114TH CONGRESS
1ST SESSION

S. 1945

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

IN THE SENATE OF THE UNITED STATES

AUGUST 5, 2015

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

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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.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Mental Health Reform Act of 2015''.

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

SEC. 2. DEFINITIONS.

In this Act:

(1) ASSISTANT SECRETARY.—Except as otherwise specified, the term ''Assistant Secretary'' means the Assistant Secretary for Mental Health and Substance Use Disorders.

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

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

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

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

as the Assistant Secretary for Mental Health and Substance Use Disorders, who shall—

(1) report directly to the Secretary;

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

(3) be selected from among individuals who—

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

(ii) have clinical, research, and policy experience in psychiatry;

(iii) graduated from an Accreditation Council for Graduate Medical Education-accredited psychiatric residency program; and

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

(B) have a doctoral degree in psychology and—

(i) clinical, research, and policy experience regarding mental illness and substance use disorders;

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

and Internship Centers as part of doctoral degree completion; and

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

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

(i) clinical, research, and policy experience regarding mental illness and substance use disorders; and

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

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

(c) DUTIES.—The Assistant Secretary shall—

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

uals with respect to the problems of individuals suffering from substance use disorders or mental illness;

(2) carry out any functions within the Department of Health and Human Services—

(A) to improve services for individuals with substance use disorders or mental illness, including services related to the prevention of, diagnosis of, intervention in, and treatment and rehabilitation of, substance use disorders or mental illness;

(B) to ensure access to effective, evidence-based diagnosis, prevention, intervention, treatment and rehabilitation for individuals with mental illnesses and individuals with a substance use disorder;

(C) to ensure that all grants with respect to serious mental illness or substance use disorders, are consistent with the grant management standards set forth by the Department, and that such grants are evidence-based, have scientific merit and avoid duplication;

(D) to develop and implement initiatives to encourage individuals to pursue careers (especially in underserved areas and populations) as

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

(E) to consult, coordinate with, facilitate joint efforts among, and support State, local, and tribal governments, nongovernmental entities, and individuals with a mental illness, particularly individuals with a serious mental illness and children and adolescents with a serious emotional disturbance, with respect to improving community-based and other mental health services;

(F) to disseminate evidenced-based and promising best practices developed by the National Mental Health Policy Lab established under section 201 and other qualified research organizations that are culturally and linguistically indicated treatment and prevention services related to a mental illness, particularly individuals with a serious mental illness and children and adolescents with a serious emotional disturbance; and

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

(3) within the Department of Health and Human Services, oversee and coordinate all programs and activities relating to—

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

(B) parity in health insurance benefits and conditions relating to mental health and substance use disorders; or

(C) the reduction of homelessness and incarceration among individuals with mental health and substance use disorders;

(4) make recommendations to the Secretary of Health and Human Services regarding public participation in decisions relating to mental health, including serious mental illness, and serious emotional disturbances across the lifespan;

(5) review and make recommendations with respect to the Department of Health and Human Services budget to ensure the adequacy of such budget;

(6) across the Federal Government, in conjunction with the Interagency Serious Mental Illness Coordinating Committee under section 501A of the Public Health Service Act (as added by section 401)—

(A) review all programs and activities relating to the diagnosis or prevention of, or treatment or rehabilitation for, mental illness or substance use disorders;

(B) identify any such programs and activities that are duplicative;

(C) identify any such programs and activities that are not evidence-based, effective, or efficient; and

(D) formulate recommendations for expanding, coordinating, eliminating, and improving programs and activities identified pursuant to subparagraphs (B) and (C) and merging such programs and activities into other, successful programs and activities;

(7) identify evidence-based and promising best practices across the Federal Government for treatment and services for individuals with mental health and substance use disorders by reviewing practices

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

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

(d) NATIONWIDE STRATEGY.—The Assistant Secretary shall ensure that the nationwide strategy in the report under subsection (c)(8) is designed—

(1) to encourage and incentivize students enrolled in an accredited medical or osteopathic school, or nursing, psychology, or social work graduate program, to specialize in the mental health field;

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

(3) to promote appropriate Federal administrative and fiscal mechanisms that support—

(A) evidence-based collaborative care models; and

(B) the necessary mental health workforce capacity for the models under subparagraph (A), including psychiatrists, child and adolescent psychiatrists, psychologists, psychiatric nurse practitioners, clinical social workers, and mental health, peer-support specialists;

(4) to increase access to child and adolescent psychiatric services in order to promote early intervention for prevention and mitigation of mental illness;

(5) to identify populations and locations that are the most underserved by mental health professionals, including psychiatrists, child and adolescent psychiatrists, psychologists, psychiatric nurse practitioners, clinical social workers, other licensed mental health professionals, and peer-support specialists; and

(6) to identify means of alleviating the strain on the budgets of the criminal justice and correctional systems and the capacity of such systems with respect to mental health and substance use disorders.

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

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

(1) shall prioritize—

(A) the integration of mental health, substance use, and physical health services for the purpose of diagnosing, preventing, treating, and providing rehabilitation for mental illness or substance use disorders, including any such services provided through the justice system (including departments of correction) or entities other than the Department of Health and Human Services;

(B) the early diagnosis and intervention services for the prevention of, or crisis intervention for, and treatment or rehabilitation for, serious mental health disorders or substance use disorders, in selecting evidence-based practices and service delivery models for evaluation and dissemination under section 201(a)(2)(C); and

(C) workforce development for—

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

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

rious mental illness or substance use disorders; and

(iii) increasing the number of mental health professionals, including psychiatrists, child and adolescent psychiatrists, psychologists, psychiatric nurse practitioners, clinical social workers, and mental health peer support specialists;

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

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

SEC. 102. REPORTS.

(a) REPORT ON BEST PRACTICES FOR PEER-SUPPORT SPECIALIST PROGRAMS, TRAINING, AND CERTIFICATION.—

(1) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, and biannually thereafter, the Assistant Secretary shall submit to Congress and make publicly available a report

on best practices and professional standards in States for—

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

(B) training and certifying peer-support specialists.

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

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

(B) uses his or her lived experience of recovery from mental illness or substance abuse, plus skills learned in formal training, to facilitate support groups, and to work on a one-on-one basis, with individuals with a serious mental illness or a substance use disorder, in consultation with, and under the supervision of, a licensed mental health or substance use treatment professional;

(C) has been an active participant in mental health or substance use treatment for at least the preceding year;

(D) provides non-medical services; and

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

(3) CONTENTS.—Each report under this subsection shall include information on best practices and standards with regard to the following:

(A) Hours of formal work or volunteer experience related to mental health and substance use issues.

(B) Types of peer specialist exams required.

(C) Code of ethics.

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

(i) ethics;

(ii) scope of practice;

(iii) crisis intervention;

(iv) State confidentiality laws;

(v) Federal privacy protections, including under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191); and

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

(E) Requirements to explain what, where, when, and how to accurately complete all required documentation activities.

