

114TH CONGRESS
1ST SESSION

S. _____

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

Mr. MURPHY introduced the following bill; which was read twice and referred to the Committee on _____

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 “_____ Act of _____”.

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.

2

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.

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 with—

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

22 (ii) completed an internship accredited
23 by the Association of Psychology Post-doc-
24 toral and Internship Centers as part of
25 doctoral degree completion; and

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

5 (C) have a doctoral degree in social work
6 with—

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

10 (ii) completed an internship accredited
11 by the Council on Social Work Education;
12 and

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

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

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

24 (1) promote, evaluate, organize, integrate, and
25 coordinate research, treatment, and services across

1 departments, agencies, organizations, and individ-
2 uals with respect to the problems of individuals suf-
3 fering from substance use disorders or mental ill-
4 ness;

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

7 (A) to improve the diagnosis, prevention,
8 intervention and treatment of, and related serv-
9 ices to, individuals with respect to substance
10 use disorders or mental illness;

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

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

22 (D) to develop and implement initiatives to
23 encourage individuals to pursue careers (espe-
24 cially in underserved areas and populations) as
25 psychiatrists, psychologists, psychiatric nurse

1 practitioners, clinical social workers, and other
2 licensed mental health professionals specializing
3 in the diagnosis, evaluation, and treatment of
4 individuals with severe mental illness, and with
5 an understanding of family involvement;

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) the diagnosis, prevention, and inter-
8 vention or treatment of, or rehabilitation for,
9 mental 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 among
14 individuals with mental health and substance
15 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 those
24 budgets;

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, prevention of, or treat-
8 ment 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 increase the mental health workforce and
7 recruit medical professionals who recognize the role
8 of the family, for the treatment of individuals with
9 mental illness and substance use 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; and

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 (e) PRIORITIZATION OF INTEGRATION OF SERVICES,
18 EARLY DIAGNOSIS, INTERVENTION, AND WORKFORCE
19 DEVELOPMENT.—In carrying out the duties described in
20 subsection (c), the Assistant Secretary—

21 (1) shall prioritize—

22 (A) the integration of mental health, sub-
23 stance use, and physical health services for the
24 purpose of diagnosing, preventing, treating, or
25 providing rehabilitation for mental illness or

1 substance use disorders, including any such
2 services provided through the justice system
3 (including departments of correction) or other
4 entities other than the Department of Health
5 and Human Services;

6 (B) the early diagnosis and intervention
7 services for the prevention of, or crisis interven-
8 tion for and treatment or rehabilitation for, se-
9 rious mental health disorders or substance use
10 disorders, in selecting evidence-based practices
11 and service delivery models for evaluation and
12 dissemination under section 201(a)(2)(C); and

13 (C) workforce development for—

14 (i) appropriate treatment of serious
15 mental illness or substance use disorders;
16 and

17 (ii) research activities that advance
18 scientific and clinical understandings of se-
19 rious mental illness or substance use dis-
20 orders, including the development and im-
21 plementation of a continuing nationwide
22 strategy to increase the psychiatric work-
23 force by increasing the number of psychia-
24 trists, child and adolescent psychiatrists,
25 psychologists, psychiatric nurse practi-

1 tioners, clinical social workers, and mental
2 health peer support specialists;

3 (2) shall give preference to models that improve
4 the coordination, quality, and efficiency of health
5 care services furnished to individuals with serious
6 mental illness; and

7 (3) may include clinical protocols and practices
8 used in the Recovery After an Initial Schizophrenia
9 Episode project of the National Institute of Mental
10 Health or similar models, such as the Specialized
11 Treatment Early in Psychosis program.

12 **SEC. 102. REPORTS.**

13 (a) REPORT ON BEST PRACTICES FOR PEER-SUP-
14 PORT SPECIALIST PROGRAMS, TRAINING, AND CERTIFI-
15 CATION.—

16 (1) IN GENERAL.—Not later than 18 months
17 after the date of enactment of this Act, and bian-
18 nually thereafter, the Assistant Secretary shall sub-
19 mit to Congress and make publicly available a report
20 on best practices and professional standards in
21 States for—

22 (A) establishing and operating health care
23 programs using peer-support specialists; and

24 (B) training and certifying peer-support
25 specialists.

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

4 (A) uses his or her lived experience of re-
5 covery from mental illness or substance abuse,
6 plus skills learned in formal training, to facili-
7 tate support groups, and to work on a one-on-
8 one basis, with individuals with a serious men-
9 tal illness or a substance use disorder, in con-
10 sultation with, and under the supervision of, a
11 licensed mental health or substance use treat-
12 ment professional;

13 (B) has been an active participant in men-
14 tal health or substance use treatment for at
15 least the preceding 2 years;

16 (C) does not provide direct medical serv-
17 ices; and

18 (D) does not perform services outside of
19 his or her area of training, expertise, com-
20 petence, or scope of practice.

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

1 (A) Hours of formal work or volunteer ex-
2 perience related to mental health and substance
3 use issues.

4 (B) Types of peer specialist exams re-
5 quired.

6 (C) Code of ethics.

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

9 (i) ethics;

10 (ii) scope of practice;

11 (iii) crisis intervention;

12 (iv) State confidentiality laws;

13 (v) Federal privacy protections, in-
14 cluding under the Health Insurance Port-
15 ability and Accountability Act of 1996
16 (Public Law 104–191); and

17 (vi) other areas, as determined by the
18 Assistant Secretary.

19 (E) Requirements to explain what, where,
20 when, and how to accurately complete all re-
21 quired documentation activities.

22 (F) Required or recommended skill sets,
23 including—

24 (i) identifying risk indicators and re-
25 sponding appropriately to individual

1 stressors, triggers, and indicators of esca-
2 lating symptoms;

3 (ii) explaining basic de-escalation
4 techniques;

5 (iii) explaining basic suicide preven-
6 tion concepts and techniques;

7 (iv) identifying indicators that an in-
8 dividual may be experiencing abuse or ne-
9 glect;

10 (v) identifying the individual's current
11 stage of change or recovery;

12 (vi) explaining the typical process that
13 should be followed to access or participate
14 in community mental health and related
15 services; and

16 (vii) identifying circumstances when it
17 is appropriate to request assistance from
18 other professionals to help meet the indi-
19 vidual's recovery goals.

20 (G) Annual requirements for continuing
21 education credits.

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

24 (1) IN GENERAL.—Not later than 18 months
25 after the date of enactment of this Act, and not less

1 than every 18 months thereafter, the Assistant Sec-
2 retary for Mental Health and Substance Use Dis-
3 orders, in collaboration with the Director of the
4 Agency for Healthcare Research and Quality and
5 Director of the National Institutes of Health, shall
6 submit to Congress and make available to the public
7 a report on mental health and substance use treat-
8 ment in the States, including the following:

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

12 (i) The numbers of individuals with
13 serious mental illness or substance use dis-
14 orders who are served with Federal funds.

15 (ii) The types of programs made avail-
16 able to individuals with serious mental ill-
17 ness or substance use disorders.

18 (B) A summary of best practice models in
19 the States highlighting programs that are cost
20 effective, provide evidence-based care, increase
21 access to care, integrate physical, psychiatric,
22 psychological, and behavioral medicine, and im-
23 prove outcomes for individuals with serious
24 mental illness or substance use disorders.

1 (C) A statistical report of outcome meas-
2 ures in each State, including—

3 (i) rates of suicide, suicide attempts,
4 substance abuse, overdose, overdose
5 deaths, emergency psychiatric hospitaliza-
6 tions, and emergency room boarding; and

7 (ii) with respect to individuals with
8 mental illness, health outcomes, emergency
9 psychiatric hospitalizations and emergency
10 room boarding, arrests, incarcerations, vic-
11 timization, homelessness, joblessness, em-
12 ployment, and enrollment in educational or
13 vocational programs.

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

20 (i) rates of keeping treatment ap-
21 pointments and compliance with prescribed
22 medications;

23 (ii) participants' perceived effective-
24 ness of the program;

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

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

17 (c) REPORTING COMPLIANCE STUDY.—

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

1 of Congress a report that evaluates the combined pa-
2 perwork burden of—

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

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

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

1 to make administrative and statutory recommenda-
2 tions to Congress (which recommendations may in-
3 clude a uniform methodology) to reduce the paper-
4 work burden experienced by centers and clinics de-
5 scribed in paragraph (1).

6 **SEC. 103. ADVISORY COUNCIL ON GRADUATE MEDICAL**
7 **EDUCATION.**

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

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

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

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

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

21 **TITLE II—GRANTS**

22 **SEC. 201. NATIONAL MENTAL HEALTH POLICY LABORA-**
23 **TORY.**

24 (a) IN GENERAL.—

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

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

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

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

21 (C) evaluate and disseminate to such
22 grantees evidence-based practices and services
23 delivery models using the best available science
24 shown to be cost-effective while enhancing the
25 quality of care furnished to individuals; and

1 (D) establish standards for the appoint-
2 ment of scientific peer-review panels to evaluate
3 grant applications.

