

114TH CONGRESS
2D SESSION

S. _____

To amend the Public Health Service Act to provide comprehensive mental health reform, and for other purposes.

IN THE SENATE OF THE UNITED STATES

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

A BILL

To amend the Public Health Service Act to provide comprehensive mental health reform, and for other purposes.

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

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

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Mental Health Reform Act of 2016”.

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

Sec. 1. Short title; table of contents.

TITLE I—STRENGTHENING LEADERSHIP AND ACCOUNTABILITY

Sec. 101. Improving oversight of mental and substance use disorder programs.

Sec. 102. Strengthening leadership of the Substance Abuse and Mental Health Services Administration.

- Sec. 103. Chief medical officer.
- Sec. 104. Strategic plan.
- Sec. 105. Biennial report concerning activities and progress.
- Sec. 106. Authorities of centers for mental health services.
- Sec. 107. Advisory councils.
- Sec. 108. Peer review.
- Sec. 109. Inter-departmental Serious Mental Illness Coordinating Committee.

TITLE II—ENSURING MENTAL AND SUBSTANCE USE DISORDER
PREVENTION, TREATMENT, AND RECOVERY PROGRAMS KEEP
PACE WITH SCIENCE

- Sec. 201. Encouraging innovation and evidence-based programs.
- Sec. 202. Promoting access to information on evidence-based programs and practices.
- Sec. 203. Priority mental health needs of regional and national significance.

TITLE III—SUPPORTING STATE RESPONSES TO MENTAL HEALTH
AND SUBSTANCE USE DISORDER NEEDS

- Sec. 301. Community Mental Health Services Block Grant.
- Sec. 302. Additional provisions related to the block grants.
- Sec. 303. Study of distribution of funds under the substance abuse prevention and treatment block grant and the community mental health services block grant.

TITLE IV—PROMOTING ACCESS TO MENTAL HEALTH AND
SUBSTANCE USE DISORDER CARE

- Sec. 401. Grants for treatment and recovery for homeless individuals.
- Sec. 402. Grants for jail diversion programs.
- Sec. 403. Promoting integration of primary and behavioral health care.
- Sec. 404. Projects for assistance in transition from homelessness.
- Sec. 405. National suicide prevention lifeline program.
- Sec. 406. Connecting individuals and families with care.
- Sec. 407. Streamlining mental and behavioral health workforce programs.
- Sec. 408. Reports.
- Sec. 409. Centers and program repeals.

TITLE V—STRENGTHENING MENTAL AND SUBSTANCE USE
DISORDER CARE FOR CHILDREN AND ADOLESCENTS

- Sec. 501. Programs for children with serious emotional disturbances.
- Sec. 502. Telehealth child psychiatry access grants.
- Sec. 503. Substance use disorder treatment and early intervention services for children and adolescents.
- Sec. 504. Residential treatment programs for pregnant and parenting women.

TITLE VI—IMPROVING PATIENT CARE AND ACCESS TO MENTAL
AND SUBSTANCE USE DISORDER BENEFITS

- Sec. 601. HIPAA clarification.
- Sec. 602. Identification of model training programs.
- Sec. 603. Confidentiality of records.
- Sec. 604. Enhanced compliance with mental health and substance use disorder coverage requirements.

Sec. 605. Action plan for enhanced enforcement of mental health and substance use disorder coverage.

Sec. 606. Report on investigations regarding parity in mental health and substance use disorder benefits.

Sec. 607. GAO study on coverage limitations for individuals with serious mental illness and substance use disorders.

Sec. 608. Clarification of existing parity rules.

1 **TITLE I—STRENGTHENING**
2 **LEADERSHIP AND ACCOUNT-**
3 **ABILITY**

4 **SEC. 101. IMPROVING OVERSIGHT OF MENTAL AND SUB-**
5 **STANCE USE DISORDER PROGRAMS.**

6 (a) IN GENERAL.—The Secretary of Health and
7 Human Services, acting through the Assistant Secretary
8 for Planning and Evaluation (referred to in this section
9 as the “Assistant Secretary”), shall ensure efficient and
10 effective planning and evaluation of mental and substance
11 use disorder programs and related activities.

12 (b) ACTIVITIES.—In carrying out subsection (a), the
13 Assistant Secretary shall—

14 (1) evaluate programs related to mental and
15 substance use disorders, including co-occurring dis-
16 orders, across agencies and other organizations, as
17 appropriate, including programs related to—

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

1 (B) the reduction of homelessness and in-
2 carceration among individuals with a mental or
3 substance use disorder; and

4 (C) public health and health services;

5 (2) consult, as appropriate, with the Adminis-
6 trator of the Substance Abuse and Mental Health
7 Services Administration, the Chief Medical Officer of
8 the Substance Abuse and Mental Health Services
9 Administration, established under section 501(g) of
10 the Public Health Service Act (42 U.S.C. 290aa(g))
11 as amended by section 103, other agencies within
12 the Department of Health and Human Services, and
13 other relevant Federal departments.

14 (c) RECOMMENDATIONS.—The Assistant Secretary
15 shall evaluate and provide recommendations to the Sub-
16 stance Abuse and Mental Health Services Administration
17 and other relevant agencies within the Department of
18 Health and Human Services on improving programs and
19 activities based on the evaluation described in subsection
20 (b)(1).

21 **SEC. 102. STRENGTHENING LEADERSHIP OF THE SUB-**
22 **STANCE ABUSE AND MENTAL HEALTH SERV-**
23 **ICES ADMINISTRATION.**

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

1 (1) in subsection (b)—

2 (A) by striking the heading and inserting
3 “CENTERS”; and

4 (B) in the matter preceding paragraph (1),
5 by striking “entities” and inserting “Centers”;
6 and

7 (2) in subsection (d)—

8 (A) in paragraph (1)—

9 (i) by striking “agencies” each place
10 the term appears and inserting “Centers”;
11 and

12 (ii) by striking “such agency” and in-
13 serting “such Center”;

14 (B) in paragraph (2)—

15 (i) by striking “agencies” and insert-
16 ing “Centers”;

17 (ii) by striking “with respect to sub-
18 stance abuse” and inserting “with respect
19 to substance use disorders”; and

20 (iii) by striking “and individuals who
21 are substance abusers” and inserting “and
22 individuals with substance use disorders”;

23 (C) in paragraph (5), by striking “sub-
24 stance abuse” and inserting “substance use dis-
25 order”;

6

1 (D) in paragraph (6)—

2 (i) by striking “the Centers for Dis-
3 ease Control” and inserting “the Centers
4 for Disease Control and Prevention,”;

5 (ii) by striking “HIV or tuberculosis
6 among substance abusers and individuals
7 with mental illness” and inserting “HIV,
8 hepatitis C, tuberculosis, and other com-
9 municable diseases among individuals with
10 mental illness or substance use disorders,”;
11 and

12 (iii) by inserting “or disorders” before
13 the semicolon;

14 (E) in paragraph (7), by striking “abuse
15 utilizing anti-addiction medications, including
16 methadone” and inserting “use disorders, in-
17 cluding services that utilize drugs or devices ap-
18 proved by the Food and Drug Administration
19 for substance use disorders”;

20 (F) in paragraph (8)—

21 (i) by striking “Agency for Health
22 Care Policy Research” and inserting
23 “Agency for Healthcare Research and
24 Quality”; and

1 (ii) by striking “treatment and pre-
2 vention” and inserting “prevention and
3 treatment”;

4 (G) in paragraph (9)—

5 (i) by inserting “and maintenance”
6 after “development”;

7 (ii) by striking “Agency for Health
8 Care Policy Research” and inserting
9 “Agency for Healthcare Research and
10 Quality”;

11 (iii) by striking “treatment and pre-
12 vention” and inserting “prevention and
13 treatment and appropriately incorporated
14 into programs carried out by the Adminis-
15 tration”;

16 (H) in paragraph (10), by striking “abuse”
17 and inserting “use disorder”;

18 (I) by striking paragraph (11) and insert-
19 ing the following:

20 “(11) work with relevant agencies of the De-
21 partment of Health and Human Services on inte-
22 grating mental health promotion and substance use
23 disorder prevention with general health promotion
24 and disease prevention and integrating mental and

1 substance use disorder treatment services with phys-
2 ical health treatment services;”;

3 (J) in paragraph (13)—

4 (i) in the matter preceding subpara-
5 graph (A), by striking “this title, assure
6 that” and inserting “this title, or part B of
7 title XIX, or grant programs otherwise
8 funded by the Administration”;

9 (ii) in subparagraph (A)—

10 (I) by inserting “require that”
11 before “all grants”; and

12 (II) by striking “and” at the end;

13 (iii) by redesignating subparagraph
14 (B) as subparagraph (C);

15 (iv) by inserting after subparagraph
16 (A) the following:

17 “(B) ensure that the director of each Cen-
18 ter of the Administration consistently docu-
19 ments the application of criteria when awarding
20 grants and the ongoing oversight of grantees
21 after such grants are awarded;”;

22 (v) in subparagraph (C), as so redес-
23 igned—

24 (I) by inserting “require that”
25 before “all grants”; and

1 (II) by inserting “and” after the
2 semicolon at the end; and

3 (vi) by adding at the end the fol-
4 lowing:

5 “(D) inform a State when any funds are
6 awarded through such a grant to any entity
7 within such State;”;

8 (K) in paragraph (16)—

9 (i) by striking “abuse and mental
10 health information” and inserting “use dis-
11 order, including evidence-based and prom-
12 ising best practices for prevention, treat-
13 ment, and recovery support services for in-
14 dividuals with mental and substance use
15 disorders,”;

16 (L) in paragraph (17)—

17 (i) by striking “substance abuse” and
18 inserting “mental and substance use dis-
19 order”; and

20 (ii) by striking “and” at the end; and

21 (M) in paragraph (18), by striking the pe-
22 riod and inserting a semicolon; and

23 (N) by adding at the end the following:

24 “(19) consult with State, local, and tribal gov-
25 ernments, nongovernmental entities, and individuals

1 with mental illness, particularly individuals with a
2 serious mental illness and children and adolescents
3 with a serious emotional disturbance, and their fam-
4 ily members, with respect to improving community-
5 based and other mental health services;

6 “(20) collaborate with the Secretary of Defense
7 and the Secretary of Veterans Affairs to improve the
8 provision of mental and substance use disorder serv-
9 ices provided by the Department of Defense and the
10 Department of Veterans Affairs to veterans, includ-
11 ing through the provision of services using the tele-
12 health capabilities of the Department of Veterans
13 Affairs;

14 “(21) collaborate with the heads of Federal de-
15 partments and programs that are members of the
16 United States Interagency Council on Homelessness,
17 particularly the Secretary of Housing and Urban
18 Development, the Secretary of Labor, and the Sec-
19 retary of Veterans Affairs, and with the heads of
20 other agencies within the Department of Health and
21 Human Services, particularly the Administrator of
22 the Health Resources and Services Administration,
23 the Assistant Secretary for the Administration for
24 Children and Families, and the Administrator of the
25 Centers for Medicare & Medicaid Services, to design

1 national strategies for providing services in sup-
2 portive housing to assist in ending chronic homeless-
3 ness and to implement programs that address chron-
4 ic homelessness; and

5 “(22) work with States and other stakeholders
6 to develop and support activities to recruit and re-
7 tain a workforce addressing mental and substance
8 use disorders.”.

9 **SEC. 103. CHIEF MEDICAL OFFICER.**

10 Section 501 of the Public Health Service Act (42
11 U.S.C. 290aa), as amended by section 102, is further
12 amended—

13 (1) by redesignating subsections (g) through (j)
14 and subsections (k) through (o) as subsections (h)
15 through (k) and subsections (m) through (q), respec-
16 tively;

17 (2) in subsection (e)(3)(C), by striking “sub-
18 section (k)” and inserting “subsection (m)”;

19 (3) in subsection (f)(2)(C)(iii), by striking “sub-
20 section (k)” and inserting “subsection (m)”;

21 (4) by inserting after subsection (f) the fol-
22 lowing:

23 “(g) CHIEF MEDICAL OFFICER.—

1 “(1) IN GENERAL.—The Administrator, with
2 the approval of the Secretary, shall appoint a Chief
3 Medical Officer within the Administration.

4 “(2) ELIGIBLE CANDIDATES.—The Adminis-
5 trator shall select the Chief Medical Officer from
6 among individuals who—

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

9 “(B) have experience in the provision of
10 mental or substance use disorder services;

11 “(C) have experience working with mental
12 or substance use disorder programs; and

13 “(D) have an understanding of biological,
14 psychosocial, and pharmaceutical treatments of
15 mental or substance use disorders.

16 “(3) DUTIES.—The Chief Medical Officer
17 shall—

18 “(A) serve as a liaison between the Admin-
19 istration and providers of mental and substance
20 use disorder prevention, treatment, and recov-
21 ery services;

22 “(B) assist the Administrator in the eval-
23 uation, organization, integration, and coordina-
24 tion of programs operated by the Administra-
25 tion;

1 “(C) promote evidence-based and prom-
2 ising best practices, including culturally and lin-
3 guistically appropriate practices, as appropriate,
4 for the prevention, treatment, and recovery of
5 substance use disorders and mental illness, in-
6 cluding serious mental illness and serious emo-
7 tional disturbance; and

8 “(D) participate in regular strategic plan-
9 ning for the Administration.”.

10 **SEC. 104. STRATEGIC PLAN.**

11 Section 501 of the Public Health Service Act (42
12 U.S.C. 290aa), as amended by section 103, is further
13 amended by inserting after subsection (k), as redesignated
14 in section 103, the following:

15 “(l) STRATEGIC PLAN.—

16 “(1) IN GENERAL.—Not later than [December
17 1, 2017], and every 4 years thereafter, the Adminis-
18 trator shall develop and carry out a strategic plan in
19 accordance with this subsection for the planning and
20 operation of programs and grants carried out by the
21 Administration.