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

(i) risk indicators and responding appropriately to individual stressors, triggers, and indicators of pre-crisis symptoms;

(ii) basic crisis avoidance techniques;

(iii) basic suicide prevention concepts and techniques;

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

(v) stages of change or recovery;

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

(vii) circumstances when it is appropriate to request assistance from other professionals to help meet the individual's recovery goals.

(G) Annual requirements for continuing education credits.

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

(1) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, and not less than every 18 months thereafter, the Assistant Secretary for Mental Health and Substance Use Disorders, in collaboration with the Director of the Agency for Healthcare Research and Quality and Director of the National Institutes of Health, shall submit to Congress and make available to the public a report on mental health and substance use treatment in the States, including the following:

(A) A detailed report on how Federal mental health and substance use treatment funds are used in each State, including:

(i) The numbers of individuals with mental illness, serious mental illness, substance use disorders, or co-occurring disorders who are served with Federal funds.

(ii) The types of programs made available to individuals with mental illness, serious mental illness, substance use disorders, or co-occurring disorders.

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

effective, provide evidence-based care, increase access to care, integrate physical, psychiatric, psychological, and behavioral medicine, and improve outcomes for individuals with serious mental illness or substance use disorders.

(C) A statistical report of outcome measures in each State for individuals with mental illness, serious mental illness, substance use disorders, or co-occurring disorders, including rates of suicide, suicide attempts, substance abuse, overdose, overdose deaths, health outcomes, emergency psychiatric hospitalizations and emergency room boarding, arrests, incarcerations, homelessness, joblessness, employment, and enrollment in educational or vocational programs.

(D) A comparative effectiveness research study analyzing outcomes for different models of outpatient treatment programs for the seriously mentally ill that include outpatient mental health services that are court ordered or voluntary, including—

(i) rates of keeping treatment appointments and compliance with prescribed medications;

(ii) participants' perceived effectiveness of the program;

(iii) rates of the programs helping individuals with serious mental illness gain control over their lives;

(iv) alcohol and drug abuse rates;

(v) incarceration and arrest rates;

(vi) violence against persons or property;

(vii) homelessness;

(viii) total treatment costs for compliance with program; and

(ix) health outcomes.

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

(c) REPORTING COMPLIANCE STUDY.—

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

enactment of this Act, the National Academy of Medicine will submit to the appropriate committees of Congress a report that evaluates the combined paperwork burden of—

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

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

(2) SCOPE.—In preparing the report under subsection (a), the National Academy of Medicine (or, if applicable, other appropriate entity) shall examine licensing, certification, service definitions, claims payment, billing codes, and financial auditing requirements used by the Office of Management and Budget, the Centers for Medicare & Medicaid Services, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Office of the Inspector General of the Department of Health and Human Services, State Medicaid agencies, State departments of

health, State departments of education, and State and local juvenile justice and social service agencies to make administrative and statutory recommendations to Congress (which recommendations may include a uniform methodology) to reduce the paperwork burden experienced by centers and clinics described in paragraph (1).

SEC. 103. ADVISORY COUNCIL ON GRADUATE MEDICAL EDUCATION.

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

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

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

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

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

TITLE II—GRANTS

SEC. 201. NATIONAL MENTAL HEALTH POLICY LABORATORY.

(a) IN GENERAL.—

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

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

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

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

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

(D) establish standards for the appointment of scientific peer-review panels to evaluate grant applications.

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

(A) shall give preference to models that—

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

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

(iii) improve the cost effectiveness, quality, effectiveness, and efficiency of health care services furnished to individuals with serious mental illness, in mental

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

(iv) recognize the importance of family participation in recovery; and

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

(4) DEADLINE FOR BEGINNING IMPLEMENTATION.—The Director of the NMHPL shall begin implementation of the duties described in this subsection not later than January 1, 2018.

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

(A) representatives of the National Institute of Mental Health on organizational and operational issues;

(B) other appropriate Federal agencies;

(C) clinical and analytical experts with expertise in medicine, psychiatric and clinical psychological care, health care management, education, corrections health care, social services, and mental health court systems; and

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

(b) STAFFING.—

(1) COMPOSITION.—In selecting the staff of the NMHPL, the Director of the NMHPL, in consultation with the Director of the National Institute of Mental Health, shall include individuals with advanced degrees and clinical and research experience, and who have an understanding of biological, psychosocial, and pharmaceutical treatments of mental illness and substance use disorders, including—

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

(i) allopathic or osteopathic medicine, and who have specialized training in psychiatry;

(ii) psychology; or

(iii) social work;

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

(C) professionals or academics with expertise in research design and methodologies.

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

(1) reduced rates of suicide, suicide attempts, substance abuse, overdose, overdose deaths, emergency psychiatric hospitalizations, emergency room boarding, incarceration, crime, arrest, homelessness, and joblessness;

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

(3) such other criteria as the Director may determine.

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

SEC. 202. INNOVATION GRANTS.

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

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

(1) enhancing the prevention, diagnosis, intervention, treatment, and rehabilitation of mental illness, serious emotional disorder, substance use disorder, and co-occurring disorders; or

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

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

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

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

(2) not less than one-third shall be awarded for screening, diagnosis, treatment, or services, as described in subsection (a), for individuals (or subpopulations of individuals) who are below the age of 18 when activities funded through the grant award are initiated.

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

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

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

SEC. 203. DEMONSTRATION GRANTS.

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

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

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

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

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

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

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

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

(3) no amounts shall be made available for primary prevention; and

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

(d) GUIDELINES.—As a condition on receipt of an award under this section, an applicant shall agree to adhere to guidelines issued by the National Mental Health Policy Laboratory (established under section 201) on research designs and data collection.

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

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

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

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

SEC. 204. EARLY CHILDHOOD INTERVENTION AND TREATMENT.

(a) GRANTS.—The Director of the National Mental Health Policy Laboratory (in this section referred to as the ''NMHPL'') shall—

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

(2) ensure that programs funded through grants under this section are based on promising or evidence-based models and methods that are culturally and linguistically relevant and can be replicated in other settings.

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

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

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

(B) provides services that include early intervention and treatment or specialized programs for preschool- and elementary school-aged children whose primary need is a social or emotional disability (in addition to any learning disability).

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

(A) whose primary need is a social or emotional disability (in addition to any learning disability); and

(B) who could benefit from early childhood intervention and specialized preschool or elementary school programs with the goal of intervening or treating social or emotional disabilities.

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

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

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

(2) Treat and educate eligible children, including by providing funding for—

(A) program and curricula development;

(B) staff;

(C) assessment, intervention, and treatment services;

(D) administrative costs, including operating costs, capital needs, and equipment;

(E) enrollment costs;

(F) collaboration with primary care physicians, psychiatrists, and clinical services of psychologists of other related mental health specialists;

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

(H) communication with families and physical and mental health professionals concerning the children.

