assistant Secretary for Mental Health and Sub-
2 stance Use Disorders, who shall—

3 (1) report directly to the Secretary;

4 (2) be appointed by the President, by and with
5 the advice and consent of the Senate; and

6 (3) be selected from among individuals who—

7 (A)(i) have a doctoral degree in medicine
8 or osteopathic medicine;

9 (ii) have clinical, research, and policy expe-
10 rience in psychiatry;

11 (iii) graduated from an Accreditation
12 Council for Graduate Medical Education-ac-
13 credited psychiatric residency program; and

14 (iv) have an understanding of biological,
15 psychosocial, and pharmaceutical treatments of
16 mental illness and substance use disorders;

17 (B) have a doctoral degree in psychology
18 and—

19 (i) clinical, research, and policy expe-
20 rience regarding mental illness and sub-
21 stance use disorders;

22 (ii) have completed an internship with
23 an organization that is a member of the
24 Association of Psychology Post-doctoral

1 and Internship Centers as part of doctoral
2 degree completion; and

3 (iii) an understanding of biological,
4 psychosocial, and pharmaceutical treat-
5 ments of mental illness and substance use
6 disorders; or

7 (C) have a doctoral degree in social work
8 and—

9 (i) clinical, research, and policy expe-
10 rience regarding mental illness and sub-
11 stance use disorders; and

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

16 (b) SAMHSA ADMINISTRATOR.—Section 501(c)(1)
17 of the Public Health Service Act (42 U.S.C. 290aa(c)(1))
18 is amended by striking “the President, by and with the
19 advice and consent of the Senate” and inserting “, and
20 serve under, the Assistant Secretary for Mental Health
21 and Substance Use Disorders”.

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

23 (1) promote, evaluate, organize, integrate, and
24 coordinate research, treatment, and services across
25 departments, agencies, organizations, and individ-

1 uals with respect to the problems of individuals suf-
2 fering from substance use disorders or mental ill-
3 ness;

4 (2) carry out any functions within the Depart-
5 ment of Health and Human Services—

6 (A) to improve services for individuals with
7 substance use disorders or mental illness, in-
8 cluding services related to the prevention of, di-
9 agnosis of, intervention in, and treatment and
10 rehabilitation of, substance use disorders or
11 mental illness;

12 (B) to ensure access to effective, evidence-
13 based diagnosis, prevention, intervention, treat-
14 ment and rehabilitation for individuals with
15 mental illnesses and individuals with a sub-
16 stance use disorder;

17 (C) to ensure that all grants with respect
18 to serious mental illness or substance use dis-
19 orders, are consistent with the grant manage-
20 ment standards set forth by the Department,
21 and that such grants are evidence-based, have
22 scientific merit and avoid duplication;

23 (D) to develop and implement initiatives to
24 encourage individuals to pursue careers (espe-
25 cially in underserved areas and populations) as

1 psychiatrists, psychologists, psychiatric nurse
2 practitioners, clinical social workers, and other
3 licensed mental health professionals specializing
4 in the diagnosis, evaluation, and treatment of
5 individuals with severe mental illness;

6 (E) to consult, coordinate with, facilitate
7 joint efforts among, and support State, local,
8 and tribal governments, nongovernmental enti-
9 ties, and individuals with a mental illness, par-
10 ticularly individuals with a serious mental ill-
11 ness and children and adolescents with a seri-
12 ous emotional disturbance, with respect to im-
13 proving community-based and other mental
14 health services;

15 (F) to disseminate evidenced-based and
16 promising best practices developed by the Na-
17 tional Mental Health Policy Lab established
18 under section 201 and other qualified research
19 organizations that are culturally and linguis-
20 tically indicated treatment and prevention serv-
21 ices related to a mental illness, particularly in-
22 dividuals with a serious mental illness and chil-
23 dren and adolescents with a serious emotional
24 disturbance; and

1 (G) to develop criteria for the application
2 of best practices within the mental health and
3 substance use disorder service delivery system;

4 (3) within the Department of Health and
5 Human Services, oversee and coordinate all pro-
6 grams and activities relating to—

7 (A) diagnosis, prevention, intervention,
8 treatment, rehabilitation with respect to mental
9 health or substance use disorders;

10 (B) parity in health insurance benefits and
11 conditions relating to mental health and sub-
12 stance use disorders; or

13 (C) the reduction of homelessness and in-
14 carceration among individuals with mental
15 health and substance use disorders;

16 (4) make recommendations to the Secretary of
17 Health and Human Services regarding public par-
18 ticipation in decisions relating to mental health, in-
19 cluding serious mental illness, and serious emotional
20 disturbances across the lifespan;

21 (5) review and make recommendations with re-
22 spect to the Department of Health and Human
23 Services budget to ensure the adequacy of such
24 budget;

1 (6) across the Federal Government, in conjunc-
2 tion with the Interagency Serious Mental Illness Co-
3 ordinating Committee under section 501A of the
4 Public Health Service Act (as added by section
5 401)—

6 (A) review all programs and activities re-
7 lating to the diagnosis or prevention of, or
8 treatment or rehabilitation for, mental illness or
9 substance use disorders;

10 (B) identify any such programs and activi-
11 ties that are duplicative;

12 (C) identify any such programs and activi-
13 ties that are not evidence-based, effective, or ef-
14 ficient; and

15 (D) formulate recommendations for ex-
16 panding, coordinating, eliminating, and improv-
17 ing programs and activities identified pursuant
18 to subparagraphs (B) and (C) and merging
19 such programs and activities into other, suc-
20 cessful programs and activities;

21 (7) identify evidence-based and promising best
22 practices across the Federal Government for treat-
23 ment and services for individuals with mental health
24 and substance use disorders by reviewing practices

1 for efficiency, effectiveness, quality, coordination,
2 and cost effectiveness; and

3 (8) not later than 18 months after the date of
4 enactment of this Act and every 2 years thereafter,
5 submit to Congress a report containing a nationwide
6 strategy to recruit, train, and increase the mental
7 health workforce for the treatment of individuals
8 with mental illness, serious mental illness, substance
9 use disorders, and co-occurring disorders.

10 (d) NATIONWIDE STRATEGY.—The Assistant Sec-
11 retary shall ensure that the nationwide strategy in the re-
12 port under subsection (c)(8) is designed—

13 (1) to encourage and incentivize students en-
14 rolled in an accredited medical or osteopathic school,
15 or nursing, psychology, or social work graduate pro-
16 gram, to specialize in the mental health field;

17 (2) to promote greater research-oriented psy-
18 chiatric, psychological, nursing, and social work
19 training on evidence-based service delivery models
20 for individuals with mental illness or substance use
21 disorders, including models with family participation;

22 (3) to promote appropriate Federal administra-
23 tive and fiscal mechanisms that support—

24 (A) evidence-based collaborative care mod-
25 els; and

1 (B) the necessary mental health workforce
2 capacity for the models under subparagraph
3 (A), including psychiatrists, child and adoles-
4 cent psychiatrists, psychologists, psychiatric
5 nurse practitioners, clinical social workers, and
6 mental health, peer-support specialists;

7 (4) to increase access to child and adolescent
8 psychiatric services in order to promote early inter-
9 vention for prevention and mitigation of mental ill-
10 ness;

11 (5) to identify populations and locations that
12 are the most underserved by mental health profes-
13 sionals, including psychiatrists, child and adolescent
14 psychiatrists, psychologists, psychiatric nurse practi-
15 tioners, clinical social workers, other licensed mental
16 health professionals, and peer-support specialists;
17 and

18 (6) to identify means of alleviating the strain
19 on the budgets of the criminal justice and correc-
20 tional systems and the capacity of such systems with
21 respect to mental health and substance use dis-
22 orders.

23 (e) PRIORITIZATION OF INTEGRATION OF SERVICES,
24 EARLY DIAGNOSIS, INTERVENTION, AND WORKFORCE

1 DEVELOPMENT.—In carrying out the duties described in
2 subsection (c), the Assistant Secretary—

3 (1) shall prioritize—

4 (A) the integration of mental health, sub-
5 stance use, and physical health services for the
6 purpose of diagnosing, preventing, treating, and
7 providing rehabilitation for mental illness or
8 substance use disorders, including any such
9 services provided through the justice system
10 (including departments of correction) or entities
11 other than the Department of Health and
12 Human Services;

13 (B) the early diagnosis and intervention
14 services for the prevention of, or crisis interven-
15 tion for, and treatment or rehabilitation for, se-
16 rious mental health disorders or substance use
17 disorders, in selecting evidence-based practices
18 and service delivery models for evaluation and
19 dissemination under section 201(a)(2)(C); and

20 (C) workforce development for—

21 (i) appropriate treatment of serious
22 mental illness or substance use disorders;

23 (ii) research activities that advance
24 scientific and clinical understandings of se-

1 rious mental illness or substance use dis-
2 orders; and

3 (iii) increasing the number of mental
4 health professionals, including psychia-
5 trists, child and adolescent psychiatrists,
6 psychologists, psychiatric nurse practi-
7 tioners, clinical social workers, and mental
8 health peer support specialists;

9 (2) shall give preference to models that improve
10 the coordination, quality, and efficiency of health
11 care services furnished to individuals with serious
12 mental illness; and

13 (3) may include clinical protocols and practices
14 used in the Recovery After an Initial Schizophrenia
15 Episode project of the National Institute of Mental
16 Health or similar models, such as the Specialized
17 Treatment Early in Psychosis program.

18 **SEC. 102. REPORTS.**

19 (a) REPORT ON BEST PRACTICES FOR PEER-SUP-
20 PORT SPECIALIST PROGRAMS, TRAINING, AND CERTIFI-
21 CATION.—

22 (1) IN GENERAL.—Not later than 18 months
23 after the date of enactment of this Act, and bian-
24 nually thereafter, the Assistant Secretary shall sub-
25 mit to Congress and make publicly available a report

1 on best practices and professional standards in
2 States for—

3 (A) establishing and operating health care
4 programs using peer-support specialists; and

5 (B) training and certifying peer-support
6 specialists.

7 (2) PEER-SUPPORT SPECIALIST DEFINED.—In
8 this subsection, the term “peer-support specialist”
9 means an individual who—

10 (A) is credentialed by the State in which
11 the individual practices;

12 (B) uses his or her lived experience of re-
13 covery from mental illness or substance abuse,
14 plus skills learned in formal training, to facili-
15 tate support groups, and to work on a one-on-
16 one basis, with individuals with a serious men-
17 tal illness or a substance use disorder, in con-
18 sultation with, and under the supervision of, a
19 licensed mental health or substance use treat-
20 ment professional;

21 (C) has been an active participant in men-
22 tal health or substance use treatment for at
23 least the preceding year;

24 (D) provides non-medical services; and

1 (E) performs services only within his or
2 her area of training, expertise, competence, or
3 scope of practice.

4 (3) CONTENTS.—Each report under this sub-
5 section shall include information on best practices
6 and standards with regard to the following:

7 (A) Hours of formal work or volunteer ex-
8 perience related to mental health and substance
9 use issues.

10 (B) Types of peer specialist exams re-
11 quired.

12 (C) Code of ethics.

13 (D) Additional training required prior to
14 certification, including in areas such as—

15 (i) ethics;

16 (ii) scope of practice;

17 (iii) crisis intervention;

18 (iv) State confidentiality laws;

19 (v) Federal privacy protections, in-
20 cluding under the Health Insurance Port-

21 ability and Accountability Act of 1996
22 (Public Law 104–191); and

23 (vi) other areas, as determined by the
24 Assistant Secretary.

1 (E) Requirements to explain what, where,
2 when, and how to accurately complete all re-
3 quired documentation activities.

4 (F) Required or recommended skill sets,
5 including knowledge of—

6 (i) risk indicators and responding ap-
7 propriately to individual stressors, triggers,
8 and indicators of pre-crisis symptoms;

9 (ii) basic crisis avoidance techniques;

10 (iii) basic suicide prevention concepts
11 and techniques;

12 (iv) indicators that an individual may
13 be experiencing abuse or neglect;

14 (v) stages of change or recovery;

15 (vi) the typical process that should be
16 followed to access or participate in commu-
17 nity mental health and related services;
18 and

19 (vii) circumstances when it is appro-
20 priate to request assistance from other
21 professionals to help meet the individual's
22 recovery goals.

23 (G) Annual requirements for continuing
24 education credits.