22 “(2) COORDINATION.—In developing and car-
23 rying out the strategic plan under this section, the
24 Administrator shall take into consideration the find-
25 ings and recommendations of the Assistant Sec-

1 retary for Planning and Evaluation under section
2 101 of the Mental Health Reform Act of 2016 and
3 the report of the Inter-Departmental Serious Mental
4 Illness Coordinating Committee under section 109 of
5 such Act.

6 “(3) PUBLICATION OF PLAN.—Not later than
7 **【December 1, 2017】**, and every 4 years thereafter,
8 the Administrator shall—

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

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

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

16 “(A) identify strategic priorities, goals, and
17 measurable objectives for mental and substance
18 use disorder activities and programs operated
19 and supported by the Administration;

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

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

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

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

14 “(i) initiatives to encourage individ-
15 uals to pursue careers (especially in rural
16 and underserved areas and populations) as
17 psychiatrists, psychologists, psychiatric
18 nurse practitioners, physician assistants,
19 clinical social workers, certified peer sup-
20 port specialists, or other licensed or cer-
21 tified mental health professionals, includ-
22 ing such professionals specializing in the
23 diagnosis, evaluation, or treatment of indi-
24 viduals with a serious mental illness or se-
25 rious emotional disturbance; and

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

6 “(E) disseminate evidenced-based and
7 promising best practices related to prevention,
8 early intervention, treatment, and recovery serv-
9 ices related to mental illness, particularly for in-
10 dividuals with a serious mental illness and chil-
11 dren and adolescents with a serious emotional
12 disturbance, and substance use disorders.”.

13 **SEC. 105. BIENNIAL REPORT CONCERNING ACTIVITIES AND**
14 **PROGRESS.**

15 (a) IN GENERAL.—Section 501 of the Public Health
16 Service Act (42 U.S.C. 290aa), as amended by section
17 104, is further by amending subsection (m), as redesign-
18 nated by section 103, to read as follows:

19 “(m) BIENNIAL REPORT CONCERNING ACTIVITIES
20 AND PROGRESS.—Not later than **【December of 2019】**,
21 and every 2 years thereafter, the Administrator shall pre-
22 pare and submit to the Committee on Energy and Com-
23 merce and the Committee on Appropriations of the House
24 of Representatives and the Committee on Health, Edu-
25 cation, Labor, and Pensions and the Committee on Appro-

1 priations of the Senate, and post on the Internet website
2 of the Administration, a report containing at a min-
3 imum—

4 “(1) a review of activities conducted or sup-
5 ported by the Administration, including progress to-
6 ward strategic priorities, goals, and objectives identi-
7 fied in the strategic plan developed under subsection
8 (1);

9 “(2) an assessment of programs and activities
10 carried out by the Administrator, including the ex-
11 tent to which programs and activities under this title
12 and part B of title XIX meet identified goals and
13 performance measures developed for the respective
14 programs and activities;

15 “(3) a description of the progress made in ad-
16 dressing gaps in mental and substance use disorder
17 prevention, treatment, and recovery services and im-
18 proving outcomes by the Administration, including
19 with respect to co-occurring disorders;

20 “(4) a description of the manner in which the
21 Administration coordinates and partners with other
22 Federal agencies and departments related to mental
23 and substance use disorders, including activities re-
24 lated to—

1 “(A) the translation of research findings
2 into improved programs, including with respect
3 to how advances in serious mental illness and
4 serious emotional disturbance research have
5 been incorporated into programs;

6 “(B) the recruitment, training, and reten-
7 tion of a mental and substance use disorder
8 workforce;

9 “(C) the integration of mental or sub-
10 stance use disorder services and physical health
11 services;

12 “(D) homelessness; and

13 “(E) veterans;

14 “(5) a description of the manner in which the
15 Administration promotes coordination by grantees
16 under this title, and part B of title XIX, with State
17 or local agencies; and

18 “(6) a description of the activities carried out
19 by the Office of Policy, Planning, and Innovation
20 under section 501A with respect to mental and sub-
21 stance use disorders, including—

22 “(A) the number and a description of
23 grants awarded;

24 “(B) the total amount of funding for
25 grants awarded;

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

3 “(3) collaborate with the Director of the Na-
4 tional Institute of Mental Health and the Chief Med-
5 ical Officer, appointed under section 501(g), to en-
6 sure that, as appropriate, programs related to the
7 prevention of mental illness and the promotion of
8 mental health are carried out in a manner that re-
9 flects the best available science and evidence-based
10 practices, including culturally and linguistically ap-
11 propriate services, as appropriate;”;

12 (3) in paragraph (5), as so redesignated, by in-
13 serting “through programs that reduce risk and pro-
14 mote resiliency” before the semicolon;

15 (4) in paragraph (6), as so redesignated, by in-
16 serting “in collaboration with the Director of the
17 National Institute of Mental Health,” before “de-
18 velop”;

19 (5) in paragraph (8), as so redesignated, by in-
20 serting “, increase meaningful participation of indi-
21 viduals with mental illness,” before “and protect the
22 legal”;

23 (6) in paragraph (10), as so redesignated, by
24 striking “professional and paraprofessional per-
25 sonnel pursuant to section 303” and inserting

1 “paraprofessional personnel and health profes-
2 sionals”;

3 (7) in paragraph (11), as so redesignated, by
4 inserting “and tele-mental health,” after “rural
5 mental health,”;

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

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

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

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

17 “(17) ensure the consistent documentation of
18 the application of criteria when awarding grants and
19 the ongoing oversight of grantees after such grants
20 are awarded.”.

21 **SEC. 107. ADVISORY COUNCILS.**

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

24 (1) in subsection (a)(1), in the matter following
25 subparagraph (D), by adding at the end the fol-

1 lowing: “Each such advisory council may also rec-
2 ommend subjects for evaluation under section 101 of
3 the Mental Health Reform Act of 2016 to the As-
4 sistant Secretary for Planning and Evaluation”; and

5 (2) in subsection (b)—

6 (A) in paragraph (2)—

7 (i) in subparagraph (E), by striking

8 “and” after the semicolon;

9 (ii) by redesignating subparagraph

10 (F) as subparagraph (J); and

11 (iii) by inserting after subparagraph

12 (E), the following:

13 “(F) the Chief Medical Officer, appointed
14 under section 501(g);

15 “(G) the Director of the National Institute
16 of Mental Health for the advisory councils ap-
17 pointed under subsections (a)(1)(A) and
18 (a)(1)(D);

19 “(H) the Director of the National Institute
20 on Drug Abuse for the advisory councils ap-
21 pointed under subsections (a)(1)(A), (a)(1)(B),
22 and (a)(1)(C);”;

23 “(I) the Director of the National Institute
24 on Alcohol Abuse and Alcoholism for the advi-

1 sory councils appointed under subsections
2 (a)(1)(A), (a)(1)(B), and (a)(1)(C); and” and
3 (B) in paragraph (3), by adding at the end
4 the following:

5 “(C) Not less than half of the members of
6 the advisory council appointed under subsection
7 (a)(1)(D)—

8 “(i) shall have—

9 “(I) a medical degree;

10 “(II) a doctoral degree in psy-
11 chology; or

12 “(III) an advanced degree in
13 nursing or social work from an ac-
14 credited graduate school or be a cer-
15 tified physician assistant and

16 “(ii) shall specialize in the mental
17 health field.”.

18 **SEC. 108. PEER REVIEW.**

19 Section 504(b) of the Public Health Service Act (42
20 U.S.C. 290aa-3(b)) is amended by adding at the end the
21 following: “In the case of any such peer review group that
22 is reviewing a grant, cooperative agreement, or contract
23 related to mental illness, not less than half of the members
24 of such peer review group shall be licensed and experi-
25 enced professionals in the prevention, diagnosis, treat-

1 ment, and recovery of mental illness or substance use dis-
2 orders and have a medical degree, a doctoral degree in
3 psychology, or an advanced degree in nursing or social
4 work from an accredited program.”.

5 **SEC. 109. INTER-DEPARTMENTAL SERIOUS MENTAL ILL-**
6 **NESS COORDINATING COMMITTEE.**

7 (a) ESTABLISHMENT.—

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

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

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

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

1 (1) a summary of advances in serious mental
2 illness research related to the prevention of, diag-
3 nosis of, intervention in, and treatment and recovery
4 of, serious mental illnesses, and advances in access
5 to services and support for individuals with a serious
6 mental illness;

7 (2) an evaluation of the impact on public health
8 of Federal programs related to serious mental ill-
9 ness, including measurements of public health out-
10 comes including—

11 (A) rates of suicide, suicide attempts, prev-
12 alence of serious mental illness and substance
13 use disorders, overdose, overdose deaths, emer-
14 gency hospitalizations, emergency room board-
15 ing, preventable emergency room visits, incar-
16 ceration, crime, arrest, homelessness, and un-
17 employment;

18 (B) increased rates of employment and en-
19 rollment in educational and vocational pro-
20 grams;

21 (C) quality of mental and substance use
22 disorder treatment services; or

23 (D) any other criteria as may be deter-
24 mined by the Secretary; and

1 (3) specific recommendations for actions that
2 agencies can take to better coordinate the adminis-
3 tration of mental health services for people with seri-
4 ous mental illness.

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

9 (e) MEMBERSHIP.—

10 (1) FEDERAL MEMBERS.—The Committee shall
11 be composed of the following Federal representa-
12 tives, or their designee—

13 (A) the Secretary of Health and Human
14 Services, who shall serve as the Chair of the
15 Committee;

16 (B) the Administrator of the Substance
17 Abuse and Mental Health Services Administra-
18 tion;

19 (C) the Attorney General of the United
20 States;

21 (D) the Secretary of Veterans Affairs;

22 (E) the Secretary of Defense;

23 (F) the Secretary of Housing and Urban
24 Development;

25 (G) the Secretary of Education;

1 (H) the Secretary of Labor;

2 (I) the Commissioner of Social Security;

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

7 (A) at least 1 member shall be an indi-
8 vidual who has received treatment for a diag-
9 nosis of a serious mental illness;

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

13 (C) at least 1 member shall be a represent-
14 ative of a leading research, advocacy, or service
15 organization for individuals with serious mental
16 illnesses;

17 (D) at least 2 members shall be—

18 (i) a licensed psychiatrist with experi-
19 ence treating serious mental illness;

20 (ii) a licensed psychologist with experi-
21 ence treating serious mental illness;

22 (iii) a licensed clinical social worker;

23 or

1 (iv) a licensed psychiatric nurse, nurse
2 practitioner, or physician assistant with ex-
3 perience treating serious mental illness;

4 (E) at least 1 member shall be a licensed
5 mental health professional with a specialty in
6 treating children and adolescents;

7 (F) at least 1 member shall be a mental
8 health professional who has research or clinical
9 mental health experience working with minori-
10 ties;

11 (G) at least 1 member shall be a mental
12 health professional who has research or clinical
13 mental health experience working with medi-
14 cally underserved populations;

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

17 (I) at least 1 member shall be a judge with
18 experience adjudicating cases related to crimi-
19 nal justice or serious mental illness; and

20 (J) at least 1 member shall be a law en-
21 forcement officer or corrections officer with ex-
22 tensive experience in interfacing with individ-
23 uals with serious mental illness or in mental
24 health crisis.

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

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

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

1 **TITLE II—ENSURING MENTAL**
2 **AND SUBSTANCE USE DIS-**
3 **ORDER PREVENTION, TREAT-**
4 **MENT, AND RECOVERY PRO-**
5 **GRAMS KEEP PACE WITH**
6 **SCIENCE**

7 **SEC. 201. ENCOURAGING INNOVATION AND EVIDENCE-**
8 **BASED PROGRAMS.**

9 Title V of the Public Health Service Act (42 U.S.C.
10 290aa et seq.), as amended by title I, is further amended
11 by inserting after section 501 (42 U.S.C. 290aa) the fol-
12 lowing:

13 **“SEC. 501A. OFFICE OF POLICY, PLANNING, AND INNOVA-**
14 **TION.**

15 “(a) **IN GENERAL.**—There shall be established within
16 the Administration an Office of Policy, Planning, and In-
17 novation (referred to in this section as the ‘Office’).

18 “(b) **RESPONSIBILITIES.**—The Office shall—

19 “(1) continue to carry out the authorities that
20 were in effect for the Office of Policy, Planning, and
21 Innovation as such Office existed prior to the date
22 of enactment of the Mental Health Reform Act of
23 2016;

24 “(2) identify, coordinate, and facilitate the im-
25 plementation of policy changes likely to have a sig-

1 nificant impact on mental and substance use dis-
2 order services;

3 “(3) collect, as appropriate, information from
4 grantees under programs operated by the Adminis-
5 tration in order to evaluate and disseminate infor-
6 mation on evidence-based practices and service deliv-
7 ery models;

8 “(4) provide leadership in identifying and co-
9 ordinating policies and programs related to mental
10 health and substance use disorders;

11 “(5) in consultation with the Assistant Sec-
12 retary for Planning and Evaluation, as appropriate,
13 periodically review programs and activities relating
14 to the diagnosis or prevention of, or treatment or re-
15 habilitation for, mental illness and substance use
16 disorders, including by—

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

19 “(B) identifying any such programs or ac-
20 tivities that are not evidence-based, effective, or
21 efficient;

22 “(C) identifying any such programs or ac-
23 tivities that have proven to be effective or effi-
24 cient in improving outcomes or increasing ac-
25 cess to evidence-based programs; and

1 “(D) formulating recommendations for co-
2 ordinating, eliminating, or improving programs
3 or activities identified under subparagraph (A),
4 (B), or (C), and merging such programs or ac-
5 tivities into other successful programs or activi-
6 ties; and

7 “(6) carry out other activities as deemed nec-
8 essary to continue to encourage innovation and dis-
9 seminate evidence-based programs and practices.