(3) Develop and implement other strategies to address identified intervention, treatment, and educational needs of eligible children that incorporate reliable and valid evaluation modalities into the program to ensure outcomes based on sound scientific metrics as determined by the NMHPL.

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

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

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

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

SEC. 205. EXTENSION OF ASSISTED OUTPATIENT TREATMENT GRANT PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

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

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

(2) in subsection (e), by striking ''and 2018'' and inserting ''2018, 2019, and 2020''; and

(3) in subsection (g)—

(A) in paragraph (1), by striking ''2018'' and inserting ''2020'';

(B) in paragraph (2) by striking ''2018'' and inserting ''2020''; and

(C) by striking ''$15,000,000'' and inserting ''$20,000,000''.

SEC. 206. BLOCK GRANTS.

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

''$483,000,000 for fiscal year 2017 and such sums as may be necessary for each of fiscal years 2018 through 2019''.

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

''(c) BEST PRACTICES IN CLINICAL CARE MODELS.—The Assistant Secretary, acting through the Administrator of the Substance Abuse and Mental Health Services and in collaboration with the Director of the National Institute of Mental Health, shall obligate 5 percent of the amounts appropriated for a fiscal year under subsection (a) for translating evidence-based (as defined in section 2 of the Mental Health Reform Act of 2015) interventions and best available science into systems of care, such as through models including the Recovery After an Initial Schizophrenia Episode research project of the National Institute of Mental Health.''.

(c) ADDITIONAL PROGRAM REQUIREMENTS.—

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

(A) by striking ''The plan provides'' and inserting the following:

''(A) IN GENERAL.—The plan provides'';

(B) in the second sentence, by striking ''health and mental health services'' and inserting ''integrated physical and mental health services'';

(C) by striking ''The plan shall include'' and all that follows through the period at the end and inserting ''The plan shall integrate and coordinate services to maximize the efficiency, effectiveness, quality, coordination, and cost effectiveness of those services and programs to produce the best possible outcomes for individuals with serious mental illness.''; and

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

''(B) ADDITIONAL REQUIREMENTS.—The plan shall include a separate description of case management services and provide for activities leading to reduction of rates of suicides, suicide attempts, substance abuse, overdose deaths, emergency hospitalizations, incarceration, crimes, arrest, homelessness, joblessness, medication nonadherence, and education and vocational programs drop outs. The plan shall include a detailed list of services available for eli-

gible patients in each county or county equivalent.''.

(2) DATA COLLECTION SYSTEM.—

(A) Subsection (b)(1)(A) (as so designated by paragraph (1)) of section 1912 of the Public Health Service Act (42 U.S.C. 300x–1(b)(1)(A)) is amended by inserting ''legal services, and'' before ''other support services''.

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

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

(A) in paragraph (1)—

(i) by striking ''Except as provided'' and inserting the following:

''(A) IN GENERAL.—Except as provided''; and

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

''(B) DE-IDENTIFIED REPORTS.—For eligible patients receiving treatment through funds

awarded under a grant under section 1911, a State shall include in the State plan for the first year beginning after the date of the enactment of the Mental Health Reform Act of 2015 and each subsequent year, a de-identified report, containing information that is open source and de-identified, on the outcomes measures collected in subsection (b)(2) of section 1912 of the Public Health Service Act and the overall cost of such treatment provided.''.

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

''(c) INCENTIVES FOR STATE-BASED OUTCOME MEASURES.—

''(1) IN GENERAL.—In addition to the amounts made available under subsection (a) for fiscal year 2019, the Secretary shall provide to each State that meets the conditions under paragraph (2) for fiscal year 2019, an amount equal to 2 percent of the formula grant amount described in section 1911 and section 1921.

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

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

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

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

''(e) EXPANSION OF MODELS.—

''(1) IN GENERAL.—Taking into account the results of evaluations under section 201(a)(2)(C) of the Mental Health Reform Act of 2015, the Assistant Secretary may, by rule, as part of the program of block grants under this subpart, provide for expanded use across the Nation of evidence-based service delivery models by providers funded under such block grants, so long as—

''(A) the Assistant Secretary for Mental Health and Substance Use Disorders (in this

subsection referred to as the 'Assistant Secretary') determines that such expansion will—

"(i) result in more effective use of funds under such block grants without reducing the quality of care; or

"(ii) improve the quality of patient care without significantly increasing spending;

"(B) the Director of the National Institute of Mental Health determines that such expansion would improve the quality of patient care; and

"(C) the Assistant Secretary determines that the change will—

"(i) significantly reduce severity and duration of symptoms of mental illness;

"(ii) reduce rates of suicide, suicide attempts, substance abuse, overdose, emergency hospitalizations, emergency room boarding, incarceration, crime, arrest, homelessness, or joblessness; or

"(iii) significantly improve the quality of patient care and mental health crisis outcomes without significantly increasing spending.

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

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

''(d) PERIOD FOR EXPENDITURE OF GRANT FUNDS.—In implementing a plan submitted under section 1912(a), a State receiving a grant under section 1911 may make such funds available to providers of services described in subsection (b) for the provision of services without fiscal year limitation.''.

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

''(c) ACTIVE OUTREACH AND ENGAGEMENT TO PERSONS WITH SERIOUS MENTAL ILLNESS.—

''(1) IN GENERAL.—A funding agreement for a grant under section 1911 is that the State involved has in effect active programs that seek to engage individuals with serious mental illness in comprehensive services in order to avert relapse, repeated hospitalizations, arrest, incarceration, suicide, and to

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

''(2) EVIDENCE-BASED ASSERTIVE OUTREACH AND ENGAGEMENT SERVICES.—

''(A) SAMHSA.—The Administrator of the Substance Abuse and Mental Health Services Administration, in cooperation with the Director of the National Institute of Mental Health, shall develop—

''(i) a list of evidence-based culturally and linguistically relevant assertive outreach and engagement services; and

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

"(B) TYPES OF ASSERTIVE OUTREACH AND ENGAGEMENT SERVICES.—For purposes of paragraph (1), appropriate programs of evidence-based assertive outreach and engagement services may include peer support programs; the Wellness Recovery Action Plan, Assertive Community Treatment, and Forensic Assertive Community Treatment of the Substance Abuse and Mental Health Services Administration; assisted outpatient treatment, appropriate supportive housing programs incorporating a Housing First model; and intensive, evidence-based approaches to early intervention in psychosis, such as the Recovery After an Initial Schizophrenia Episode model of the National Institute of Mental Health and the Specialized Treatment Early in Psychosis program.

"(d) PSYCHIATRIC ADVANCED DIRECTIVES.—A funding agreement for a grant under section 1911 is that the State involved has in effect active programs that seek to engage individuals with serious mental illness in proactively making their own health care decisions and enhancing communication between themselves, their families, and their treatment providers by allowing for early intervention and reducing legal proceedings related to in-

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

''(1) of assertive outreach and engagement services focusing on individuals diagnosed with serious mental illness or self-identifying as in recovery from serious mental illness to obtain a psychiatric advanced directive; or

''(2) to support States in providing accessible legal counsel to individuals diagnosed with serious mental illness.''.