1 (b) REPORT ON MENTAL HEALTH AND SUBSTANCE
2 USE TREATMENT IN THE STATES.—

3 (1) IN GENERAL.—Not later than 18 months
4 after the date of enactment of this Act, and not less
5 than every 18 months thereafter, the Assistant Sec-
6 retary for Mental Health and Substance Use Dis-
7 orders, in collaboration with the Director of the
8 Agency for Healthcare Research and Quality and
9 Director of the National Institutes of Health, shall
10 submit to Congress and make available to the public
11 a report on mental health and substance use treat-
12 ment in the States, including the following:

13 (A) A detailed report on how Federal men-
14 tal health and substance use treatment funds
15 are used in each State, including:

16 (i) The numbers of individuals with
17 mental illness, serious mental illness, sub-
18 stance use disorders, or co-occurring dis-
19 orders who are served with Federal funds.

20 (ii) The types of programs made avail-
21 able to individuals with mental illness, seri-
22 ous mental illness, substance use disorders,
23 or co-occurring disorders.

24 (B) A summary of best practice models in
25 the States highlighting programs that are cost

1 effective, provide evidence-based care, increase
2 access to care, integrate physical, psychiatric,
3 psychological, and behavioral medicine, and im-
4 prove outcomes for individuals with serious
5 mental illness or substance use disorders.

6 (C) A statistical report of outcome meas-
7 ures in each State for individuals with mental
8 illness, serious mental illness, substance use dis-
9 orders, or co-occurring disorders, including
10 rates of suicide, suicide attempts, substance
11 abuse, overdose, overdose deaths, health out-
12 comes, emergency psychiatric hospitalizations
13 and emergency room boarding, arrests, incar-
14 cerations, homelessness, joblessness, employ-
15 ment, and enrollment in educational or voca-
16 tional programs.

17 (D) A comparative effectiveness research
18 study analyzing outcomes for different models
19 of outpatient treatment programs for the seri-
20 ously mentally ill that include outpatient mental
21 health services that are court ordered or vol-
22 untary, including—

23 (i) rates of keeping treatment ap-
24 pointments and compliance with prescribed
25 medications;

- 1 (ii) participants' perceived effective-
2 ness of the program;
- 3 (iii) rates of the programs helping in-
4 dividuals with serious mental illness gain
5 control over their lives;
- 6 (iv) alcohol and drug abuse rates;
- 7 (v) incarceration and arrest rates;
- 8 (vi) violence against persons or prop-
9 erty;
- 10 (vii) homelessness;
- 11 (viii) total treatment costs for compli-
12 ance with program; and
- 13 (ix) health outcomes.

14 (2) DEFINITION.—In this subsection, the term
15 “emergency room boarding” means the practice of
16 admitting patients to an emergency department and
17 holding such patients in the department until inpa-
18 tient psychiatric beds become available.

19 (c) REPORTING COMPLIANCE STUDY.—

20 (1) IN GENERAL.—The Assistant Secretary for
21 Mental Health and Substance Use Disorders shall
22 enter into an arrangement with the National Acad-
23 emy of Medicine (or, if the National Academy of
24 Medicine declines, another appropriate entity) under
25 which, not later than 18 months after the date of

1 enactment of this Act, the National Academy of
2 Medicine will submit to the appropriate committees
3 of Congress a report that evaluates the combined pa-
4 perwork burden of—

5 (A) community mental health centers
6 meeting the criteria specified in section 1913(c)
7 of the Public Health Service Act (42 U.S.C.
8 300x-2(c)), including such centers meeting
9 such criteria as in effect on the day before the
10 date of enactment of this Act; and

11 (B) community mental health centers, as
12 defined in section 1861(ff)(3)(B) of the Social
13 Security Act.

14 (2) SCOPE.—In preparing the report under sub-
15 section (a), the National Academy of Medicine (or,
16 if applicable, other appropriate entity) shall examine
17 licensing, certification, service definitions, claims
18 payment, billing codes, and financial auditing re-
19 quirements used by the Office of Management and
20 Budget, the Centers for Medicare & Medicaid Serv-
21 ices, the Health Resources and Services Administra-
22 tion, the Substance Abuse and Mental Health Serv-
23 ices Administration, the Office of the Inspector Gen-
24 eral of the Department of Health and Human Serv-
25 ices, State Medicaid agencies, State departments of

1 health, State departments of education, and State
2 and local juvenile justice and social service agencies
3 to make administrative and statutory recommenda-
4 tions to Congress (which recommendations may in-
5 clude a uniform methodology) to reduce the paper-
6 work burden experienced by centers and clinics de-
7 scribed in paragraph (1).

8 **SEC. 103. ADVISORY COUNCIL ON GRADUATE MEDICAL**
9 **EDUCATION.**

10 (a) IN GENERAL.—Section 762(b) of the Public
11 Health Service Act (42 U.S.C. 294o(b)) is amended—

12 (1) by redesignating paragraphs (4) through
13 (6) as paragraphs (5) through (7), respectively; and

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

16 “(4) the Assistant Secretary for Mental Health
17 and Substance Use Disorders;”.

18 (b) CONFORMING AMENDMENT.—Section 762(c) of
19 the Public Health Service Act (42 U.S.C. 294o(c)) is
20 amended by striking “paragraphs (4), (5), and (6)” each
21 place it appears and inserting “paragraphs (5), (6), and
22 (7)”.

TITLE II—GRANTS**SEC. 201. NATIONAL MENTAL HEALTH POLICY LABORATORY.**

(a) IN GENERAL.—

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

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

(A) identify, coordinate, and implement policy changes and other trends likely to have the most significant impact on mental health services and monitor their impact;

(B) collect information from grantees under programs established or amended by this Act and under other mental health programs under the Public Health Service Act, including grantees that are States receiving funds under a block grant under part B of title XIX of the Public Health Service Act (42 U.S.C. 300x et seq.);

1 (C) evaluate and disseminate to such
2 grantees evidence-based practices and service
3 delivery models using the best available science
4 shown to be cost-effective while enhancing the
5 quality of care furnished to individuals; and

6 (D) establish standards for the appoint-
7 ment of scientific peer-review panels to evaluate
8 grant applications.

9 (3) EVIDENCE-BASED PRACTICES AND SERVICE
10 DELIVERY MODELS.—In selecting evidence-based
11 best practices and service delivery models for evalua-
12 tion and dissemination under paragraph (2)(C), the
13 Director of the NMHPL—

14 (A) shall give preference to models that—

15 (i) improve the coordination between
16 mental health and physical health pro-
17 viders;

18 (ii) improve the coordination among
19 such providers and the justice and correc-
20 tions system;

21 (iii) improve the cost effectiveness,
22 quality, effectiveness, and efficiency of
23 health care services furnished to individ-
24 uals with serious mental illness, in mental

1 health crisis, or at risk to themselves, their
2 families, and the general public; and

3 (iv) recognize the importance of fam-
4 ily participation in recovery; and

5 (B) may include clinical protocols and
6 practices used in the Recovery After Initial
7 Schizophrenia Episode project of the National
8 Institute of Mental Health and the Specialized
9 Treatment Early in Psychosis program.

10 (4) DEADLINE FOR BEGINNING IMPLEMENTA-
11 TION.—The Director of the NMHPL shall begin im-
12 plementation of the duties described in this sub-
13 section not later than January 1, 2018.

14 (5) CONSULTATION.—In carrying out the duties
15 under this subsection, the Director of the NMHPL
16 may consult with—

17 (A) representatives of the National Insti-
18 tute of Mental Health on organizational and
19 operational issues;

20 (B) other appropriate Federal agencies;

21 (C) clinical and analytical experts with ex-
22 pertise in medicine, psychiatric and clinical psy-
23 chological care, health care management, edu-
24 cation, corrections health care, social services,
25 and mental health court systems; and

1 (D) other individuals and agencies as the
2 Assistant Secretary determines appropriate.

3 (b) STAFFING.—

4 (1) COMPOSITION.—In selecting the staff of the
5 NMHPL, the Director of the NMHPL, in consulta-
6 tion with the Director of the National Institute of
7 Mental Health, shall include individuals with ad-
8 vanced degrees and clinical and research experience,
9 and who have an understanding of biological, psy-
10 chosocial, and pharmaceutical treatments of mental
11 illness and substance use disorders, including—

12 (A) individuals with a medical degree or
13 doctoral degree from an accredited program
14 in—

15 (i) allopathic or osteopathic medicine,
16 and who have specialized training in psy-
17 chiatry;

18 (ii) psychology; or

19 (iii) social work;

20 (B) professionals or academics with clinical
21 or research expertise in substance use disorders
22 and treatment; and

23 (C) professionals or academics with exper-
24 tise in research design and methodologies.

1 (c) REPORT ON QUALITY OF CARE.—Not later than
2 2 years after the date of enactment of this Act, and every
3 2 years thereafter, the Director of the NMHPL shall sub-
4 mit to Congress a report on the quality of care furnished
5 through grant programs administered by the Assistant
6 Secretary under the respective services delivery models, in-
7 cluding measurement of patient-level outcomes and public
8 health outcomes, such as—

9 (1) reduced rates of suicide, suicide attempts,
10 substance abuse, overdose, overdose deaths, emer-
11 gency psychiatric hospitalizations, emergency room
12 boarding, incarceration, crime, arrest, homelessness,
13 and joblessness;

14 (2) rates of employment and enrollment in edu-
15 cational and vocational programs; and

16 (3) such other criteria as the Director may de-
17 termine.

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

23 **SEC. 202. INNOVATION GRANTS.**

24 (a) IN GENERAL.—The Assistant Secretary shall
25 award grants to State and local governments, educational

1 institutions, and nonprofit organizations for expanding a
2 model that has been scientifically demonstrated to show
3 promise, but would benefit from further applied research,
4 for—

5 (1) enhancing the prevention, diagnosis, inter-
6 vention, treatment, and rehabilitation of mental ill-
7 ness, serious emotional disorder, substance use dis-
8 order, and co-occurring disorders; or

9 (2) integrating or coordinating physical health,
10 mental health, and substance use services.

11 (b) DURATION.—A grant under this section shall be
12 for a period of not more than 3 years.

13 (c) LIMITATIONS.—Of the amounts made available
14 for carrying out this section for a fiscal year—

15 (1) not more than one-third shall be awarded
16 for use for prevention; and

17 (2) not less than one-third shall be awarded for
18 screening, diagnosis, treatment, or services, as de-
19 scribed in subsection (a), for individuals (or sub-
20 populations of individuals) who are below the age of
21 18 when activities funded through the grant award
22 are initiated.

23 (d) GUIDELINES.—As a condition on receipt of an
24 award under this section, an applicant shall agree to ad-

1 here to guidelines issued by the National Mental Health
2 Policy Laboratory on research designs and data collection.

3 (e) AUTHORIZATION OF APPROPRIATIONS.—To carry
4 out this section, there are authorized to be appropriated
5 \$10,000,000 for each of fiscal years 2017 through 2021.

6 **SEC. 203. DEMONSTRATION GRANTS.**

7 (a) GRANTS.—The Assistant Secretary shall award
8 grants to States, counties, local governments, educational
9 institutions, and private nonprofit organizations for the
10 expansion, replication, or scaling of evidence-based pro-
11 grams across a wider area to enhance effective screening,
12 early diagnosis, intervention, and treatment with respect
13 to mental illness and serious mental illness, primarily by—

14 (1) applied delivery of care, including training
15 staff in effective evidence-based treatment; and

16 (2) integrating models of care across specialties
17 and jurisdictions.

18 (b) DURATION.—A grant under this section shall be
19 for a period of not less than 2 years and not more than
20 5 years.

21 (c) LIMITATIONS.—Of the amounts made available
22 for carrying out this section for a fiscal year—

23 (1) not less than half shall be awarded for
24 screening, diagnosis, intervention, and treatment, as
25 described in subsection (a), for individuals (or sub-

1 populations of individuals) who are below the age of
2 26 when activities funded through the grant award
3 are initiated;

4 (2) no amounts shall be made available for any
5 program or project that is not evidence-based;

6 (3) no amounts shall be made available for pri-
7 mary prevention; and

8 (4) no amounts shall be made available solely
9 for the purpose of expanding facilities or increasing
10 staff at an existing program.

11 (d) GUIDELINES.—As a condition on receipt of an
12 award under this section, an applicant shall agree to ad-
13 here to guidelines issued by the National Mental Health
14 Policy Laboratory (established under section 201) on re-
15 search designs and data collection.

16 (e) REPORTING.—As a condition on receipt of an
17 award under this section, an applicant shall agree—

18 (1) to report to the National Mental Health
19 Policy Laboratory and the Assistant Secretary the
20 results of programs and activities funded through
21 the award; and

22 (2) to include in such reporting any relevant
23 data requested by the National Mental Health Policy
24 Laboratory and the Assistant Secretary.

1 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
2 out this section, there are authorized to be appropriated
3 \$10,000,000 for each of fiscal years 2017 through 2021.