10 “(c) PROMOTING INNOVATION.—

11 “(1) IN GENERAL.—The Administrator, in co-
12 ordination with the Office, may award grants to
13 States, local governments, Indian tribes or tribal or-
14 ganizations (as such terms are defined in section 4
15 of the Indian Self-Determination and Education As-
16 sistance Act (25. U.S.C. 450b)), educational institu-
17 tions, and nonprofit organizations to develop evi-
18 dence-based interventions, including culturally and
19 linguistically appropriate services, as appropriate,
20 for—

21 “(A) evaluating a model that has been sci-
22 entifically demonstrated to show promise, but
23 would benefit from further applied development,
24 for—

1 “(i) enhancing the prevention, diag-
2 nosis, intervention, treatment, and recovery
3 of mental illness, serious emotional dis-
4 turbance, substance use disorders, and co-
5 occurring disorders; or

6 “(ii) integrating or coordinating phys-
7 ical health services and mental and sub-
8 stance use disorder services; and

9 “(B) expanding, replicating, or scaling evi-
10 dence-based programs across a wider area to
11 enhance effective screening, early diagnosis,
12 intervention, and treatment with respect to
13 mental illness, serious mental illness, and seri-
14 ous emotional disturbance, primarily by—

15 “(i) applying delivery of care, includ-
16 ing training staff in effective evidence-
17 based treatment; or

18 “(ii) integrating models of care across
19 specialties and jurisdictions.

20 “(2) CONSULTATION.—In awarding grants
21 under this paragraph, the Administrator shall, as
22 appropriate, consult with the Chief Medical Officer,
23 the advisory councils described in section 502, the
24 National Institute of Mental Health, the National

1 Institute on Drug Abuse, and the National Institute
2 on Alcohol Abuse and Alcoholism.

3 “(d) AUTHORIZATION OF APPROPRIATIONS.—To
4 carry out the activities under subsection (c), there are au-
5 thorized to be appropriated such [sums as may be nec-
6 essary] for each of fiscal years 2017 through 2021.”.

7 **SEC. 202. PROMOTING ACCESS TO INFORMATION ON EVI-**
8 **DENCE-BASED PROGRAMS AND PRACTICES.**

9 (a) IN GENERAL.—The Administrator of the Sub-
10 stance Abuse and Mental Health Services Administration
11 (referred to in this section as the “Administrator”) may
12 improve access to reliable and valid information on evi-
13 dence-based programs and practices, including informa-
14 tion on the strength of evidence associated with such pro-
15 grams and practices, related to mental and substance use
16 disorders for States, local communities, nonprofit entities,
17 and other stakeholders by posting on the website of the
18 Administration information on evidence-based programs
19 and practices that have been reviewed by the Adminis-
20 trator pursuant to the requirements of this section.

21 (b) NOTICE.—In carrying out subsection (a), the Ad-
22 ministrator may establish a period for the submission of
23 applications for evidence-based programs and practices to
24 be posted publicly in accordance with subsection (a). In
25 establishing such application period, the Administrator

1 shall provide for the public notice of such application pe-
2 riod in the Federal Register. Such notice may solicit appli-
3 cations for evidence-based practices and programs to ad-
4 dress gaps identified by the Assistant Secretary for Plan-
5 ning and Evaluation of the Department of Health and
6 Human Services in the evaluation and recommendations
7 under section 101 or priorities identified in the strategic
8 plan established under section 501(l) of the Public Health
9 Service Act (42 U.S.C. 290aa).

10 (c) REQUIREMENTS.—The Administrator may estab-
11 lish minimum requirements for applications referred to
12 under this section, including applications related to the
13 submission of research and evaluation.

14 (d) REVIEW AND RATING.—The Administrator shall
15 review applications prior to public posting, and may
16 prioritize the review of applications for evidenced-based
17 practices and programs that are related to topics included
18 in the notice established under subsection (b). The Admin-
19 istrator may utilize a rating and review system, which may
20 include information on the strength of evidence associated
21 with such programs and practices and a rating of the
22 methodological rigor of the research supporting the appli-
23 cation.

1 **SEC. 203. PRIORITY MENTAL HEALTH NEEDS OF REGIONAL**
2 **AND NATIONAL SIGNIFICANCE.**

3 Section 520A of the Public Health Service Act (42
4 U.S.C. 290bb-32) is amended—

5 (1) in subsection (a)—

6 (A) in paragraph (4), by inserting before
7 the period “, that may include technical assist-
8 ance centers”; and

9 (B) in the flush sentence following para-
10 graph (4)—

11 (i) by inserting “, contracts,” before
12 “or cooperative agreements”; and

13 (ii) by striking “Indian tribes and
14 tribal organizations” and inserting “terri-
15 tories, Indian tribes or tribal organizations
16 (as such terms are defined in section 4 of
17 the Indian Self-Determination and Edu-
18 cation Assistance Act), health facilities, or
19 programs operated by or pursuant to a
20 contract or grant with the Indian Health
21 Service, or”; and

22 (2) in subsection (f)—

23 (A) in paragraph (1) by striking the para-
24 graph heading;

25 (B) by striking “\$300,000,000” and all
26 that follows through “2003” and inserting

1 “**[such sums as may be necessary]** for each of
2 fiscal years 2017 through 2021”; and

3 (C) by striking paragraph (2).

4 **TITLE III—SUPPORTING STATE**
5 **RESPONSES TO MENTAL**
6 **HEALTH AND SUBSTANCE**
7 **USE DISORDER NEEDS**

8 **SEC. 301. COMMUNITY MENTAL HEALTH SERVICES BLOCK**
9 **GRANT.**

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

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

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

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

20 (b) **STATE PLAN.**—Section 1912(b) of the Public
21 Health Service Act (42 U.S.C. 300x-1(b)) is amended—

22 (1) in paragraph (3), by redesignating subpara-
23 graphs (A) through (C) as clauses (i) through (iii),
24 respectively, and realigning the margins accordingly;

1 (2) by redesignating paragraphs (1) through
2 (5) as subparagraphs (A) through (E), respectively,
3 and realigning the margins accordingly;

4 (3) by striking the matter preceding subpara-
5 graph (A) (as so redesignated), and inserting the
6 following:

7 “(b) CRITERIA FOR PLAN.—In accordance with sub-
8 section (a), a State shall submit to the Secretary a plan
9 that, at a minimum, includes the following:

10 “(1) SYSTEM OF CARE.—A description of the
11 State’s system of care that contains the following:”;

12 (4) by striking subparagraph (A) (as so redesign-
13 ated), and inserting the following:

14 “(A) COMPREHENSIVE COMMUNITY-BASED
15 HEALTH SYSTEMS.—The plan shall—

16 “(i) identify the single State agency to
17 be responsible for the administration of the
18 program under the grant, including any
19 third party who administers mental health
20 services and is responsible for complying
21 with the requirements of this part with re-
22 spect to the grant;

23 “(ii) provide for an organized commu-
24 nity-based system of care for individuals
25 with mental illness and describe available

1 services and resources in a comprehensive
2 system of care, including services for indi-
3 viduals with co-occurring disorders;

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

1 “(iv) include a description of how the
2 State promotes evidence-based practices,
3 including those evidence-based programs
4 that address the needs of individuals with
5 early serious mental illness regardless of
6 the age of the individual at onset;

7 “(v) include a description of case
8 management services;

9 “(vi) include a description of activities
10 leading to reduction of hospitalization, ar-
11 rest, incarceration, or suicide, including
12 through promoting comprehensive, individ-
13 ualized treatment;

14 “(vii) include a description of activi-
15 ties that seek to engage individuals with
16 serious mental illness in making health
17 care decisions, including activities that en-
18 hance communication between individuals,
19 families, and treatment providers;

20 “(viii) include a description of how the
21 State integrates mental health and primary
22 health care, which may include providing,
23 in the case of individuals with co-occurring
24 mental and substance use disorders, both
25 mental and substance use disorder services

1 in primary care settings or arrangements
2 to provide primary and specialty care serv-
3 ices in community-based mental and sub-
4 stance use disorder service settings; and

5 “(ix) include a description of how the
6 State ensures a smooth transition for chil-
7 dren with serious emotion disturbances
8 from the children’s service system to the
9 adult service system.”;

10 (5) in subparagraph (B) (as so redesignated),
11 by striking “to be achieved in the implementation of
12 the system described in paragraph (1)” and insert-
13 ing “and outcome measures for programs and serv-
14 ices provided under this subpart”;

15 (6) in subparagraph (C) (as so redesignated)—

16 (A) by striking “disturbance” in the mat-
17 ter preceding clause (i) (as so redesignated) and
18 all that follows through “substance abuse serv-
19 ices” in clause (i) (as so redesignated) and in-
20 serting the following: “disturbance (as defined
21 pursuant to subsection (c)), the plan shall pro-
22 vide for a system of integrated social services,
23 educational services, child welfare services, juve-
24 nile justice services, law enforcement services,
25 and substance use disorder services”;

1 (B) by striking “Education Act;” and in-
2 serting “Education Act.”; and

3 (C) by striking clauses (ii) and (iii) (as so
4 redesignated);

5 (7) in subparagraph (D) (as so redesignated),
6 by striking “plan described” and inserting “plan
7 shall describe”; and

8 (8) in subparagraph (E) (as so redesignated)—

9 (A) in the subparagraph heading by strik-
10 ing “SYSTEMS” and inserting “SERVICES”;

11 (B) by striking “plan describes” and all
12 that follows through “and provides for” and in-
13 serting “plan shall describe the financial re-
14 sources available, the existing mental health
15 workforce, and workforce trained in treating in-
16 dividuals with co-occurring mental and sub-
17 stance use disorders, and provides for”;

18 (C) by inserting before the period the fol-
19 lowing: “, and the manner in which the State
20 intends to comply with each of the funding
21 agreements in this subpart and subpart III”;

22 (9) by striking the flush matter at the end; and

23 (10) by adding at the end the following:

24 “(2) GOALS AND OBJECTIVES.—The establish-
25 ment of goals and objectives for the period of the

1 plan, including targets and milestones that are in-
2 tended to be met, and the activities that will be un-
3 dertaken to achieve those targets.”.

4 (c) BEST PRACTICES IN CLINICAL CARE MODELS.—
5 Section 1920 of the Public Health Service Act (42 U.S.C.
6 300x-9) is amended by adding at the end the following:

7 “(c) BEST PRACTICES IN CLINICAL CARE MOD-
8 ELS.—

9 “(1) IN GENERAL.—Except as provided in para-
10 graph (2), a State shall expend not less than 5 per-
11 cent of the amount the State receives for carrying
12 out this section in each fiscal year to support evi-
13 dence-based programs that address the needs of in-
14 dividuals with early serious mental illness, including
15 psychotic disorders, regardless of the age of the indi-
16 vidual at onset.

17 “(2) STATE FLEXIBILITY.—In lieu of expending
18 5 percent of the amount the State receives under
19 this section in a fiscal year as required under para-
20 graph (1), a State may elect to expend not less than
21 10 percent of such amount in the succeeding fiscal
22 year.”.

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

1 (1) by redesignating paragraph (1) as subpara-
2 graph (A), and realigning the margin accordingly;

3 (2) by inserting after the subsection heading
4 the following:

5 “(1) REQUIREMENT.—”;

6 (3) by inserting after subparagraph (A) (as so
7 redesignated), the following:

8 “(B) CONDITION.—A State shall be
9 deemed to be in compliance with subparagraph
10 (A) for a fiscal year if State expenditures of the
11 type described in such subparagraph for such
12 fiscal year are at least 97 percent of the aver-
13 age of such State expenditures for the pre-
14 ceding 2-fiscal year period.”;

15 (4) by redesignating paragraphs (2) through
16 (4) as paragraphs (3) through (5), respectively;

17 (5) by inserting after paragraph (1), the fol-
18 lowing:

19 “(2) FUTURE FISCAL YEARS.—Determinations
20 of whether a State has complied with paragraph (1)
21 for each fiscal year shall be based on the State fund-
22 ing level for the preceding 2-fiscal year period, as re-
23 quired under paragraph (1)(A), without regard to
24 reductions in the actual amount of State expendi-

1 tures as permitted under paragraph (1)(B) or under
2 a waiver under paragraph (4).”;

3 (6) in paragraph (3) (as so redesignated), by
4 striking “subsection (a)” and inserting “paragraph
5 (1)”;

6 (7) in paragraph (4) (as so redesignated)—

7 (A) by striking “The Secretary” and in-
8 serting the following:

9 “(A) IN GENERAL.—The Secretary”;

10 (B) by striking “paragraph (1) if the Sec-
11 retary” and inserting the following: “paragraph
12 (1) in whole or in part, if—

13 “(i) the Secretary”;

14 (C) by striking “State justify the waiver.”
15 and inserting “State in the fiscal year involved
16 or in the previous fiscal year justify the waiver;
17 or”; and

18 (D) by adding at the end the following:

19 “(ii) the State, or any part of the
20 State, has experienced a natural disaster
21 that has received a Presidential Disaster
22 Declaration under section 102 of the Rob-
23 ert T. Stafford Disaster Relief Emergency
24 Assistance Act.

1 “(B) DATE CERTAIN FOR ACTION UPON
2 REQUEST.—The Secretary shall approve or
3 deny a request for a waiver under subparagraph
4 (A) not later than 120 days after the date on
5 which the request is made.