SEC. 207. TELEHEALTH CHILD PSYCHIATRY ACCESS GRANTS.

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

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

(2) supporting the expansion of existing statewide or regional child psychiatry access programs.

(b) PROGRAM REQUIREMENTS.—

(1) IN GENERAL.—To be eligible for funding under subsection (a), a child psychiatry access program shall—

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

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

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

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

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

(F) conduct training and provide technical assistance to pediatric primary care providers to support the early identification, diagnosis, treatment, and referral of children with behavioral health conditions;

(G) inform and assist pediatric providers in accessing child psychiatry consultations and in scheduling and conducting technical assistance;

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

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

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

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

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

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

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

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

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

SEC. 208. LIABILITY PROTECTIONS FOR HEALTH CARE PROFESSIONAL VOLUNTEERS AT COMMUNITY HEALTH CENTERS AND COMMUNITY MENTAL HEALTH CENTERS.

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

''(q)(1) In this subsection, the term 'community mental health center' means—

''(A) a community mental health center, as defined in section 1861(ff) of the Social Security Act; or

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

''(2) For purposes of this section, a health care professional volunteer at an entity described in subsection (g)(4) or a community mental health center shall, in providing health care services eligible for funding under section 330 or subpart I of part B of title XIX to an indi-

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

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

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

''(B) The center or entity is sponsoring the health care professional volunteer pursuant to paragraph (4)(B).

''(C) The health care professional does not receive any compensation for the service from the individual or from any third-party payer (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program), except that the health care professional

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

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

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

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

''(A) The first sentence of paragraph (2) applies in lieu of the first sentence of subsection (g)(1)(A).

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

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

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

''(C) In the case of a health care professional who is determined by the Secretary pursuant to subsection (g)(1)(E) to be a health professional volunteer at such center, this subsection applies to the health care professional (with respect to services described in paragraph (2)) for any cause of action arising from an act or omission of the health care professional occurring on or after the date on which the Secretary makes such determination.

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

''(5)(A) Amounts in the fund established under subsection (k)(2) shall be available for transfer under subparagraph (C) for purposes of carrying out this subsection for health professional volunteers at entities described in subsection (g)(4).

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

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

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

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

''(i) the Secretary may issue regulations for carrying out this subsection, and the Secretary may accept and consider applications submitted pursuant to paragraph (4)(B); and

''(ii) reports under paragraph (5)(B) may be submitted to Congress.''.

SEC. 209. MINORITY FELLOWSHIP PROGRAM.

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

(1) by redesignating part G (42 U.S.C. 290kk et seq.), relating to services provided through religious organizations and added by section 144 of the Community Renewal Tax Relief Act of 2000, as enacted into law by section 1(a)(7) of Public Law 106–554, as part J;

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

(3) by adding at the end the following:

"PART K—MINORITY FELLOWSHIP PROGRAM

"SEC. 597. FELLOWSHIPS.

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

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

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

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

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

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

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

SEC. 210. NATIONAL HEALTH SERVICE CORPS.

(a) DEFINITIONS.—

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

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

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

ing ''(which may be a group comprised of children and adolescents)'' after ''population group''.

(4) MEDICAL FACILITY.—Section 332(a)(2)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(2)(A)) is amended by inserting ''medical residency or fellowship training site for training in child and adolescent psychiatry,'' before ''facility operated by a city or county health department,''.

(b) ELIGIBILITY TO PARTICIPATE IN LOAN REPAYMENT PROGRAM.—Section 338B(b)(1)(B) of the Public Health Service Act (42 U.S.C. 254l–1(b)(1)(B)) is amended by inserting '', including any child and adolescent psychiatry medical residency or fellowship training program'' before the semicolon.

SEC. 211. REAUTHORIZATION OF MENTAL AND BEHAVIORAL HEALTH EDUCATION TRAINING GRANT.

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

''SEC. 756. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.

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

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

''(1) accredited institutions of higher education or accredited professional training programs that are establishing or expanding internships or other field placement programs in mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse prevention and treatment, marriage and family therapy, school counseling, or professional counseling, with a preference for programs addressing child and adolescent mental health, in particular transitional age youth between 16 to 25 years old;

''(2) accredited doctoral, internship, and post-doctoral residency programs of health service psychology (which includes clinical psychology, counseling, and school psychology) for the development and implementation of interdisciplinary training of psychology graduate students for providing behavioral and mental health services, including substance abuse prevention and treatment services, as well as the development of faculty in health service psychology;

''(3) accredited master's and doctoral degree programs of social work for the development and implementation of interdisciplinary training of social work graduate students for providing behavioral and mental health services, including substance abuse prevention and treatment services, and the development of faculty in social work; or

''(4) paraprofessional certificate training programs offered by accredited community and technical colleges granting State licensure or certification in a behavioral health-related paraprofessional field, such as community health worker, outreach worker, social services aide, mental health worker, substance abuse or addictions worker, youth worker, promotora, or peer paraprofessional, with preference for pre-service or in-service training of paraprofessional child and adolescent mental health workers.

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

''(1) an ability to recruit and place psychiatrists, psychologists, social workers, or paraprofessionals in areas with a high need and high demand population;

''(2) participation of individuals and groups from different racial, ethnic, cultural, geographic, religious, linguistic, and class backgrounds, and different genders and orientations in the institution's programs;

''(3) knowledge and understanding of the concerns of the individuals and groups described in paragraph (2), especially individuals with mental health symptoms or diagnoses, particularly children and adolescents, with a special emphasis on transitional-aged persons 16 to 25 years old;

''(4) prioritization of cultural and linguistic competency in training professionals and paraprofessionals in any academic program, field placement, internship, or post-doctoral position; and

''(5) the willingness to provide to the Secretary such data, assurances, and information as the Secretary may require.

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

''(1) programs that have demonstrated the ability to train psychology and social work professionals to work in integrated care settings; and

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

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

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

''(e) REPORT TO CONGRESS.—Not later than 2 years after the date of enactment of the Mental Health Reform Act of 2015, and annually thereafter, the Secretary, acting through the Administrators of the Substance Abuse and Mental Health Services Administration and the Health Resources Services Administration, shall submit to Congress a report on the effectiveness of—

''(1) providing graduate students support for experiential training (internship or field placement);

''(2) recruitment of students interested in behavioral health practice;

''(3) development and implementation of interprofessional training and integration within primary care;

''(4) development and implementation of accredited field placements and internships; and

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

''(f) AUTHORIZATION OF APPROPRIATIONS.—For each of fiscal years 2017 through 2021, there are authorized to be appropriated to carry out this section $44,000,000, to be allocated as follows:

''(1) $15,000,000 shall be allocated to institutions to expand mental health internships or other field placement programs under subsection (a)(1).

