AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 2646

OFFERED BY M__. _____

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Helping Families in Mental Health Crisis Act of 2016''.

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

TITLE I—ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE

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

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

''(c) ASSISTANT SECRETARY AND DEPUTY ASSISTANT SECRETARY.—

''(1) ASSISTANT SECRETARY.—

''(A) APPOINTMENT.—The Administration shall be headed by an official to be known as the Assistant Secretary for Mental Health and Substance Use (hereinafter in this title referred to as the 'Assistant Secretary') who shall be appointed by the President, by and with the advice and consent of the Senate.

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

''(i) a doctoral degree in medicine, osteopathic medicine, or psychology;

''(ii) clinical and research experience regarding mental health and substance use disorders; and

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

''(2) DEPUTY ASSISTANT SECRETARY.—The Assistant Secretary, with the approval of the Secretary, may appoint a Deputy Assistant Secretary and may

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

(b) TRANSFER OF AUTHORITIES.—The Secretary of Health and Human Services shall delegate to the Assistant Secretary for Mental Health and Substance Use all duties and authorities that—

(1) as of the day before the date of enactment of this Act, were vested in the Administrator of the Substance Abuse and Mental Health Services Administration; and

(2) are not terminated by this Act.

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

(1) in paragraph (17), by striking ''and'' at the end;

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

(3) by adding at the end the following:

''(19) evaluate, in consultation with the Assistant Secretary for Financial Resources, the information used for oversight of grants under programs related to mental and substance use disorders, includ-

ing co-occurring disorders, administered by the Center for Mental Health Services;

''(20) periodically review Federal programs and activities relating to the diagnosis or prevention of, or treatment or rehabilitation for, mental illness and substance use disorders to identify any such programs or activities that have proven to be effective or efficient in improving outcomes or increasing access to evidence-based programs;

''(21) establish standards for the appointment of peer-review panels to evaluate grant applications and recommend standards for mental health grant programs; and''.

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

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

''(A) the capacity of the grantee to implement the award;

''(B) requirements for the description of the program implementation approach;

''(C) the extent to which the grant plan submitted by the grantee as part of its application must explain how the grantee will reach the population of focus and provide a statement of need, including to what extent the grantee will increase the number of clients served and the estimated percentage of clients receiving services who report positive functioning after 6 months or no past-month substance use, as applicable;

''(D) the extent to which the grantee must collect and report on required performance measures; and

''(E) the extent to which the grantee is proposing evidence-based practices and the extent to which—

''(i) those evidence-based practices must be used with respect to a population similar to the population for which the evidence-based practices were shown to be effective; or

''(ii) if no evidence-based practice exists for a population of focus, the way in

which the grantee will implement adaptations of evidence-based practices, promising practices, or cultural practices.''.

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

(1) in subsection (b)—

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

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

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

(2) in subsection (c), by striking ''(4), (5), and (6)'' each place it appears and inserting ''(5), (6), and (7)''.

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

(1) by striking ''Administrator of the Substance Abuse and Mental Health Services Administration'' each place it appears and inserting ''Assistant Secretary for Mental Health and Substance Use''; and

(2) by striking ''Administrator'' each place it appears and inserting ''Assistant Secretary'', except where the term ''Administrator'' appears within the term—

(A) Associate Administrator;

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

(C) Administrator of the Centers for Medicare & Medicaid Services; or

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

(g) REFERENCES.—After executing subsections (a), (b), and (e), any reference in statute, regulation, or guidance to the Administrator of the Substance Abuse and Mental Health Services Administration shall be construed to be a reference to the Assistant Secretary for Mental Health and Substance Use.

SEC. 102. IMPROVING OVERSIGHT OF MENTAL HEALTH AND SUBSTANCE USE PROGRAMS.

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

"SEC. 501A. IMPROVING OVERSIGHT OF MENTAL HEALTH AND SUBSTANCE USE PROGRAMS.

''(a) ACTIVITIES.—For the purpose of ensuring efficient and effective planning and evaluation of mental and substance use disorder programs and related activities, the Assistant Secretary for Planning and Evaluation, in consultation with the Assistant Secretary for Mental Health and Substance Use, shall—

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

''(2) evaluate programs related to mental and substance use disorders, including co-occurring disorders, across Federal departments and agencies, as appropriate, including programs related to—

''(A) prevention, intervention, treatment, and recovery support services, including such services for individuals with a serious mental illness or serious emotional disturbance;

''(B) the reduction of homelessness and involvement with the criminal justice system among individuals with a mental or substance use disorder; and

''(C) public health and health services; and

''(3) consult, as appropriate, with the Assistant Secretary, the Behavioral Health Coordinating Council of the Department of Health and Human Services, other agencies within the Department of Health and Human Services, and other relevant Federal departments.