6 “(C) APPLICABILITY OF WAIVER.—A waiv-
7 er provided by the Secretary under subpara-
8 graph (A) shall be applicable only to the fiscal
9 year involved.”; and
10 (8) in paragraph (5) (as so redesignated)—

11 (A) in subparagraph (A)—

12 (i) by inserting after the subpara-
13 graph designation the following: “IN GEN-
14 ERAL”; and

15 (ii) by striking “maintained material
16 compliance” and insert “complied”; and

17 (B) in subparagraph (B), by inserting
18 after the subparagraph designation the fol-
19 lowing: “SUBMISSION OF INFORMATION TO THE
20 SECRETARY”.

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

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

1 **“SEC. 1958. JOINT APPLICATIONS.**

2 “The Secretary, acting through the Administrator,
3 shall permit a joint application to be submitted for grants
4 under subpart I and subpart II upon the request of a
5 State. Such application may be jointly reviewed and ap-
6 proved by the Secretary with respect to such subparts,
7 consistent with the purposes and authorized activities of
8 each such grant program. A State submitting such a joint
9 application shall otherwise meet the requirements with re-
10 spect to each such subpart.”.

11 **SEC. 303. STUDY OF DISTRIBUTION OF FUNDS UNDER THE**
12 **SUBSTANCE ABUSE PREVENTION AND TREAT-**
13 **MENT BLOCK GRANT AND THE COMMUNITY**
14 **MENTAL HEALTH SERVICES BLOCK GRANT.**

15 (a) IN GENERAL.—The Secretary of Health and
16 Human Services, acting through the Administrator of the
17 Substance Abuse and Mental Health Services Administra-
18 tion, shall, directly or through a grant or contract, conduct
19 a study to examine whether the funds under the substance
20 abuse prevention and treatment block grant and the com-
21 munity mental health services block grant under title XIX
22 of the Public Health Service Act (42 U.S.C. 300w et seq.)
23 are being distributed to States and territories according
24 to need, and to recommend changes in such distribution
25 if necessary. Such study shall include—

1 (1) an analysis of whether the distributions
2 under such block grants accurately reflect the need
3 for the services under the grants in such States and
4 territories;

5 (2) an examination of whether the indices used
6 under the formulas for distribution of funds under
7 such block grants are appropriate, and if not, alter-
8 natives recommended by the Secretary;

9 (3) where recommendations are included under
10 paragraph (2) for the use of different indices, a de-
11 scription of the variables and data sources that
12 should be used to determine the indices;

13 (4) an evaluation of the variables and data
14 sources that are being used for each of the indices
15 involved, and whether such variables and data
16 sources accurately represent the need for services,
17 the cost of providing services, and the ability of the
18 States to pay for such services;

19 (5) the impact that the minimum allotment pro-
20 visions under each such block grant have on each
21 State's final allotment and its effect, if any, on each
22 State's formula-based allotment;

23 (6) recommendations for modifications to the
24 minimum allotment provisions to ensure an appro-
25 priate distribution of funds; and

1 (7) any other information that the Secretary
2 determines appropriate.

3 (b) REPORT.—Not later than 24 months after the
4 date of enactment of this Act, the Secretary of Health and
5 Human Services shall submit to the Committee on Health,
6 Education, Labor, and Pensions of the Senate and the
7 Committee on Energy and Commerce of the House of
8 Representatives, a report containing the findings and rec-
9 ommendations of the study conducted under subsection
10 (a).

11 **TITLE IV—PROMOTING ACCESS**
12 **TO MENTAL HEALTH AND**
13 **SUBSTANCE USE DISORDER**
14 **CARE**

15 **SEC. 401. GRANTS FOR TREATMENT AND RECOVERY FOR**
16 **HOMELESS INDIVIDUALS.**

17 Section 506 of the Public Health Service Act (42
18 U.S.C. 290aa-5) is amended—

19 (1) in subsections (a), by striking “substance
20 abuse” and inserting “substance use disorder”;

21 (2) in subsection (b)—

22 (A) in paragraphs (1) and (3), by striking
23 “substance abuse” each place the term appears
24 and inserting “substance use disorder”; and

1 (B) in paragraph (4), by striking “sub-
2 stance abuse” and inserting “a substance use
3 disorder”;

4 (3) in subsection (c)—

5 (A) in paragraph (1), by striking “sub-
6 stance abuse disorder” and inserting “sub-
7 stance use disorder”; and

8 (B) in paragraph (2)—

9 (i) in subparagraph (A), by striking
10 “substance abuse” and inserting “a sub-
11 stance use disorder”; and

12 (ii) in subparagraph (B), by striking
13 “substance abuse” and inserting “sub-
14 stance use disorder”; and

15 (4) in subsection (e), by striking “,
16 \$50,000,000 for fiscal year 2001, and such sums as
17 may be necessary for each of the fiscal years 2002
18 and 2003” and inserting “[such sums as may be
19 necessary] for each of fiscal years 2017 through
20 2021”.

21 **SEC. 402. GRANTS FOR JAIL DIVERSION PROGRAMS.**

22 Section 520G of the Public Health Service Act (42
23 U.S.C. 290bb–38) is amended—

1 (1) by striking “substance abuse” each place
2 such term appears and inserting “substance use dis-
3 order”;

4 (2) in subsection (a)—

5 (A) by striking “Indian tribes, and tribal
6 organizations” and inserting “and Indian tribes
7 and tribal organizations (as such terms are de-
8 fined in section 4 of the Indian Self-Determina-
9 tion and Education Assistance Act (25 U.S.C.
10 450b)”;

11 (B) by inserting “or a health facility or
12 program operated by or pursuant to a contract
13 or grant with the Indian Health Service,” after
14 “entities,”;

15 (3) in subsection (c)(2)(A)(i), by striking “the
16 best known” and inserting “evidence-based”; and

17 【(4) in subsection (i), by striking “\$10,000,000
18 for fiscal year 2001, and such sums as may be nec-
19 essary for fiscal years 2002 through 2003” and in-
20 serting “such sums as may be necessary for each of
21 fiscal years 2017 through 2021”.】

22 **SEC. 403. PROMOTING INTEGRATION OF PRIMARY AND BE-**
23 **HAVIORAL HEALTH CARE.**

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

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

2 “(a) DEFINITIONS.—In this section:

3 “(1) ELIGIBLE ENTITY.—The term ‘eligible en-
4 tity’ means a State, or other appropriate State agen-
5 cy, in collaboration with one or more qualified com-
6 munity programs as described in section 1913(b)(1).

7 “(2) INTEGRATED CARE.—The term ‘integrated
8 care’ means collaboration in merged or transformed
9 practices offering mental and physical health serv-
10 ices within the same shared practice space in the
11 same facility.

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

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

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

20 “(C) children and adolescents with serious
21 emotional disturbance with co-occurring pri-
22 mary care conditions or chronic diseases; or

23 “(D) individuals with substance use dis-
24 orders.

25 “(b) GRANTS.—

1 “(1) IN GENERAL.—The Secretary may award
2 grants and cooperative agreements to eligible entities
3 to support the improvement of integrated care for
4 primary care and behavioral health care in accord-
5 ance with paragraph (2).

6 “(2) PURPOSES.—Grants and cooperative
7 agreements awarded under this section shall be de-
8 signed to—

9 “(A) promote full collaboration in clinical
10 practices between primary and behavioral
11 health care;

12 “(B) support the improvement of inte-
13 grated care models for primary care and behav-
14 ioral health care to improve the overall wellness
15 and physical health status of individuals with
16 serious mental illness or serious emotional dis-
17 turbance; and

18 “(C) promote integrated care services re-
19 lated to screening, diagnosis, and treatment of
20 mental illness and co-occurring primary care
21 conditions and chronic diseases.

22 “(c) APPLICATIONS.—

23 “(1) IN GENERAL.—An eligible entity desiring a
24 grant or cooperative agreement under this section
25 shall submit an application to the Secretary at such

1 time, in such manner, and accompanied by such in-
2 formation as the Secretary may require, including
3 the contents described in paragraph (2).

4 “(2) CONTENTS.—The contents described in
5 this paragraph are—

6 “(A) a description of a plan to achieve
7 fully collaborative agreements to provide serv-
8 ices to special populations;

9 “(B) a document that summarizes the poli-
10 cies, if any, that serve as barriers to the provi-
11 sion of integrated care, and the specific steps,
12 if applicable, that will be taken to address such
13 barriers;

14 “(C) a description of partnerships or other
15 arrangements with local health care providers
16 to provide services to special populations;

17 “(D) an agreement and plan to report per-
18 formance measures necessary to evaluate pa-
19 tient outcomes and to facilitate evaluations
20 across participating projects to the Secretary;
21 and

22 “(E) a plan for sustainability beyond the
23 grant or cooperative agreement period under
24 subsection (e).

1 “(d) GRANT AMOUNTS.—The maximum amount that
2 an eligible entity may receive for a year through a grant
3 or cooperative agreement under this section shall be
4 \$2,000,000. In the case of a recipient of funding under
5 this section that is a State, not more than 10 percent of
6 funds awarded under this section may be allocated to
7 State administrative functions, and the remaining
8 amounts shall be allocated to health facilities that provide
9 integrated care.

10 “(e) DURATION.—A grant or cooperative agreement
11 under this section shall be for a period not to exceed 5
12 years.

13 “(f) REPORT ON PROGRAM OUTCOMES.—An eligible
14 entity receiving a grant or cooperative agreement under
15 this section shall submit an annual report to the Secretary
16 that includes—

17 “(1) the progress to reduce barriers to inte-
18 grated care as described in the entity’s application
19 under subsection (c); and

20 “(2) a description of functional outcomes of
21 special populations, including—

22 “(A) with respect to individuals with seri-
23 ous mental illness, participation in supportive
24 housing or independent living programs, attend-
25 ance in social and rehabilitative programs, par-

1 participation in job training opportunities, satisfac-
2 tory performance in work settings, attendance
3 at scheduled medical and mental health ap-
4 pointments, and compliance with prescribed
5 medication regimes;

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

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

22 “(g) TECHNICAL ASSISTANCE FOR PRIMARY-BEHAV-
23 IORAL HEALTH CARE INTEGRATION.—

24 “(1) IN GENERAL.—The Secretary may provide
25 appropriate information, training, and technical as-

1 sistance to eligible entities that receive a grant or
2 cooperative agreement under this section, in order to
3 help such entities meet the requirements of this sec-
4 tion, including assistance with—

5 “(A) development and selection of inte-
6 grated care models;

7 “(B) dissemination of evidence-based inter-
8 ventions in integrated care;

9 “(C) establishment of organizational prac-
10 tices to support operational and administrative
11 success; and

12 “(D) other activities, as the Secretary de-
13 termines appropriate.

14 “(2) **ADDITIONAL DISSEMINATION OF TECH-**
15 **NICAL INFORMATION.**—The information and re-
16 sources provided by the Secretary under paragraph
17 (1) shall, as appropriate, be made available to
18 States, political subdivisions of States, Indian tribes
19 or tribal organizations (as defined in section 4 of the
20 Indian Self-Determination and Education Assistance
21 Act), outpatient mental health and addiction treat-
22 ment centers, community mental health centers that
23 meet the criteria under section 1913(e), certified
24 community behavioral health clinics described in sec-
25 tion 223 of the Protecting Access to Medicare Act

1 of 2014 (42 U.S.C. 1396a note), primary care orga-
2 nizations such as Federally qualified health centers
3 or rural health clinics as defined in section 1861(aa)
4 of the Social Security Act (42 U.S.C. 1395x(aa)),
5 other community-based organizations, or other enti-
6 ties engaging in integrated care activities, as the
7 Secretary determines appropriate.

8 “(h) AUTHORIZATION OF APPROPRIATIONS.—To
9 carry out this section, there are authorized to be appro-
10 priated [such sums as may be necessary] for each of fiscal
11 years 2017 through 2021.”.

12 **SEC. 404. PROJECTS FOR ASSISTANCE IN TRANSITION**
13 **FROM HOMELESSNESS.**

14 (a) FORMULA GRANTS TO STATES.—Section 521 of
15 the Public Health Service Act (42 U.S.C. 290cc–21) is
16 amended by striking “each of the fiscal years 1991
17 through 1994” and inserting “fiscal year 2017 and each
18 subsequent fiscal year”.

19 (b) PURPOSE OF GRANTS.—Section 522 of the Public
20 Health Service Act (42 U.S.C. 290cc–22) is amended—

21 (1) in subsection (a)(1)(B), by striking “sub-
22 stance abuse” and inserting “a substance use dis-
23 order”;

24 (2) in subsection (b)(6), by striking “substance
25 abuse” and inserting “substance use disorder”;

1 (3) in subsection (c), by striking “substance
2 abuse” and inserting “a substance use disorder”;

3 (4) in subsection (e)—

4 (A) in paragraph (1), by striking “sub-
5 stance abuse” and inserting “a substance use
6 disorder”; and

7 (B) in paragraph (2), by striking “sub-
8 stance abuse” and inserting “substance use dis-
9 order”; and

10 (5) in subsection (h), by striking “substance
11 abuse” each place such term appears and inserting
12 “substance use disorder”.

13 (c) DESCRIPTION OF INTENDED EXPENDITURES OF
14 GRANT.—Section 527 of the Public Health Service Act
15 (42 U.S.C. 290cc–27) is amended by striking “substance
16 abuse” each place such term appears and inserting “sub-
17 stance use disorder”.

18 (d) TECHNICAL ASSISTANCE.—Section 530 of the
19 Public Health Service Act (42 U.S.C. 290cc–30) is amend-
20 ed by striking “through the National Institute of Mental
21 Health, the National Institute of Alcohol Abuse and Alco-
22 holism, and the National Institute on Drug Abuse” and
23 inserting “acting through the Administrator”.