''(2) $14,000,000 shall be allocated to training in graduate psychology under subsection (a)(2).

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

''(4) $5,000,000 shall be allocated to training paraprofessionals under subsection (a)(4).''.

SEC. 212. NATIONAL SUICIDE PREVENTION LIFELINE PROGRAM.

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

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

''(a) IN GENERAL.—The Secretary shall maintain the National Suicide Prevention Lifeline program. The activities of the Secretary under such program shall include—

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

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

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

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

''(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $5,000,000 for each of fiscal years 2016 through 2020.''.

TITLE III—INTEGRATION

SEC. 301. PRIMARY AND BEHAVIORAL HEALTH CARE INTEGRATION GRANT PROGRAMS.

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

''SEC. 520K. INTEGRATION INCENTIVE GRANTS.

''(a) IN GENERAL.—There is established within the Substance Abuse and Mental Health Services Administration a primary and behavioral health care integration grant program. The Assistant Secretary for Mental Health and Substance Use Disorders may award grants and cooperative agreements to eligible entities to expend

funds for improvements in integrated settings with integrated practices.

''(b) DEFINITIONS.—In this section:

''(1) INTEGRATED CARE.—The term 'integrated care' means full collaboration in merged or transformed practices offering mental and physical health services within the same shared practice space in the same facility, where the entity—

''(A) provides services in a shared space that ensures services will be available and accessible promptly and in a manner which preserves human dignity and assures continuity of care;

''(B) ensures communication among the integrated care team that is consistent and team-based;

''(C) ensures shared decisionmaking between mental health and primary care providers;

''(D) provides evidence-based services in a mode of service delivery appropriate for the target population;

''(E) employs staff who are multidisciplinary and culturally and linguistically competent;

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

''(G) provides targeted case management, including services to assist individuals gaining access to needed medical, social, educational, and other services and applying for income security, housing, employment, and other benefits to which they may be entitled.

''(2) INTEGRATED CARE TEAM.—The term 'integrated care team' means a team that includes—

''(A) allopathic or osteopathic medical doctors, including a primary care physician and a board certified psychiatrist;

''(B) licensed clinical mental health professionals, such as psychologists or social workers;

''(C) a case manager; and

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

''(3) SPECIAL POPULATION.—The term 'special population' means—

''(A) adults with mental illnesses who have co-occurring primary care conditions with chronic diseases;

''(B) adults with serious mental illnesses who have co-occurring primary care conditions with chronic diseases;

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

''(D) individuals with substance use disorder.

''(c) PURPOSE.—The grant program under this section shall be designed to lead to full collaboration between primary and behavioral health in an integrated practice model at a statewide level, to ensure that—

''(1) the overall wellness and physical health status of individuals with serious mental illness and co-occurring substance use disorders is supported through integration of primary care into community mental health centers meeting the criteria specified in section 1913(c) of the Social Security Act or certified community behavioral health clinics described in section 223 of the Protecting Access to Medicare Act of 2014; and

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

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

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

''(1) a document that summarizes the State-specific policies that inhibit the provision of integrated care, and the specific steps that will be taken to address such barriers, such as through licensing and billing procedures; and

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

and clinical outcomes to inform clinical interventions, patient education, and engagement with merged or transformed integrated practices in compliance with applicable national and State health information privacy laws.

''(f) GRANT AMOUNTS.—The maximum annual grant amount under this section shall be $2,000,000, of which not more than 10 percent may be allocated to State administrative functions, and the remaining amounts shall be allocated to health facilities that provide integrated care.

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

''(h) REPORT ON PROGRAM OUTCOMES.—An entity receiving a grant or cooperative agreement under this section shall submit an annual report to the Administrator that includes—

''(1) the progress to reduce barriers to integrated care, including regulatory and billing barriers, as described in the entity's application under subsection (d); and

''(2) a description of functional outcomes of special populations, including—

''(A) with respect to individuals with serious mental illness, participation in supportive

housing or independent living programs, attendance in social and rehabilitative programs, participation in job training opportunities, satisfactory performance in work settings, attendance at scheduled medical and mental health appointments, and compliance with prescribed medication regimes;

''(B) with respect to individuals with co-occurring mental illness and primary care conditions and chronic diseases, attendance at scheduled medical and mental health appointments, compliance with prescribed medication regimes, and participation in learning opportunities related to improved health and lifestyle practice; and

''(C) with respect to children and adolescents with serious emotional disorders who have co-occurring primary care conditions and chronic diseases, attendance at scheduled medical and mental health appointments, compliance with prescribed medication regimes, and participation in learning opportunities at school and extracurricular activities.

''(i) TECHNICAL ASSISTANCE CENTER FOR PRIMARY-BEHAVIORAL HEALTH CARE INTEGRATION.—

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

''(A) development and selection of integrated care models;

''(B) dissemination of evidence-based interventions in integrated care;

''(C) establishment of organizational practices to support operational and administrative success; and

''(D) other activities, as the Assistant Secretary for Mental Health and Substance Use Disorders determines appropriate.

''(2) ADDITIONAL DISSEMINATION OF TECHNICAL INFORMATION.—The information and resources provided by the technical assistance program established under paragraph (1) shall be made available to States, political subdivisions of a State, Indian tribes or tribal organizations (as defined in sec-

tion 4 of the Indian Self-Determination and Education Assistance Act), outpatient mental health and addiction treatment centers, community mental health centers that meet the criteria under section 1913(c), certified community behavioral health clinics described in section 223 of the Protecting Access to Medicare Act of 2014, primary care organizations such as Federally qualified health centers or rural health centers, other community-based organizations, or other entities engaging in integrated care activities, as the Assistant Secretary for Mental Health and Substance Use Disorders determines appropriate.

''(j) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $50,000,000 for each of fiscal years 2017 through 2021, of which $2,000,000 shall be available to the technical assistance program under subsection (i).''.

TITLE IV—INTERAGENCY SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE

SEC. 401. INTERAGENCY SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE.

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

"SEC. 501A. INTERAGENCY SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE.

''(a) ESTABLISHMENT.—The Assistant Secretary for Mental Health and Substance Use Disorders (in this section referred to as the 'Assistant Secretary') shall establish a committee, to be known as the Interagency Serious Mental Illness Coordinating Committee (in this section referred to as the 'Committee'), to assist the Assistant Secretary in carrying out the Assistant Secretary's duties.