4 **SEC. 204. EARLY CHILDHOOD INTERVENTION AND TREAT-**
5 **MENT.**

6 (a) GRANTS.—The Director of the National Mental
7 Health Policy Laboratory (in this section referred to as
8 the “NMHPL”) shall—

9 (1) award grants to eligible entities to initiate
10 and undertake early childhood intervention and
11 treatment programs, and specialized programs for
12 preschool- and elementary school-aged children at
13 significant risk or who show early signs of social or
14 emotional disability (in addition to any learning dis-
15 ability); and

16 (2) ensure that programs funded through
17 grants under this section are based on promising or
18 evidence-based models and methods that are cul-
19 turally and linguistically relevant and can be rep-
20 licated in other settings.

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

23 (1) ELIGIBLE ENTITY.—The term “eligible enti-
24 ty” means a nonprofit institution that—

1 (A) is accredited by a State mental health
2 or education agency, as applicable, for the
3 intervention, treatment, or education of children
4 from 3 to 12 years of age; and

5 (B) provides services that include early
6 intervention and treatment or specialized pro-
7 grams for preschool- and elementary school-
8 aged children whose primary need is a social or
9 emotional disability (in addition to any learning
10 disability).

11 (2) ELIGIBLE CHILD.—The term “eligible
12 child” means a child who is at least 3 years old and
13 not more than 12 years old—

14 (A) whose primary need is a social or emo-
15 tional disability (in addition to any learning dis-
16 ability); and

17 (B) who could benefit from early childhood
18 intervention and specialized preschool or ele-
19 mentary school programs with the goal of inter-
20 vening or treating social or emotional disabil-
21 ities.

22 (c) APPLICATION.—An eligible entity seeking a grant
23 under subsection (a) shall submit to the Secretary an ap-
24 plication at such time, in such manner, and containing
25 such information as the Secretary may require.

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

5 (1) Deliver for eligible children mental health
6 education and treatment, early childhood education
7 and intervention, and specialized programs for
8 preschool- and elementary school-aged children at
9 significant risk or who show early signs of social or
10 emotional disability (in addition to any learning dis-
11 ability), including the provision of day treatment and
12 social-emotional and behavioral services.

13 (2) Treat and educate eligible children, includ-
14 ing by providing funding for—

15 (A) program and curricula development;

16 (B) staff;

17 (C) assessment, intervention, and treat-
18 ment services;

19 (D) administrative costs, including oper-
20 ating costs, capital needs, and equipment;

21 (E) enrollment costs;

22 (F) collaboration with primary care physi-
23 cians, psychiatrists, and clinical services of psy-
24 chologists of other related mental health spe-
25 cialists;

1 (G) services to meet emergency needs of
2 children; and

3 (H) communication with families and phys-
4 ical and mental health professionals concerning
5 the children.

6 (3) Develop and implement other strategies to
7 address identified intervention, treatment, and edu-
8 cational needs of eligible children that incorporate
9 reliable and valid evaluation modalities into the pro-
10 gram to ensure outcomes based on sound scientific
11 metrics as determined by the NMHPL.

12 (e) AMOUNT OF AWARDS.—The amount of an award
13 to an eligible entity under subsection (a)(1) shall be not
14 more than \$600,000 per fiscal year.

15 (f) PROJECT TERMS.—The period of a grant for
16 awards under subsection (a)(1), shall be not less than 3
17 fiscal years and not more than 10 fiscal years.

18 (g) MATCHING FUNDS.—The Director of the
19 NMHPL may not award a grant under this section to an
20 eligible entity unless the eligible entity agrees, with respect
21 to the costs to be incurred by the eligible entity in carrying
22 out the activities described in subsection (d), to make
23 available non-Federal contributions (in cash or in kind)
24 toward such costs in an amount that is not less than 10
25 percent of Federal funds provided in the grant.

1 (h) AUTHORIZATION OF APPROPRIATIONS.—To carry
 2 out this section, there are authorized to be appropriated
 3 \$10,000,000 for each of fiscal years 2017 through 2021.

4 **SEC. 205. EXTENSION OF ASSISTED OUTPATIENT TREAT-**
 5 **MENT GRANT PROGRAM FOR INDIVIDUALS**
 6 **WITH SERIOUS MENTAL ILLNESS.**

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

9 (1) in subsection (a), by striking “4-year” and
 10 inserting “6-year”;

11 (2) in subsection (e), by striking “and 2018”
 12 and inserting “2018, 2019, and 2020”; and

13 (3) in subsection (g)—

14 (A) in paragraph (1), by striking “2018”
 15 and inserting “2020”;

16 (B) in paragraph (2) by striking “2018”
 17 and inserting “2020”; and

18 (C) by striking “\$15,000,000” and insert-
 19 ing “\$20,000,000”.

20 **SEC. 206. BLOCK GRANTS.**

21 (a) REAUTHORIZATION OF BLOCK GRANT.—Section
 22 1920(a) of the Public Health Service Act (42 U.S.C.
 23 300x–9(a)) is amended by striking “\$450,000,000 for fis-
 24 cal year 2001, and such sums as may be necessary for
 25 each of the fiscal years 2002 and 2003” and inserting

1 “\$483,000,000 for fiscal year 2017 and such sums as may
2 be necessary for each of fiscal years 2018 through 2019”.

3 (b) BEST PRACTICES IN CLINICAL CARE MODELS.—
4 Section 1920 of the Public Health Service Act (42 U.S.C.
5 300x–9) is amended by adding at the end the following:

6 “(c) BEST PRACTICES IN CLINICAL CARE MOD-
7 ELS.—The Assistant Secretary, acting through the Ad-
8 ministrator of the Substance Abuse and Mental Health
9 Services and in collaboration with the Director of the Na-
10 tional Institute of Mental Health, shall obligate 5 percent
11 of the amounts appropriated for a fiscal year under sub-
12 section (a) for translating evidence-based (as defined in
13 section 2 of the Mental Health Reform Act of 2015) inter-
14 ventions and best available science into systems of care,
15 such as through models including the Recovery After an
16 Initial Schizophrenia Episode research project of the Na-
17 tional Institute of Mental Health.”.

18 (c) ADDITIONAL PROGRAM REQUIREMENTS.—

19 (1) INTEGRATED SERVICES.—Subsection (b)(1)
20 of section 1912 of the Public Health Service Act (42
21 U.S.C. 300x–1(b)(1)) is amended—

22 (A) by striking “The plan provides” and
23 inserting the following:

24 “(A) IN GENERAL.—The plan provides”;

1 (B) in the second sentence, by striking
2 “health and mental health services” and insert-
3 ing “integrated physical and mental health
4 services”;

5 (C) by striking “The plan shall include”
6 and all that follows through the period at the
7 end and inserting “The plan shall integrate and
8 coordinate services to maximize the efficiency,
9 effectiveness, quality, coordination, and cost ef-
10 fectiveness of those services and programs to
11 produce the best possible outcomes for individ-
12 uals with serious mental illness.”; and

13 (D) by adding at the end the following new
14 subparagraph:

15 “(B) ADDITIONAL REQUIREMENTS.—The
16 plan shall include a separate description of case
17 management services and provide for activities
18 leading to reduction of rates of suicides, suicide
19 attempts, substance abuse, overdose deaths,
20 emergency hospitalizations, incarceration,
21 crimes, arrest, homelessness, joblessness, medi-
22 cation nonadherence, and education and voca-
23 tional programs drop outs. The plan shall in-
24 clude a detailed list of services available for eli-

1 gible patients in each county or county equiva-
2 lent.”.

3 (2) DATA COLLECTION SYSTEM.—

4 (A) Subsection (b)(1)(A) (as so designated
5 by paragraph (1)) of section 1912 of the Public
6 Health Service Act (42 U.S.C. 300x-
7 1(b)(1)(A)) is amended by inserting “legal serv-
8 ices, and” before “other support services”.

9 (B) Subsection (b)(2) of section 1912 of
10 the Public Health Service Act (42 U.S.C. 300x-
11 1(b)(2)) is amended by inserting “and outcome
12 measures for services and resources” before the
13 period.

14 (3) IMPLEMENTATION OF PLAN.—Subsection
15 (d) of section 1912 of the Public Health Service Act
16 (42 U.S.C. 300x-1(d)) is amended—

17 (A) in paragraph (1)—

18 (i) by striking “Except as provided”
19 and inserting the following:

20 “(A) IN GENERAL.—Except as provided”;

21 and

22 (ii) by adding at the end the following
23 new subparagraph:

24 “(B) DE-IDENTIFIED REPORTS.—For eligi-
25 ble patients receiving treatment through funds

1 awarded under a grant under section 1911, a
2 State shall include in the State plan for the
3 first year beginning after the date of the enact-
4 ment of the Mental Health Reform Act of 2015
5 and each subsequent year, a de-identified re-
6 port, containing information that is open source
7 and de-identified, on the outcomes measures
8 collected in subsection (b)(2) of section 1912 of
9 the Public Health Service Act and the overall
10 cost of such treatment provided.”.

11 (4) INCENTIVES FOR STATE-BASED OUTCOME
12 MEASURES.—Section 1920 of the Public Health
13 Service Act (42 U.S.C. 300x–9) is amended by add-
14 ing at the end the following:

15 “(c) INCENTIVES FOR STATE-BASED OUTCOME
16 MEASURES.—

17 “(1) IN GENERAL.—In addition to the amounts
18 made available under subsection (a) for fiscal year
19 2019, the Secretary shall provide to each State that
20 meets the conditions under paragraph (2) for fiscal
21 year 2019, an amount equal to 2 percent of the for-
22 mula grant amount described in section 1911 and
23 section 1921.

24 “(2) CONDITIONS.—The Secretary shall define
25 the conditions under which a State is eligible to re-

1 ceive the additional amount under paragraph (1),
2 based on the report on mental health and substance
3 use treatment in the States under section 102(b) of
4 the Mental Health Reform Act of 2015.

5 “(3) CLARIFICATION.—Any amounts made
6 available under paragraph (1) shall be in addition to
7 the State’s block grant allocation and shall be made
8 to a State for a fiscal year, as a single payment, not
9 later than the last day of the first calendar quarter
10 of fiscal year 2020.”.

11 (5) EVIDENCE-BASED SERVICES DELIVERY
12 MODELS.—Section 1912 of the Public Health Serv-
13 ice Act (42 U.S.C. 300x–1) is amended by adding at
14 the end the following new subsection:

15 “(e) EXPANSION OF MODELS.—

16 “(1) IN GENERAL.—Taking into account the re-
17 sults of evaluations under section 201(a)(2)(C) of
18 the Mental Health Reform Act of 2015, the Assist-
19 ant Secretary may, by rule, as part of the program
20 of block grants under this subpart, provide for ex-
21 panded use across the Nation of evidence-based serv-
22 ice delivery models by providers funded under such
23 block grants, so long as—

24 “(A) the Assistant Secretary for Mental
25 Health and Substance Use Disorders (in this

1 subsection referred to as the ‘Assistant Sec-
2 retary’) determines that such expansion will—

3 “(i) result in more effective use of
4 funds under such block grants without re-
5 ducing the quality of care; or

6 “(ii) improve the quality of patient
7 care without significantly increasing spend-
8 ing;

9 “(B) the Director of the National Institute
10 of Mental Health determines that such expan-
11 sion would improve the quality of patient care;
12 and

13 “(C) the Assistant Secretary determines
14 that the change will—

15 “(i) significantly reduce severity and
16 duration of symptoms of mental illness;

17 “(ii) reduce rates of suicide, suicide
18 attempts, substance abuse, overdose, emer-
19 gency hospitalizations, emergency room
20 boarding, incarceration, crime, arrest,
21 homelessness, or joblessness; or

22 “(iii) significantly improve the quality
23 of patient care and mental health crisis
24 outcomes without significantly increasing
25 spending.

1 “(2) DEFINITION.—In this subsection, the term
2 ‘emergency room boarding’ means the practice of ad-
3 mitting patients to an emergency department and
4 holding such patients in the department until inpa-
5 tient psychiatric beds become available.”.

6 (d) PERIOD FOR EXPENDITURE OF GRANT FUNDS.—
7 Section 1913 of the Public Health Service Act (42 U.S.C.
8 300x–2) is amended by adding at the end the following:
9 “(d) PERIOD FOR EXPENDITURE OF GRANT
10 FUNDS.—In implementing a plan submitted under section
11 1912(a), a State receiving a grant under section 1911 may
12 make such funds available to providers of services de-
13 scribed in subsection (b) for the provision of services with-
14 out fiscal year limitation.”.