4 (3) EVIDENCE-BASED PRACTICES AND SERVICE
5 DELIVERY MODELS.—In selecting evidence-based
6 best practices and service delivery models for evalua-
7 tion and dissemination under paragraph (2)(C), the
8 Director of the NMHPL—

9 (A) shall give preference to models that—

10 (i) improve the coordination between
11 mental health and physical health pro-
12 viders;

13 (ii) improve the coordination among
14 such providers and the justice and correc-
15 tions system;

16 (iii) improve the cost effectiveness,
17 quality, effectiveness, and efficiency of
18 health care services furnished to individ-
19 uals with serious mental illness, in mental
20 health crisis, or at risk to themselves, their
21 families, and the general public; and

22 (iv) recognize the importance of fam-
23 ily participation in recovery; and

24 (B) may include clinical protocols and
25 practices used in the Recovery After Initial

1 Schizophrenia Episode project of the National
2 Institute of Mental Health and the Specialized
3 Treatment Early in Psychosis program.

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

8 (5) CONSULTATION.—In carrying out the duties
9 under this subsection, the Director of the NMHPL
10 may consult with—

11 (A) representatives of the National Insti-
12 tute of Mental Health on organizational and
13 operational issues;

14 (B) other appropriate Federal agencies;

15 (C) clinical and analytical experts with ex-
16 pertise in medicine, psychiatric and clinical psy-
17 chological care, health care management, edu-
18 cation, corrections health care, social services,
19 and mental health court systems; and

20 (D) other individuals and agencies as the
21 Assistant Secretary determines appropriate.

22 (b) STAFFING.—

23 (1) COMPOSITION.—In selecting the staff of the
24 NMHPL, the Director of the NMHPL, in consulta-
25 tion with the Director of the National Institute of

1 Mental Health, shall include individuals with ad-
2 vanced degrees and clinical and research experience,
3 and who have an understanding of biological, psy-
4 chosocial, and pharmaceutical treatments of mental
5 illness and substance use disorders, including—

6 (A) individuals with a medical degree or
7 doctoral degree from an accredited program
8 in—

9 (i) allopathic or osteopathic medicine,
10 and who have specialized training in psy-
11 chiatry;

12 (ii) psychology; or

13 (iii) social work;

14 (B) professionals or academics with clinical
15 or research expertise in substance use disorders
16 and treatment; and

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

19 (c) REPORT ON QUALITY OF CARE.—Not later than
20 2 years after the date of enactment of this Act, and every
21 2 years thereafter, the Director of the NMHPL shall sub-
22 mit to Congress a report on the quality of care furnished
23 through grant programs administered by the Assistant
24 Secretary under the respective services delivery models, in-

1 cluding measurement of patient-level outcomes and public
2 health outcomes, such as—

3 (1) reduced rates of suicide, suicide attempts,
4 substance abuse, overdose, overdose deaths, emer-
5 gency psychiatric hospitalizations, emergency room
6 boarding, incarceration, crime, arrest, victimization,
7 homelessness, and joblessness;

8 (2) rates of employment and enrollment in edu-
9 cational and vocational programs; and

10 (3) such other criteria as the Director may de-
11 termine.

12 (d) DEFINITION.—In this section, the term “emer-
13 gency room boarding” means the practice of admitting pa-
14 tients to an emergency department and holding such pa-
15 tients in the department until inpatient psychiatric beds
16 become available.

17 **SEC. 202. INNOVATION GRANTS.**

18 (a) IN GENERAL.—The Assistant Secretary shall
19 award grants to State and local governments, educational
20 institutions, and nonprofit organizations for expanding a
21 model that has been scientifically demonstrated to show
22 promise, but would benefit from further applied research,
23 for—

1 (1) enhancing the screening, diagnosis, and
2 treatment of mental illness and serious mental ill-
3 ness; or

4 (2) integrating or coordinating physical, mental
5 health, and substance use services.

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

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

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

12 (2) not less than one-third shall be awarded for
13 screening, diagnosis, treatment, or services, as de-
14 scribed in subsection (a), for individuals (or sub-
15 populations of individuals) who are below the age of
16 18 when activities funded through the grant award
17 are initiated.

18 (d) GUIDELINES.—As a condition on receipt of an
19 award under this section, an applicant shall agree to ad-
20 here to guidelines issued by the National Mental Health
21 Policy Laboratory on research designs and data collection.

22 (e) AUTHORIZATION OF APPROPRIATIONS.—To carry
23 out this section, there are authorized to be appropriated
24 \$10,000,000 for each of fiscal years 2017 through 2021.

1 **SEC. 203. DEMONSTRATION GRANTS.**

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

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

11 (2) integrating models of care across specialties
12 and jurisdictions.

13 (b) DURATION.—A grant under this section shall be
14 for a period of not less than 2 years and not more than
15 5 years.

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

18 (1) not less than half shall be awarded for
19 screening, diagnosis, intervention, and treatment, as
20 described in subsection (a), for individuals (or sub-
21 populations of individuals) who are below the age of
22 26 when activities funded through the grant award
23 are initiated;

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

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

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

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

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

13 (1) to report to the National Mental Health
14 Policy Laboratory and the Assistant Secretary the
15 results of programs and activities funded through
16 the award; and

17 (2) to include in such reporting any relevant
18 data requested by the National Mental Health Policy
19 Laboratory and the Assistant Secretary.

20 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
21 out this section, there are authorized to be appropriated
22 \$10,000,000 for each of fiscal years 2017 through 2021.

1 **SEC. 204. EARLY CHILDHOOD INTERVENTION AND TREAT-**
2 **MENT.**

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

6 (1) award grants to eligible entities to initiate
7 and undertake early childhood intervention and
8 treatment programs, and specialized preschool and
9 elementary school programs for children at signifi-
10 cant risk or who show early signs of social or emo-
11 tional disability (in addition to any learning dis-
12 ability); and

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

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

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

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

1 (B) provides services that include early
2 intervention and treatment or specialized pre-
3 school and elementary school programs focused
4 on children whose primary need is a social or
5 emotional disability (in addition to any learning
6 disability).

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

10 (A) whose primary need is a social or emo-
11 tional disability (in addition to any learning dis-
12 ability); and

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

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

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

1 (1) Deliver (or facilitate) for eligible children
2 mental health treatment and education, early child-
3 hood education and intervention, and specialized pre-
4 school and elementary school programs, including
5 the provision of day treatment and social-emotional
6 and behavioral services.

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

9 (A) program start-up, curricula develop-
10 ment, and operating and capital needs;

11 (B) staff and equipment;

12 (C) assessment, intervention, and treat-
13 ment services;

14 (D) administrative costs;

15 (E) enrollment costs;

16 (F) collaboration with primary care physi-
17 cians, psychiatrists, and clinical services of psy-
18 chologists of other related mental health spe-
19 cialists;

20 (G) services to meet emergency needs of
21 children; and

22 (H) communication with families and phys-
23 ical and mental health professionals concerning
24 the children.

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

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

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

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

21 (h) AUTHORIZATION OF APPROPRIATIONS.—To carry
22 out this section, there are authorized to be appropriated
23 \$10,000,000 for each of fiscal years 2017 through 2021.

1 **SEC. 205. EXTENSION OF ASSISTED OUTPATIENT TREAT-**
2 **MENT GRANT PROGRAM FOR INDIVIDUALS**
3 **WITH SERIOUS MENTAL ILLNESS.**

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

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

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

10 (3) in subsection (g)—

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

13 (B) in paragraph (2) by striking “2018”
14 and inserting “2020”.

15 **SEC. 206. BLOCK GRANTS.**

16 (a) REAUTHORIZATION OF BLOCK GRANT.—Section
17 1920(a) of the Public Health Service Act (42 U.S.C. 300x-
18 9(a)) is amended by striking “\$450,000,000 for fiscal year
19 2001, and such sums as may be necessary for each of the
20 fiscal years 2002 and 2003” and inserting “\$483,000,000
21 for fiscal year 2017 and such sums as may be necessary
22 for each of fiscal years 2018 through 2019”.

23 (b) BEST PRACTICES IN CLINICAL CARE MODELS.—
24 Section 1920 of the Public Health Service Act (42 U.S.C.
25 300x-9) is amended by adding at the end the following:

1 “(c) BEST PRACTICES IN CLINICAL CARE MOD-
2 ELS.—The Secretary, acting through the Director of the
3 National Institute of Mental Health, shall obligate 5 per-
4 cent of the amounts appropriated for a fiscal year under
5 subsection (a) for translating evidence-based (as defined
6 in section 2 of the [_____ Act of 2015]) interventions
7 and best available science into systems of care, such as
8 through models including the Recovery After an Initial
9 Schizophrenia Episode research project of the National In-
10 stitute of Mental Health.”.

11 (c) ADDITIONAL PROGRAM REQUIREMENTS.—

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

15 (A) by striking “The plan provides” and
16 inserting the following:

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

18 (B) in the second sentence, by striking
19 “health and mental health services” and insert-
20 ing “integrated physical and mental health
21 services”;

22 (C) by striking “The plan shall include”
23 and all that follows through the period at the
24 end and inserting “The plan shall integrate and
25 coordinate services to maximize the efficiency,

1 effectiveness, quality, coordination, and cost ef-
2 fectiveness of those services and programs to
3 produce the best possible outcomes for individ-
4 uals with serious mental illness.”; and

5 (D) by adding at the end the following new
6 subparagraph:

7 “(B) ADDITIONAL REQUIREMENTS.—The
8 plan shall include a separate description of case
9 management services and provide for activities
10 leading to reduction of rates of suicides, suicide
11 attempts, substance abuse, overdose deaths,
12 emergency hospitalizations, incarceration,
13 crimes, arrest, victimization, homelessness, job-
14 lessness, medication nonadherence, and edu-
15 cation and vocational programs drop outs. The
16 plan shall include a detailed list of services
17 available for eligible patients in each county or
18 county equivalent, including assisted outpatient
19 treatment.”.