1 (e) DEFINITIONS.—Section 534(4) of the Public
2 Health Service Act (42 U.S.C. 290cc–34(4)) is amended
3 to read as follows:

4 “(4) SUBSTANCE USE DISORDER SERVICES.—
5 The term ‘substance use disorder services’ has the
6 meaning given the term ‘substance abuse services’ in
7 section 330(h)(5)(C).”.

8 **[(f) FUNDING.—Section 535(a) of the Public Health**
9 **Service Act (42 U.S.C. 290cc–35(a)) is amended by strik-**
10 **ing “\$75,000,000 for each of the fiscal years 2001**
11 **through 2003” and inserting “such sums as may be nec-**
12 **essary for each of fiscal years 2017 through 2021”.]**

13 (g) STUDY CONCERNING FORMULA.—

14 (1) IN GENERAL.—Not later than 1 year after
15 the date of enactment of this Act, the Administrator
16 of the Substance Abuse and Mental Health Services
17 Administration (referred to in this section as the
18 “Administrator”) shall conduct a study concerning
19 the formula used under section 524(a) of the Public
20 Health Service Act (42 U.S.C. 290cc–24(a)) for
21 making allotments to States under section 521 of
22 such Act (42 U.S.C. 290cc–21). Such study shall in-
23 clude an evaluation of quality indicators of need for
24 purposes of revising the formula for determining the

1 amount of each allotment for the fiscal years fol-
2 lowing the submission of the study.

3 (2) REPORT.—The Administrator shall submit
4 to the appropriate committees of Congress a report
5 concerning the results of the study conducted under
6 paragraph (1)

7 **SEC. 405. NATIONAL SUICIDE PREVENTION LIFELINE PRO-**
8 **GRAM.**

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

13 **“SEC. 520E–3. NATIONAL SUICIDE PREVENTION LIFELINE**
14 **PROGRAM.**

15 “(a) IN GENERAL.—The Secretary, acting through
16 the Administrator, shall maintain the National Suicide
17 Prevention Lifeline program (referred to in this section
18 as the ‘program’), authorized under section 520A and in
19 effect prior to the date of enactment of the Mental Health
20 Reform Act of 2016.

21 “(b) ACTIVITIES.—In maintaining the program, the
22 activities of the Secretary shall include—

23 “(1) coordinating a network of crisis centers
24 across the United States for providing suicide pre-

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

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

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

10 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
11 carry out this section, there are authorized to be appro-
12 priated [such sums as may be necessary] for each of fiscal
13 years 2017 through 2021.”.

14 **SEC. 406. CONNECTING INDIVIDUALS AND FAMILIES WITH**
15 **CARE.**

16 Subpart 3 of part B of title V of the Public Health
17 Service Act (42 U.S.C. 290bb–31 et seq.), as amended by
18 section 405, is further amended by inserting after section
19 520E–3, the following:

20 **“SEC. 520E–4. TREATMENT REFERRAL ROUTING SERVICE.**

21 “(a) IN GENERAL.—The Secretary, acting through
22 the Administrator, shall maintain the National Treatment
23 Referral Routing Service (referred to in this section as the
24 ‘Routing Service’) to assist individuals and families in lo-

1 cating mental and substance use disorder treatment pro-
2 viders.

3 “(b) ACTIVITIES OF THE SECRETARY.—To maintain
4 the Routing Service, the activities of the Secretary shall
5 include administering—

6 “(1) a nationwide, telephone number providing
7 year-round access to information that is updated on
8 a regular basis regarding local behavioral health pro-
9 viders and community-based organizations in a man-
10 ner that is confidential, without requiring individuals
11 to identify themselves, is in languages that include
12 at least English and Spanish, and is at no cost to
13 the individual using the Routing Service; and

14 “(2) an Internet website to provide a search-
15 able, online treatment services locator that includes
16 information on the name, location, contact informa-
17 tion, and basic services provided for behavioral
18 health treatment providers and community-based or-
19 ganizations.

20 “(c) RULE OF CONSTRUCTION.—Nothing in this sec-
21 tion shall be construed to prevent the Administrator from
22 using any unobligated amounts otherwise made available
23 to the Substance Abuse and Mental Health Services Ad-
24 ministration to maintain the Routing Service.”.

1 **SEC. 407. STREAMLINING MENTAL AND BEHAVIORAL**
2 **HEALTH WORKFORCE PROGRAMS.**

3 (a) IN GENERAL.—Part D of title VII of the Public
4 Health Service Act (42 U.S.C. 294 et seq.) is amended—

5 (1) by striking sections 755 (42 U.S.C. 294e)
6 and section 756 (42 U.S.C. 294e-1);

7 (2) by redesignating sections 757 and 759 as
8 sections 756 and 757, respectively; and

9 (3) by inserting after section 754 the following:

10 **“SEC. 755. MENTAL AND BEHAVIORAL HEALTH EDUCATION**
11 **AND TRAINING GRANTS.**

12 “(a) GRANTS AUTHORIZED.—The Secretary may
13 award grants to eligible institutions of higher education
14 to support the recruitment of students for, and education
15 and clinical experience of the students in—

16 “(1) accredited institutions of higher education
17 or accredited professional training programs that are
18 establishing or expanding internships or other field
19 placement programs in mental health in psychiatry,
20 psychology, school psychology, behavioral pediatrics,
21 psychiatric nursing, social work, school social work,
22 substance use disorder prevention and treatment,
23 marriage and family therapy, occupational therapy,
24 school counseling, or professional counseling, includ-
25 ing such internships or programs with a focus on

1 child and adolescent mental health and transitional-
2 age youth;

3 “(2) accredited doctoral, internship, and post-
4 doctoral residency programs of health service psy-
5 chology, including clinical psychology, counseling,
6 and school psychology, for the development and im-
7 plementation of interdisciplinary training of psy-
8 chology graduate students for providing behavioral
9 and mental health services, including substance use
10 disorder prevention and treatment services, and the
11 development of faculty in health service psychology;

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

19 “(4) State-licensed mental health nonprofit and
20 for-profit organizations to enable such organizations
21 to pay for programs for preservice or in-service
22 training in a behavioral health-related paraprofes-
23 sional field with preference for preservice or in-serv-
24 ice training of paraprofessional child and adolescent
25 mental health workers.

1 “(b) ELIGIBILITY REQUIREMENTS.—To be eligible
2 for a grant under this section, an institution of higher edu-
3 cation shall demonstrate—

4 “(1) an ability to recruit and place the students
5 described in subsection (a) in areas with a high need
6 and high demand population;

7 “(2) that individuals and groups from different
8 racial, ethnic, cultural, geographic, religious, lin-
9 guistic, and class backgrounds, and different genders
10 and sexual orientations, participate in the programs
11 of the institution;

12 “(3) knowledge and understanding of the con-
13 cerns of the individuals and groups described in
14 paragraph (2), especially individuals with mental
15 health symptoms or diagnoses, particularly children
16 and adolescents, and transitional-age youth;

17 “(4) that any internship or other field place-
18 ment program assisted through the grant will
19 prioritize cultural and linguistic competency; and

20 “(5) the institution of higher education will pro-
21 vide to the Secretary such data, assurances, and in-
22 formation as the Secretary may require.

23 “(c) INSTITUTIONAL REQUIREMENT.—For grants
24 awarded under paragraphs (2) and (3) of subsection (a),
25 at least 4 of the grant recipients shall be historically black

1 colleges or universities or other minority-serving institu-
2 tions.

3 “(d) PRIORITY.—In selecting grant recipients, the
4 Secretary shall give priority to—

5 “(1) for grants awarded under subparagraphs
6 (1), (2), and (3) of subsection (a), programs that
7 have demonstrated the ability to train psychology
8 and social work professionals to work in integrated
9 care settings; and

10 “(2) for grant under subsection (a)(4), pro-
11 grams for paraprofessionals that emphasize the role
12 of the family and the lived experience of the con-
13 sumer and family-paraprofessional partnerships.

14 “(e) REPORT TO CONGRESS.—Not later than 2 years
15 after the date of enactment of the Mental Health Reform
16 Act of 2016, and annually thereafter, the Secretary shall
17 submit to Congress a report on the effectiveness of the
18 grants under this section in—

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

21 “(2) recruiting of students interested in behav-
22 ioral health practice;

23 “(3) developing and implementing interprofes-
24 sional training and integration within primary care;

1 “(4) developing and implementing accredited
2 field placements and internships; and

3 “(5) collecting data on the number of students
4 trained in mental health and the number of available
5 accredited internships and field placements.

6 “(f) AUTHORIZATION OF APPROPRIATION.—There
7 are authorized to be appropriated to carry out this section
8 **【such sums as may be necessary】** for each of fiscal years
9 2017 through 2021.”.

10 (b) CONFORMING AMENDMENTS.—The Public
11 Health Service Act (42 U.S.C. 201 et seq.), as amended
12 by subsection (a), is further amended—

13 (1) in section 338A(d)(2)(A) (42 U.S.C.
14 254l(d)(2)(A)), by striking “or under section 758”;

15 (2) in section 756(b)(2) (42 U.S.C. 794f(b)(2)),
16 as redesignated by subsection (a), by striking
17 “753(b), and 755(b)” and inserting “and 753(b)”;
18 and

19 (3) in section 761 (42 U.S.C. 294n)—

20 (A) in subsection (b)(2)(E), by striking
21 “757(d)(3)” and inserting “756(d)(3)”;

22 (B) in subsection (d)(2)(B), by striking
23 “757(d)(3)” and inserting “756(d)(3)”;

24 (C) in subsection (d)(3), by striking
25 “757(d)(4)” and inserting “756(d)(4)”.

1 **SEC. 408. REPORTS.**

2 (a) REPORT ON MENTAL HEALTH AND SUBSTANCE
3 USE TREATMENT IN STATES.—

4 (1) IN GENERAL.—Not later than 18 months
5 after the date of enactment of this Act, and not less
6 than every 2 years thereafter, the Assistant Sec-
7 retary for Planning and Evaluation of the Depart-
8 ment of Health and Human Services, in collabora-
9 tion with the Administrator of the Substance Abuse
10 and Mental Health Services Administration, the Di-
11 rector of the Agency for Healthcare Research and
12 Quality, and the Director of the National Institutes
13 of Health, shall submit to Congress and make avail-
14 able on the Internet website of the Department a re-
15 port on mental and substance use disorder treatment
16 in the States, including each of the following:

17 (A) A detailed description on how Federal
18 mental and substance use disorder treatment
19 funds are used in each State, including—

20 (i) the numbers of individuals with
21 mental illness, serious mental illness, seri-
22 ous emotional disturbance, substance use
23 disorders, or co-occurring disorders who
24 are served using Federal funds; and

25 (ii) the types of Federal programs
26 made available to individuals with mental

1 illness, serious mental illness, serious emo-
2 tional disturbance, substance use disorders,
3 or co-occurring disorders.

4 (B) A summary of best practices or evi-
5 dence-based models in the States, including pro-
6 grams that are cost effective, provide evidence-
7 based care, increase access to care, integrate
8 physical, psychiatric, psychological, and behav-
9 ioral medicine, and improve outcomes for indi-
10 viduals with serious mental illness, serious emo-
11 tional disturbance, or substance use disorders.

12 (C) An analysis of outcome measures in
13 each State for individuals with mental illness,
14 serious mental illness, serious emotional dis-
15 turbance, substance use disorders, or co-occur-
16 ring disorders, including rates of suicide, sui-
17 cide attempts, substance abuse, overdose, over-
18 dose deaths, positive health outcomes, emer-
19 gency psychiatric hospitalizations and emer-
20 gency room boarding, arrests, incarcerations,
21 homelessness, joblessness, employment, and en-
22 rollment in educational or vocational programs.

23 (D) An analysis of outcomes for different
24 models of outpatient treatment programs for in-

1 individuals with a serious mental illness or seri-
2 ous emotional disturbance, including—

3 (i) rates of keeping treatment ap-
4 pointments and adherence to treatment
5 plans;

6 (ii) participants' perceived effective-
7 ness of the program;

8 (iii) alcohol and drug abuse rates;

9 (iv) incarceration and arrest rates;

10 (v) violence against persons or prop-
11 erty;

12 (vi) homelessness;

13 (vii) total treatment costs for compli-
14 ance with the program; and

15 (viii) health outcomes.

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

21 (b) REPORTING COMPLIANCE STUDY FOR COMMU-
22 NITY MENTAL HEALTH CENTERS.—

23 (1) IN GENERAL.—The Comptroller General of
24 the United States shall conduct a review and submit

1 to the appropriate committees of Congress a report
2 evaluating the combined paperwork burden of—

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

9 (B) community mental health centers, as
10 defined in section 1861(ff)(3)(B) of the Social
11 Security Act (42 U.S.C. 1395x(ff)(3)(B)).

12 (2) SCOPE.—In preparing the report under
13 paragraph (1), the Comptroller General of the
14 United States shall examine requirements for licens-
15 ing, certification, service definitions, claims pay-
16 ments, billing codes, and financial auditing that
17 are—

18 (A) used by the Office of Management and
19 Budget, the Centers for Medicare & Medicaid
20 Services, the Health Resources and Services
21 Administration, the Substance Abuse and Men-
22 tal Health Services Administration, the Office
23 of the Inspector General of the Department of
24 Health and Human Services, and State Med-
25 icaid agencies; and

1 (B) required by the Federal Government
2 for State agencies to utilize in order to make
3 administrative and statutory recommendations
4 to Congress (which recommendations may in-
5 clude a uniform methodology) to reduce the pa-
6 perwork burden experienced by the centers de-
7 scribed in paragraph (1).