15 (e) ACTIVE OUTREACH AND ENGAGEMENT.—Section
16 1915 of the Public Health Service Act (42 U.S.C. 300x–
17 4) is amended by adding at the end of the following:

18 “(c) ACTIVE OUTREACH AND ENGAGEMENT TO PER-
19 SONS WITH SERIOUS MENTAL ILLNESS.—

20 “(1) IN GENERAL.—A funding agreement for a
21 grant under section 1911 is that the State involved
22 has in effect active programs that seek to engage in-
23 dividuals with serious mental illness in comprehen-
24 sive services in order to avert relapse, repeated hos-
25 pitalizations, arrest, incarceration, suicide, and to

1 provide the patient with the opportunity to live in
2 the least restrictive setting, through a comprehensive
3 program of evidence-based and culturally relevant
4 assertive outreach and engagement services focusing
5 on individuals who are homeless, have co-occurring
6 disorders, are at risk for incarceration or re-incar-
7 ceration, or have a history of treatment failure, in-
8 cluding repeated hospitalizations or emergency room
9 usage.

10 “(2) EVIDENCE-BASED ASSERTIVE OUTREACH
11 AND ENGAGEMENT SERVICES.—

12 “(A) SAMHSA.—The Administrator of
13 the Substance Abuse and Mental Health Serv-
14 ices Administration, in cooperation with the Di-
15 rector of the National Institute of Mental
16 Health, shall develop—

17 “(i) a list of evidence-based culturally
18 and linguistically relevant assertive out-
19 reach and engagement services; and

20 “(ii) criteria to be used to assess the
21 scope and effectiveness of the approaches
22 taken by such services, such as the ability
23 to provide same-day appointments for
24 emergent situations.

1 “(B) TYPES OF ASSERTIVE OUTREACH
2 AND ENGAGEMENT SERVICES.—For purposes of
3 paragraph (1), appropriate programs of evi-
4 dence-based assertive outreach and engagement
5 services may include peer support programs;
6 the Wellness Recovery Action Plan, Assertive
7 Community Treatment, and Forensic Assertive
8 Community Treatment of the Substance Abuse
9 and Mental Health Services Administration; as-
10 sisted outpatient treatment, appropriate sup-
11 portive housing programs incorporating a Hous-
12 ing First model; and intensive, evidence-based
13 approaches to early intervention in psychosis,
14 such as the Recovery After an Initial Schizo-
15 phrenia Episode model of the National Institute
16 of Mental Health and the Specialized Treat-
17 ment Early in Psychosis program.

18 “(d) PSYCHIATRIC ADVANCED DIRECTIVES.—A
19 funding agreement for a grant under section 1911 is that
20 the State involved has in effect active programs that seek
21 to engage individuals with serious mental illness in
22 proactively making their own health care decisions and en-
23 hancing communication between themselves, their fami-
24 lies, and their treatment providers by allowing for early
25 intervention and reducing legal proceedings related to in-

1 voluntary treatment by developing psychiatric advanced
 2 directives through a comprehensive program—

3 “(1) of assertive outreach and engagement serv-
 4 ices focusing on individuals diagnosed with serious
 5 mental illness or self-identifying as in recovery from
 6 serious mental illness to obtain a psychiatric ad-
 7 vanced directive; or

8 “(2) to support States in providing accessible
 9 legal counsel to individuals diagnosed with serious
 10 mental illness.”.

11 **SEC. 207. TELEHEALTH CHILD PSYCHIATRY ACCESS**
 12 **GRANTS.**

13 (a) IN GENERAL.—The Secretary, acting through the
 14 Administrator of the Health Resources and Services Ad-
 15 ministration, shall award grants to States and Indian
 16 tribes or tribal organizations (as defined in section 4 of
 17 the Indian Self-Determination and Education Assistance
 18 Act) to promote behavioral health integration in pediatric
 19 primary care by—

20 (1) supporting the creation of statewide child
 21 psychiatry access programs; and

22 (2) supporting the expansion of existing state-
 23 wide or regional child psychiatry access programs.

24 (b) PROGRAM REQUIREMENTS.—

1 (1) IN GENERAL.—To be eligible for funding
2 under subsection (a), a child psychiatry access pro-
3 gram shall—

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

8 (B) support and further develop organized
9 State networks of child and adolescent psychia-
10 trists to provide consultative support to pedi-
11 atric primary care sites;

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

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

21 (E) provide rapid (within 30 minutes)
22 statewide clinical telephone consultations when
23 requested between the pediatric mental health
24 teams and pediatric primary care providers;

1 (F) conduct training and provide technical
2 assistance to pediatric primary care providers to
3 support the early identification, diagnosis,
4 treatment, and referral of children with behav-
5 ioral health conditions;

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

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

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

20 (2) PEDIATRIC MENTAL HEALTH TEAMS.—For
21 purposes of this subsection, the term “pediatric
22 mental health team” means a team of case coordina-
23 tors, child and adolescent psychiatrists, and a li-
24 censed clinical mental health professional, such as a
25 psychologist, social worker, or mental health coun-

1 selor. Such a team may be regionally based, provided
2 there is access to a pediatric mental health team
3 across the State.

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

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

19 (e) MATCHING REQUIREMENT.—The Secretary may
20 not award a grant under the grant program unless the
21 State involved agrees, with respect to the costs to be in-
22 curred by the State in carrying out the purpose described
23 in this section, to make available non-Federal contribu-
24 tions (in cash or in kind) toward such costs in an amount

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

3 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
4 out this section, there are authorized to be appropriated
5 \$25,000,000 for fiscal year 2017 and such sums as may
6 be necessary for each of fiscal years 2018 through 2021.

7 **SEC. 208. LIABILITY PROTECTIONS FOR HEALTH CARE**
8 **PROFESSIONAL VOLUNTEERS AT COMMU-**
9 **NITY HEALTH CENTERS AND COMMUNITY**
10 **MENTAL HEALTH CENTERS.**

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

14 “(q)(1) In this subsection, the term ‘community men-
15 tal health center’ means—

16 “(A) a community mental health center, as de-
17 fined in section 1861(ff) of the Social Security Act;
18 or

19 “(B) a community mental health center meeting
20 the criteria specified in section 1913(c).

21 “(2) For purposes of this section, a health care pro-
22 fessional volunteer at an entity described in subsection
23 (g)(4) or a community mental health center shall, in pro-
24 viding health care services eligible for funding under sec-
25 tion 330 or subpart I of part B of title XIX to an indi-

1 vidual, be deemed to be an employee of the Public Health
2 Service for a calendar year that begins during a fiscal year
3 for which a transfer was made under paragraph (5)(C).
4 The preceding sentence is subject to the provisions of this
5 subsection.

6 “(3) In providing a health care service to an indi-
7 vidual, a health care professional shall, for purposes of this
8 subsection be considered to be a health professional volun-
9 teer at an entity described in subsection (g)(4) or at a
10 community mental health center if the following conditions
11 are met:

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

17 “(B) The center or entity is sponsoring the
18 health care professional volunteer pursuant to para-
19 graph (4)(B).

20 “(C) The health care professional does not re-
21 ceive any compensation for the service from the indi-
22 vidual or from any third-party payer (including re-
23 imbursement under any insurance policy or health
24 plan, or under any Federal or State health benefits
25 program), except that the health care professional

1 may receive repayment from the entity described in
2 subsection (g)(4) or the center for reasonable ex-
3 penses incurred by the health care professional in
4 the provision of the service to the individual.

5 “(D) Before the service is provided, the health
6 care professional or the center or entity described in
7 subsection (g)(4) posts a clear and conspicuous no-
8 tice at the site where the service is provided of the
9 extent to which the legal liability of the health care
10 professional is limited pursuant to this subsection.

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

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

22 “(A) The first sentence of paragraph (2) ap-
23 plies in lieu of the first sentence of subsection
24 (g)(1)(A).

1 “(B) With respect to an entity described in sub-
2 section (g)(4) or a federally qualified community be-
3 havioral health clinic, a health care professional is
4 not a health professional volunteer at such center
5 unless the center sponsors the health care profes-
6 sional. For purposes of this subsection, the center
7 shall be considered to be sponsoring the health care
8 professional if—

9 “(i) with respect to the health care profes-
10 sional, the center submits to the Secretary an
11 application meeting the requirements of sub-
12 section (g)(1)(D); and

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

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

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

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

11 “(B) Not later than May 1 of each fiscal year, the
12 Attorney General, in consultation with the Secretary, shall
13 submit to Congress a report providing an estimate of the
14 amount of claims (together with related fees and expenses
15 of witnesses) that, by reason of the acts or omissions of
16 health care professional volunteers, will be paid pursuant
17 to this subsection during the calendar year that begins in
18 the following fiscal year. Subsection (k)(1)(B) applies to
19 the estimate under the preceding sentence regarding
20 health care professional volunteers to the same extent and
21 in the same manner as such subsection applies to the esti-
22 mate under such subsection regarding officers, governing
23 board members, employees, and contractors of entities de-
24 scribed in subsection (g)(4).

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

7 “(6)(A) This subsection takes effect on October 1,
8 2017, except as provided in subparagraph (B).

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

11 “(i) the Secretary may issue regulations for car-
12 rying out this subsection, and the Secretary may ac-
13 cept and consider applications submitted pursuant to
14 paragraph (4)(B); and

15 “(ii) reports under paragraph (5)(B) may be
16 submitted to Congress.”.

17 **SEC. 209. MINORITY FELLOWSHIP PROGRAM.**

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

20 (1) by redesignating part G (42 U.S.C. 290kk
21 et seq.), relating to services provided through reli-
22 gious organizations and added by section 144 of the
23 Community Renewal Tax Relief Act of 2000, as en-
24 acted into law by section 1(a)(7) of Public Law 106–
25 554, as part J;

1 (2) by redesignating sections 581 through 584
2 of part J, as so redesignated, as sections 596
3 through 596C, respectively; and

4 (3) by adding 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 ethnic minorities; and

19 “(3) increasing the number of culturally com-
20 petent behavioral health professionals who teach, ad-
21 minister, conduct services research, and provide di-
22 rect mental health or substance use services to un-
23 derserved minority populations.

24 “(b) TRAINING COVERED.—The fellowships under
25 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, and substance use and addiction counseling.

5 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
6 carry out this section, there are authorized to be appro-
7 priated \$10,000,000 for each of fiscal years 2017 through
8 2021.”.

9 **SEC. 210. NATIONAL HEALTH SERVICE CORPS.**

10 (a) DEFINITIONS.—

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

16 (2) BEHAVIORAL AND MENTAL HEALTH PRO-
17 FESSIONALS.—Clause (i) of section 331(a)(3)(E)(i)
18 of the Public Health Service Act (42 U.S.C.
19 254d(a)(3)(E)(i)) is amended by inserting “, includ-
20 ing such professionals who are pediatric subspecial-
21 ists” before the period at the end.

22 (3) HEALTH PROFESSIONAL SHORTAGE
23 AREA.—Section 332(a)(1) of the Public Health Serv-
24 ice Act (42 U.S.C. 254e(a)(1)) is amended by insert-

1 ing “(which may be a group comprised of children
2 and adolescents)” after “population group”.

3 (4) **MEDICAL FACILITY.**—Section 332(a)(2)(A)
4 of the Public Health Service Act (42 U.S.C.
5 254e(a)(2)(A)) is amended by inserting “medical
6 residency or fellowship training site for training in
7 child and adolescent psychiatry,” before “facility op-
8 erated by a city or county health department,”.

9 (b) **ELIGIBILITY TO PARTICIPATE IN LOAN REPAY-**
10 **MENT PROGRAM.**—Section 338B(b)(1)(B) of the Public
11 Health Service Act (42 U.S.C. 254l–1(b)(1)(B)) is amend-
12 ed by inserting “, including any child and adolescent psy-
13 chiatry medical residency or fellowship training program”
14 before the semicolon.

15 **SEC. 211. REAUTHORIZATION OF MENTAL AND BEHAV-**
16 **IORAL HEALTH EDUCATION TRAINING**
17 **GRANT.**

18 Section 756 of the Public Health Service Act (42
19 U.S.C. 294e–1) is amended to read as follows:

20 **“SEC. 756. MENTAL AND BEHAVIORAL HEALTH EDUCATION**
21 **AND TRAINING GRANTS.**

22 “(a) **GRANTS AUTHORIZED.**—The Secretary, acting
23 through the Administrators of the Substance Abuse and
24 Mental Health Administration and the Health Resources
25 and Services Administration, may award grants to eligible

1 institutions to support the recruitment of students for,
2 and education and clinical experience of the students in—

3 “(1) accredited institutions of higher education
4 or accredited professional training programs that are
5 establishing or expanding internships or other field
6 placement programs in mental health in psychiatry,
7 psychology, school psychology, behavioral pediatrics,
8 psychiatric nursing, social work, school social work,
9 substance abuse prevention and treatment, marriage
10 and family therapy, school counseling, or profes-
11 sional counseling, with a preference for programs
12 addressing child and adolescent mental health, in
13 particular transitional age youth between 16 to 25
14 years old;

15 “(2) accredited doctoral, internship, and post-
16 doctoral residency programs of health service psy-
17 chology (which includes clinical psychology, coun-
18 seling, and school psychology) for the development
19 and implementation of interdisciplinary training of
20 psychology graduate students for providing behav-
21 ioral and mental health services, including substance
22 abuse prevention and treatment services, as well as
23 the development of faculty in health service psy-
24 chology;

1 “(3) accredited master’s and doctoral degree
2 programs of social work for the development and im-
3 plementation of interdisciplinary training of social
4 work graduate students for providing behavioral and
5 mental health services, including substance abuse
6 prevention and treatment services, and the develop-
7 ment of faculty in social work; or

8 “(4) paraprofessional certificate training pro-
9 grams offered by accredited community and tech-
10 nical colleges granting State licensure or certifi-
11 cation in a behavioral health-related paraprofessional
12 field, such as community health worker, outreach
13 worker, social services aide, mental health worker,
14 substance abuse or addictions worker, youth worker,
15 promotora, or peer paraprofessional, with preference
16 for pre-service or in-service training of paraprofes-
17 sional child and adolescent mental health workers.