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

''(1) develop and annually update a summary of advances in serious mental illness research related to prevention of, diagnosis of, intervention in, and treatment and rehabilitation of, serious mental illness, and access to services and supports for individuals with serious mental illness;

''(2) monitor Federal programs and activities with respect to serious mental illness;

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

''(4) make recommendations to the Assistant Secretary regarding public participation in decisions relating to serious mental illness;

''(5) develop and update every 3 years a strategic plan for the conduct and support of programs and services to assist individuals with serious mental illness, including—

''(A) a summary of the advances in serious mental illness research developed in under paragraph (1);

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

''(C) an analysis of the efficiency, effectiveness, quality, coordination, and cost-effectiveness of Federal programs and activities relating to the prevention, diagnosis, treatment, or rehabilitation of serious mental illness, including an accounting of the costs of such programs and activities with administrative costs disaggregated from the costs of services and care; and

''(D) a plan with recommendations—

''(i) for the coordination and improvement of Federal programs and activities related to serious mental illness, including budgetary requirements;

''(ii) for improving outcomes for individuals with a serious mental illness in-

cluding appropriate benchmarks to measure progress on achieving improvements;

"(iii) for the mental health workforce;

"(iv) to disseminate relevant information developed by the coordinating committee to the public, health care providers, social service providers, public health officials, courts, law enforcement, and other relevant groups;

"(v) to identify research needs, including longitudinal studies of pediatric populations; and

"(vi) for vulnerable and underserved populations, including pediatric and geriatric populations; and

"(6) submit to Congress such strategic plan and any updates to such plan.

"(c) MEMBERSHIP.—

"(1) IN GENERAL.—The Committee shall be composed of not more than 9 Federal representatives including—

"(A) the Assistant Secretary for Mental Health and Substance Use Disorders (or the Assistant Secretary's designee), who shall serve as the Chair of the Committee;

"(B) the Director of the National Institute of Mental Health (or the Director's designee);

"(C) the Attorney General of the United States (or the Attorney General's designee);

"(D) the Director of the Centers for Disease Control and Prevention (or the Director's designee);

"(E) the Director of the National Institutes of Health (or the Director's designee);

"(F) a member of the United States Interagency Council on Homelessness;

"(G) representatives, appointed by the Assistant Secretary, of Federal agencies that serve individuals with serious mental illness, including representatives of the Centers for Medicare & Medicaid Services, the Administration on Community Living, the Agency for Healthcare Research and Quality, the Bureau of Indian Affairs, the Department of Defense, the Department of Education, the Department of Housing and Urban Development, the Department of Labor, the Department of Veterans Affairs, and the Social Security Administration; and

"(H) the additional members appointed under paragraph (2).

"(2) ADDITIONAL MEMBERS.—At least 14 members of the Committee shall be non-Federal public members appointed by the Assistant Secretary, of which—

"(A) at least 1 member shall be an individual in recovery from a diagnosis of serious mental illness who has benefitted from and is receiving medical treatment under the care of a licensed mental health professional;

"(B) at least 1 member shall be a parent or legal guardian of an individual with a history of serious mental illness who has either attempted suicide or is incarcerated for violence committed while experiencing a serious mental illness;

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

"(D) at least 2 members shall be—

"(i) a licensed psychiatrist with experience treating serious mental illness;

"(ii) a licensed psychologist with experience treating serious mental illness;

"(iii) a licensed clinical social worker; or

"(iv) a licensed psychiatric nurse or nurse practitioner;

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

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

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

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

"(I) at least 1 member shall be a law enforcement officer or corrections officer with extensive experience in interfacing with psychiatric and psychological disorders or individuals in mental health crisis; and

"(J) 4 members, of which—

"(i) 1 shall be appointed by the majority leader of the Senate;

"(ii) 1 shall be appointed by the minority leader of the Senate;

"(iii) 1 shall be appointed by the Speaker of the House of Representatives; and

"(iv) 1 shall be appointed by the minority leader of the House of Representatives.

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

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

"(A) reduced rates of suicide, suicide attempts, substance abuse, overdose, overdose deaths, emergency hospitalizations, emergency room boarding (as defined in section 1912(e)), incarceration, crime, arrest, homelessness, and joblessness;

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

''(C) such other criteria as may be determined by the Assistant Secretary;

''(2) formulating recommendations for the coordination and improvement of Federal programs and activities described in paragraph (2);

''(3) identifying any such programs and activities that are duplicative; and

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

''(e) ADMINISTRATIVE SUPPORT; TERMS OF SERVICE; OTHER PROVISIONS.—The following provisions shall apply with respect to the Committee:

''(1) The Assistant Secretary shall provide such administrative support to the Committee as may be necessary for the Committee to carry out its responsibilities.

''(2) Members of the Committee appointed under subsection (c)(2) shall serve for a term of 4 years, and may be reappointed for one or more additional 4-year terms. Any member appointed to fill a

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

''(3) The Committee shall meet at the call of the chair or upon the request of the Assistant Secretary. The Committee shall meet not fewer than 2 times each year.

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

''(f) SUBCOMMITTEES; ESTABLISHMENT AND MEMBERSHIP.—In carrying out its functions, the Committee may establish subcommittees and convene workshops and conferences. Such subcommittees shall be composed of Committee members and may hold such meetings as are necessary to enable the subcommittees to carry out their duties.''.

TITLE V—HIPAA CLARIFICATION

SEC. 501. FINDINGS.

The Senate makes the following findings:

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

and well-being of individuals experiencing temporary psychosis. However, a lack of understanding by health professionals has been a barrier to many family members assisting in the treatment of an individual with serious mental illness.

(2) The privacy rule under section 164.510(b)(2) of title 45, Code of Federal Regulations allows for the disclosure of protected health information in the event that a covered entity receives the individual's agreement provides an opportunity for an individual to object, and the individual does not express an objection or the covered entity reasonably infers that the individual does not object.

(3) The privacy rule under section 164.510(b)(3) of title 45, Code of Federal Regulations allows for the disclosure of protected health information if an individual is not present or is otherwise incapacitated if the medical provider determines that the disclosure is in the best interests of the individual.

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

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

given advanced notice of the desire to share information with family members or other caregivers. This notice should include an explanation of what information is to be shared and why it is clinically desirable to share such information.

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

SEC. 502. MODIFICATIONS TO HIPAA.

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

(1) Timely intervention for treatment of a serious mental or general medical illness.

(2) Safe and stable housing for the individual.

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

(4) An increased capacity of caregivers to support the patient to live within the community.

SEC. 503. DEVELOPMENT AND DISSEMINATION OF MODEL TRAINING PROGRAMS.

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

Secretary of Health and Human Services (in this section referred to as the ''Secretary''), in consultation with appropriate experts, shall develop and disseminate—

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

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

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

(b) PERIODIC UPDATES.—The Secretary shall—

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

(2) disseminate the updated model programs and materials.

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

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

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

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

SEC. 504. CONFIDENTIALITY OF RECORDS.