20 (2) DATA COLLECTION SYSTEM.—

21 (A) Subsection (b)(1)(A) (as so designated
22 by paragraph (1)) of section 1912 of the Public
23 Health Service Act (42 U.S.C. 300x-
24 1(b)(1)(A)) is amended by inserting “legal serv-
25 ices, and” before “other support services”.

1 (B) Subsection (b)(2) of section 1912 of
2 the Public Health Service Act (42 U.S.C. 300x–
3 1(b)(2)) is amended by inserting “and outcome
4 measures for services and resources” before the
5 period.

6 (3) IMPLEMENTATION OF PLAN.—Subsection
7 (d) of section 1912 of the Public Health Service Act
8 (42 U.S.C. 300x–1(d)) is amended—

9 (A) in paragraph (1)—

10 (i) by striking “Except as provided”
11 and inserting the following:

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

13 and

14 (ii) by adding at the end the following
15 new subparagraph:

16 “(B) DE-IDENTIFIED REPORTS.—For eligi-
17 ble patients receiving treatment through funds
18 awarded under a grant under section 1911, a
19 State shall include in the State plan for the
20 first year beginning after the date of the enact-
21 ment of the _____ Act of _____
22 and each subsequent year, a de-identified re-
23 port, containing information that is open source
24 and de-identified, on the outcomes measures
25 collected in subsection (b)(2) of section 1912 of

1 the Public Health Service Act and the overall
2 cost of such treatment provided.”.

3 **[(4) INCENTIVES FOR STATE-BASED OUTCOME**
4 **MEASURES.—To be supplied.]**

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

9 “(e) EXPANSION OF MODELS.—

10 “(1) IN GENERAL.—Taking into account the re-
11 sults of evaluations under section 201(a)(2)(C) of
12 the [____ Act of 2015], the Assistant Secretary
13 may, by rule, as part of the program of block grants
14 under this subpart, provide for expanded use across
15 the Nation of evidence-based service delivery models
16 by providers funded under such block grants, so long
17 as—

18 “(A) the Assistant Secretary for Mental
19 Health and Substance Use Disorders (in this
20 subsection referred to as the ‘Assistant Sec-
21 retary’) determines that such expansion will—

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

1 “(ii) improve the quality of patient
2 care without significantly increasing spend-
3 ing;

4 “(B) the Director of the National Institute
5 of Mental Health determines that such expan-
6 sion would improve the quality of patient care;
7 and

8 “(C) the Assistant Secretary determines
9 that the change will—

10 “(i) significantly reduce severity and
11 duration of symptoms of mental illness;

12 “(ii) reduce rates of suicide, suicide
13 attempts, substance abuse, overdose, emer-
14 gency hospitalizations, emergency room
15 boarding, incarceration, crime, arrest, vic-
16 timization, homelessness, or joblessness; or

17 “(iii) significantly improve the quality
18 of patient care and mental health crisis
19 outcomes without significantly increasing
20 spending.

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

1 (d) PERIOD FOR EXPENDITURE OF GRANT FUNDS.—
2 Section 1913 of the Public Health Service Act (42 U.S.C.
3 300x-2) is amended by adding at the end the following:

4 “(d) PERIOD FOR EXPENDITURE OF GRANT
5 FUNDS.—In implementing a plan submitted under section
6 1912(a), a State receiving a grant under section 1911 may
7 make such funds available to providers of services de-
8 scribed in subsection (b) for the provision of services with-
9 out fiscal year limitation.”.

10 (e) ACTIVE OUTREACH AND ENGAGEMENT.—Section
11 1915 of the Public Health Service Act (42 U.S.C. 300x-
12 4) is amended by adding at the end of the following:

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

15 “(1) IN GENERAL.—A funding agreement for a
16 grant under section 1911 is that the State involved
17 has in effect active programs that seek to engage in-
18 dividuals with serious mental illness in comprehen-
19 sive services in order to avert relapse, repeated hos-
20 pitalizations, arrest, incarceration, suicide, and to
21 provide the patient with the opportunity to live in
22 the least restrictive setting, through a comprehensive
23 program of evidence-based and culturally relevant
24 assertive outreach and engagement services focusing
25 on individuals who are homeless, have co-occurring

1 disorders, are at risk for incarceration or re-incar-
2 ceration, or have a history of treatment failure, in-
3 cluding repeated hospitalizations or emergency room
4 usage.

5 “(2) EVIDENCE-BASED ASSERTIVE OUTREACH
6 AND ENGAGEMENT SERVICES.—

7 “(A) SAMHSA.—The Administrator of
8 the Substance Abuse and Mental Health Serv-
9 ices Administration, in cooperation with the Di-
10 rector of the National Institute of Mental
11 Health, shall develop—

12 “(i) a list of evidence-based culturally
13 and linguistically relevant assertive out-
14 reach and engagement services; and

15 “(ii) criteria to be used to assess the
16 scope and effectiveness of the approaches
17 taken by such services, such as the ability
18 to provide same-day appointments for
19 emergent situations.

20 “(B) TYPES OF ASSERTIVE OUTREACH
21 AND ENGAGEMENT SERVICES.—For purposes of
22 paragraph (1), appropriate programs of evi-
23 dence-based assertive outreach and engagement
24 services may include peer support programs;
25 the Wellness Recovery Action Plan, Assertive

1 Community Treatment, and Forensic Assertive
2 Community Treatment of the Substance Abuse
3 and Mental Health Services Administration; ap-
4 propriate supportive housing programs incor-
5 porating a Housing First model; and intensive,
6 evidence-based approaches to early intervention
7 in psychosis, such as the Recovery After an Ini-
8 tial Schizophrenia Episode model of the Na-
9 tional Institute of Mental Health and the Spe-
10 cialized Treatment Early in Psychosis program.

11 “(d) PSYCHIATRIC ADVANCED DIRECTIVES.—A
12 funding agreement for a grant under section 1911 is that
13 the State involved has in effect active programs that seek
14 to engage individuals with serious mental illness in
15 proactively making their own health care decisions and en-
16 hancing communication between themselves, their fami-
17 lies, and their treatment providers by allowing for early
18 intervention and reducing legal proceedings related to in-
19 voluntary treatment by developing psychiatric advanced
20 directives through a comprehensive program—

21 “(1) of assertive outreach and engagement serv-
22 ices focusing on individuals diagnosed with serious
23 mental illness or self-identifying as in recovery from
24 serious mental illness to obtain a psychiatric ad-
25 vanced directive; or

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

4 **SEC. 207. TELEHEALTH CHILD PSYCHIATRY ACCESS**
5 **GRANTS.**

6 (a) IN GENERAL.—The Secretary, acting through the
7 Administrator of the Health Resources and Services Ad-
8 ministration, shall award grants to States, Indian tribes,
9 and tribal organizations to promote behavioral health inte-
10 gration in pediatric primary care by—

11 (1) supporting the creation of statewide child
12 psychiatry access programs; and

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

15 (b) PROGRAM REQUIREMENTS.—

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

19 (A) be a statewide network of pediatric
20 mental health teams that provide support to pe-
21 diatric primary care sites as an integrated
22 team;

23 (B) support and further develop organized
24 State networks of child and adolescent psychia-

1 trists to provide consultative support to pedi-
2 atric primary care sites;

3 (C) conduct an assessment of critical be-
4 havioral consultation needs among pediatric
5 providers and such providers' preferred mecha-
6 nisms for receiving consultation and training
7 and technical assistance;

8 (D) develop an online database and com-
9 munication mechanisms, including telehealth, to
10 facilitate consultation support to pediatric prac-
11 tices;

12 (E) provide rapid (within 30 minutes)
13 statewide clinical telephone consultations when
14 requested between the pediatric mental health
15 teams and pediatric primary care providers;

16 (F) conduct training and provide technical
17 assistance to pediatric primary care providers to
18 support the early identification, diagnosis,
19 treatment, and referral of children with behav-
20 ioral health conditions;

21 (G) inform and assist pediatric providers
22 in accessing child psychiatry consultations and
23 in scheduling and conducting technical assist-
24 ance;

1 (H) assist with referrals to specialty care
2 and community and behavioral health resources;
3 and

4 (I) establish mechanisms for measuring
5 and monitoring increased access to child and
6 adolescent psychiatric services by pediatric pri-
7 mary care providers and expanded capacity of
8 pediatric primary care providers to identify,
9 treat, and refer children with mental health
10 problems.

11 (2) PEDIATRIC MENTAL HEALTH TEAMS.—For
12 the purposes of this subsection, the term “pediatric
13 mental health team” means a team of case coordina-
14 tors, child and adolescent psychiatrists, and a li-
15 censed clinical mental health professional, such as a
16 psychologist, social worker, or mental health coun-
17 selor. Such a team may be regionally-based, provided
18 there is access to a pediatric mental health team
19 across the State.