18 “(b) ELIGIBILITY REQUIREMENTS.—To be eligible to
19 receive a grant under this section, an institution shall
20 demonstrate—

21 “(1) an ability to recruit and place psychia-
22 trists, psychologists, social workers, or paraprofes-
23 sionals in areas with a high need and high demand
24 population;

1 “(2) participation of individuals and groups
2 from different racial, ethnic, cultural, geographic, re-
3 ligious, linguistic, and class backgrounds, and dif-
4 ferent genders and orientations in the institution’s
5 programs;

6 “(3) knowledge and understanding of the con-
7 cerns of the individuals and groups described in
8 paragraph (2), especially individuals with mental
9 health symptoms or diagnoses, particularly children
10 and adolescents, with a special emphasis on transi-
11 tional-aged persons 16 to 25 years old;

12 “(4) prioritization of cultural and linguistic
13 competency in training professionals and paraprofes-
14 sionals in any academic program, field placement,
15 internship, or post-doctoral position; and

16 “(5) the willingness to provide to the Secretary
17 such data, assurances, and information as the Sec-
18 retary may require.

19 “(c) PRIORITY.—In selecting grant recipients the
20 Secretary shall give priority to—

21 “(1) programs that have demonstrated the abil-
22 ity to train psychology and social work professionals
23 to work in integrated care settings; and

24 “(2) programs for paraprofessionals that offer
25 curriculum with an emphasis on the role of the fam-

1 ily and the lived experience of the consumer and
2 family-paraprofessional partnerships.

3 “(d) INSTITUTIONAL REQUIREMENT.—Of the grants
4 awarded under paragraphs (2) and (3) of subsection (a),
5 at least 4 of the grant recipients shall be historically black
6 colleges or other minority serving institutions.

7 “(e) REPORT TO CONGRESS.—Not later than 2 years
8 after the date of enactment of the Mental Health Reform
9 Act of 2015, and annually thereafter, the Secretary, acting
10 through the Administrators of the Substance Abuse and
11 Mental Health Services Administration and the Health
12 Resources Services Administration, shall submit to Con-
13 gress a report on the effectiveness of—

14 “(1) providing graduate students support for
15 experiential training (internship or field placement);

16 “(2) recruitment of students interested in be-
17 havioral health practice;

18 “(3) development and implementation of inter-
19 professional training and integration within primary
20 care;

21 “(4) development and implementation of ac-
22 credited field placements and internships; and

23 “(5) data collected on the number of students
24 trained in mental health and the number of available
25 accredited internships and field placements.

1 “(f) AUTHORIZATION OF APPROPRIATIONS.—For
 2 each of fiscal years 2017 through 2021, there are author-
 3 ized to be appropriated to carry out this section
 4 \$44,000,000, to be allocated as follows:

5 “(1) \$15,000,000 shall be allocated to institu-
 6 tions to expand mental health internships or other
 7 field placement programs under subsection (a)(1).

8 “(2) \$14,000,000 shall be allocated to training
 9 in graduate psychology under subsection (a)(2).

10 “(3) \$10,000,000 shall be allocated to training
 11 in graduate social work under subsection (a)(3).

12 “(4) \$5,000,000 shall be allocated to training
 13 paraprofessionals under subsection (a)(4).”.

14 **SEC. 212. NATIONAL SUICIDE PREVENTION LIFELINE PRO-**
 15 **GRAM.**

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

19 **“SEC. 520E–3. NATIONAL SUICIDE PREVENTION LIFELINE**
 20 **PROGRAM.**

21 “(a) IN GENERAL.—The Secretary shall maintain the
 22 National Suicide Prevention Lifeline program. The activi-
 23 ties of the Secretary under such program shall include—

24 “(1) coordinating a network of crisis centers
 25 across the Nation for providing suicide prevention

1 and crisis intervention services to individuals seeking
2 help at any time, day or night;

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

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

10 “(b) AUTHORIZATION OF APPROPRIATIONS.—To
11 carry out this section, there are authorized to be appro-
12 priated \$5,000,000 for each of fiscal years 2016 through
13 2020.”.

14 **TITLE III—INTEGRATION**

15 **SEC. 301. PRIMARY AND BEHAVIORAL HEALTH CARE INTE-** 16 **GRATION GRANT PROGRAMS.**

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

19 **“SEC. 520K. INTEGRATION INCENTIVE GRANTS.**

20 “(a) IN GENERAL.—There is established within the
21 Substance Abuse and Mental Health Services Administra-
22 tion a primary and behavioral health care integration
23 grant program. The Assistant Secretary for Mental
24 Health and Substance Use Disorders may award grants
25 and cooperative agreements to eligible entities to expend

1 funds for improvements in integrated settings with inte-
2 grated practices.

3 “(b) DEFINITIONS.—In this section:

4 “(1) INTEGRATED CARE.—The term ‘integrated
5 care’ means full collaboration in merged or trans-
6 formed practices offering mental and physical health
7 services within the same shared practice space in the
8 same facility, where the entity—

9 “(A) provides services in a shared space
10 that ensures services will be available and ac-
11 cessible promptly and in a manner which pre-
12 serves human dignity and assures continuity of
13 care;

14 “(B) ensures communication among the in-
15 tegrated care team that is consistent and team-
16 based;

17 “(C) ensures shared decisionmaking be-
18 tween mental health and primary care pro-
19 viders;

20 “(D) provides evidence-based services in a
21 mode of service delivery appropriate for the tar-
22 get population;

23 “(E) employs staff who are multidisci-
24 plinary and culturally and linguistically com-
25 petent;

1 “(F) provides integrated services related to
2 screening, diagnosis, and treatment of mental
3 illness and co-occurring primary care conditions
4 and chronic diseases; and

5 “(G) provides targeted case management,
6 including services to assist individuals gaining
7 access to needed medical, social, educational,
8 and other services and applying for income se-
9 curity, housing, employment, and other benefits
10 to which they may be entitled.

11 “(2) INTEGRATED CARE TEAM.—The term ‘in-
12 tegrated care team’ means a team that includes—

13 “(A) allopathic or osteopathic medical doc-
14 tors, including a primary care physician and a
15 board certified psychiatrist;

16 “(B) licensed clinical mental health profes-
17 sionals, such as psychologists or social workers;

18 “(C) a case manager; and

19 “(D) other members, which may include
20 psychiatric advanced practice nurses and other
21 allied health professionals, such as mental
22 health counselors, or others as appropriate.

23 “(3) SPECIAL POPULATION.—The term ‘special
24 population’ means—

1 “(A) adults with mental illnesses who have
2 co-occurring primary care conditions with
3 chronic diseases;

4 “(B) adults with serious mental illnesses
5 who have co-occurring primary care conditions
6 with chronic diseases;

7 “(C) children and adolescents with serious
8 emotional disorders with co-occurring primary
9 care conditions and chronic diseases; or

10 “(D) individuals with substance use dis-
11 order.

12 “(c) PURPOSE.—The grant program under this sec-
13 tion shall be designed to lead to full collaboration between
14 primary and behavioral health in an integrated practice
15 model at a statewide level, to ensure that—

16 “(1) the overall wellness and physical health
17 status of individuals with serious mental illness and
18 co-occurring substance use disorders is supported
19 through integration of primary care into community
20 mental health centers meeting the criteria specified
21 in section 1913(c) of the Social Security Act or cer-
22 tified community behavioral health clinics described
23 in section 223 of the Protecting Access to Medicare
24 Act of 2014; and

1 “(2) the mental health status of individuals
2 with significant co-occurring psychiatric and physical
3 conditions will be supported through integration of
4 behavioral health into primary care settings.

5 “(d) ELIGIBLE ENTITIES.—To be eligible to receive
6 a grant or cooperative agreement under this section, an
7 entity shall be a State department of health, State mental
8 health or addiction agency, or State Medicaid agency. The
9 Administrator shall give preference to States that have ex-
10 isting integrated care models, such as those authorized by
11 section 1945 of the Social Security Act.

12 “(e) APPLICATION.—An eligible entity desiring a
13 grant or cooperative agreement under this section shall
14 submit an application to the Administrator at such time,
15 in such manner, and accompanied by such information as
16 the Administrator may require, including a description of
17 a plan to achieve fully collaborative agreements to provide
18 services to special populations and—

19 “(1) a document that summarizes the State-
20 specific policies that inhibit the provision of inte-
21 grated care, and the specific steps that will be taken
22 to address such barriers, such as through licensing
23 and billing procedures; and

24 “(2) a plan to develop and share a de-identified
25 patient registry to track treatment implementation

1 and clinical outcomes to inform clinical interven-
2 tions, patient education, and engagement with
3 merged or transformed integrated practices in com-
4 pliance with applicable national and State health in-
5 formation privacy laws.

6 “(f) GRANT AMOUNTS.—The maximum annual grant
7 amount under this section shall be \$2,000,000, of which
8 not more than 10 percent may be allocated to State ad-
9 ministrative functions, and the remaining amounts shall
10 be allocated to health facilities that provide integrated
11 care.

12 “(g) DURATION.—A grant under this section shall be
13 for a period of 5 years.

14 “(h) REPORT ON PROGRAM OUTCOMES.—An entity
15 receiving a grant or cooperative agreement under this sec-
16 tion shall submit an annual report to the Administrator
17 that includes—

18 “(1) the progress to reduce barriers to inte-
19 grated care, including regulatory and billing bar-
20 riers, as described in the entity’s application under
21 subsection (d); and

22 “(2) a description of functional outcomes of
23 special populations, including—

24 “(A) with respect to individuals with seri-
25 ous mental illness, participation in supportive

1 housing or independent living programs, attend-
2 ance in social and rehabilitative programs, par-
3 ticipation in job training opportunities, satisfac-
4 tory performance in work settings, attendance
5 at scheduled medical and mental health ap-
6 pointments, and compliance with prescribed
7 medication regimes;

8 “(B) with respect to individuals with co-oc-
9 ccurring mental illness and primary care condi-
10 tions and chronic diseases, attendance at sched-
11 uled medical and mental health appointments,
12 compliance with prescribed medication regimes,
13 and participation in learning opportunities re-
14 lated to improved health and lifestyle practice;
15 and

16 “(C) with respect to children and adoles-
17 cents with serious emotional disorders who have
18 co-occurring primary care conditions and chron-
19 ic diseases, attendance at scheduled medical
20 and mental health appointments, compliance
21 with prescribed medication regimes, and partici-
22 pation in learning opportunities at school and
23 extracurricular activities.

24 “(i) TECHNICAL ASSISTANCE CENTER FOR PRIMARY-
25 BEHAVIORAL HEALTH CARE INTEGRATION.—

1 “(1) IN GENERAL.—The Assistant Secretary for
2 Mental Health and Substance Use Disorders shall
3 establish a program through which such Assistant
4 Secretary shall provide appropriate information,
5 training, and technical assistance to eligible entities
6 that receive a grant or cooperative agreement under
7 this section, in order to help such entities to meet
8 the requirements of this section, including assistance
9 with—

10 “(A) development and selection of inte-
11 grated care models;

12 “(B) dissemination of evidence-based inter-
13 ventions in integrated care;

14 “(C) establishment of organizational prac-
15 tices to support operational and administrative
16 success; and

17 “(D) other activities, as the Assistant Sec-
18 retary for Mental Health and Substance Use
19 Disorders determines appropriate.

20 “(2) ADDITIONAL DISSEMINATION OF TECH-
21 NICAL INFORMATION.—The information and re-
22 sources provided by the technical assistance program
23 established under paragraph (1) shall be made avail-
24 able to States, political subdivisions of a State, In-
25 dian tribes or tribal organizations (as defined in sec-

1 tion 4 of the Indian Self-Determination and Edu-
 2 cation Assistance Act), outpatient mental health and
 3 addiction treatment centers, community mental
 4 health centers that meet the criteria under section
 5 1913(e), certified community behavioral health clin-
 6 ics described in section 223 of the Protecting Access
 7 to Medicare Act of 2014, primary care organizations
 8 such as Federally qualified health centers or rural
 9 health centers, other community-based organiza-
 10 tions, or other entities engaging in integrated care
 11 activities, as the Assistant Secretary for Mental
 12 Health and Substance Use Disorders determines ap-
 13 propriate.