''(b) RECOMMENDATIONS.—The Assistant Secretary for Planning and Evaluation shall develop an evaluation strategy that identifies priority programs to be evaluated by the Assistant Secretary and priority programs to be evaluated by other relevant agencies within the Department of Health and Human Services. The Assistant Secretary shall provide recommendations on improving programs and activities based on the evaluation described in subsection (a)(2) as needing improvement.''.

SEC. 103. NATIONAL MENTAL HEALTH AND SUBSTANCE USE POLICY LABORATORY.

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

''SEC. 501B. NATIONAL MENTAL HEALTH AND SUBSTANCE USE POLICY LABORATORY.

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

stance Use Policy Laboratory (referred to in this section as the 'Laboratory').

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

''(1) continue to carry out the authorities and activities that were in effect for the Office of Policy, Planning, and Innovation as such Office existed prior to the date of enactment of the Helping Families in Mental Health Crisis Act of 2016;

''(2) identify, coordinate, and facilitate the implementation of policy changes likely to have a significant effect on mental health, mental illness, and the prevention and treatment of substance use disorder services;

''(3) collect, as appropriate, information from grantees under programs operated by the Administration in order to evaluate and disseminate information on evidence-based practices, including culturally and linguistically appropriate services, as appropriate, and service delivery models;

''(4) provide leadership in identifying and coordinating policies and programs, including evidence-based programs, related to mental and substance use disorders;

''(5) recommend ways in which payers may implement program and policy findings of the Adminis-

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

''(6) in consultation with the Assistant Secretary for Planning and Evaluation, as appropriate, periodically review Federal programs and activities relating to the diagnosis or prevention of, or treatment or rehabilitation for, mental illness and substance use disorders, including by—

''(A) identifying any such programs or activities that are duplicative;

''(B) identifying any such programs or activities that are not evidence-based, effective, or efficient; and

''(C) formulating recommendations for coordinating, eliminating, or improving programs or activities identified under subparagraph (A), (B), or (C), and merging such programs or activities into other successful programs or activities; and

''(7) carry out other activities as deemed necessary to continue to encourage innovation and disseminate evidence-based programs and practices, including programs and practices with scientific merit.

''(c) EVIDENCE-BASED PRACTICES AND SERVICE DELIVERY MODELS.—

''(1) IN GENERAL.—In selecting evidence-based best practices and service delivery models for evaluation and dissemination, the Laboratory—

''(A) shall give preference to models that improve—

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

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

''(iii) the cost effectiveness, quality, effectiveness, and efficiency of health care services furnished to individuals with serious mental illness or serious emotional disturbance, in mental health crisis, or at risk to themselves, their families, and the general public; and

''(B) may include clinical protocols and practices used in the Recovery After Initial Schizophrenia Episode (RAISE) project and the North American Prodrome Longitudinal Study (NAPLS) of the National Institute of Mental Health.

''(2) DEADLINE FOR BEGINNING IMPLEMENTATION.—The Laboratory shall begin implementation

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

''(3) CONSULTATION.—In carrying out the duties under this subsection, the Laboratory shall consult with—

''(A) representatives of the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism, on an ongoing basis;

''(B) other appropriate Federal agencies;

''(C) clinical and analytical experts with expertise in psychiatric medical care and clinical psychological care, health care management, education, corrections health care, and mental health court systems, as appropriate; and

''(D) other individuals and agencies as determined appropriate by the Assistant Secretary.''.

SEC. 104. PEER-SUPPORT SPECIALIST PROGRAMS.

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

Substance Abuse and Mental Health Services Administration and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report containing the results of such study.

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

(1) hours of formal work or volunteer experience related to mental and substance use disorders conducted through such programs;

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

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

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

(5) requirements for continuing education.

SEC. 105. PROHIBITION AGAINST LOBBYING USING FEDERAL FUNDS BY SYSTEMS ACCEPTING FEDERAL FUNDS TO PROTECT AND ADVOCATE THE RIGHTS OF INDIVIDUALS WITH MENTAL ILLNESS.