20 (c) APPLICATION.—A State, political subdivision of
21 a State, Indian tribe, or tribal organization that desires
22 a grant under this section shall submit an application to
23 the Secretary at such time, in such manner, and con-
24 taining such information as the Secretary may require, in-

1 cluding a plan for the rigorous evaluation of activities that
2 are carried out with funds received under such grant.

3 (d) EVALUATION.—A State, political subdivision of a
4 State, Indian tribe, or tribal organization that receives a
5 grant under this section shall prepare and submit an eval-
6 uation to the Secretary at such time, in such manner, and
7 containing such information as the Secretary may reason-
8 ably require, including an evaluation of activities carried
9 out with funds received under such grant and a process
10 and outcome evaluation.

11 (e) MATCHING REQUIREMENT.—The Secretary may
12 not award a grant under the grant program unless the
13 State involved agrees, with respect to the costs to be in-
14 curred by the State in carrying out the purpose described
15 in this section, to make available non-Federal contribu-
16 tions (in cash or in kind) toward such costs in an amount
17 that is not less than 20 percent of Federal funds provided
18 in the grant.

19 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
20 out this section, there are authorized to be appropriated
21 \$25,000,000 for fiscal year 2017 and such sums as may
22 be necessary for each of fiscal years 2018 through 2021.

1 **SEC. 208. LIABILITY PROTECTIONS FOR HEALTH CARE**
2 **PROFESSIONAL VOLUNTEERS AT COMMU-**
3 **NITY HEALTH CENTERS AND COMMUNITY**
4 **MENTAL HEALTH CENTERS.**

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

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

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

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

15 “(2) For purposes of this section, a health care pro-
16 fessional volunteer at an entity described in subsection
17 (g)(4) or a community mental health center shall, in pro-
18 viding health care services eligible for funding under sec-
19 tion 330 or subpart I of part B of title XIX to an indi-
20 vidual, be deemed to be an employee of the Public Health
21 Service for a calendar year that begins during a fiscal year
22 for which a transfer was made under paragraph (5)(C).
23 The preceding sentence is subject to the provisions of this
24 subsection.

25 “(3) In providing a health care service to an indi-
26 vidual, a health care professional shall, for purposes of this

1 subsection be considered to be a health professional volun-
2 teer at an entity described in subsection (g)(4) or at a
3 community mental health center if the following conditions
4 are met:

5 “(A) The service is provided to the individual at
6 the facilities of an entity described in subsection
7 (g)(4), at a federally qualified community behavioral
8 health clinic, or through offsite programs or events
9 carried out by the center.

10 “(B) The center or entity is sponsoring the
11 health care professional volunteer pursuant to para-
12 graph (4)(B).

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

23 “(D) Before the service is provided, the health
24 care professional or the center or entity described in
25 subsection (g)(4) posts a clear and conspicuous no-

1 tice at the site where the service is provided of the
2 extent to which the legal liability of the health care
3 professional is limited pursuant to this subsection.

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

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

15 “(A) The first sentence of paragraph (2) ap-
16 plies in lieu of the first sentence of subsection
17 (g)(1)(A).

18 “(B) With respect to an entity described in sub-
19 section (g)(4) or a federally qualified community be-
20 havioral health clinic, a health care professional is
21 not a health professional volunteer at such center
22 unless the center sponsors the health care profes-
23 sional. For purposes of this subsection, the center
24 shall be considered to be sponsoring the health care
25 professional if—

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

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

9 “(C) In the case of a health care professional
10 who is determined by the Secretary pursuant to sub-
11 section (g)(1)(E) to be a health professional volun-
12 teer at such center, this subsection applies to the
13 health care professional (with respect to services de-
14 scribed in paragraph (2)) for any cause of action
15 arising from an act or omission of the health care
16 professional occurring on or after the date on which
17 the Secretary makes such determination.

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

23 “(5)(A) Amounts in the fund established under sub-
24 section (k)(2) shall be available for transfer under sub-
25 paragraph (C) for purposes of carrying out this subsection

1 for health professional volunteers at entities described in
2 subsection (g)(4).

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

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

23 “(6)(A) This subsection takes effect on October 1,
24 2017, except as provided in subparagraph (B).

1 “(B) Effective on the date of the enactment of this
2 subsection—

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

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

9 **SEC. 209. MINORITY FELLOWSHIP PROGRAM.**

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

12 (1) by redesignating part G (42 U.S.C. 290kk
13 et seq.), relating to services provided through reli-
14 gious organizations and added by section 144 of the
15 Community Renewal Tax Relief Act of 2000, as en-
16 acted into law by section 1(a)(7) of Public Law 106–
17 554, as part J;

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

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

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

23 **“SEC. 597. FELLOWSHIPS.**

24 “(a) IN GENERAL.—The Secretary shall maintain a
25 program, to be known as the Minority Fellowship Pro-

1 gram, under which the Secretary awards fellowships,
2 which may include stipends, for the purposes of—

3 “(1) increasing behavioral health practitioners’
4 knowledge of issues related to prevention, treatment,
5 and recovery support for mental and substance use
6 disorders among racial and ethnic minority popu-
7 lations;

8 “(2) improving the quality of mental and sub-
9 stance use disorder prevention and treatment deliv-
10 ered to ethnic minorities; and

11 “(3) increasing the number of culturally com-
12 petent behavioral health professionals who teach, ad-
13 minister, conduct services research, and provide di-
14 rect mental health or substance use services to un-
15 derserved minority populations.

16 “(b) TRAINING COVERED.—The fellowships under
17 subsection (a) shall be for postbaccalaureate training (in-
18 cluding for master’s and doctoral degrees) for mental
19 health professionals, including in the fields of psychiatry,
20 nursing, social work, psychology, marriage and family
21 therapy, and substance use and addiction counseling.

22 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
23 carry out this section, there are authorized to be appro-
24 priated \$6,000,000 for each of fiscal years 2017 through
25 2021.”.

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

2 (a) DEFINITIONS.—

3 (1) PRIMARY HEALTH SERVICES.—Section
4 331(a)(3)(D) of the Public Health Service Act (42
5 U.S.C. 254d(a)(3)(D)) is amended by inserting “(in-
6 cluding pediatric mental health subspecialty serv-
7 ices)” after “pediatrics”.

8 (2) BEHAVIORAL AND MENTAL HEALTH PRO-
9 FESSIONALS.—Clause (i) of section 331(a)(3)(E)(i)
10 of the Public Health Service Act (42 U.S.C.
11 254d(a)(3)(E)(i)) is amended by inserting “, includ-
12 ing such professionals who are pediatric subspecial-
13 ists” before the period at the end.

14 (3) HEALTH PROFESSIONAL SHORTAGE
15 AREA.—Section 332(a)(1) of the Public Health Serv-
16 ice Act (42 U.S.C. 254e(a)(1)) is amended by insert-
17 ing “(which may be a group comprised of children
18 and adolescents)” after “population group”.

19 (4) MEDICAL FACILITY.—Section 332(a)(2)(A)
20 of the Public Health Service Act (42 U.S.C.
21 254e(a)(2)(A)) is amended by inserting “medical
22 residency or fellowship training site for training in
23 child and adolescent psychiatry,” before “facility op-
24 erated by a city or county health department,”.

25 (b) ELIGIBILITY TO PARTICIPATE IN LOAN REPAY-
26 MENT PROGRAM.—Section 338B(b)(1)(B) of the Public

1 Health Service Act (42 U.S.C. 254l-1(b)(1)(B)) is amend-
2 ed by inserting “, including any child and adolescent psy-
3 chiatry medical residency or fellowship training program”
4 before the semicolon.

5 **SEC. 211. REAUTHORIZATION OF MENTAL AND BEHAV-**
6 **IORAL HEALTH EDUCATION TRAINING**
7 **GRANT.**

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

10 **“SEC. 756. MENTAL AND BEHAVIORAL HEALTH EDUCATION**
11 **AND TRAINING GRANTS.**

12 “(a) GRANTS AUTHORIZED.—The Secretary, acting
13 through the Administrators of the Substance Abuse and
14 Mental Health Administration and the Health Resources
15 and Services Administration, may award grants to eligible
16 institutions to support the recruitment of students for,
17 and education and clinical experience of the students in—

18 “(1) accredited institutions of higher education
19 or accredited professional training programs that are
20 establishing or expanding internships or other field
21 placement programs in mental health in psychiatry,
22 psychology, school psychology, behavioral pediatrics,
23 psychiatric nursing, social work, school social work,
24 substance abuse prevention and treatment, marriage
25 and family therapy, school counseling, or profes-

1 sional counseling, with a preference for programs
2 addressing child and adolescent mental health, in
3 particular transitional age youth between 16 to 25
4 years old;

5 “(2) accredited master’s, doctoral, internship,
6 and post-doctoral residency programs of psychology
7 for the development and implementation of inter-
8 disciplinary training of psychology graduate students
9 for providing behavioral and mental health services,
10 including substance abuse prevention and treatment
11 services, as well as the development of faculty in
12 psychology;

13 “(3) accredited master’s and doctoral degree
14 programs of social work for the development and im-
15 plementation of interdisciplinary training of social
16 work graduate students for providing behavioral and
17 mental health services, including substance abuse
18 prevention and treatment services, and the develop-
19 ment of faculty in social work; or

20 “(4) paraprofessional certificate training pro-
21 grams offered by accredited community and tech-
22 nical colleges granting State licensure or certifi-
23 cation in a behavioral health-related paraprofessional
24 field, such as community health worker, outreach
25 worker, social services aide, mental health worker,

1 substance abuse or addictions worker, youth worker,
2 promotora, or peer paraprofessional, with preference
3 for pre-service or in-service training of paraprofes-
4 sional child and adolescent mental health workers.