14 “(j) AUTHORIZATION OF APPROPRIATIONS.—To
 15 carry out this section, there are authorized to be appro-
 16 priated \$50,000,000 for each of fiscal years 2017 through
 17 2021, of which \$2,000,000 shall be available to the tech-
 18 nical assistance program under subsection (i).”.

19 **TITLE IV—INTERAGENCY SERI-**
 20 **OUS MENTAL ILLNESS CO-**
 21 **ORDINATING COMMITTEE**

22 **SEC. 401. INTERAGENCY SERIOUS MENTAL ILLNESS CO-**
 23 **ORDINATING COMMITTEE.**

24 Title V of the Public Health Service Act is amended
 25 by inserting after section 501 the following:

1 **“SEC. 501A. INTERAGENCY SERIOUS MENTAL ILLNESS CO-**
2 **ORDINATING COMMITTEE.**

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

10 “(b) RESPONSIBILITIES.—The Committee shall—

11 “(1) develop and annually update a summary of
12 advances in serious mental illness research related to
13 prevention of, diagnosis of, intervention in, and
14 treatment and rehabilitation of, serious mental ill-
15 ness, and access to services and supports for individ-
16 uals with serious mental illness;

17 “(2) monitor Federal programs and activities
18 with respect to serious mental illness;

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

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

1 “(5) develop and update every 3 years a stra-
2 tegic plan for the conduct and support of programs
3 and services to assist individuals with serious mental
4 illness, including—

5 “(A) a summary of the advances in serious
6 mental illness research developed in under para-
7 graph (1);

8 “(B) a list of the Federal programs and
9 activities identified in paragraph (2);

10 “(C) an analysis of the efficiency, effective-
11 ness, quality, coordination, and cost-effective-
12 ness of Federal programs and activities relating
13 to the prevention, diagnosis, treatment, or reha-
14 bilitation of serious mental illness, including an
15 accounting of the costs of such programs and
16 activities with administrative costs
17 disaggregated from the costs of services and
18 care; and

19 “(D) a plan with recommendations—

20 “(i) for the coordination and improve-
21 ment of Federal programs and activities
22 related to serious mental illness, including
23 budgetary requirements;

24 “(ii) for improving outcomes for indi-
25 viduals with a serious mental illness in-

1 cluding appropriate benchmarks to meas-
2 ure progress on achieving improvements;

3 “(iii) for the mental health workforce;

4 “(iv) to disseminate relevant informa-
5 tion developed by the coordinating com-
6 mittee to the public, health care providers,
7 social service providers, public health offi-
8 cials, courts, law enforcement, and other
9 relevant groups;

10 “(v) to identify research needs, includ-
11 ing longitudinal studies of pediatric popu-
12 lations; and

13 “(vi) for vulnerable and underserved
14 populations, including pediatric and geri-
15 atric populations; and

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

18 “(c) MEMBERSHIP.—

19 “(1) IN GENERAL.—The Committee shall be
20 composed of not more than 9 Federal representa-
21 tives including—

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

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

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

5 “(D) the Director of the Centers for Dis-
6 ease Control and Prevention (or the Director’s
7 designee);

8 “(E) the Director of the National Insti-
9 tutes of Health (or the Director’s designee);

10 “(F) a member of the United States Inter-
11 agency Council on Homelessness;

12 “(G) representatives, appointed by the As-
13 sistant Secretary, of Federal agencies that serve
14 individuals with serious mental illness, including
15 representatives of the Centers for Medicare &
16 Medicaid Services, the Administration on Com-
17 munity Living, the Agency for Healthcare Re-
18 search and Quality, the Bureau of Indian Af-
19 fairs, the Department of Defense, the Depart-
20 ment of Education, the Department of Housing
21 and Urban Development, the Department of
22 Labor, the Department of Veterans Affairs, and
23 the Social Security Administration; and

24 “(H) the additional members appointed
25 under paragraph (2).

1 “(2) ADDITIONAL MEMBERS.—At least 14
2 members of the Committee shall be non-Federal
3 public members appointed by the Assistant Sec-
4 retary, of which—

5 “(A) at least 1 member shall be an indi-
6 vidual in recovery from a diagnosis of serious
7 mental illness who has benefitted from and is
8 receiving medical treatment under the care of a
9 licensed mental health professional;

10 “(B) at least 1 member shall be a parent
11 or legal guardian of an individual with a history
12 of serious mental illness who has either at-
13 tempted suicide or is incarcerated for violence
14 committed while experiencing a serious mental
15 illness;

16 “(C) at least 1 member shall be a rep-
17 resentative of a leading research, advocacy, and
18 service organization for individuals with serious
19 mental illness;

20 “(D) at least 2 members shall be—

21 “(i) a licensed psychiatrist with expe-
22 rience treating serious mental illness;

23 “(ii) a licensed psychologist with expe-
24 rience treating serious mental illness;

1 “(iii) a licensed clinical social worker;

2 or

3 “(iv) a licensed psychiatric nurse or
4 nurse practitioner;

5 “(E) at least 1 member shall be a mental
6 health professional with a significant focus in
7 his or her practice on working with children
8 and adolescents;

9 “(F) at least 1 member shall be a mental
10 health professional who has demonstrated cul-
11 tural competencies and has research or clinical
12 mental health experience working with minori-
13 ties;

14 “(G) at least 1 member shall be a State
15 certified mental health peer specialist;

16 “(H) at least 1 member shall be a judge
17 with experience adjudicating cases related to
18 criminal justice and serious mental illness;

19 “(I) at least 1 member shall be a law en-
20 forcement officer or corrections officer with ex-
21 tensive experience in interfacing with psy-
22 chiatric and psychological disorders or individ-
23 uals in mental health crisis; and

24 “(J) 4 members, of which—

1 “(i) 1 shall be appointed by the ma-
2 jority leader of the Senate;

3 “(ii) 1 shall be appointed by the mi-
4 nority leader of the Senate;

5 “(iii) 1 shall be appointed by the
6 Speaker of the House of Representatives;

7 and

8 “(iv) 1 shall be appointed by the mi-
9 nority leader of the House of Representa-
10 tives.

11 “(d) REPORTS TO CONGRESS.—Not later than 1 year
12 after the date of release of the first strategic plan under
13 subsection (b)(5) and annually thereafter, the Committee
14 shall submit a report to Congress—

15 “(1) evaluating the impact on public health of
16 projects addressing priority mental health needs of
17 regional and national significance under sections
18 501, 509, 516, and 520A, including measurement of
19 public health outcomes such as—

20 “(A) reduced rates of suicide, suicide at-
21 tempts, substance abuse, overdose, overdose
22 deaths, emergency hospitalizations, emergency
23 room boarding (as defined in section 1912(e)),
24 incarceration, crime, arrest, homelessness, and
25 joblessness;

1 “(B) increased rates of employment and
2 enrollment in educational and vocational pro-
3 grams; and

4 “(C) such other criteria as may be deter-
5 mined by the Assistant Secretary;

6 “(2) formulating recommendations for the co-
7 ordination and improvement of Federal programs
8 and activities described in paragraph (2);

9 “(3) identifying any such programs and activi-
10 ties that are duplicative; and

11 “(4) summarizing all recommendations made,
12 activities carried out, and results achieved pursuant
13 to the workforce development strategy under section
14 101(c)(8) of the Mental Health Reform Act of 2015.

15 “(e) ADMINISTRATIVE SUPPORT; TERMS OF SERV-
16 ICE; OTHER PROVISIONS.—The following provisions shall
17 apply with respect to the Committee:

18 “(1) The Assistant Secretary shall provide such
19 administrative support to the Committee as may be
20 necessary for the Committee to carry out its respon-
21 sibilities.

22 “(2) Members of the Committee appointed
23 under subsection (c)(2) shall serve for a term of 4
24 years, and may be reappointed for one or more addi-
25 tional 4-year terms. Any member appointed to fill a

1 vacancy for an unexpired term shall be appointed for
2 the remainder of such term. A member may serve
3 after the expiration of the member's term until a
4 successor has taken office.

5 “(3) The Committee shall meet at the call of
6 the chair or upon the request of the Assistant Sec-
7 retary. The Committee shall meet not fewer than 2
8 times each year.

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

12 “(f) SUBCOMMITTEES; ESTABLISHMENT AND MEM-
13 BERSHIP.—In carrying out its functions, the Committee
14 may establish subcommittees and convene workshops and
15 conferences. Such subcommittees shall be composed of
16 Committee members and may hold such meetings as are
17 necessary to enable the subcommittees to carry out their
18 duties.”.

19 **TITLE V—HIPAA CLARIFICATION**

20 **SEC. 501. FINDINGS.**

21 The Senate makes the following findings:

22 (1) The privacy regulations promulgated under
23 section 264(c) of the Health Insurance Portability
24 and Accountability Act (42 U.S.C. 1320d–2 note)
25 recognize the value of family members in the health

1 and well-being of individuals experiencing temporary
2 psychosis. However, a lack of understanding by
3 health professionals has been a barrier to many fam-
4 ily members assisting in the treatment of an indi-
5 vidual with serious mental illness.

6 (2) The privacy rule under section
7 164.510(b)(2) of title 45, Code of Federal Regula-
8 tions allows for the disclosure of protected health in-
9 formation in the event that a covered entity receives
10 the individual's agreement provides an opportunity
11 for an individual to object, and the individual does
12 not express an objection or the covered entity rea-
13 sonably infers that the individual does not object.

14 (3) The privacy rule under section
15 164.510(b)(3) of title 45, Code of Federal Regula-
16 tions allows for the disclosure of protected health in-
17 formation if an individual is not present or is other-
18 wise incapacitated if the medical provider determines
19 that the disclosure is in the best interests of the in-
20 dividual.

21 (4) Engagement by family members has been
22 shown to help individuals with serious mental illness
23 adhere to a treatment plan and improved outcomes.

24 (5) Whenever possible, an individual who is the
25 subject of protected health information shall be

1 given advanced notice of the desire to share informa-
2 tion with family members or other caregivers. This
3 notice should include an explanation of what infor-
4 mation is to be shared and why it is clinically desir-
5 able to share such information.

6 (6) The use of psychiatric advance directives
7 should be encouraged for individuals with serious
8 mental illness.

9 **SEC. 502. MODIFICATIONS TO HIPAA.**

10 In applying section 164.510(b)(3) of title 45, Code
11 of Federal Regulations, for the purposes of assisting
12 health professionals to determine the best interests of the
13 individual, the Secretary of Health and Human Services
14 shall consider the following factors:

15 (1) Timely intervention for treatment of a seri-
16 ous mental or general medical illness.

17 (2) Safe and stable housing for the individual.

18 (3) Increased daily living skills that are likely to
19 allow the individual to live within the community.

20 (4) An increased capacity of caregivers to sup-
21 port the patient to live within the community.

22 **SEC. 503. DEVELOPMENT AND DISSEMINATION OF MODEL**
23 **TRAINING PROGRAMS.**

24 (a) INITIAL PROGRAMS AND MATERIALS.—Not later
25 than 1 year after the date of enactment of this Act, the

1 Secretary of Health and Human Services (in this section
2 referred to as the “Secretary”), in consultation with ap-
3 propriate experts, shall develop and disseminate—

4 (1) a model program and materials for training
5 health care providers (including physicians, emer-
6 gency medical personnel, psychiatrists, psychologists,
7 counselors, therapists, behavioral health facilities
8 and clinics, care managers, and hospitals) regarding
9 the circumstances under which, consistent with the
10 standards governing the privacy and security of indi-
11 vidually identifiable health information promulgated
12 by the Secretary under section 264 of the Health In-
13 surance Portability and Accountability Act of 1996
14 (42 U.S.C. 1320d–2 note) and part C of title XI of
15 the Social Security Act (42 U.S.C. 1320d et seq.),
16 the protected health information of patients with a
17 mental illness may be disclosed with and without pa-
18 tient consent;

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

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

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

2 (1) periodically review, evaluate, and update the
3 model programs and materials developed under sub-
4 section (a); and

5 (2) disseminate the updated model programs
6 and materials.

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

12 (d) COORDINATION.—The Secretary shall carry out
13 this section in coordination with the Director of the Office
14 for Civil Rights within the Department of Health and
15 Human Services, the Administrator of the Substance
16 Abuse and Mental Health Services Administration, the
17 Administrator of the Health Resources and Services Ad-
18 ministration, and the heads of other relevant agencies
19 within the Department of Health and Human Services.