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

''(i) STREAMLINED CONSENT IN INTEGRATED CARE SETTINGS.—

''(1) IN GENERAL.—For the sharing of records described in subsection (a) involving the interchange of electronic health records (as defined in section 13400 of division A of Public Law 111–5) solely for the purposes of improving the provision of health care and health care coordination solely within accountable care organizations described in section 1899 of the Social Security Act, health information exchanges (as defined for purposes of section 3013), health homes (as defined in section 1945(h)(3) of the Social Security Act), or other integrated care arrangements (in existence before, on, or after the date of the enactment of the Mental Health Reform Act of 2015), a patient's prior written or electronic consent for disclosure and re-disclosure of records may be provided annually in a generalized and rev-

ocable format to and for all of the health care providers in the accountable care organization, health information exchange, health home, or other integrated care arrangement, who are involved in the patient's care.

''(2) DISCLOSURE REQUIRED.—For all other disclosures or re-disclosures of the records described in subsection (a), except those expressly proscribed in paragraph 1, patient consent is required to be obtained in accordance with the procedures described in part 2 of title 42, Code of Federal Regulations.

''(3) PROHIBITIONS.—It shall be unlawful for any health plan or health insurance program to use the records described in subsection (a) or this subsection to deny or condition the issuance of a plan, policy, or coverage on the basis of the contents of such records, or for a health care provider to use the records described in subsection (a) and this section to discriminate in the provision of medically necessary health care services to an individual who is the subject of such records.''.

TITLE VI—MEDICARE AND MEDICAID REFORMS

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

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

(1) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting after paragraph (77) the following new paragraph:

''(78) not prohibit payment under the plan for a mental health service or primary care service furnished to an individual at a community mental health center meeting the criteria specified in section 1913(c) of the Public Health Service Act or a Federally qualified health center (as defined in section 1861(aa)(4)) for which payment would otherwise be payable under the plan, with respect to such individual, if such service were not a same-day qualifying service (as defined in subsection (ll)).''.

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

''(ll) SAME-DAY QUALIFYING SERVICES DEFINED.—For purposes of subsection (a)(78), the term 'same-day qualifying service' means—

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

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

(b) STATE OPTION TO PROVIDE MEDICAL ASSISTANCE FOR CERTAIN INPATIENT PSYCHIATRIC SERVICES TO NONELDERLY ADULTS.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (a)—

(A) in paragraph (16)—

(i) by striking ''effective'' and inserting ''(A) effective''; and

(ii) by inserting before the semicolon at the end the following: '', and (B) qualified inpatient psychiatric hospital services (as defined in subsection (h)(3)) for indi-

viduals over 21 years of age and under 65 years of age''; and

(B) in the subdivision (B) that follows paragraph (29), by inserting ''(other than services described in subparagraph (B) of paragraph (16) for individuals described in such subparagraph)'' after ''patient in an institution for mental diseases''; and

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

''(3) For purposes of subsection (a)(16)(B), the term 'qualified inpatient psychiatric hospital services'' means, with respect to individuals described in such subsection, services described in subparagraphs (A) and (B) of paragraph (1) that are furnished in an acute care psychiatric unit in a State-operated psychiatric hospital or a psychiatric hospital (as defined section 1861(f)) if such unit or hospital, as applicable, has a facility-wide average (determined on an annual basis) length of stay of less than 20 days.''.

(c) STUDY AND REPORT.—

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

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

(A) An assessment of the level of State expenditures on short-term acute inpatient psychiatric hospital care for which no Federal financial participation is provided for the most recent State fiscal year ending prior to the effective date of the amendments made by this section and an analysis of the impact of the changes to the Medicaid IMD exclusion made by such amendments on State expenditures for such care.

(B) An assessment of the extent to which States used disproportionate share hospital payment adjustments described in section 1923 of the Social Security Act (42 U.S.C. 1396r–4) to fund short-term acute inpatient psychiatric hospital care prior to the effective date of the amendments made by this section and an analysis of the impact of the changes to the Medicaid IMD exclusion made by such amendments

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

(C) The total amount by which State expenditures and the extent to which States use disproportionate share hospital payment adjustments for short-term acute inpatient psychiatric hospital care have been reduced due to the changes to the Medicaid IMD exclusion made by the amendments made by this section.

(D) Recommendations for strategies to encourage States to reinvest savings in State expenditures and disproportionate share hospital payment adjustments that result from the changes to the Medicaid IMD exclusion made by the amendments made by this section in community-based mental health services.

(3) DEFINITIONS.—For purposes of this subsection:

(A) MEDICAID IMD EXCLUSION.—The term ''Medicaid IMD exclusion'' means the prohibition on Federal matching payments under Medicaid for care or services provided to patients who have attained age 22, but have not attained age 65, in an institution for mental diseases under subdivision (B) of the matter fol-

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

(B) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(C) SHORT-TERM ACUTE INPATIENT PSYCHIATRIC HOSPITAL CARE.—The term ''short-term acute inpatient psychiatric hospital care'' means care provided in either—

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

(ii) a psychiatric hospital with an average length of stay of fewer than 20 days on an annual basis.

(d) EFFECTIVE DATE.—

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

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

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

(3) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act, which the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet any requirement imposed by amendments made by this section, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this section. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year

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

SEC. 602. MODIFICATIONS TO MEDICARE DISCHARGE PLANNING REQUIREMENTS.

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

(1) in paragraph (1), by inserting ''and, in the case of a psychiatric hospital or a psychiatric unit (as described in the matter following clause (v) of section 1886(d)(1)(B)), if it also meets the guidelines and standards established by the Secretary under paragraph (4)'' before the period at the end; and

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

''(4) The Secretary shall develop guidelines and standards, in addition to those developed under paragraph (2), for the discharge planning process of a psychiatric hospital or a psychiatric unit (as described in the matter following clause (v) of section 1886(d)(1)(B)) in order to ensure a timely and smooth transition to the most appropriate type of, and setting for, posthospital or rehabilitative care. The Secretary shall issue final regulations implementing such guidelines and standards not later

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

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

''(B) The hospital or unit must—

''(i) identify organizations that offer community services to the community that is served by the hospital or unit and the types of services provided by the organizations; and

''(ii) make demonstrated efforts to establish connections, relationships, and partnerships with such organizations.

''(C) The hospital or unit must arrange (with the participation of the patient and of any other individuals selected by the patient for such purpose) for the development and implementation of a discharge plan for the patient as part of the patient's overall treatment plan from admission to discharge. Such discharge plan shall meet the requirements described in subparagraphs (G) and (H) of paragraph (2).

''(D) The hospital or unit shall coordinate with the patient (or assist the patient with) the referral for posthospital or rehabilitative care and as part of that referral the hospital or unit shall include transmitting to the receiving organization, in a timely manner, appropriate information about the care furnished to the patient by the hospital or unit and recommendations for posthospital or rehabilitative care to be furnished to the patient by the organization.''.

TITLE VII—RESEARCH BY NATIONAL INSTITUTE OF MENTAL HEALTH

SEC. 701. INCREASE IN FUNDING FOR CERTAIN RESEARCH.