5 “(b) ELIGIBILITY REQUIREMENTS.—To be eligible to
6 receive a grant under this section, an institution shall
7 demonstrate—

8 “(1) an ability to recruit and place psycholo-
9 gists, social workers, and paraprofessionals in areas
10 with a high need and high demand population; and

11 “(2) participation of individuals and groups
12 from different racial, ethnic, cultural, geographic, re-
13 ligious, linguistic, and class backgrounds, and dif-
14 ferent genders and orientations in the institution’s
15 programs;

16 “(3) knowledge and understanding of the con-
17 cerns of the individuals and groups described in
18 paragraph (2), notably individuals with mental
19 health symptoms or diagnoses, particularly children
20 and adolescents, with a special emphasis on transi-
21 tional-aged persons 16 to 25 years old;

22 “(4) prioritization of cultural and linguistic
23 competency in training professionals and paraprofes-
24 sionals in any academic program, field placement,
25 internship, or post-doctoral position; and

1 “(5) the willingness to provide to the Secretary
2 such data, assurances, and information as the Sec-
3 retary may require.

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

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

9 “(2) programs for paraprofessionals that offer
10 curriculum with an emphasis on the role of the fam-
11 ily and the lived experience of the consumer and
12 family-paraprofessional partnerships.

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

17 “(e) REPORT TO CONGRESS.—Not later than 2 years
18 after the date of enactment of the _____ Act of
19 _____, and annually thereafter, the Secretary, acting
20 through the Administrators of the Substance Abuse and
21 Mental Health Services Administration and the Health
22 Resources Services Administration, shall submit to Con-
23 gress a report on the effectiveness of—

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

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

3 “(3) development and implementation of inter-
4 professional training and integration within primary
5 care;

6 “(4) development and implementation of ac-
7 credited field placements and internships; and

8 “(5) data collected on the number of students
9 trained in mental health and the number of available
10 accredited internships and field placements.

11 “(f) AUTHORIZATION OF APPROPRIATIONS.—For
12 each of fiscal years 2017 through 2021, there are author-
13 ized to be appropriated to carry out this section
14 \$44,000,000, to be allocated as follows:

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

18 “(2) \$14,000,000 shall be allocated to training
19 in graduate psychology under subsection (a)(2).

20 “(3) \$10,000,000 shall be allocated to training
21 in graduate social work under subsection (a)(3).

22 “(4) \$5,000,000 shall be allocated to training
23 paraprofessionals under subsection (a)(4).”.

1 **TITLE III—INTEGRATION**

2 **SEC. 301. PRIMARY AND BEHAVIORAL HEALTH CARE INTE-**
3 **GRATION GRANT PROGRAMS.**

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

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

7 “(a) IN GENERAL.—There is established within the
8 Substance Abuse and Mental Health Services Administra-
9 tion a primary and behavioral health care integration
10 grant program. The Secretary may award grants and co-
11 operative agreements to eligible entities to expend funds
12 for improvements in integrated settings with integrated
13 practices.

14 “(b) DEFINITIONS.—In this section:

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

20 “(A) provides services in a shared space
21 that ensures services will be available and ac-
22 cessible promptly and in a manner which pre-
23 serves human dignity and assures continuity of
24 care;

1 “(B) ensures communication among the
2 health care team that is consistent and team-
3 based;

4 “(C) ensures shared decisionmaking be-
5 tween mental health and primary care pro-
6 viders;

7 “(D) provides evidence-based services in a
8 mode of service delivery appropriate for the tar-
9 get population;

10 “(E) employs staff who are multidisci-
11 plinary and culturally and linguistically com-
12 petent;

13 “(F) provides integrated services related to
14 screening, diagnosis, and treatment of mental
15 illness and co-occurring primary care conditions
16 and chronic diseases; and

17 “(G) provides targeted case management,
18 including services to assist individuals gaining
19 access to needed medical, social, educational,
20 and other services and applying for income se-
21 curity, housing, employment, and other benefits
22 to which they may be entitled.

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

1 “(A) allopathic or osteopathic medical doc-
2 tors, including a primary care physician and a
3 board certified psychiatrist;

4 “(B) licensed clinical mental health profes-
5 sionals, such as a psychologists or social work-
6 ers;

7 “(C) a case manager; and

8 “(D) other members, which may include
9 psychiatric advanced practice nurses and other
10 allied health professionals, such as mental
11 health counselors, or others as appropriate.

12 “(3) SPECIAL POPULATION.—The term ‘special
13 population’ means—

14 “(A) adults with mental illnesses who have
15 co-occurring primary care conditions with
16 chronic diseases;

17 “(B) adults with serious mental illnesses
18 who have co-occurring primary care conditions
19 with chronic diseases; or

20 “(C) children and adolescents with serious
21 emotional disorders with co-occurring primary
22 care conditions and chronic diseases.

23 “(c) PURPOSE.—The grant program under this sec-
24 tion shall be designed to lead to full collaboration between

1 primary and behavioral health in an integrated practice
2 model at a statewide level, to ensure that—

3 “(1) the overall wellness and physical health
4 status of individuals with serious mental illness and
5 co-occurring substance use disorders is supported
6 through integration of primary care into community
7 behavioral health centers; and

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

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

19 “(e) APPLICATION.—An eligible entity desiring a
20 grant or cooperative agreement under this section shall
21 submit an application to the Administrator at such time,
22 in such manner, and accompanied by such information as
23 the Administrator may require, including a description of
24 a plan to achieve fully collaborative agreements to provide
25 services to special populations and—

1 “(1) a document that summarizes the State-
2 specific policies that inhibit the provision of inte-
3 grated care, and the specific steps that will be taken
4 to address such barriers, such as through licensing
5 and billing procedures; and

6 “(2) a plan to develop and share a de-identified
7 patient registry to track treatment implementation
8 and clinical outcomes to inform clinical interven-
9 tions, patient education, and engagement with
10 merged or transformed integrated practices in com-
11 pliance with applicable national and State health in-
12 formation privacy laws.

13 “(f) GRANT AMOUNTS.—The maximum annual grant
14 amount under this section shall be \$2,000,000, of which
15 not more than 10 percent may be allocated to State admin-
16 istrative functions, and the remaining amounts shall be
17 allocated to health facilities that provide integrated care.

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

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

24 “(1) the progress to reduce barriers to inte-
25 grated care, including regulatory and billing bar-

1 riers, as described in the entity’s application under
2 subsection (d);

3 “(2) a description of functional outcomes of
4 special populations, including—

5 “(A) with respect to individuals with seri-
6 ous mental illness, participation in supportive
7 housing or independent living programs, accept-
8 able attendance in social and rehabilitative pro-
9 grams, adequate participation in job training
10 opportunities, satisfactory performance in work
11 settings, attendance at scheduled medical and
12 mental health appointments, and compliance
13 with prescribed medication regimes;

14 “(B) with respect to individuals with co-oc-
15 ccurring mental illness and primary care condi-
16 tions and chronic diseases, attendance at sched-
17 uled medical and mental health appointments,
18 compliance with prescribed medication regimes,
19 and participation in learning opportunities re-
20 lated to improved health and lifestyle practice;
21 and

22 “(C) with respect to children and adoles-
23 cents with serious emotional disorders who have
24 co-occurring primary care conditions and chron-
25 ic diseases, attendance at scheduled medical

1 and mental health appointments, compliance
2 with prescribed medication regimes, participa-
3 tion in learning opportunities at school and ap-
4 propriate extracurricular activities.

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

7 “(1) IN GENERAL.—The Secretary, acting
8 through the Administrator, shall establish a program
9 through which the Secretary shall provide appro-
10 priate information, training, and technical assistance
11 to eligible entities that receive a grant or cooperative
12 agreement under this section, in order to help such
13 entities to meet the requirements of this section, in-
14 cluding assistance with—

15 “(A) development and selection of inte-
16 grated care models;

17 “(B) dissemination of evidence-based inter-
18 ventions in integrated care;

19 “(C) establishment of organizational prac-
20 tices to support operational and administrative
21 success; and

22 “(D) other activities, as the Secretary de-
23 termines appropriate.

24 “(2) ADDITIONAL DISSEMINATION OF TECH-
25 NICAL INFORMATION.—The information and re-

1 sources provided by the technical assistance program
2 established under paragraph (1) shall be made avail-
3 able to States, political subdivisions of a State, In-
4 dian tribes or tribal organizations (as defined in sec-
5 tion 4 of the Indian Self-Determination and Edu-
6 cation Assistance Act), outpatient mental health and
7 addiction treatment centers, community mental
8 health centers that meet the criteria under section
9 1913(c), certified community behavioral health clin-
10 ics described in section 223 of the Protecting Access
11 to Medicare Act of 2014, primary care organizations
12 such as Federally qualified health centers or rural
13 health centers, other community-based organiza-
14 tions, or other entities engaging in integrated care
15 activities, as the Secretary determines appropriate.