8 (c) WORKFORCE DEVELOPMENT REPORT.—

9 (1) PUBLIC REPORT.—

10 (A) IN GENERAL.—Not later than 2 years
11 after the date of enactment of this Act, the Ad-
12 ministrator of the Substance Abuse and Mental
13 Health Services Administration, in consultation
14 with the Administrator of the Health Resources
15 and Services Administration, shall conduct a
16 study and publicly post on the appropriate
17 Internet website of the Department of Health
18 and Human Services a report on the mental
19 health and substance use disorder workforce in
20 order to inform Federal, State, and local efforts
21 related to workforce enhancement.

22 (B) CONTENTS.—The report under this
23 paragraph shall contain—

1 (i) national and State-level projections
2 of the supply and demand of mental health
3 and substance use disorder health workers;

4 (ii) an assessment of the mental
5 health and substance use disorder work-
6 force capacity, strengths, and weaknesses
7 as of the date of the report;

8 (iii) information on trends within the
9 mental health and substance use disorder
10 provider workforce; and

11 (iv) any additional information deter-
12 mined by the Administrator of the Sub-
13 stance Abuse and Mental Health Services
14 Administration, in consultation with the
15 Administrator of the Health Resources and
16 Services Administration, to be relevant to
17 the mental health and substance use dis-
18 order provider workforce.

19 (2) REPORT TO CONGRESS.—

20 (A) IN GENERAL.—Not later than 3 years
21 after the date of enactment of this Act, the Ad-
22 ministrator of the Substance Abuse and Mental
23 Health Services Administration, in consultation
24 with the Administrator of the Health Resources
25 and Services Administration, shall evaluate and

1 report to the Committee on Health, Education,
2 Labor, and Pensions of the Senate and the
3 Committee on Energy and Commerce of the
4 House of Representatives on the programs
5 within such Administrations to support the de-
6 velopment of the mental health and substance
7 use disorder workforce.

8 (B) CONTENTS.—The report under this
9 paragraph shall include—

10 (i) an evaluation of the outcomes of
11 each program described in subparagraph
12 (A), including whether the program met
13 identified goals and performance measures
14 developed for the respective program and
15 activities carried out by the program;

16 (ii) an evaluation of how each pro-
17 gram, and the programs together, target
18 any workforce weaknesses identified by the
19 report under paragraph (1); and

20 (iii) recommendations for improving
21 coordination among programs, and ad-
22 dressing gaps and overlap within pro-
23 grams, including recommendations for
24 Congress, as appropriate.

25 (d) PEER-SUPPORT SPECIALIST PROGRAMS.—

1 (1) IN GENERAL.—Not later than 2 years after
2 the date of enactment of this Act, the Comptroller
3 General of the United States shall conduct a study
4 on peer-support specialist programs in selected
5 States that receive funding from the Substance
6 Abuse and Mental Health Services Administration
7 and report to the Committee on Health, Education,
8 Labor, and Pensions of the Senate and the Com-
9 mittee on Energy and Commerce of the House of
10 Representatives.

11 (2) CONTENTS OF STUDY.—In conducting the
12 study under paragraph (1), the Comptroller General
13 of the United States shall examine and identify best
14 practices in the selected States related to training
15 and credential requirements for peer-specialist pro-
16 grams, such as—

17 (A) hours of formal work or volunteer ex-
18 perience related to mental and substance use
19 disorders conducted through such programs;

20 (B) types of peer support specialist exams
21 required for such programs in the States;

22 (C) codes of ethics used by such programs
23 in the States;

24 (D) required or recommended skill sets of
25 such programs in the State; and

1 (E) requirements for continuing education.

2 **SEC. 409. CENTERS AND PROGRAM REPEALS.**

3 Part B of title V of the Public Health Service Act
4 (42 U.S.C. 290bb et seq.) is amended by striking the sec-
5 ond section 514 (42 U.S.C. 290bb–9), relating to meth-
6 amphetamine and amphetamine treatment initiatives, and
7 section 514A, 517, 519A, 519C, 519E, 520D, and 520H
8 (42 U.S.C. 290bb–8, 290bb–23, 290bb–25a, 290bb–25e,
9 290bb–25e, 290bb–35, and 290bb–39).

10 **TITLE V—STRENGTHENING MEN-**
11 **TAL AND SUBSTANCE USE**
12 **DISORDER CARE FOR CHIL-**
13 **DREN AND ADOLESCENTS**

14 **SEC. 501. PROGRAMS FOR CHILDREN WITH SERIOUS EMO-**
15 **TIONAL DISTURBANCES.**

16 (a) **COMPREHENSIVE COMMUNITY MENTAL HEALTH**
17 **SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL**
18 **DISTURBANCES.**—Section 561(a)(1) of the Public Health
19 Service Act (42 U.S.C. 290ff(a)(1)) is amended by insert-
20 ing “, which may include efforts to identify and serve chil-
21 dren at risk” before the period.

22 (b) **REQUIREMENTS WITH RESPECT TO CARRYING**
23 **OUT PURPOSE OF GRANTS.**—Section 562(b) of the Public
24 Health Service Act (42 U.S.C. 290ff–1(b)) is amended by
25 striking “will not provide an individual with access to the

1 system if the individual is more than 21 years of age”
2 and inserting “will provide an individual with access to
3 the system through the age of 21 years”.

4 (c) ADDITIONAL PROVISIONS.—Section 564(f) of the
5 Public Health Service Act (42 U.S.C. 290ff–3(f)) is
6 amended by inserting “(and provide a copy to the State
7 involved)” after “to the Secretary”.

8 (d) GENERAL PROVISIONS.—Section 565 of the Pub-
9 lic Health Service Act (42 U.S.C. 290ff–4) is amended—

10 (1) in subsection (b)(1)—

11 (A) in the matter preceding subparagraph
12 (A), by striking “receiving a grant under sec-
13 tion 561(a)” and inserting “, regardless of
14 whether such public entity is receiving a grant
15 under section 561(a)”; and

16 (B) in subparagraph (B), by striking “pur-
17 suant to” and inserting “described in”;

18 (2) in subsection (d)(1), by striking “not more
19 than 21 years of age” and inserting “through the
20 age of 21 years”; and

21 (3) in subsection (f)(1), by striking
22 “\$100,000,000 for fiscal year 2001, and such sums
23 as may be necessary for each of the fiscal years
24 2002 and 2003” and inserting “[such sums as may

1 be necessary] for each of fiscal years 2017 through
2 2021”.

3 **SEC. 502. TELEHEALTH CHILD PSYCHIATRY ACCESS**
4 **GRANTS.**

5 (a) DEFINITIONS.—In this subsection:

6 (1) ELIGIBLE ENTITY.—The term “eligible enti-
7 ty” means a State, political subdivision of a State,
8 Indian tribe, or tribal organization.

9 (2) INDIAN TRIBE; TRIBAL ORGANIZATION.—
10 The terms “Indian tribe” and “tribal organization”
11 have the meanings given such terms in section 4 of
12 the Indian Self-Determination and Education Assist-
13 ance Act (25 U.S.C. 450b)).

14 (3) PEDIATRIC MENTAL HEALTH TEAMS.—The
15 term “pediatric mental health team” means a team
16 of case coordinators, child and adolescent psychia-
17 trists, and a licensed clinical mental health profes-
18 sional, such as a psychologist, social worker, or men-
19 tal health counselor. Such a team may be regionally
20 based, provided there is access to a pediatric mental
21 health team across the State.

22 (4) SECRETARY.—The term “Secretary” means
23 the Secretary of Health and Human Services.

24 (b) GRANTS.—The Secretary, acting through the Ad-
25 ministrator of the Health Resources and Services Admin-

1 istration, may award grants to eligible entities that satisfy
2 all requirements under this section to promote behavioral
3 health integration in pediatric primary care by—

4 (1) supporting the development of statewide or
5 regional child psychiatry access programs; and

6 (2) supporting the improvement of statewide or
7 regional child psychiatry access programs in exist-
8 ence on the day before the date of enactment of this
9 Act.

10 (c) CHILD PSYCHIATRY ACCESS PROGRAM REQUIRE-
11 MENTS.—To be eligible for support under subsection (b),
12 a child psychiatry access program shall—

13 (1) be a statewide or regional network of pedi-
14 atric mental health teams that provide support to
15 pediatric primary care sites as an integrated team;

16 (2) support and further develop organized State
17 networks of child and adolescent psychiatrists to
18 provide consultative support to pediatric primary
19 care sites;

20 (3) conduct an assessment of critical behavioral
21 consultation needs among pediatric providers and
22 such providers' preferred mechanisms for receiving
23 consultation, training, and technical assistance;

24 (4) develop an online database and communica-
25 tion mechanisms, including through telehealth serv-

1 ices, to facilitate consultation support to pediatric
2 practices;

3 (5) provide rapid statewide or regional clinical
4 telephone consultations when requested between the
5 pediatric mental health teams and pediatric primary
6 care providers;

7 (6) conduct training and provide technical as-
8 sistance to pediatric primary care providers to sup-
9 port the early identification, diagnosis, treatment,
10 and referral of children with behavioral health condi-
11 tions;

12 (7) inform and assist pediatric providers in ac-
13 cessing child psychiatry consultations and in sched-
14 uling and conducting technical assistance;

15 (8) assist with referrals to specialty care and
16 community and behavioral health resources; and

17 (9) establish mechanisms for measuring and
18 monitoring increased access to child and adolescent
19 psychiatric services by pediatric primary care pro-
20 viders and expanded capacity of pediatric primary
21 care providers to identify, treat, and refer children
22 with mental health problems.

23 (d) APPLICATION.—An eligible entity that desires a
24 grant under this section shall submit an application to the
25 Secretary at such time, in such manner, and containing

1 such information as the Secretary may require, including
2 a plan for the comprehensive evaluation and the perform-
3 ance and outcome evaluation described in subsection (e).

4 (e) EVALUATION.—An eligible entity that receives a
5 grant under this section shall prepare and submit an eval-
6 uation to the Secretary at such time, in such manner, and
7 containing such information as the Secretary may reason-
8 ably require, including a comprehensive evaluation of ac-
9 tivities carried out with funds received through such grant
10 and a performance and outcome evaluation of such activi-
11 ties.

12 (f) FUNDING.—

13 (1) FEDERAL FUNDS.—In addition to the fund-
14 ing provided through contributions under paragraph
15 (2), the Secretary shall fund the grant program
16 under this section using such sums as may be nec-
17 essary out of any unobligated amounts made avail-
18 able to carry out section 330I, 330K, or 330L of the
19 Public Health Service Act (42 U.S.C. 254c–14,
20 254c–16, 254c–18).

21 (2) MATCHING REQUIREMENT.—The Secretary
22 may not award a grant under this section unless the
23 eligible entity desiring the grant agrees, with respect
24 to the costs to be incurred by the eligible entity in
25 carrying out the purpose of the grant described in

1 subsection (b), to make available non-Federal con-
2 tributions (in cash or in kind) toward such costs in
3 an amount that is not less than 20 percent of Fed-
4 eral funds provided through the grant.

5 **SEC. 503. SUBSTANCE USE DISORDER TREATMENT AND**
6 **EARLY INTERVENTION SERVICES FOR CHIL-**
7 **DREN AND ADOLESCENTS.**

8 The first section 514 of the Public Health Service
9 Act (42 U.S.C. 290bb-7), relating to substance abuse
10 treatment services for children and adolescents, is amend-
11 ed—

12 (1) in the heading, by striking “**ABUSE**
13 **TREATMENT**” and inserting “**USE DISORDER**
14 **TREATMENT AND EARLY INTERVENTION**”;

15 (2) by striking subsection (a) and inserting the
16 following:

17 “(a) IN GENERAL.—The Secretary shall award
18 grants, contracts, or cooperative agreements to public and
19 private nonprofit entities, including Indian tribes or tribal
20 organizations (as such terms are defined in section 4 of
21 the Indian Self-Determination and Education Assistance
22 Act (25 U.S.C. 450b)), or health facilities or programs
23 operated by or pursuant to a contract or grant with the
24 Indian Health Service, for the purpose of—

1 “(1) providing early identification and services
2 to meet the needs of children and adolescents who
3 are at risk of substance use disorders; and

4 “(2) providing substance use disorder treatment
5 services for children, including children and adoles-
6 cents with co-occurring mental illness and substance
7 use disorders.”;

8 (3) in subsection (b)—

9 (A) by striking paragraph (1) and insert-
10 ing the following:

11 “(1) apply evidence-based and cost effective
12 methods”;

13 (B) in paragraph (2)—

14 (i) by striking “treatment”; and

15 (ii) by inserting “substance abuse,”
16 after “child welfare,”;

17 (C) in paragraph (3), by striking “sub-
18 stance abuse disorders” and inserting “sub-
19 stance use disorders, including children and
20 adolescents with co-occurring mental illness and
21 substance use disorders,”;

22 (D) in paragraph (5), by striking “treat-
23 ment;” and inserting “services; and”;

1 (E) in paragraph (6), by striking “sub-
2 stance abuse treatment; and” and inserting
3 “treatment.”; and

4 (F) by striking paragraph (7); and
5 (4) in subsection (f), by striking “\$40,000,000”
6 and all that follows through the period and inserting
7 “**【**such sums as may be necessary**】** for each of fiscal
8 years 2017 through 2021.”.