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

(1) in paragraph (9), by striking ''and'' at the end;

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

(3) by adding at the end the following:

''(11) agree to refrain, during any period for which funding is provided to the system under this part, from using Federal funds to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local, or tribal government in policymaking

and administrative processes within the executive branch of that government;''.

SEC. 106. REPORTING FOR PROTECTION AND ADVOCACY ORGANIZATIONS.

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

(b) DETAILED ACCOUNTING.—Section 114(a) of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10824(a)) is amended—

(1) in paragraph (3), by striking ''and'' at the end;

(2) in paragraph (4), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(5) using data from the existing required annual program progress reports submitted by each system funded under this title, a detailed accounting for each such system of how funds are spent, disaggregated according to whether the funds were received from the Federal Government, the State government, a local government, or a private entity.''.

SEC. 107. GRIEVANCE PROCEDURE.

Section 105 of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10805), as amended, is further amended by adding at the end the following:

''(d) GRIEVANCE PROCEDURE.—The Secretary shall establish an independent grievance procedure for persons described in subsection (a)(9).''.

SEC. 108. CENTER FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY.

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

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

''(4) The Center for Behavioral Health Statistics and Quality.'';

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

(A) in subparagraph (C), by striking ''and'' at the end;

(B) in subparagraph (D), by striking the period at the end and inserting ''and''; and

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

''(E) the Center for Behavioral Health Statistics and Quality.''; and

(3) in part B (42 U.S.C. 290bb et seq.) by adding at the end the following new subpart:

"Subpart 4—Center for Behavioral Health Statistics and Quality

"SEC. 520L. CENTER FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY.

''(a) ESTABLISHMENT.—There is established in the Administration a Center for Behavioral Health Statistics and Quality (in this section referred to as the 'Center'). The Center shall be headed by a Director (in this section referred to as the 'Director') appointed by the Secretary from among individuals with extensive experience and academic qualifications in research and analysis in behavioral health care or related fields.

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

''(1) coordinate the Administration's integrated data strategy by coordinating—

''(A) surveillance and data collection (including that authorized by section 505);

''(B) evaluation;

''(C) statistical and analytic support;

''(D) service systems research; and

''(E) performance and quality information systems;

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

''(3) coordinate evaluation efforts for the grant programs, contracts, and collaborative agreements of the Administration.

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

''(1) the number of patients screened positive for unhealthy alcohol use who receive brief counseling as appropriate; the number of patients screened positive for tobacco use and receiving smoking cessation interventions; the number of patients with a new diagnosis of major depressive episode who are assessed for suicide risk; the number of patients screened positive for clinical depression with a documented followup plan; and the number of patients with a documented pain assessment that have a followup treatment plan when pain is present; and satisfaction with care;

''(2) the incidence and prevalence of substance use and mental disorders; the number of suicide attempts and suicide completions; overdoses seen in emergency rooms resulting from alcohol and drug use; emergency room boarding; overdose deaths; emergency psychiatric hospitalizations; new criminal justice involvement while in treatment; stable housing; and rates of involvement in employment, education, and training; and

''(3) such other measures for outcomes of services as the Director may determine.

''(d) STAFFING COMPOSITION.—The staff of the Center may include individuals with advanced degrees and field expertise as well as clinical and research experience in mental and substance use disorders such as—

''(1) professionals with clinical and research expertise in the prevention and treatment of, and recovery from, substance use and mental disorders;

''(2) professionals with training and expertise in statistics or research and survey design and methodologies; and

''(3) other related fields in the social and behavioral sciences, as specified by relevant position descriptions.

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

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

SEC. 109. STRATEGIC PLAN.

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

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

(2) by inserting after subsection (k) the following:

''(l) STRATEGIC PLAN.—

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

''(2) COORDINATION.—In developing and carrying out the strategic plan under this section, the

Assistant Secretary shall take into consideration the report of the Interdepartmental Serious Mental Illness Coordinating Committee under section 301 of such Act.

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

''(A) submit the strategic plan developed under paragraph (1) to the appropriate committees of Congress; and

''(B) post such plan on the Internet website of the Administration.