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

1 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
2 authorized to be appropriated to carry out this section
3 \$5,000,000 for each of fiscal years 2017 through 2022.

4 **SEC. 504. CONFIDENTIALITY OF RECORDS.**

5 Section 543 of the Public Health Service Act (42
6 U.S.C. 290dd–2) is amended by inserting after subsection
7 (h) the following:

8 “(i) STREAMLINED CONSENT IN INTEGRATED CARE
9 SETTINGS.—

10 “(1) IN GENERAL.—For the sharing of records
11 described in subsection (a) involving the interchange
12 of electronic health records (as defined in section
13 13400 of division A of Public Law 111–5) solely for
14 the purposes of improving the provision of health
15 care and health care coordination solely within ac-
16 countable care organizations described in section
17 1899 of the Social Security Act, health information
18 exchanges (as defined for purposes of section 3013),
19 health homes (as defined in section 1945(h)(3) of
20 the Social Security Act), or other integrated care ar-
21 rangements (in existence before, on, or after the
22 date of the enactment of the Mental Health Reform
23 Act of 2015), a patient’s prior written or electronic
24 consent for disclosure and re-disclosure of records
25 may be provided annually in a generalized and rev-

1 ocable format to and for all of the health care pro-
2 viders in the accountable care organization, health
3 information exchange, health home, or other inte-
4 grated care arrangement, who are involved in the
5 patient's care.

6 “(2) DISCLOSURE REQUIRED.—For all other
7 disclosures or re-disclosures of the records described
8 in subsection (a), except those expressly proscribed
9 in paragraph 1, patient consent is required to be ob-
10 tained in accordance with the procedures described
11 in part 2 of title 42, Code of Federal Regulations.

12 “(3) PROHIBITIONS.—It shall be unlawful for
13 any health plan or health insurance program to use
14 the records described in subsection (a) or this sub-
15 section to deny or condition the issuance of a plan,
16 policy, or coverage on the basis of the contents of
17 such records, or for a health care provider to use the
18 records described in subsection (a) and this section
19 to discriminate in the provision of medically nec-
20 essary health care services to an individual who is
21 the subject of such records.”.

1 **TITLE VI—MEDICARE AND**
2 **MEDICAID REFORMS**

3 **SEC. 601. ENHANCED MEDICAID COVERAGE RELATING TO**
4 **CERTAIN MENTAL HEALTH SERVICES.**

5 (a) MEDICAID COVERAGE OF MENTAL HEALTH
6 SERVICES AND PRIMARY CARE SERVICES FURNISHED ON
7 THE SAME DAY.—

8 (1) IN GENERAL.—Section 1902(a) of the So-
9 cial Security Act (42 U.S.C. 1396a(a)) is amended
10 by inserting after paragraph (77) the following new
11 paragraph:

12 “(78) not prohibit payment under the plan for
13 a mental health service or primary care service fur-
14 nished to an individual at a community mental
15 health center meeting the criteria specified in section
16 1913(c) of the Public Health Service Act or a Fed-
17 erally qualified health center (as defined in section
18 1861(aa)(4)) for which payment would otherwise be
19 payable under the plan, with respect to such indi-
20 vidual, if such service were not a same-day quali-
21 fying service (as defined in subsection (l)).”.

22 (2) SAME-DAY QUALIFYING SERVICES DE-
23 FINED.—Section 1902 of the Social Security Act (42
24 U.S.C. 1396a) is amended by adding at the end the
25 following new subsection:

1 “(II) SAME-DAY QUALIFYING SERVICES DEFINED.—

2 For purposes of subsection (a)(78), the term ‘same-day
3 qualifying service’ means—

4 “(1) a primary care service furnished to an in-
5 dividual 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; and

9 “(2) a mental health service furnished to an 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 (b) STATE OPTION TO PROVIDE MEDICAL ASSIST-
15 ANCE FOR CERTAIN INPATIENT PSYCHIATRIC SERVICES
16 TO NONELDERLY ADULTS.—Section 1905 of the Social
17 Security Act (42 U.S.C. 1396d) is amended—

18 (1) in subsection (a)—

19 (A) in paragraph (16)—

20 (i) by striking “effective” and insert-
21 ing “(A) effective”; and

22 (ii) by inserting before the semicolon
23 at the end the following: “, and (B) quali-
24 fied inpatient psychiatric hospital services
25 (as defined in subsection (h)(3)) for indi-

1 viduals over 21 years of age and under 65
2 years of age”; and

3 (B) in the subdivision (B) that follows
4 paragraph (29), by inserting “(other than serv-
5 ices described in subparagraph (B) of para-
6 graph (16) for individuals described in such
7 subparagraph)” after “patient in an institution
8 for mental diseases”; and

9 (2) in subsection (h), by adding at the end the
10 following new paragraph:

11 “(3) For purposes of subsection (a)(16)(B), the
12 term ‘qualified inpatient psychiatric hospital serv-
13 ices’ means, with respect to individuals described in
14 such subsection, services described in subparagraphs
15 (A) and (B) of paragraph (1) that are furnished in
16 an acute care psychiatric unit in a State-operated
17 psychiatric hospital or a psychiatric hospital (as de-
18 fined section 1861(f)) if such unit or hospital, as ap-
19 plicable, has a facility-wide average (determined on
20 an annual basis) length of stay of less than 20
21 days.”.

22 (c) STUDY AND REPORT.—

23 (1) STUDY.—The Secretary shall conduct a
24 study to determine the impact of the amendments
25 made by this section on the Medicaid IMD exclusion.

1 (2) REPORT.—Not later than 2 years after the
2 date of enactment of this Act, the Secretary shall
3 submit to Congress a report containing the results
4 of the study conducted under paragraph (1). The re-
5 port shall include the following information:

6 (A) An assessment of the level of State ex-
7 penditures on short-term acute inpatient psy-
8 chiatric hospital care for which no Federal fi-
9 nancial participation is provided for the most
10 recent State fiscal year ending prior to the ef-
11 fective date of the amendments made by this
12 section and an analysis of the impact of the
13 changes to the Medicaid IMD exclusion made
14 by such amendments on State expenditures for
15 such care.

16 (B) An assessment of the extent to which
17 States used disproportionate share hospital pay-
18 ment adjustments described in section 1923 of
19 the Social Security Act (42 U.S.C. 1396r-4) to
20 fund short-term acute inpatient psychiatric hos-
21 pital care prior to the effective date of the
22 amendments made by this section and an anal-
23 ysis of the impact of the changes to the Med-
24 icaid IMD exclusion made by such amendments

1 on the use of such payment adjustments to
2 fund such care.

3 (C) The total amount by which State ex-
4 penditures and the extent to which States use
5 disproportionate share hospital payment adjust-
6 ments for short-term acute inpatient psychiatric
7 hospital care have been reduced due to the
8 changes to the Medicaid IMD exclusion made
9 by the amendments made by this section.

10 (D) Recommendations for strategies to en-
11 courage States to reinvest savings in State ex-
12 penditures and disproportionate share hospital
13 payment adjustments that result from the
14 changes to the Medicaid IMD exclusion made
15 by the amendments made by this section in
16 community-based mental health services.

17 (3) DEFINITIONS.—For purposes of this sub-
18 section:

19 (A) MEDICAID IMD EXCLUSION.—The term
20 “Medicaid IMD exclusion” means the prohibi-
21 tion on Federal matching payments under Med-
22 icaid for care or services provided to patients
23 who have attained age 22, but have not at-
24 tained age 65, in an institution for mental dis-
25 eases under subdivision (B) of the matter fol-

1 lowing paragraph (29) of section 1905(a) of the
2 Social Security Act (42 U.S.C. 1396d(a)).

3 (B) SECRETARY.—The term “Secretary”
4 means the Secretary of Health and Human
5 Services.

6 (C) SHORT-TERM ACUTE INPATIENT PSY-
7 CHIATRIC HOSPITAL CARE.—The term “short-
8 term acute inpatient psychiatric hospital care”
9 means care provided in either—

10 (i) an acute-care psychiatric unit with
11 an average annual length of stay of fewer
12 than 20 days that is operated within a
13 State-operated psychiatric hospital; or

14 (ii) a psychiatric hospital with an av-
15 erage length of stay of fewer than 20 days
16 on an annual basis.

17 (d) EFFECTIVE DATE.—

18 (1) IN GENERAL.—Subject to paragraphs (2)
19 and (3), the amendments made by this section shall
20 apply to items and services furnished after the first
21 day of the first calendar year that begins after the
22 date of the enactment of this section.

23 (2) CERTIFICATION OF NO INCREASED SPEND-
24 ING.—The amendments made by this section shall
25 not be effective unless the Chief Actuary of the Cen-

1 ters for Medicare & Medicaid Services certifies that
2 the inclusion of qualified inpatient psychiatric hos-
3 pital services (as defined by paragraph (3) of section
4 1905(h) of the Social Security Act (42 U.S.C.
5 1396d(h)), as added by subsection (b)) furnished to
6 nonelderly adults as medical assistance under section
7 1905(a) of the Social Security Act (42 U.S.C.
8 1396d(a)), as amended by subsection (b), would not
9 result in any increase in net program spending
10 under title XIX of such Act.

11 (3) EXCEPTION FOR STATE LEGISLATION.—In
12 the case of a State plan under title XIX of the So-
13 cial Security Act, which the Secretary of Health and
14 Human Services determines requires State legisla-
15 tion in order for the respective plan to meet any re-
16 quirement imposed by amendments made by this
17 section, the respective plan shall not be regarded as
18 failing to comply with the requirements of such title
19 solely on the basis of its failure to meet such an ad-
20 ditional requirement before the first day of the first
21 calendar quarter beginning after the close of the
22 first regular session of the State legislature that be-
23 gins after the date of enactment of this section. For
24 purposes of the previous sentence, in the case of a
25 State that has a 2-year legislative session, each year

1 of the session shall be considered to be a separate
2 regular session of the State legislature.

3 **SEC. 602. MODIFICATIONS TO MEDICARE DISCHARGE PLAN-**
4 **NING REQUIREMENTS.**

5 Section 1861(ee) of the Social Security Act (42
6 U.S.C. 1395x(ee)) is amended—

7 (1) in paragraph (1), by inserting “and, in the
8 case of a psychiatric hospital or a psychiatric unit
9 (as described in the matter following clause (v) of
10 section 1886(d)(1)(B)), if it also meets the guide-
11 lines and standards established by the Secretary
12 under paragraph (4)” before the period at the end;
13 and

14 (2) by adding at the end the following new
15 paragraph:

16 “(4) The Secretary shall develop guidelines and
17 standards, in addition to those developed under
18 paragraph (2), for the discharge planning process of
19 a psychiatric hospital or a psychiatric unit (as de-
20 scribed in the matter following clause (v) of section
21 1886(d)(1)(B)) in order to ensure a timely and
22 smooth transition to the most appropriate type of,
23 and setting for, posthospital or rehabilitative care.
24 The Secretary shall issue final regulations imple-
25 menting such guidelines and standards not later

1 than 24 months after the date of the enactment of
2 this paragraph. The guidelines and standards shall
3 include the following:

4 “(A) The hospital or unit must identify the
5 types of services needed upon discharge by a
6 patient being treated by the hospital or unit.

7 “(B) The hospital or unit must—

8 “(i) identify organizations that offer
9 community services to the community that
10 is served by the hospital or unit and the
11 types of services provided by the organiza-
12 tions; and

13 “(ii) make demonstrated efforts to es-
14 tablish connections, relationships, and
15 partnerships with such organizations.

16 “(C) The hospital or unit must arrange
17 (with the participation of the patient and of any
18 other individuals selected by the patient for
19 such purpose) for the development and imple-
20 mentation of a discharge plan for the patient as
21 part of the patient’s overall treatment plan
22 from admission to discharge. Such discharge
23 plan shall meet the requirements described in
24 subparagraphs (G) and (H) of paragraph (2).

1 “(D) The hospital or unit shall coordinate
 2 with the patient (or assist the patient with) the
 3 referral for posthospital or rehabilitative care
 4 and as part of that referral the hospital or unit
 5 shall include transmitting to the receiving orga-
 6 nization, in a timely manner, appropriate infor-
 7 mation about the care furnished to the patient
 8 by the hospital or unit and recommendations
 9 for posthospital or rehabilitative care to be fur-
 10 nished to the patient by the organization.”.