16 “(j) AUTHORIZATION OF APPROPRIATIONS.—To
17 carry out this section, there are authorized to be appro-
18 priated \$50,000,000 for each of fiscal years 2017 through
19 2021, of which \$2,000,000 shall be available to the tech-
20 nical assistance program under subsection (i).”.

1 **TITLE IV—INTERAGENCY SERI-**
2 **OUS MENTAL ILLNESS CO-**
3 **ORDINATING COMMITTEE**

4 **SEC. 401. INTERAGENCY SERIOUS MENTAL ILLNESS CO-**
5 **ORDINATING COMMITTEE.**

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

8 **“SEC. 501A. INTERAGENCY SERIOUS MENTAL ILLNESS CO-**
9 **ORDINATING COMMITTEE.**

10 “(a) ESTABLISHMENT.—The Assistant Secretary for
11 Mental Health and Substance Use Disorders (in this sec-
12 tion referred to as the ‘Assistant Secretary’) shall estab-
13 lish a committee, to be known as the Interagency Serious
14 Mental Illness Coordinating Committee (in this section re-
15 ferred to as the ‘Committee’), to assist the Assistant Sec-
16 retary in carrying out the Assistant Secretary’s duties.

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

18 “(1) develop and annually update a summary of
19 advances in serious mental illness research related to
20 causes, prevention, treatment, early screening, diag-
21 nosis or rule out, intervention, and access to services
22 and supports for individuals with serious mental ill-
23 ness;

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

1 “(3) make recommendations to the Assistant
2 Secretary regarding any appropriate changes to such
3 activities, including recommendations to the Director
4 of NIH with respect to the strategic plan developed
5 under paragraph (5);

6 “(4) make recommendations to the Assistant
7 Secretary regarding public participation in decisions
8 relating to serious mental illness;

9 “(5) develop and update every 3 years a stra-
10 tegic plan for the conduct and support of serious
11 mental illness, including—

12 “(A) a summary of the advances in serious
13 mental illness research developed in under para-
14 graph (1);

15 “(B) a list of the Federal programs and
16 activities relating to the prevention of, diag-
17 nosis, treatment, or rehabilitation for serious
18 mental illness identified in paragraph (2);

19 “(C) an analysis of the efficiency, effective-
20 ness, quality, coordination, and cost-effective-
21 ness of Federal programs and activities relating
22 to the prevention of, diagnosis, treatment, or
23 rehabilitation for serious mental illness, includ-
24 ing an accounting of the costs of such programs
25 and activities with administrative costs

1 disaggregated from the costs of services and
2 care; and

3 “(D) a plan with recommendations—

4 “(i) for the coordination and improve-
5 ment of Federal programs and activities
6 related to serious mental illness, including
7 budgetary requirements;

8 “(ii) for improving outcomes for indi-
9 viduals with a serious mental illness in-
10 cluding appropriate benchmarks to meas-
11 ure progress on achieving improvements;

12 “(iii) for the mental health workforce;
13 and

14 “(iv) to disseminate relevant informa-
15 tion developed by the coordinating com-
16 mittee to the public, health care providers,
17 social service providers, public health offi-
18 cials, courts, law enforcement, and other
19 relevant groups; and

20 “(6) submit to Congress such strategic plan
21 and any updates to such plan.

22 “(c) MEMBERSHIP.—

23 “(1) IN GENERAL.—The Committee shall be
24 composed of not more than 9 Federal representa-
25 tives including—

1 “(A) the Assistant Secretary for Mental
2 Health and Substance Use Disorders (or the
3 Assistant Secretary’s designee), who shall serve
4 as the Chair of the Committee;

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

7 “(C) the Attorney General of the United
8 States (or the Attorney General’s designee);

9 “(D) the Director of the Centers for Dis-
10 ease Control and Prevention (or the Director’s
11 designee);

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

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

16 “(G) representatives, appointed by the As-
17 sistant Secretary, of Federal agencies that serve
18 individuals with serious mental illness, including
19 representatives of the Administration on Com-
20 munity Living, the Agency for Healthcare Re-
21 search and Quality, the Bureau of Indian Af-
22 fairs, the Department of Defense, the Depart-
23 ment of Education, the Department of Housing
24 and Urban Development, the Department of

1 Labor, the Department of Veterans Affairs, and
2 the Social Security Administration; and

3 “(H) the additional members appointed
4 under paragraph (2).

5 “(2) ADDITIONAL MEMBERS.—Not more than
6 14 members of the Committee of the total member-
7 ship of the Committee, whichever is greater, shall be
8 composed of non-Federal public members to be ap-
9 pointed by the Assistant Secretary, of which—

10 “(A) at least 1 member shall be an indi-
11 vidual in recovery from a diagnosis of serious
12 mental illness who has benefitted from and is
13 receiving medical treatment under the care of a
14 licensed mental health professional;

15 “(B) at least 1 member shall be a parent
16 or legal guardian of an individual with a history
17 of serious mental illness who has either at-
18 tempted suicide or is incarcerated for violence
19 committed while experiencing a serious mental
20 illness;

21 “(C) at least 1 member shall be a rep-
22 resentative of a leading research, advocacy, and
23 service organization for individuals with serious
24 mental illness;

25 “(D) at least 2 members shall be—

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

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

5 “(iii) a licensed clinical social worker;
6 or

7 “(iv) a licensed psychiatric nurse or
8 nurse practitioner;

9 “(E) at least 1 member shall be a mental
10 health professional with a significant focus in
11 his or her practice on working with children
12 and adolescents;

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

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

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

23 “(I) at least 1 member shall be a law en-
24 forcement officer or corrections officer with ex-
25 tensive experience in interfacing with psy-

1 chiatric and psychological disorders or individ-
2 uals in mental health crisis; and

3 “(J) 4 members, of which—

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

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

8 “(iii) 1 shall be appointed by the
9 Speaker of the House of Representatives;
10 and

11 “(iv) 1 shall be appointed by the mi-
12 nority leader of the House of Representa-
13 tives.

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

18 “(1) evaluating the impact on public health of
19 projects addressing priority mental health needs of
20 regional and national significance under sections
21 501, 509, 516, and 520A, including measurement of
22 public health outcomes such as—

23 “(A) reduced rates of suicide, suicide at-
24 tempts, substance abuse, overdose, overdose
25 deaths, emergency hospitalizations, emergency

1 room boarding (as defined in section 1912(e)),
2 incarceration, crime, arrest, victimization,
3 homelessness, and joblessness;

4 “(B) increased rates of employment and
5 enrollment in educational and vocational pro-
6 grams; and

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

9 “(2) formulating recommendations for the co-
10 ordination and improvement of Federal programs
11 and activities described in paragraph (2);

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

14 “(4) summarizing all recommendations made,
15 activities carried out, and results achieved pursuant
16 to the workforce development strategy under [sec-
17 tion 101(e)(8) of the _____ Act of
18 _____].

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

22 “(1) The Assistant Secretary shall provide such
23 administrative support to the Committee as may be
24 necessary for the Committee to carry out its respon-
25 sibilities.

1 “(2) Members of the Committee appointed
2 under subsection (c)(2) shall serve for a term of 4
3 years, and may be reappointed for one or more addi-
4 tional 4-year terms. Any member appointed to fill a
5 vacancy for an unexpired term shall be appointed for
6 the remainder of such term. A member may serve
7 after the expiration of the member’s term until a
8 successor has taken office.

9 “(3) The Committee shall meet at the call of
10 the chair or upon the request of the Assistant Sec-
11 retary. The Committee shall meet not fewer than 2
12 times each year.

13 “(4) All meetings of the Committee shall be
14 public and shall include appropriate time periods for
15 questions and presentations by the public.

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

23 **TITLE V—HIPAA CLARIFICATION**

24 **SEC. 501. FINDINGS.**

25 The Senate makes the following findings:

1 (1) The privacy regulations promulgated under
2 section 264(c) of the Health Insurance Portability
3 and Accountability Act (42 U.S.C. 1320–2 note) rec-
4 ognizes the value of family members in the health
5 and well-being of individuals experiencing temporary
6 psychosis. However, a lack of understanding by
7 health professionals has been a barrier to many fam-
8 ily members assisting in the treatment of an indi-
9 vidual with serious mental illness.

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

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

1 (4) Engagement by family members has been
2 shown to help individuals with serious mental illness
3 adhere to a treatment plan and generally improved
4 outcomes.

5 (5) Whenever possible, an individual who is the
6 subject of protected health or mental health informa-
7 tion shall be given advanced notice of the desire to
8 share information with family members or other
9 caregivers. This notice should include an explanation
10 of what information is to be shared and why it is
11 clinically desirable to share such information.

12 (6) The use of psychiatric advance directives
13 should be encouraged for individuals with serious
14 mental illness.