''(4) CONTENTS.—The strategic plan developed under paragraph (1) shall—

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

''(B) identify ways to improve services for individuals with a mental or substance use disorder, including services related to the prevention of, diagnosis of, intervention in, treatment of, and recovery from, mental or substance use

disorders, including serious mental illness or serious emotional disturbance, and access to services and supports for individuals with a serious mental illness or serious emotional disturbance;

''(C) ensure that programs provide, as appropriate, access to effective and evidence-based prevention, diagnosis, intervention, treatment, and recovery services, including culturally and linguistically appropriate services, as appropriate, for individuals with a mental or substance use disorder;

''(D) identify opportunities to collaborate with the Health Resources and Services Administration to develop or improve—

''(i) initiatives to encourage individuals to pursue careers (especially in rural and underserved areas and populations) as psychiatrists, psychologists, psychiatric nurse practitioners, physician assistants, occupational therapists, clinical social workers, certified peer support specialists, licensed professional counselors, or other licensed or certified mental health professionals, including such professionals specializing in the diagnosis, evaluation, or

treatment of individuals with a serious mental illness or serious emotional disturbance; and

''(ii) a strategy to improve the recruitment, training, and retention of a workforce for the treatment of individuals with mental or substance use disorders, or co-occurring disorders;

''(E) identify opportunities to improve collaboration with States, local governments, communities, and Indian tribes and tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)); and

''(F) specify a strategy to disseminate evidenced-based and promising best practices related to prevention, diagnosis, early intervention, treatment, and recovery services related to mental illness, particularly for individuals with a serious mental illness and children and adolescents with a serious emotional disturbance, and substance use disorders.''.

SEC. 110. AUTHORITIES OF CENTERS FOR MENTAL HEALTH SERVICES AND SUBSTANCE ABUSE TREATMENT.

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

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

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

''(3) collaborate with the Director of the National Institute of Mental Health to ensure that, as appropriate, programs related to the prevention and treatment of mental illness and the promotion of mental health are carried out in a manner that reflects the best available science and evidence-based practices, including culturally and linguistically appropriate services;'';

(3) in paragraph (5), as so redesignated, by inserting ''through policies and programs that reduce risk and promote resiliency'' before the semicolon;

(4) in paragraph (6), as so redesignated, by inserting ''in collaboration with the Director of the National Institute of Mental Health,'' before ''develop'';

(5) in paragraph (8), as so redesignated, by inserting ‘‘, increase meaningful participation of individuals with mental illness in programs and activities of the Administration,’’ before ‘‘and protect the legal’’;

(6) in paragraph (10), as so redesignated, by striking ‘‘professional and paraprofessional personnel pursuant to section 303’’ and inserting ‘‘paraprofessional personnel and health professionals’’;

(7) in paragraph (11), as so redesignated, by inserting ‘‘and telemental health,’’ after ‘‘rural mental health,’’;

(8) in paragraph (12), as so redesignated, by striking ‘‘establish a clearinghouse for mental health information to assure the widespread dissemination of such information’’ and inserting ‘‘disseminate mental health information, including evidenced-based practices,’’;

(9) in paragraph (15), as so redesignated, by striking ‘‘and’’ at the end;

(10) in paragraph (16), as so redesignated, by striking the period and inserting ‘‘; and’’; and

(11) by adding at the end the following:

''(17) consult with other agencies and offices of the Department of Health and Human Services to ensure, with respect to each grant awarded by the Center for Mental Health Services, the consistent documentation of the application of criteria when awarding grants and the ongoing oversight of grantees after such grants are awarded.''.

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

(1) in subsection (a)—

(A) by striking ''treatment of substance abuse'' and inserting ''treatment of substance use disorders''; and

(B) by striking ''abuse treatment systems'' and inserting ''use disorder treatment systems''; and

(2) in subsection (b)—

(A) in paragraph (3), by striking ''abuse'' and inserting ''use disorder'';

(B) in paragraph (4), by striking ''individuals who abuse drugs'' and inserting ''individuals who use drugs'';

(C) in paragraph (9), by striking ''carried out by the Director'';

(D) by striking paragraph (10);

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

(F) in paragraph (12), as so redesignated, by striking ''; and'' and inserting a semicolon; and

(G) by striking paragraph (13), as so redesignated, and inserting the following:

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

''(14) work with States, providers, and individuals in recovery, and their families, to promote the expansion of recovery support services and systems of care oriented towards recovery.''.