11 **TITLE VII—RESEARCH BY NA-**
 12 **TIONAL INSTITUTE OF MEN-**
 13 **TAL HEALTH**

14 **SEC. 701. INCREASE IN FUNDING FOR CERTAIN RESEARCH.**

15 Section 402A(a) of the Public Health Service Act (42
 16 U.S.C. 282a(a)) is amended by adding at the end the fol-
 17 lowing:

18 “(3) FUNDING FOR THE BRAIN INITIATIVE AT
 19 THE NATIONAL INSTITUTE OF MENTAL HEALTH.—

20 “(A) FUNDING.—In addition to amounts
 21 made available pursuant to paragraphs (1) and
 22 (2), there are authorized to be appropriated to
 23 the National Institute of Mental Health for the
 24 purposes described in subparagraph (B)

1 \$40,000,000 for each of fiscal years 2017
2 through 2021.

3 “(B) PURPOSES.—Amounts appropriated
4 pursuant to subparagraph (A) shall be used ex-
5 clusively for the purpose of conducting or sup-
6 porting—

7 “(i) research on the determinants of
8 self- and other directed-violence in mental
9 illness, including studies directed at reduc-
10 ing the risk of self harm, suicide, and
11 interpersonal violence; or

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

15 **TITLE VIII—SAMHSA REAUTHOR-**
16 **IZATION AND REFORMS**
17 **Subtitle A—Organization and**
18 **General Authorities**

19 **SEC. 801. PEER REVIEW.**

20 (a) Section 501(h) of the Public Health Service Act
21 (42 U.S.C. 290aa(h)) is amended by inserting at the end
22 the following: “In the case of any such peer-review group
23 that is reviewing a proposal or grant related to mental
24 illness, no fewer than half of the members of the group
25 shall have a medical degree, a doctoral degree in psy-

1 chology, or advanced degree in nursing or social work from
2 an accredited graduate school, and shall specialize in the
3 mental health field.”.

4 (b) Section 504 of the Public Health Service Act (42
5 U.S.C. 290aa-3) is amended by adding at the end of sub-
6 section (b) the following: “At least half of the members
7 of any peer-review group established under subsection (a)
8 shall have a medical degree, a doctoral degree in psy-
9 chology, or advanced degree in nursing or social work from
10 an accredited graduate school, and shall specialize in the
11 mental health field.”.

12 **SEC. 802. ADVISORY COUNCILS.**

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

16 “(C) Not fewer than half of the members
17 of the group shall have a medical degree, a doc-
18 toral degree in psychology, or advanced degree
19 in nursing or social work from an accredited
20 graduate school and shall specialize in the men-
21 tal health field.

22 “(D) Each advisory committee shall in-
23 clude at least one member of the National Insti-
24 tute of Mental Health and 1 member from any

1 Federal agency that has a program serving a
2 similar population.”.

3 **SEC. 803. GRANTS FOR JAIL DIVERSION PROGRAMS REAU-**
4 **THORIZATION.**

5 Section 520G(i) of the Public Health Service Act (42
6 U.S.C. 290bb–38(i)) is amended by striking “\$10,000,000
7 for fiscal year 2001, and such sums as may be necessary
8 for fiscal years 2002 through 2003” and inserting
9 “\$5,000,000 for each of fiscal years 2017 through 2021”.

10 **SEC. 804. PROJECTS FOR ASSISTANCE IN TRANSITION**
11 **FROM HOMELESSNESS.**

12 Section 535(a) of the Public Health Service Act (42
13 U.S.C. 290cc–35(a)) is amended by striking “\$75,000,000
14 for each of the fiscal years 2001 through 2003” and in-
15 serting “\$65,000,000 for each of fiscal years 2017
16 through 2021”.

17 **SEC. 805. COMPREHENSIVE COMMUNITY MENTAL HEALTH**
18 **SERVICES FOR CHILDREN WITH SERIOUS**
19 **EMOTIONAL DISTURBANCES.**

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

22 (1) in subsection (b)(1), by striking “receiving
23 a grant under section 561(a)” and inserting “(irre-
24 spective of whether the public entity is in receipt of
25 a grant under section 561(a))”;

1 (2) in subsection (b)(1)(B), by striking “pursu-
 2 ant to section 562” and inserting “described in sec-
 3 tion 562”; and

4 (3) in subsection (f)(1), by striking
 5 “\$100,000,000 for fiscal year 2001, and such sums
 6 as may be necessary for each of the fiscal years
 7 2002 and 2003” and inserting “\$117,000,000 for
 8 each of fiscal years 2017 through 2021”.

9 **SEC. 806. REAUTHORIZATION OF PRIORITY MENTAL**
 10 **HEALTH NEEDS OF REGIONAL AND NA-**
 11 **TIONAL SIGNIFICANCE.**

12 Section 520A(f)(1) of the Public Health Service Act
 13 (42 U.S.C. 290bb–32(f)(1)) is amended by striking
 14 “\$300,000,000 for fiscal year 2001, and such sums as
 15 may be necessary for each of the fiscal years 2002 and
 16 2003” and inserting “\$370,000,000 for each of fiscal
 17 years 2017 through 2021”.

18 **TITLE IX—MENTAL HEALTH**
 19 **PARITY**

20 **SEC. 901. GAO STUDY ON PREVENTING DISCRIMINATORY**
 21 **COVERAGE LIMITATIONS FOR INDIVIDUALS**
 22 **WITH SERIOUS MENTAL ILLNESS AND SUB-**
 23 **STANCE USE DISORDERS.**

24 Not later than 1 year after the date of enactment
 25 of this Act, the Comptroller General of the United States,

1 in consultation with the Assistant Secretary for Mental
2 Health and Substance Use Disorders, the Secretary of
3 Health and Human Services, the Secretary of Labor, and
4 the Secretary of the Treasury, shall submit to Congress
5 a report detailing the extent to which covered group health
6 plans (or health insurance coverage offered in connection
7 with such plans), including Medicaid managed care plans
8 under section 1903 of the Social Security Act (42 U.S.C.
9 1396b), comply with the Paul Wellstone and Pete Domen-
10 ici Mental Health Parity and Addiction Equity Act of
11 2008 (subtitle B of title V of division C of Public Law
12 110–343) (in this section referred to as the “law”), includ-
13 ing—

14 (1) how nonquantitative treatment limitations,
15 including medical necessity criteria, of covered group
16 health plans comply with the law;

17 (2) how the responsible Federal departments
18 and agencies ensure that plans comply with the law;
19 and

20 (3) how proper enforcement, education, and co-
21 ordination activities within responsible Federal de-
22 partments and agencies can be used to ensure full
23 compliance with the law, including educational ac-
24 tivities directed to State insurance commissioners.

1 **SEC. 902. 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,
6 the Administrator of the Centers for Medicare & Medicaid
7 Services, in collaboration with the Assistant Secretary of
8 Labor of the Employee Benefits Security Administration
9 and the Secretary of the Treasury, and in consultation
10 with the Assistant Secretary for Mental Health and Sub-
11 stance Use Disorders, shall submit to Congress a report—

12 (1) identifying Federal investigations conducted
13 or completed during the preceding 12-month period
14 regarding compliance with parity in mental health
15 and substance use disorder benefits, including bene-
16 fits provided to persons with serious mental illness
17 and substance use disorders, under the Paul
18 Wellstone and Pete Domenici Mental Health Parity
19 and Addiction Equity Act of 2008 (subtitle B of title
20 V of division C of Public Law 110–343); and

21 (2) summarizing the results of such investiga-
22 tions.

23 (b) CONTENTS.—Subject to subsection (c), each re-
24 port under subsection (a) shall include the following infor-
25 mation:

1 (1) The number of investigations opened and
2 closed during the covered reporting period.

3 (2) The benefit classification or classifications
4 examined by each investigation.

5 (3) The subject matter or subject matters of
6 each investigation, including quantitative and non-
7 quantitative treatment limitations.

8 (4) A summary of the basis of the final decision
9 rendered for each investigation.

10 (c) **LIMITATION.**—Individually identifiable informa-
11 tion shall be excluded from reports under subsection (a)
12 consistent with Federal privacy protections.

13 **SEC. 903. STRENGTHENING PARITY IN MENTAL HEALTH**
14 **AND SUBSTANCE USE DISORDER BENEFITS.**

15 Section 2726(a) of the Public Health Service Act (42
16 U.S.C. 300gg–26(a)) is amended by adding at the end the
17 following new paragraph:

18 “(6) **DISCLOSURE AND ENFORCEMENT RE-**
19 **QUIREMENTS.**—

20 “(A) **DISCLOSURE REQUIREMENTS.**—

21 “(i) **REGULATIONS.**—Not later than
22 March 1, 2016, the Secretary, in coopera-
23 tion with the Secretary of Labor and the
24 Secretary of the Treasury shall issue addi-
25 tional regulations or sub-regulatory guid-

1 ance for carrying out this section, includ-
2 ing an explanation of documents that are
3 required to be disclosed, and analyses that
4 are required to be conducted, including
5 how non-quantitative treatment limitations
6 are applied to mental health or substance
7 use disorder benefits and medical or sur-
8 gical benefits covered under the plan, by a
9 group health plan (or health insurance
10 issuer) offering health insurance coverage
11 in the group or individual market in order
12 for such plan or issuer to demonstrate
13 compliance with the provisions of this sec-
14 tion. The disclosure requirements shall in-
15 clude a report detailing the specific anal-
16 yses performed to develop a compliance re-
17 view of the requirements of the Paul
18 Wellstone and Pete Domenici Mental
19 Health Parity and Addiction Equity Act of
20 2008, including the amendments made by
21 such Act. With respect to non-quantitative
22 treatment limitations, this report shall—

23 “(I) identify the specific factors
24 used by the plan in performing its

1 non-quantitative treatment limitations
2 analysis;

3 “(II) identify and define the spe-
4 cific evidentiary standards relied on to
5 evaluate the factors;

6 “(III) describe how the evi-
7 dentiary standards were applied to
8 each service category;

9 “(IV) disclose the results of the
10 analyses of the specific evidentiary
11 standards in each service category;
12 and

13 “(V) disclose the plan’s specific
14 findings in each service category and
15 the conclusions reached with respect
16 to compliance with comparability and
17 stringency of application tests under
18 the non-quantitative treatment limita-
19 tions rule.

20 “(ii) GUIDANCE.—The Secretary, in
21 cooperation with the Secretary of Labor
22 and the Secretary of the Treasury shall
23 issue guidance to group health plans and
24 health insurance issuers offering health in-
25 surance coverage in the group or individual

1 markets on how to satisfy the requirements
2 of this section with respect to making in-
3 formation, including certificate of coverage
4 documents and instruments under which
5 the plan is administered and operated that
6 specify, include, or refer to procedures, for-
7 mulas, and methodologies applied to deter-
8 mine a participant or beneficiary's benefit
9 under the plan, regardless of whether such
10 information is contained in a document
11 designated as the 'plan document' available
12 to current and potential participants and
13 beneficiaries. This guidance shall include
14 plan disclosure of how the plan has met
15 the 2-part test under the non-quantitative
16 treatment limitations rule of comparability
17 and stringency in application.

18 “(B) ENFORCEMENT.—

19 “(i) PROCESS FOR COMPLAINTS.—The
20 Secretary, in cooperation with the Sec-
21 retary of Labor and the Secretary of the
22 Treasury, as appropriate, shall, with re-
23 spect to group health plans and health in-
24 surance issuers offering health insurance
25 coverage in the group or individual market,

1 issue guidance to clarify the process and
2 timeline for current and potential partici-
3 pants and beneficiaries and their author-
4 ized representatives and providers with re-
5 spect to such plans and coverage to file
6 formal complaints of such plans or issuers
7 being in violation of this section, including
8 guidance on the relevant individual State,
9 regional, and national offices with which
10 such claims should be filed by plan type.

11 “(ii) AUTHORITY FOR PUBLIC EN-
12 FORCEMENT.—The Secretary shall make
13 available to the public de-identified infor-
14 mation on audits and investigations of
15 group health plans and health insurance
16 issuers conducted under this section.

17 “(iii) AUDITS.—

18 “(I) RANDOMIZED AUDITS.—The
19 Secretary is authorized to conduct
20 randomized audits of group health
21 plans and health insurance issuers of-
22 fering health insurance coverage in
23 the group or individual market to de-
24 termine compliance with this section.
25 Such audits shall be conducted on no

1 fewer than 12 plans and issuers per
2 plan year. The information shall be
3 made plainly available on the public
4 Internet websites of the Department
5 of Health and Human Services and
6 the Department of Labor.

7 “(II) ADDITIONAL AUDITS.—In
8 the case of a group health plan or
9 health insurance issuer offering health
10 insurance coverage in the group or in-
11 dividual market with respect to which
12 at least 5 substantiated claims of the
13 same type of non-compliance with this
14 section have been filed during a plan
15 year, the Secretary shall audit plan
16 documents to determine compliance
17 with this section. Information detail-
18 ing the results of the audit shall be
19 made available on the public Internet
20 website of the Department of Health
21 and Human Services.”.

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