15 **SEC. 502. MODIFICATIONS TO HIPAA.**

16 In applying section 164.510(b)(3) of title 45, Code
17 of Federal Regulations, for the purposes of assisting
18 health professionals to determine the best interests of the
19 individual, factors shall include the following:

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

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

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

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

3 **SEC. 503. DEVELOPMENT AND DISSEMINATION OF MODEL**
4 **TRAINING PROGRAMS.**

5 (a) INITIAL PROGRAMS AND MATERIALS.—Not later
6 than 1 year after the date of enactment of this Act, the
7 Secretary of Health and Human Services (in this section
8 referred to as the “Secretary”), in consultation with ap-
9 propriate experts, shall develop and disseminate—

10 (1) a model program and materials for training
11 health care providers (including physicians, emer-
12 gency medical personnel, psychologists, counselors,
13 therapists, behavioral health facilities and clinics,
14 care managers, and hospitals) regarding the cir-
15 cumstances under which, consistent with the stand-
16 ards governing the privacy and security of individ-
17 ually identifiable health information promulgated by
18 the Secretary under section 264 of the Health Insur-
19 ance Portability and Accountability Act of 1996 (42
20 U.S.C. 1320–2 note) and part C of title XI of the
21 Social Security Act (42 U.S.C. 1320d et seq.), the
22 protected health information of patients with a men-
23 tal illness may be disclosed with and without patient
24 consent;

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

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

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

9 (1) periodically review, evaluate, and update the
10 model programs and materials developed under sub-
11 section (a); and

12 (2) disseminate the updated model programs
13 and materials.

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

19 (d) COORDINATION.—The Secretary shall carry out
20 this section in coordination with the Director of the Office
21 for Civil Rights within the Department of Health and
22 Human Services, the Administrator of the Substance
23 Abuse and Mental Health Services Administration, the
24 Administrator of the Health Resources and Services Ad-

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

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

8 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
9 authorized to be appropriated to carry out this section
10 \$5,000,000 for each of fiscal years 2017 through 2022.

11 **【SEC. 504. CONFIDENTIALITY OF RECORDS.**

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

15 **【“(i) STREAMLINED CONSENT IN INTEGRATED CARE
16 SETTINGS.—】**

17 **【“(1) IN GENERAL.—**For the sharing of
18 records described in subsection (a) involving the
19 interchange of electronic health records (as defined
20 in section 13400 of division A of Public Law 111–
21 5)) solely for the purposes of improving the provi-
22 sion of health care and health care coordination sole-
23 ly within accountable care organizations described in
24 section 1899 of the Social Security Act, health infor-
25 mation exchanges (as defined for purposes of section

1 3013), health homes (as defined in section
2 1945(h)(3) of the Social Security Act), or other inte-
3 grated care arrangements (in existence before, on, or
4 after the date of the enactment of the _____
5 Act of _____), a patient’s prior written or elec-
6 tronic consent for disclosure and re-disclosure of
7 records may be provided annually in a generalized
8 and revocable format to and for all of the health
9 care providers in the accountable care organization,
10 health information exchange, health home or other
11 integrated care arrangement, who are involved in the
12 patient’s care.】

13 【“(2) DISCLOSURE REQUIRED.—For all other
14 disclosures or re-disclosures of the records described
15 in subsection (a), except those expressly proscribed
16 in paragraph 1, patient consent is required to be ob-
17 tained in accordance with the procedures described
18 in part 2 of title 42, Code of Federal Regulations.】

19 【“(3) PROHIBITIONS.—It shall be unlawful for
20 any health plan or health insurance program to use
21 the records described in subsection (a) or this sub-
22 section to deny or condition the issuance of a plan,
23 policy, or coverage on the basis of the contents of
24 such records, or for a health care provider to use the
25 records described in subsection (a) and this section

1 to discriminate in the provision of medically nec-
2 essary health care services to an individual who is
3 the subject of such records.”.]

4 **TITLE VI—MEDICARE AND**
5 **MEDICAID REFORMS**

6 **SEC. 601. ENHANCED MEDICAID COVERAGE RELATING TO**
7 **CERTAIN MENTAL HEALTH SERVICES.**

8 (a) MEDICAID COVERAGE OF MENTAL HEALTH
9 SERVICES AND PRIMARY CARE SERVICES FURNISHED ON
10 THE SAME DAY.—

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

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

1 (ii) by inserting before the semicolon
2 at the end the following: “, and (B) quali-
3 fied inpatient psychiatric hospital services
4 (as defined in subsection (h)(3)) for indi-
5 viduals over 21 years of age and under 65
6 years of age”; and

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

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

15 “(3) For purposes of subsection (a)(16)(B), the
16 term ‘qualified inpatient psychiatric hospital serv-
17 ices’ means, with respect to individuals described in
18 such subsection, services described in subparagraphs
19 (A) and (B) of paragraph (1) that are furnished in
20 an acute care psychiatric unit in a State-operated
21 psychiatric hospital or a psychiatric hospital (as de-
22 fined section 1861(f)) if such unit or hospital, as ap-
23 plicable, has a facility-wide average (determined on
24 an annual basis) length of stay of less than 30
25 days.”.

1 (c) STUDY AND REPORT.—

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

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

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

20 (B) An assessment of the extent to which
21 States used disproportionate share hospital pay-
22 ment adjustments described in section 1923 of
23 the Social Security Act (42 U.S.C. 1396r-4) to
24 fund short-term acute inpatient psychiatric hos-
25 pital care prior to the effective date of the

1 amendments made by this section and an anal-
2 ysis of the impact of the changes to the Med-
3 icaid IMD exclusion made by such amendments
4 on the use of such payment adjustments to
5 fund such care.

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

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

20 (3) DEFINITIONS.—For purposes of this sub-
21 section:

22 (A) MEDICAID IMD EXCLUSION.—The term
23 “Medicaid IMD exclusion” means the prohibi-
24 tion on Federal matching payments under Med-
25 icaid for care or services provided to patients

1 who have attained age 22, but have not at-
2 tained age 65, in an institution for mental dis-
3 eases under subdivision (B) of the matter fol-
4 lowing paragraph (29) of section 1905(a) of the
5 Social Security Act (42 U.S.C. 1396d(a)).

6 (B) SECRETARY.—The term “Secretary”
7 means the Secretary of Health and Human
8 Services.

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

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

17 (ii) a psychiatric hospital with an av-
18 erage length of stay of fewer than 20 days
19 on an annual basis.

20 (d) EFFECTIVE DATE.—

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

1 (2) CERTIFICATION OF NO INCREASED SPEND-
2 ING.—The amendments made by this section shall
3 not be effective unless the Chief Actuary of the Cen-
4 ters for Medicare & Medicaid Services certifies that
5 the inclusion of qualified inpatient psychiatric hos-
6 pital services (as defined by paragraph (3) of section
7 1905(h) of the Social Security Act (42 U.S.C.
8 1396d(h)), as added by subsection (b)) furnished to
9 nonelderly adults as medical assistance under section
10 1905(a) of the Social Security Act (42 U.S.C.
11 1396d(a)), as amended by subsection (b), would not
12 result in any increase in net program spending
13 under title XIX of such Act.

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

1 gins after the date of enactment of this section. For
2 purposes of the previous sentence, in the case of a
3 State that has a 2-year legislative session, each year
4 of the session shall be considered to be a separate
5 regular session of the State legislature.

6 **SEC. 602. MODIFICATIONS TO MEDICARE DISCHARGE PLAN-**
7 **NING REQUIREMENTS.**

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

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

17 (2) by adding at the end the following new
18 paragraph:

19 “(4) The Secretary shall develop guidelines and
20 standards, in addition to those developed under
21 paragraph (2), for the discharge planning process of
22 a psychiatric hospital or a psychiatric unit (as de-
23 scribed in the matter following clause (v) of section
24 1886(d)(1)(B)) in order to ensure a timely and
25 smooth transition to the most appropriate type of,

1 and setting for, posthospital or rehabilitative care.
2 The Secretary shall issue final regulations imple-
3 menting such guidelines and standards not later
4 than 24 months after the date of the enactment of
5 this paragraph. The guidelines and standards shall
6 include the following:

7 “(A) The hospital or unit must identify the
8 types of services needed upon discharge by a
9 patient being treated by the hospital or unit.

10 “(B) The hospital or unit must—

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

16 “(ii) make demonstrated efforts to es-
17 tablish connections, relationships, and
18 partnerships with such organizations.

19 “(C) The hospital or unit must arrange
20 (with the participation of the patient and of any
21 other individuals selected by the patient for
22 such purpose) for the development and imple-
23 mentation of a discharge plan for the patient as
24 part of the patient’s overall treatment plan
25 from admission to discharge. Such discharge

1 plan shall meet the requirements described in
2 subparagraphs (G) and (H) of paragraph (2).

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

13 **TITLE VII—RESEARCH BY NA-**
14 **TIONAL INSTITUTE OF MEN-**
15 **TAL HEALTH**

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

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

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

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

1 purposes described in subparagraph (B)
2 \$40,000,000 for each of fiscal years 2017
3 through 2021.

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

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

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

16 **TITLE VIII—SAMHSA REAUTHOR-**
17 **IZATION AND REFORMS**

18 **Subtitle A—Organization and**
19 **General Authorities**

20 **SEC. 801. PEER REVIEW.**

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

1 shall have a medical degree, a doctoral degree in psy-
2 chology, or advanced degree in nursing or social work from
3 an accredited graduate school, and shall specialize in the
4 mental health field.”.

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

13 **SEC. 802. ADVISORY COUNCILS.**

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

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

23 “(D) Each advisory committee shall in-
24 clude at least one member of the National Insti-
25 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 “\$4,269,000 for fiscal year 2017, and such sums as may
10 be necessary for each of fiscal years 2018 through 2021”.