SEC. 111. ADVISORY COUNCILS.

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

(1) in paragraph (2)—

(A) in subparagraph (E), by striking ''and'' after the semicolon;

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

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

''(F) for the advisory councils appointed under subsections (a)(1)(A) and (a)(1)(D), the Director of the National Institute of Mental Health;

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

''(H) for the advisory councils appointed under subsections (a)(1)(A), (a)(1)(B), and (a)(1)(C), the Director of the National Institute on Alcohol Abuse and Alcoholism; and''; and

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

''(C) Not less than half of the members of the advisory council appointed under subsection (a)(1)(D)—

''(i) shall have—

''(I) a medical degree;

''(II) a doctoral degree in psychology; or

''(III) an advanced degree in nursing or social work from an ac-

credited graduate school or be a certified physician assistant; and

''(ii) shall specialize in the mental health field.''.

SEC. 112. PEER REVIEW.

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

TITLE II—MEDICAID MENTAL HEALTH COVERAGE

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

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

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

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

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

SEC. 202. OPTIONAL LIMITED COVERAGE OF INPATIENT SERVICES FURNISHED IN INSTITUTIONS FOR MENTAL DISEASES.

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

''(I)(i) Notwithstanding the limitation specified in the subdivision (B) following paragraph (29) of section 1905(a) and subject to clause (ii), a State may, under a risk contract entered into by the State under this title (or under section 1115) with a medicaid managed care organization or a prepaid inpatient health plan (as defined in

section 438.2 of title 42, Code of Federal Regulations (or any successor regulation)), make a monthly capitation payment to such organization or plan for enrollees with the organization or plan who are over 21 years of age and under 65 years of age and are receiving inpatient treatment in an institution for mental diseases (as defined in section 1905(i)), so long as each of the following conditions is met:

''(I) The institution is a hospital providing inpatient psychiatric or substance use disorder services or a sub-acute facility providing psychiatric or substance use disorder crisis residential services.

''(II) The length of stay in such an institution for such treatment is for a short-term stay of no more than 15 days during the period of the monthly capitation payment.

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

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

for the covered service or setting under the State plan.

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

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

''(ii) For purposes of setting the amount of such a monthly capitation payment, a State may use the utilization of services provided to an individual under this subparagraph when developing the inpatient psychiatric or substance use disorder component of such payment, but the amount of such payment for such services may not exceed the cost of the same services furnished through providers included under the State plan.''.

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

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

(a) STUDY.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall conduct a study on coverage under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) of services provided through a medicaid managed care organization (as defined in section 1903(m) of such Act (42 U.S.C. 1396b(m)) or a prepaid inpatient health plan (as defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation)) with respect to individuals over the age of 21 and under the age of 65 for the treatment of a mental health disorder in institutions for mental diseases (as defined in section 1905(i) of such Act (42 U.S.C. 1396d(i))). Such study shall include information on the following:

(1) The extent to which States, including the District of Columbia and each territory or possession of the United States, are providing capitated payments to such organizations or plans for enrollees who are receiving services in institutions for mental diseases.

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

stitutions for mental diseases through such organizations and plans.

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

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

(5) The extent to which the provision of services within such institutions has affected the capitated payments for such organizations or plans.

(b) REPORT.—Not later than three years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a).

SEC. 204. GUIDANCE ON OPPORTUNITIES FOR INNOVATION.

Not later than one year after the date of the enactment of this Act, the Administrator of the Centers for Medicare & Medicaid Services shall issue a State Medicaid

Director letter regarding opportunities to design innovative service delivery systems, including systems for providing community-based services, for individuals with serious mental illness or serious emotional disturbance who are receiving medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.). The letter shall include opportunities for demonstration projects under section 1115 of such Act (42 U.S.C. 1315), to improve care for such individuals.

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

(a) COLLECTION OF INFORMATION.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall, with respect to each State that has participated in the demonstration project established under section 2707 of the Patient Protection and Affordable Care Act (42 U.S.C. 1396a note), collect from each such State information on the following:

(1) The number of institutions for mental diseases (as defined in section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i))) and beds in such institutions that received payment for the provision of services to individuals who receive medical assistance under a State plan under the Medicaid pro-

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

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

(3) The number of forensic psychiatric hospitals, the number of beds in such hospitals, and the number of forensic psychiatric beds in other hospitals in such State, based on the most recent data available, to the extent practical, as determined by such Administrator.