Section 402A(a) of the Public Health Service Act (42 U.S.C. 282a(a)) is amended by adding at the end the following:

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

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

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

''(B) PURPOSES.—Amounts appropriated pursuant to subparagraph (A) shall be used exclusively for the purpose of conducting or supporting—

''(i) research on the determinants of self- and other directed-violence in mental illness, including studies directed at reducing the risk of self harm, suicide, and interpersonal violence; or

''(ii) brain research through the Brain Research through Advancing Innovative Neurotechnologies Initiative.''.

TITLE VIII—SAMHSA REAUTHORIZATION AND REFORMS

Subtitle A—Organization and General Authorities

SEC. 801. PEER REVIEW.

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

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

(b) Section 504 of the Public Health Service Act (42 U.S.C. 290aa–3) is amended by adding at the end of subsection (b) the following: ''At least half of the members of any peer-review group established under subsection (a) shall have a medical degree, a doctoral degree in psychology, or advanced degree in nursing or social work from an accredited graduate school, and shall specialize in the mental health field.''.

SEC. 802. ADVISORY COUNCILS.

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

''(C) Not fewer than half of the members of the group shall have a medical degree, a doctoral degree in psychology, or advanced degree in nursing or social work from an accredited graduate school and shall specialize in the mental health field.

''(D) Each advisory committee shall include at least one member of the National Institute of Mental Health and 1 member from any

Federal agency that has a program serving a similar population.''.

SEC. 803. GRANTS FOR JAIL DIVERSION PROGRAMS REAUTHORIZATION.

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

SEC. 804. PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS.

Section 535(a) of the Public Health Service Act (42 U.S.C. 290cc–35(a)) is amended by striking ''$75,000,000 for each of the fiscal years 2001 through 2003'' and inserting ''$65,000,000 for each of fiscal years 2017 through 2021''.

SEC. 805. COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES.

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

(1) in subsection (b)(1), by striking ''receiving a grant under section 561(a)'' and inserting ''(irrespective of whether the public entity is in receipt of a grant under section 561(a))'';

(2) in subsection (b)(1)(B), by striking ''pursuant to section 562'' and inserting ''described in section 562''; and

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

SEC. 806. REAUTHORIZATION OF PRIORITY MENTAL HEALTH NEEDS OF REGIONAL AND NATIONAL SIGNIFICANCE.

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

TITLE IX—MENTAL HEALTH PARITY

SEC. 901. GAO STUDY ON PREVENTING DISCRIMINATORY COVERAGE LIMITATIONS FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS AND SUBSTANCE USE DISORDERS.

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

in consultation with the Assistant Secretary for Mental Health and Substance Use Disorders, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury, shall submit to Congress a report detailing the extent to which covered group health plans (or health insurance coverage offered in connection with such plans), including Medicaid managed care plans under section 1903 of the Social Security Act (42 U.S.C. 1396b), comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (subtitle B of title V of division C of Public Law 110–343) (in this section referred to as the ''law''), including—

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

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

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

SEC. 902. REPORT ON INVESTIGATIONS REGARDING PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Administrator of the Centers for Medicare & Medicaid Services, in collaboration with the Assistant Secretary of Labor of the Employee Benefits Security Administration and the Secretary of the Treasury, and in consultation with the Assistant Secretary for Mental Health and Substance Use Disorders, shall submit to Congress a report—

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

(2) summarizing the results of such investigations.

(b) CONTENTS.—Subject to subsection (c), each report under subsection (a) shall include the following information:

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

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

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

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

(c) LIMITATION.—Individually identifiable information shall be excluded from reports under subsection (a) consistent with Federal privacy protections.

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

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

''(6) DISCLOSURE AND ENFORCEMENT REQUIREMENTS.—

''(A) DISCLOSURE REQUIREMENTS.—

''(i) REGULATIONS.—Not later than March 1, 2016, the Secretary, in cooperation with the Secretary of Labor and the Secretary of the Treasury shall issue additional regulations or sub-regulatory guid-

ance for carrying out this section, including an explanation of documents that are required to be disclosed, and analyses that are required to be conducted, including how non-quantitative treatment limitations are applied to mental health or substance use disorder benefits and medical or surgical benefits covered under the plan, by a group health plan (or health insurance issuer) offering health insurance coverage in the group or individual market in order for such plan or issuer to demonstrate compliance with the provisions of this section. The disclosure requirements shall include a report detailing the specific analyses performed to develop a compliance review of the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, including the amendments made by such Act. With respect to non-quantitative treatment limitations, this report shall—

''(I) identify the specific factors used by the plan in performing its

non-quantitative treatment limitations analysis;

''(II) identify and define the specific evidentiary standards relied on to evaluate the factors;

''(III) describe how the evidentiary standards were applied to each service category;

''(IV) disclose the results of the analyses of the specific evidentiary standards in each service category; and

''(V) disclose the plan's specific findings in each service category and the conclusions reached with respect to compliance with comparability and stringency of application tests under the non-quantitative treatment limitations rule.

''(ii) GUIDANCE.—The Secretary, in cooperation with the Secretary of Labor and the Secretary of the Treasury shall issue guidance to group health plans and health insurance issuers offering health insurance coverage in the group or individual

markets on how to satisfy the requirements of this section with respect to making information, including certificate of coverage documents and instruments under which the plan is administered and operated that specify, include, or refer to procedures, formulas, and methodologies applied to determine a participant or beneficiary's benefit under the plan, regardless of whether such information is contained in a document designated as the 'plan document' available to current and potential participants and beneficiaries. This guidance shall include plan disclosure of how the plan has met the 2-part test under the non-quantitative treatment limitations rule of comparability and stringency in application.

''(B) ENFORCEMENT.—

''(i) PROCESS FOR COMPLAINTS.—The Secretary, in cooperation with the Secretary of Labor and the Secretary of the Treasury, as appropriate, shall, with respect to group health plans and health insurance issuers offering health insurance coverage in the group or individual market,

issue guidance to clarify the process and timeline for current and potential participants and beneficiaries and their authorized representatives and providers with respect to such plans and coverage to file formal complaints of such plans or issuers being in violation of this section, including guidance on the relevant individual State, regional, and national offices with which such claims should be filed by plan type.

''(ii) AUTHORITY FOR PUBLIC ENFORCEMENT.—The Secretary shall make available to the public de-identified information on audits and investigations of group health plans and health insurance issuers conducted under this section.

''(iii) AUDITS.—

''(I) RANDOMIZED AUDITS.—The Secretary is authorized to conduct randomized audits of group health plans and health insurance issuers offering health insurance coverage in the group or individual market to determine compliance with this section. Such audits shall be conducted on no

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

''(II) ADDITIONAL AUDITS.—In the case of a group health plan or health insurance issuer offering health insurance coverage in the group or individual market with respect to which at least 5 substantiated claims of the same type of non-compliance with this section have been filed during a plan year, the Secretary shall audit plan documents to determine compliance with this section. Information detailing the results of the audit shall be made available on the public Internet website of the Department of Health and Human Services.''.

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