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

13 Section 535(a) of the Public Health Service Act (42
14 U.S.C. 290cc–35(a)) is amended by striking “\$75,000,000
15 for each of the fiscal years 2001 through 2003” and in-
16 serting “\$64,635,000 for fiscal year 2017, and such sums
17 as may be necessary for each of fiscal years 2018 through
18 2021”.

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

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

24 (1) in subsection (b)(1), by striking “receiving
25 a grant under section 561(a)” and inserting “(irre-

1 spective of whether the public entity is in receipt of
2 a grant under section 561(a))”;

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

6 (3) in subsection (f)(1), by striking
7 “\$100,000,000 for fiscal year 2001, and such sums
8 as may be necessary for each of the fiscal years
9 2002 and 2003” and inserting “\$117,315,000 for
10 fiscal year 2017, and such sums as may be nec-
11 essary for each of fiscal years 2018 through 2021”.

12 **SEC. 806. REAUTHORIZATION OF PRIORITY MENTAL**
13 **HEALTH NEEDS OF REGIONAL AND NA-**
14 **TIONAL SIGNIFICANCE.**

15 Section 520A(f)(1) of the Public Health Service Act
16 (42 U.S.C. 290bb–32(f)(1)) is amended by striking
17 “\$300,000,000 for fiscal year 2001, and such sums as
18 may be necessary for each of the fiscal years 2002 and
19 2003” and inserting “\$377,000,000 for each of fiscal
20 years 2017 through 2021”.

1 **TITLE IX—MENTAL HEALTH**
2 **PARITY**

3 **SEC. 901. GAO STUDY ON PREVENTING DISCRIMINATORY**
4 **COVERAGE LIMITATIONS FOR INDIVIDUALS**
5 **WITH SERIOUS MENTAL ILLNESS AND SUB-**
6 **STANCE USE DISORDERS.**

7 Not later than 1 year after the date of enactment
8 of this Act, the Comptroller General of the United States,
9 in consultation with the Assistant Secretary for Mental
10 Health and Substance Use Disorders, the Secretary of
11 Health and Human Services, the Secretary of Labor, and
12 the Secretary of the Treasury, shall submit to Congress
13 a report detailing the extent to which covered group health
14 plans (or health insurance coverage offered in connection
15 with such plans), including Medicaid managed care plans
16 under section 1903 of the Social Security Act (42 U.S.C.
17 1396b), comply with the Paul Wellstone and Pete Domen-
18 icki Mental Health Parity and Addiction Equity Act of
19 2008 (subtitle B of title V of division C of Public Law
20 110–343) (in this section referred to as the “law”), includ-
21 ing—

22 (1) how nonquantitative treatment limitations,
23 including medical necessity criteria, of covered group
24 health plans comply with the law;

1 (2) how the responsible Federal departments
2 and agencies ensure that plans comply with the law;
3 and

4 (3) how proper enforcement, education, and co-
5 ordination activities within responsible Federal de-
6 partments and agencies can be used to ensure full
7 compliance with the law, including educational ac-
8 tivities directed to State insurance commissioners.

9 **SEC. 902. REPORT ON INVESTIGATIONS REGARDING PAR-**
10 **ITY IN MENTAL HEALTH AND SUBSTANCE**
11 **USE DISORDER BENEFITS.**

12 (a) IN GENERAL.—Not later than 1 year after the
13 enactment of this Act, and annually thereafter, the Ad-
14 ministrators of the Centers for Medicare & Medicaid Serv-
15 ices, in collaboration with the Assistant Secretary of Labor
16 of the Employee Benefits Security Administration and the
17 Secretary of the Treasury, and in consultation with the
18 Assistant Secretary for Mental Health and Substance Use
19 Disorders, shall submit to Congress a report—

20 (1) identifying Federal investigations conducted
21 or completed during the preceding 12-month period
22 regarding compliance with parity in mental health
23 and substance use disorder benefits, including bene-
24 fits provided to persons with serious mental illness
25 and substance use disorders, under the Paul

1 Wellstone and Pete Domenici Mental Health Parity
2 and Addiction Equity Act of 2008 (subtitle B of title
3 V of division C of Public Law 110–343); and

4 (2) summarizing the results of such investiga-
5 tions.

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

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

11 (2) The benefit classification or classifications
12 examined by each investigation.

13 (3) The subject matter or subject matters of
14 each investigation, including quantitative and non-
15 quantitative treatment limitations.

16 (4) A summary of the basis of the final decision
17 rendered for each investigation.

18 (c) LIMITATION.—Individually identifiable informa-
19 tion shall be excluded from reports under subsection (a)
20 consistent with Federal privacy protections.

21 **SEC. 903. STRENGTHENING PARITY IN MENTAL HEALTH**
22 **AND SUBSTANCE USE DISORDER BENEFITS.**

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

1 “(6) DISCLOSURE AND ENFORCEMENT RE-
2 QUIREMENTS.—

3 “(A) DISCLOSURE REQUIREMENTS.—

4 “(i) REGULATIONS.—Not later than
5 March 1, 2016, the Secretary, in coopera-
6 tion with the Secretary of Labor and the
7 Secretary of the Treasury shall issue addi-
8 tional regulations or sub-regulatory guid-
9 ance for carrying out this section, includ-
10 ing an explanation of documents that are
11 required to be disclosed, and analyses that
12 are required be conducted, including how
13 non-quantitative treatment limitations are
14 applied to mental health or substance use
15 disorder benefits and medical or surgical
16 benefits covered under the plan, by a group
17 health plan (or health insurance issuer) of-
18 fering health insurance coverage in the
19 group or individual market in order for
20 such plan or issuer to demonstrate compli-
21 ance with the provisions of this section.
22 The disclosure requirements shall include a
23 report detailing the specific analyses per-
24 formed to develop a compliance review of
25 the requirements of the Paul Wellstone

1 and Pete Domenici Mental Health Parity
2 and Addiction Equity Act of 2008, includ-
3 ing the amendments made by such Act.
4 With respect to non-quantitative treatment
5 limitations, this report shall—

6 “(I) identify the specific factors
7 in fact used by the plan in performing
8 its non-quantitative treatment limita-
9 tions analysis;

10 “(II) identify and define the spe-
11 cific evidentiary standards relied on to
12 evaluate the factors;

13 “(III) describe how the evi-
14 dentiary standards were applied to
15 each service category;

16 “(IV) disclose the results of the
17 analyses of the specific evidentiary
18 standards in each service category;
19 and

20 “(V) disclose the plan’s specific
21 findings in each service category and
22 the conclusions reached with respect
23 to compliance with comparability and
24 stringency of application tests under

1 the non-quantitative treatment limita-
2 tions rule.

3 “(ii) GUIDANCE.—The Secretary, in
4 cooperation with the Secretary of Labor
5 and the Secretary of the Treasury shall
6 issue guidance to group health plans and
7 health insurance issuers offering health in-
8 surance coverage in the group or individual
9 markets on how to satisfy the requirements
10 of this section with respect to making in-
11 formation, including certificate of coverage
12 documents and instruments under which
13 the plan is administered and operated that
14 specify, include or refer to procedures, for-
15 mulas, and methodologies applied to deter-
16 mine a participant or beneficiary’s benefit
17 under the plan, regardless of whether such
18 information is contained in a document
19 designated as the ‘plan document’ available
20 to current and potential participants and
21 beneficiaries. This guidance shall include
22 plan disclosure of how the plan has met
23 the 2-part test under the non-quantitative
24 treatment limitations rule of comparability
25 and stringency in application.

1 “(B) ENFORCEMENT.—

2 “(i) PROCESS FOR COMPLAINTS.—The
3 Secretary, in cooperation with the Sec-
4 retary of Labor and Secretary of the
5 Treasury, as appropriate, shall, with re-
6 spect to group health plans and health in-
7 surance issuers offering health insurance
8 coverage in the group or individual market,
9 issue guidance to clarify the process and
10 timeline for current and potential partici-
11 pants and beneficiaries and their author-
12 ized representatives and providers with re-
13 spect to such plans and coverage to file
14 formal complaints of such plans or issuers
15 being in violation of this section, including
16 guidance on the relevant individual State,
17 regional, and national offices with which
18 such claims should be filed by plan type.

19 “(ii) AUTHORITY FOR PUBLIC EN-
20 FORCEMENT.—The Secretary shall make
21 available to the public de-identified infor-
22 mation on audits and investigations of
23 group health plans and health insurance
24 issuers conducted under this section.

25 “(iii) AUDITS.—

1 “(I) RANDOMIZED AUDITS.—The
2 Secretary is authorized to conduct
3 randomized audits of group health
4 plans and health insurance issuers of-
5 fering health insurance coverage in
6 the group or individual market to de-
7 termine compliance with this section.
8 Such audits shall be conducted on no
9 fewer than 12 plans and issuers per
10 plan year. The information shall be
11 made plainly available on the public
12 Internet websites of the Department
13 of Health and Human Services and
14 the Department of Labor.

15 “(II) ADDITIONAL AUDITS.—In
16 the case of a group health plan or
17 health insurance issuer offering health
18 insurance coverage in the group or in-
19 dividual market with respect to which
20 at least 5 substantiated claims of the
21 same type of non-compliance with this
22 section have been filed during a plan
23 year, the Secretary shall audit plan
24 documents to determine compliance
25 with this section. Information detail-

1 ing the results of the audit shall be
2 made available on the public Internet
3 website of the Department of Health
4 and Human Services.”.