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

for mental diseases in the State received during the period beginning on July 1, 2012, and ending on June 30, 2015, and the extent to which the demonstration project reduced the amount of such payments.

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

(A) the types of such facilities or sites (such as an institution for mental diseases, a hospital emergency department, or other inpatient hospital);

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

(C) the payment rate under the State plan (or a waivers of such plan) for services furnished to such an individual for that treatment, disaggregated by facility type, during the period

in which the demonstration project is in operation.

(6) The extent to which the utilization of hospital emergency departments during the period in which the demonstration project was is in operation differed, with respect to individuals who are receiving medical assistance under a State plan under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or under a waiver of such plan), between—

(A) those individuals who received treatment in an institution for mental diseases under the demonstration project;

(B) those individuals who met the eligibility requirements for the demonstration project but who did not receive treatment in an institution for mental diseases under the demonstration project; and

(C) those individuals with serious mental illness who did not meet such eligibility requirements and did not receive treatment for such illness in an institution for mental diseases.

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

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

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

Section 1905(a)(16) of the Social Security Act (42 U.S.C. 1396d(a)(16)) is amended by inserting before the semicolon at the end the following: ", and, effective January 1, 2019, the full-range of early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for such individuals whether or not such screening, diagnostic, and treatment services are furnished by the provider of inpatient psychiatric hospital services for individuals under age 21".

SEC. 207. ELECTRONIC VISIT VERIFICATION SYSTEM REQUIRED FOR PERSONAL CARE SERVICES AND HOME HEALTH CARE SERVICES UNDER MEDICAID.

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

"(l)(1) Subject to paragraphs (3) and (4), with respect to any amount expended for personal care services

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

''(A) in the case of personal care services—

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

''(ii) for calendar quarters in 2021, by .5 percentage points;

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

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

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

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

''(ii) for calendar quarters in 2025, by .5 percentage points;

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

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

''(2) Subject to paragraphs (3) and (4), in implementing the requirement for the use of an electronic visit verification system under paragraph (1), a State shall—

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

''(i) is minimally burdensome;

''(ii) takes into account existing best practices and electronic visit verification systems in use in the State; and

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

''(B) take into account a stakeholder process that includes input from beneficiaries, family caregivers, personal care or home health care services workers, and other stakeholders, as determined by the State in accordance with guidance from the Secretary; and

''(C) ensure that individuals who furnish personal care services, home health care services, or both under the State plan (or under a waiver of the plan) are provided the opportunity for training on the use of such system.

''(3) Paragraphs (1) and (2) shall not apply in the case of a State that, as of the date of the enactment of this subsection, requires the use of any system for the electronic verification of visits conducted as part of both personal care services and home health care services.

''(4)(A) In the case of a State described in subparagraph (B), the reduction under paragraph (1) shall not apply—

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

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

''(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that demonstrates to the Secretary that the State—

''(i) has made a good faith effort to comply with the requirements of paragraphs (1) and (2) (including by taking steps to adopt the technology used for an electronic visit verification system); or

''(ii) in implementing such a system, has encountered unavoidable system delays.

''(5) In this subsection:

''(A) The term 'electronic visit verification system' means, with respect to personal care services or home health care services, a system under which visits conducted as part of such services are electronically verified with respect to—

''(i) the type of service performed;

''(ii) the individual receiving the service;

''(iii) the date of the service;

''(iv) the location of service delivery;

''(v) the individual providing the service; and

''(vi) the time the service begins and ends.

''(B) The term 'home health care services' means services described in section 1905(a)(7) provided under a State plan under this title (or under a waiver of the plan).

''(C) The term 'personal care services' means personal care services provided under a State plan under this title (or under a waiver of the plan), including services provided under section 1905(a)(24), 1915(c), 1915(i), 1915(j), or 1915(k) or under a wavier under section 1115.

''(6)(A) In the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system operated by the State or a contractor on behalf of the State, the Secretary shall pay to the State, for each quarter, an amount equal to 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such system, and 75 per centum of so much of the sums for the operation and maintenance of such system.

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

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

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

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

(2) the provision of notice and educational materials to family caregivers and beneficiaries with respect to the use of such electronic visit verification systems and other means to prevent such fraud.