9 **SEC. 504. RESIDENTIAL TREATMENT PROGRAMS FOR**
10 **PREGNANT AND PARENTING WOMEN.**

11 Section 508 of the Public Health Service Act (42
12 U.S.C. 290bb-1) is amended—

13 (1) in the section heading, by striking
14 “**POSTPARTUM**” and inserting “**PARENTING**”;

15 (2) in subsection (a)—

16 (A) in the matter preceding paragraph
17 (1)—

18 (i) by inserting “(referred to in this
19 section as the ‘Director’)” after “Treat-
20 ment”;

21 (ii) by striking “grants,” and insert-
22 ing “grants, including the grants under
23 subsection (r),”;

24 (iii) by striking “postpartum” and in-
25 serting “parenting”; and

1 (iv) by striking “for substance abuse”
2 and inserting “for substance use dis-
3 orders”; and

4 (B) in paragraph (1), by inserting “or re-
5 ceive outpatient treatment services from” after
6 “reside in”; and

7 (3) in subsection (b)(2), by striking “the serv-
8 ices will be made available to each woman” and in-
9 serting “services will be made available to each
10 woman and child”;

11 (4) in subsection (c)—

12 (A) in paragraph (1), by striking “to the
13 woman of the services” and inserting “of serv-
14 ices for the woman and her child”; and

15 (B) in paragraph (2)—

16 (i) in subparagraph (A), by striking
17 “substance abuse” and inserting “sub-
18 stance use disorders”; and

19 (ii) in subparagraph (B), by striking
20 “such abuse” and inserting “such a dis-
21 order”;

22 (5) in subsection (d)—

23 (A) in paragraph (3)(A), by striking “ma-
24 ternal substance abuse” and inserting “a ma-
25 ternal substance use disorder”;

1 (B) by amending paragraph (4) to read as
2 follows:

3 “(4) Providing therapeutic, comprehensive child
4 care for children during the periods in which the
5 woman is engaged in therapy or in other necessary
6 health and rehabilitative activities.”;

7 (C) in paragraphs (9), (10), and (11), by
8 striking “women” each place such term appears
9 and inserting “woman”;

10 (D) in paragraph (9), by striking “units”
11 and inserting “unit”; and

12 (E) in paragraph (11)—

13 (i) in subparagraph (A), by striking
14 “their children” and inserting “any child
15 of such woman”;

16 (ii) in subparagraph (B), by striking
17 “; and” and inserting a semicolon;

18 (iii) in subparagraph (C), by striking
19 the period and inserting “; and”; and

20 (iv) by adding at the end the fol-
21 lowing:

22 “(D) family reunification with children in
23 kinship or foster care arrangements, where safe
24 and appropriate.”;

25 (6) in subsection (e)—

- 1 (A) in paragraph (1)—
- 2 (i) in the matter preceding subpara-
- 3 graph (A), by striking “substance abuse”
- 4 and inserting “substance use disorders”;
- 5 and
- 6 (ii) in subparagraph (B), by striking
- 7 “substance abuse” and inserting “sub-
- 8 stance abuse disorders”; and
- 9 (B) in paragraph (2)—
- 10 (i) by striking “(A) Subject” and in-
- 11 sserting the following:
- 12 “(A) IN GENERAL.—Subject”;
- 13 (ii) in subparagraph (B)—
- 14 (I) by striking “(B)(i) In the
- 15 case” and inserting the following:
- 16 “(B) WAIVER OF PARTICIPATION AGREE-
- 17 MENTS.—
- 18 “(i) IN GENERAL.—In the case”; and
- 19 (II) by striking “(ii) A deter-
- 20 mination” and inserting the following:
- 21 “(ii) DONATIONS.—A determination”;
- 22 and
- 23 (iii) by striking “(C) With respect”
- 24 and inserting the following:

1 “(C) NONAPPLICATION OF CERTAIN RE-
2 QUIREMENTS.—With respect”;

3 (7) in subsection (g)—

4 (A) by striking “who are engaging in sub-
5 stance abuse” and inserting “who have a sub-
6 stance use disorder”; and

7 (B) by striking “such abuse” and inserting
8 “such disorder”;

9 (8) in subsection (h)(1), by striking
10 “postpartum” and inserting “parenting”;

11 (9) in subsection (j)—

12 (A) in the matter preceding paragraph (1),
13 by striking “to on” and inserting “to or on”;
14 and

15 (B) in paragraph (3), by striking “Office
16 for” and inserting “Office of”;

17 (10) by amending subsection (m) to read as fol-
18 lows:

19 “(m) ALLOCATION OF AWARDS.—In making awards
20 under subsection (a), the Director shall give priority to
21 an applicant that agrees to use the award for a program
22 serving an area that is a rural area, an area designated
23 under section 332 by the Secretary as a health profes-
24 sional shortage area, or an area determined by the Direc-

1 tor to have a shortage of family-based substance use dis-
2 order treatment options.”;

3 (11) in subsection (q)—

4 (A) in paragraph (3), by striking “funding
5 agreement under subsection (a)” and inserting
6 “funding agreement”; and

7 (B) in paragraph (4), by striking “sub-
8 stance abuse” and inserting “a substance use
9 disorder”;

10 (12) by redesignating subsection (r) as sub-
11 section (s);

12 (13) by inserting after subsection (q) the fol-
13 lowing:

14 “(r) PILOT PROGRAM FOR STATE SUBSTANCE
15 ABUSE AGENCIES.—

16 “(1) IN GENERAL.—From amounts made avail-
17 able under subsection (s), the Director may carry
18 out a pilot program under which the Director makes
19 competitive grants to State substance abuse agencies
20 to—

21 “(A) enhance flexibility in the use of funds
22 designed to support family-based services for
23 pregnant and parenting women with a primary
24 diagnosis of a substance use disorder, including
25 an opioid use disorder;

1 “(B) help State substance abuse agencies
2 address identified gaps in services provided to
3 such women along the continuum of care, in-
4 cluding services provided to women in non-resi-
5 dential based settings; and

6 “(C) promote a coordinated, effective, and
7 efficient State system managed by State sub-
8 stance abuse agencies by encouraging new ap-
9 proaches and models of service delivery that are
10 evidence-based.

11 “(2) REQUIREMENTS.—Notwithstanding any
12 other provisions of this section, in carrying out the
13 pilot program under this subsection, the Director—

14 “(A) shall require a State substance abuse
15 agency to submit to the Director an application,
16 in such form and manner and containing such
17 information as specified by the Director, to be
18 eligible to receive a grant under the program;

19 “(B) shall identify, based on applications
20 submitted under subparagraph (A), State sub-
21 stance abuse agencies that are eligible for such
22 grants;

23 “(C) shall require services proposed to be
24 furnished through such a grant to support fam-
25 ily-based treatment and other services for preg-

1 nant and parenting women with a primary diag-
2 nosis of a substance use disorder, including an
3 opioid use disorder;

4 “(D) shall not require that services fur-
5 nished through such a grant be provided solely
6 to women that reside in facilities;

7 “(E) shall not require that grant recipients
8 under the program make available all services
9 described in subsection (d); and

10 “(F) may waive the requirements of sub-
11 section (f), depending on the circumstances of
12 the grantee.

13 “(3) REQUIRED SERVICES.—

14 “(A) IN GENERAL.—The Director shall
15 specify minimum services required to be made
16 available to eligible women through a grant
17 awarded under the pilot program under this
18 subsection. Notwithstanding any other provision
19 of this section, such minimum services—

20 “(i) shall include the requirements de-
21 scribed in subsection (c);

22 “(ii) may include any of the services
23 described in subsection (d);

24 “(iii) may include other services, as
25 appropriate; and

1 “(iv) shall be based on the rec-
2 ommendations submitted under subpara-
3 graph (B).

4 “(B) STAKEHOLDER INPUT.—The Director
5 shall consider recommendations from stake-
6 holders, including State substance abuse agen-
7 cies, health care providers, persons in recovery
8 from substance a substance use disorder, and
9 other appropriate individuals, for the minimum
10 services described in subparagraph (A).

11 “(4) EVALUATION AND REPORT TO CON-
12 GRESS.—

13 “(A) EVALUATIONS.—Out of amounts
14 made available to the Center for Behavioral
15 Health Statistics and Quality, the Director of
16 the Center for Behavioral Health Statistics and
17 Quality, in cooperation with the Director of the
18 Center for Substance Abuse Treatment and the
19 recipients of grants under this subsection, shall
20 conduct an evaluation of the pilot program, be-
21 ginning one year after the date on which a
22 grant is first awarded under this subsection.

23 “(B) REPORTS.—

24 “(i) IN GENERAL.—Not later than
25 120 days after the completion of the eval-

1 uation under subparagraph (A), the Direc-
2 tor of the Center for Behavioral Health
3 Statistics and Quality, in coordination with
4 the Director of the Center for Substance
5 Abuse Treatment, shall submit to the rel-
6 evant Committees of the Senate and the
7 House of Representatives a report on such
8 evaluation.

9 “(ii) CONTENTS.—The report to Con-
10 gress under clause (i) shall include, at a
11 minimum, outcomes information from the
12 pilot program under this section, including
13 any resulting reductions in the use of alco-
14 hol and other drugs, engagement in treat-
15 ment services, retention in the appropriate
16 level and duration of services, increased ac-
17 cess to the use of drugs approved by the
18 Food and Drug Administration for the
19 treatment of substance use disorders in
20 combination with counseling, and other ap-
21 propriate measures.

22 “(5) STATE SUBSTANCE ABUSE AGENCIES DE-
23 FINED.—For purposes of this subsection, the term
24 ‘State substance abuse agency’ means, with respect
25 to a State, the agency in such State that manages

1 the block grant for prevention and treatment of sub-
2 stance use disorders under subpart II of part B of
3 title XIX with respect to the State.”; and

4 【(14) in subsection (s), as so redesignated, by
5 striking “such sums as may be necessary to fiscal
6 years 2001 through 2003.” and inserting “such
7 sums as may be necessary for each of fiscal years
8 2017 through 2021. Of the amounts made available
9 for a fiscal year pursuant to the previous sentence,
10 not more than 25 percent of such amounts shall be
11 made available for such fiscal year to carry out sub-
12 section (r).”.]

13 **TITLE VI—IMPROVING PATIENT**
14 **CARE AND ACCESS TO MEN-**
15 **TAL AND SUBSTANCE USE**
16 **DISORDER BENEFITS**

17 **SEC. 601. HIPAA CLARIFICATION.**

18 (a) IN GENERAL.—The Secretary of Health and
19 Human Services, acting through the Director of the Office
20 for Civil Rights, shall ensure that providers, professionals,
21 patients and their families, and others involved in mental
22 or substance use disorder treatment or care have ade-
23 quate, accessible, and easily comprehensible resources re-
24 lating to appropriate uses and disclosures of protected
25 health information under the regulations promulgated

1 under section 264(c) of the Health Insurance Portability
2 and Accountability Act of 1996 (42 U.S.C. 1320d–2 note),
3 including resources to clarify permitted uses and dislo-
4 sures of such information that—

5 (1) require the patient’s consent;

6 (2) require providing the patient with an oppor-
7 tunity to object;

8 (3) are based on the exercise of professional
9 judgment regarding whether the patient would ob-
10 ject when the opportunity to object cannot prac-
11 ticably be provided because of the patient’s inca-
12 pacity or an emergency treatment circumstance; and

13 (4) are determined, based on the exercise of
14 professional judgment, to be in the best interest of
15 the patient when the patient is not present or other-
16 wise incapacitated.

17 (b) CONSIDERATIONS.—In carrying out subsection
18 (a), the Secretary of Health and Human Services shall
19 consider actual and perceived barriers to the ability of
20 family members to assist in the treatment of patients with
21 a serious mental illness.

22 **SEC. 602. IDENTIFICATION OF MODEL TRAINING PRO-**
23 **GRAMS.**

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

1 of Health and Human Services (in this section referred
2 to as the “Secretary”), in consultation with appropriate
3 experts, shall identify or, in the case that none exist, rec-
4 ognize private or public entities to develop—

5 (1) model programs and materials for training
6 health care providers (including physicians, emer-
7 gency medical personnel, psychiatrists, psychologists,
8 counselors, therapists, behavioral health facilities
9 and clinics, care managers, and hospitals, including
10 individuals such as a general counsel or regulatory
11 compliance staff who are responsible for establishing
12 provider privacy policies) regarding the permitted
13 uses and disclosures, consistent with the standards
14 governing the privacy and security of individually
15 identifiable health information pursuant to regula-
16 tions promulgated by the Secretary under section
17 264(c) of the Health Insurance Portability and Ac-
18 countability Act of 1996 (42 U.S.C. 1320d–2 note)
19 and part C of title XI of the Social Security Act (42
20 U.S.C. 1320d et seq.), of the protected health infor-
21 mation of patients seeking or undergoing mental
22 health or substance use disorder treatment or care;
23 and

24 (2) model programs and materials for training
25 patients and their families regarding their rights to

1 protect and obtain information under the standards
2 described in paragraph (1).

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

4 (1) periodically review, evaluate, and update the
5 model programs and materials identified under sub-
6 section (a); and

7 (2) disseminate the updated model programs
8 and materials.

9 (c) COORDINATION.—The Secretary shall carry out
10 this section in coordination with the Director of the Office
11 for Civil Rights, the Assistant Secretary for Planning and
12 Evaluation, the Administrator of the Substance Abuse and
13 Mental Health Services Administration, the Administrator
14 of the Health Resources and Services Administration, and
15 the heads of other relevant agencies within the Depart-
16 ment of Health and Human Services.

17 (d) INPUT OF CERTAIN ENTITIES.—In identifying
18 the model programs and materials under subsections (a)
19 and (b), the Secretary shall solicit input from key stake-
20 holders, including relevant national, State, and local asso-
21 ciations, medical societies licensing boards, providers of
22 mental and substance use disorder treatment and care,
23 and organizations representing patients and consumers.