(c) RULES OF CONSTRUCTION.—

(1) NO EMPLOYER-EMPLOYEE RELATIONSHIP ESTABLISHED.—Nothing in the amendment made by this section may be construed as establishing an employer-employee relationship between the agency or entity that provides for personal care services or home health care services and the individuals who, under a contract with such an agency or entity, furnish such services for purposes of part 552 of title 29, Code of Federal Regulations (or any successor regulations).

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

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

(3) NO LIMITS ON PROVISION OF CARE.—Nothing in the amendment made by this section may be construed to limit, with respect to personal care services or home health care services provided under a State plan under title XIX of the Social Security Act (or under a waiver of the plan), provider selection, constrain beneficiaries' selection of a caregiver, or impede the manner in which care is delivered.

(4) NO PROHIBITION ON STATE QUALITY MEASURES REQUIREMENTS.—Nothing in the amendment made by this section shall be construed as prohibiting a State, in implementing an electronic visit verification system (as defined in subsection (l)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), from establishing requirements related to quality measures for such system.

TITLE III—INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE

SEC. 301. INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 3 months after the date of enactment of this Act, the Secretary of Health and Human Services, or the designee of the Secretary, shall establish a committee to be known as the ''Interdepartmental Serious Mental Illness Coordinating Committee'' (in this section referred to as the ''Committee'').

(2) FEDERAL ADVISORY COMMITTEE ACT.—Except as provided in this section, the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Committee.

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

(c) RESPONSIBILITIES.—Not later than 1 year after the date of enactment of this Act, and 5 years after such date of enactment, the Committee shall submit to Congress a report including—

(1) a summary of advances in serious mental illness and serious emotional disturbance research related to the prevention of, diagnosis of, intervention in, and treatment and recovery of, serious mental illnesses, serious emotional disturbances, and advances in access to services and support for individuals with a serious mental illness or serious emotional disturbance;

(2) an evaluation of the effect on public health of Federal programs related to serious mental illness or serious emotional disturbance, including measurements of public health outcomes such as—

(A) rates of suicide, suicide attempts, prevalence of serious mental illness, serious emotional disturbances, and substance use disorders, overdose, overdose deaths, emergency hospitalizations, emergency room boarding, preventable emergency room visits, involvement with the criminal justice system, crime, homelessness, and unemployment;

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

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

(D) any other criteria as may be determined by the Secretary;

(3) a plan to improve outcomes for individuals with serious mental illness or serious emotional disturbances, including reducing incarceration for such individuals, reducing homelessness, and increasing employment; and

(4) specific recommendations for actions that agencies can take to better coordinate the administration of mental health services for people with serious mental illness or serious emotional disturbances.

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

(e) MEMBERSHIP.—

(1) FEDERAL MEMBERS.—The Committee shall be composed of the following Federal representatives, or their designees:

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

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

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

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

(E) The Attorney General of the United States.

(F) The Secretary of Veterans Affairs.

(G) The Secretary of Defense.

(H) The Secretary of Housing and Urban Development.

(I) The Secretary of Education.

(J) The Secretary of Labor.

(K) The Commissioner of Social Security.

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

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

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

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

a serious mental illness or serious emotional disturbance;

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

(D) at least 2 members shall be—

(i) a licensed psychiatrist with experience treating serious mental illnesses or serious emotional disturbances;

(ii) a licensed psychologist with experience treating serious mental illnesses or serious emotional disturbances;

(iii) a licensed clinical social worker with experience treating serious mental illness or serious emotional disturbances; or

(iv) a licensed psychiatric nurse, nurse practitioner, or physician assistant with experience treating serious mental illnesses or serious emotional disturbances;

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

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

(G) at least 1 member shall be a mental health professional who has research or clinical mental health experience working with medically underserved populations;

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

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

(J) at least 1 member shall be a law enforcement officer or corrections officer with extensive experience in interfacing with individuals with a serious mental illness or serious emotional disturbance, or in a mental health crisis; and

(K) at least 1 member shall be a homeless services provider with experience working with individuals with serious mental illness, with serious emotional disturbance, or having mental health crisis.

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

(f) WORKING GROUPS.—In carrying out its functions, the Committee may establish working groups. Such working groups shall be composed of Committee members, or their designees, and may hold such meetings as are necessary.

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

TITLE IV—COMPASSIONATE COMMUNICATION ON HIPAA

SEC. 401. SENSE OF CONGRESS.