1 **SEC. 603. CONFIDENTIALITY OF RECORDS.**

2 Not later than 1 year after the date on which the
3 Secretary of Health and Human Services first finalizes the
4 regulations updating part 2 of title 42, Code of Federal
5 Regulations (relating to confidentiality of alcohol and drug
6 abuse patient records) after the date of enactment of this
7 Act, the Secretary shall convene relevant stakeholders to
8 determine the impact of such regulations on patient care,
9 health outcomes, and patient privacy.

10 **SEC. 604. ENHANCED COMPLIANCE WITH MENTAL HEALTH**
11 **AND SUBSTANCE USE DISORDER COVERAGE**
12 **REQUIREMENTS.**

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

16 “(6) ADDITIONAL GUIDANCE.—

17 “(A) IN GENERAL.—Not later than 1 year
18 after the date of enactment of the Mental
19 Health Reform Act of 2016, the Secretary, in
20 coordination with the Secretary of Labor and
21 the Secretary of the Treasury, shall issue guid-
22 ance to group health plans and health insurance
23 issuers offering group or individual health in-
24 surance coverage to assist such plans and
25 issuers in satisfying the requirements of this
26 section.

1 “(B) DISCLOSURE.—

2 “(i) GUIDANCE FOR PLANS AND
3 ISSUERS.—The guidance issued under this
4 paragraph shall include specific examples
5 of methods that group health plans and
6 health insurance issuers offering group or
7 individual health insurance coverage may
8 use for disclosing information to dem-
9 onstrate compliance with the requirements
10 under this section (and any regulations
11 promulgated pursuant to this section), in-
12 cluding methods for complying with re-
13 quirements for non-quantitative treatment
14 limitations.

15 “(ii) DOCUMENTS FOR PARTICIPANTS,
16 BENEFICIARIES, OR CONTRACTING PRO-
17 VIDERS.—The guidance issued under this
18 paragraph may include examples of stand-
19 ardized methods that group health plans
20 and health insurance issuers offering group
21 or individual health insurance coverage
22 may use to provide any participant, bene-
23 ficiary, or contracting provider, upon re-
24 quest, with documents containing coverage
25 information that the health plans or

1 issuers are required, by this section or any
2 other provision of law, to disclose to such
3 participants, beneficiaries, or contracting
4 providers, including—

5 “(I) information, including infor-
6 mation that is comparative in nature,
7 on non-quantitative treatment limita-
8 tions for both medical and surgical
9 benefits and mental health and sub-
10 stance use disorder benefits;

11 “(II) information, including in-
12 formation that is comparative in na-
13 ture, about the processes, strategies,
14 evidentiary standards, and other fac-
15 tors used to apply non-quantitative
16 treatment limitations for both medical
17 and surgical benefits and mental
18 health and substance use disorder
19 benefits, including how such limita-
20 tions are applied to mental health or
21 substance use disorder benefits; and

22 “(III) information, including in-
23 formation that is comparative in na-
24 ture, about how non-quantitative
25 treatment limitations are applied to

1 medical and surgical benefits relative
2 to how such limitations are applied to
3 mental health or substance use dis-
4 order benefits.

5 “(C) NON-QUANTITATIVE TREATMENT
6 LIMITATIONS.—The guidance issued under this
7 paragraph shall include information that group
8 health plans and health insurance issuers offer-
9 ing group or individual health insurance cov-
10 erage may use to comply with requirements for
11 non-quantitative treatment limitations under
12 this section, including—

13 “(i) examples of appropriate types of
14 non-quantitative treatment limitations on
15 mental health and substance use disorder
16 benefits that comply or do not comply with
17 this section, including—

18 “(I) medical management stand-
19 ards that limit or exclude benefits
20 based on medical necessity, medical
21 appropriateness, or whether a treat-
22 ment is experimental or investigative;

23 “(II) limitations with respect to
24 prescription drug formulary design;
25 and

1 “(III) use of fail-first or step
2 therapy protocols;

3 “(ii) examples of network admission
4 standards and individual provider reim-
5 bursement rates, as such standards and
6 rates apply to network adequacy, that com-
7 ply or do not comply with this section;

8 “(iii) examples of sources of informa-
9 tion that may serve as evidentiary stand-
10 ards for the purpose of determining com-
11 pliance or non-compliance with applicable
12 non-quantitative treatment limitation re-
13 quirements;

14 “(iv) examples of specific factors that
15 may be used by such plans or issuers in
16 performing a non-quantitative treatment
17 limitation analysis;

18 “(v) examples of specific evidentiary
19 standards that may be used by such plans
20 or issuers to evaluate the specific factors
21 described in clause (iv);

22 “(vi) examples of how a lack of clin-
23 ical evidence may be taken into consider-
24 ation by such plans or issuers in the case
25 of experimental treatment exclusions;

1 “(vii) examples of how specific evi-
2 dentiary standards may be applied to each
3 service category or classification of bene-
4 fits;

5 “(viii) examples of new mental health
6 or substance use disorder treatments that
7 comply or do not comply with this section,
8 such as evidence-based early intervention
9 programs for individuals with a serious
10 mental illness and types of medical man-
11 agement techniques that have been deter-
12 mined to meet or fail to meet requirements
13 for non-quantitative treatment limitations;

14 “(ix) examples of coverage determina-
15 tions that comply or do not comply with
16 this section and for which there is an indi-
17 rect relationship between the covered men-
18 tal health or substance use disorder benefit
19 and a traditional covered medical and sur-
20 gical benefit, such as residential treatment
21 or hospitalizations involving involuntary
22 commitment;

23 “(x) examples of how non-quantitative
24 treatment limitations and their application,
25 determinations that treatments are no

1 longer medically necessary, and efforts to
2 terminate or reduce care may be resolved
3 in a manner that is least burdensome to
4 the patient and provides for continuity of
5 patient care; and

6 “(xi) additional examples of coverage
7 of mental health and substance use dis-
8 order benefits that comply or do not com-
9 ply with this section, including cases in
10 which restrictions based on geographic lo-
11 cations, facility type, provider specialty, or
12 other criteria limit the scope or duration of
13 benefits.

14 “(D) PUBLIC COMMENT.—Prior to issuing
15 any final guidance under this section, the Sec-
16 retary shall provide a public comment period of
17 not less than 60 days during which any member
18 of the public may provide comments on a draft
19 of the guidance.”.

20 (b) IMPROVING COMPLIANCE.—

21 (1) IN GENERAL.—In the case of a group
22 health plan or health insurance issuer offering
23 health insurance coverage in the group or individual
24 market with respect to which there are at least 5
25 findings of non-compliance with section 2726 of the

1 Public Health Service Act (42 U.S.C. 300gg–26),
2 section 712 of the Employee Retirement Income Se-
3 curity Act of 1974 (29 U.S.C. 1185a), or section
4 9812 of the Internal Revenue Code, the appropriate
5 Secretary shall audit plan documents for such health
6 plan or issuer in the following plan year in order to
7 help improve compliance with such section.

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

15 **SEC. 605. ACTION PLAN FOR ENHANCED ENFORCEMENT OF**
16 **MENTAL HEALTH AND SUBSTANCE USE DIS-**
17 **ORDER COVERAGE.**

18 (a) PUBLIC MEETING.—

19 (1) IN GENERAL.—Not later than 6 months
20 after the date of enactment of this Act, the Sec-
21 retary of Health and Human Services shall convene
22 a public meeting of stakeholders described in para-
23 graph (2) to produce an action plan for improved
24 Federal and State coordination related to the en-

1 enforcement of mental health parity and addiction eq-
2 uity requirements.

3 (2) STAKEHOLDERS.—The stakeholders de-
4 scribed in this paragraph shall include each of the
5 following:

6 (A) The Federal Government, including
7 representatives from—

8 (i) the Department of Health and
9 Human Services;

10 (ii) the Department of the Treasury;

11 (iii) the Department of Labor; and

12 (iv) the Department of Justice.

13 (B) State governments, including—

14 (i) State health insurance commis-
15 sioners;

16 (ii) appropriate State agencies, includ-
17 ing agencies on public health or mental
18 health; and

19 (iii) State attorneys general or other
20 representatives of State entities involved in
21 the enforcement of mental health parity
22 laws.

23 (C) Representatives from key stakeholder
24 groups, including—

- 1 (i) the National Association of Insur-
2 ance Commissioners;
3 (ii) health insurance providers;
4 (iii) providers of mental health and
5 substance use disorder treatment;
6 (iv) employers; and
7 (v) patients or their advocates.

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

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

16 (1) reflect the input of the stakeholders invited
17 to the public meeting under subsection (a);

18 (2) identify specific strategic objectives regard-
19 ing how the various Federal and State agencies
20 charged with enforcement of mental health parity
21 and addiction equity requirements will collaborate to
22 improve enforcement of such requirements;

23 (3) provide a timeline for when such objectives
24 shall be met; and

1 (4) provide specific examples of how such objec-
2 tives may be met, which may include—

3 (A) providing common educational infor-
4 mation and documents to patients about their
5 rights under Federal or State mental health
6 parity and addiction equity requirements;

7 (B) facilitating the centralized collection
8 of, monitoring of, and response to patient com-
9 plaints or inquiries relating to Federal or State
10 mental health parity and addiction equity re-
11 quirements, which may be through the develop-
12 ment and administration of a single, toll-free
13 telephone number and an Internet website por-
14 tal;

15 (C) Federal and State law enforcement
16 agencies entering into memoranda of under-
17 standing to better coordinate enforcement re-
18 sponsibilities and information sharing, including
19 whether such agencies should make the results
20 of enforcement actions related to mental health
21 parity and addiction equity requirements pub-
22 licly available; and

23 (D) recommendations to the Secretary and
24 Congress regarding the need for additional legal
25 authority to improve enforcement of mental

1 health parity and addiction equity requirements,
2 including requirements for non-quantitative
3 treatment limitations and the extent and fre-
4 quency of how such limitations are applied both
5 to medical and surgical benefits and to mental
6 health and substance use disorder benefits.

7 **SEC. 606. REPORT ON INVESTIGATIONS REGARDING PAR-**
8 **ITY IN MENTAL HEALTH AND SUBSTANCE**
9 **USE DISORDER BENEFITS.**

10 (a) IN GENERAL.—Not later than 1 year after the
11 date of enactment of this Act, and annually thereafter for
12 the subsequent 5 years, the Administrator of the Centers
13 for Medicare & Medicaid Services, in collaboration with
14 the Assistant Secretary of Labor of the Employee Benefits
15 Security Administration and the Secretary of the Treas-
16 ury, shall submit to the Committee on Health, Education,
17 Labor, and Pensions of the Senate a report summarizing
18 the results of all closed Federal investigations completed
19 during the preceding 12-month period with findings of any
20 serious violation regarding compliance with parity in men-
21 tal health and substance use disorder benefits, including
22 benefits provided to persons with a serious mental illness
23 or a substance use disorder, under section 2726 of the
24 Public Health Service Act (42 U.S.C. 300gg–26), section
25 712 of the Employee Retirement Income Security Act of

1 1974 (29 U.S.C. 1185a), and section 9812 of the Internal
2 Revenue Code of 1986.

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

6 (1) The number of open or closed Federal in-
7 vestigations conducted during the covered reporting
8 period.

9 (2) Each benefit classification examined by any
10 such investigation conducted during the covered re-
11 porting period.

12 (3) Each subject matter, including compliance
13 with requirements for quantitative and non-quant-
14 itative treatment limitations, of any such investiga-
15 tion conducted during the covered reporting period.

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

20 (c) LIMITATION.—Any individually identifiable infor-
21 mation shall be excluded from reports under subsection
22 (a) consistent with protections under the health privacy
23 and security rules promulgated under section 264(c) of the
24 Health Insurance Portability and Accountability Act of
25 1996 (42 U.S.C. 1320d–2 note).

1 **SEC. 607. GAO STUDY ON COVERAGE LIMITATIONS FOR IN-**
2 **DIVIDUALS WITH SERIOUS MENTAL ILLNESS**
3 **AND SUBSTANCE USE DISORDERS.**

4 Not later than 3 years after the date of enactment
5 of this Act, the Comptroller General of the United States,
6 in consultation with the Secretary of Health and Human
7 Services, the Secretary of Labor, and the Secretary of the
8 Treasury, shall submit to the Committee on Health, Edu-
9 cation, Labor, and Pensions of the Senate a report detail-
10 ing the extent to which group health plans or health insur-
11 ance issuers offering group or individual health insurance
12 coverage that provides both medical and surgical benefits
13 and mental health or substance use disorder benefits, and
14 medicaid managed care organizations with a contract
15 under section 1903(m) of the Social Security Act (42
16 U.S.C. 1396b(m)), comply with section 2726 of the Public
17 Health Service Act (42 U.S.C. 300gg-26), section 712 of
18 the Employee Retirement Income Security Act of 1974
19 (29 U.S.C. 1185a), and section 9812 of the Internal Rev-
20 enue Code of 1986, including—

21 (1) how non-quantitative treatment limitations,
22 including medical necessity criteria, of such plans or
23 issuers comply with such sections;

24 (2) how the responsible Federal departments
25 and agencies ensure that such plans or issuers com-
26 ply with such sections, including an assessment of

1 how the Secretary of Health and Human Services
2 has used its authority to conduct audits of such
3 plans to ensure compliance;

4 (3) a review of how the various Federal and
5 State agencies responsible for enforcing mental
6 health parity requirements have improved enforce-
7 ment of such requirements in accordance with the
8 objectives and timeline described in the action plan
9 under section 605; and

10 (4) recommendations for how additional en-
11 forcement, education, and coordination activities by
12 responsible Federal and State departments and
13 agencies could better ensure compliance with such
14 sections, including recommendations regarding the
15 need for additional legal authority.

16 **SEC. 608. CLARIFICATION OF EXISTING PARITY RULES.**

17 **【Note: Language to be provided.】**