(a) FINDINGS.—Congress finds the following:

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

(2) Persons with serious mental illness (in this section referred to as ''SMI''), including schizo-

phrenia spectrum, bipolar disorders, and major depressive disorder, may be significantly impaired in their ability to understand or make sound decisions for their care and needs. By nature of their illness, cognitive impairments in reasoning and judgment, as well as the presence of hallucinations, delusions, and severe emotional distortions, they may lack the awareness they even have a mental illness (a condition known as anosognosia), and thus may be unable to make sound decisions regarding their care, nor follow through consistently and effectively on their care needs.

(3) Persons with mental illness or SMI may require and benefit from mental health treatment in order to recover to the fullest extent of their ability; these beneficial interventions may include psychiatric care, psychological care, medication, peer support, educational support, employment support, and housing support.

(4) Persons with SMI who are provided with professional and supportive services may still experience times when their symptoms may greatly impair their abilities to make sound decisions for their personal care or may discontinue their care as a result of this impaired decision making resulting in a fur-

ther deterioration of their condition. They may experience a temporary or prolonged impairment as a result of their diminished capacity to care for themselves.

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

(6) Persons with SMI—

(A) are at high risk for other chronic physical illnesses, with approximately 50 percent having two or more co-occurring chronic physical illnesses such as cardiac, pulmonary, cancer, and endocrine disorders; and

(B) have three times the odds of having chronic bronchitis, five times the odds of having emphysema, and four times the odds of having COPD, are more than four times as likely to have fluid and electrolyte disorders, and are nearly three times as likely to be nicotine dependent.

(7) Some psychotropic medications, such as second generation antipsychotics, significantly increase risk for chronic illnesses such as diabetes and cardiovascular disease.

(8) When the individual fails to seek or maintain treatment for these physical conditions over a long term, it can result in the individual becoming gravely disabled, or developing life-threatening illnesses. Early and consistent treatment can ameliorate or reduce symptoms or cure the disease.

(9) Persons with SMI die 7 to 24 years earlier than their age cohorts primarily because of complications from their chronic physical illness and fail to seek or maintain treatment resulting from emotional and cognitive impairments from their SMI.

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

(11) When the individual with SMI is significantly diminished in their capacity to care for themselves long term or acutely, other supportive interventions to assist their care may be necessary to protect their health and safety.

(12) Prognosis for the physical and psychiatric health of those with SMI may improve when responsible caregivers facilitate and participate in care.

(13) When an individual with SMI is chronically incapacitated in their ability to care for themselves, caregivers can pursue legal guardianship to facilitate care in appropriate areas while being mindful to allow the individual to make decisions for themselves in areas where they are capable.

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

(15) All professional and support efforts should be made to help the individual with SMI and experience acute or chronic physical illnesses to understand and follow through on treatment.

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

sible under HIPAA rules. This confusion may hinder communication with responsible caregivers who may be able to facilitate care for the patient with SMI in instances when the individual does not give permission for disclosure.

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

SEC. 402. CONFIDENTIALITY OF RECORDS.

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

submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate, and make publicly available, a report on the findings of such stakeholders.

SEC. 403. CLARIFICATION OF CIRCUMSTANCES UNDER WHICH DISCLOSURE OF PROTECTED HEALTH INFORMATION IS PERMITTED.

(a) IN GENERAL.—Not later than one year after the date of enactment of this section, the Secretary of Health and Human Services shall promulgate final regulations clarifying the circumstances under which, consistent with the provisions of subpart C of title XI of the Social Security Act and regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, a health care provider or covered entity may disclose the protected health information of a patient with a mental illness, including for purposes of—

(1) communicating (including with respect to treatment, side effects, risk factors, and the availability of community resources) with a family member of such patient, caregiver of such patient, or other individual to the extent that such family member, caregiver, or individual is involved in the care of the patient;

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

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

(4) considering the patient's capacity to agree or object to the sharing of the protected health information of the patient;

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

(A) the patient consents;

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

(C) the patient does not consent and the patient is not incapacitated or in an emergency circumstance, but the ability of the patient to make rational health care decisions is significantly diminished by reason of the physical or mental health condition of the patient; and

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

terioration of the patient's mental or physical health;

(6) involving a patient's family members, caregivers, or others involved in the patient's care or care plan, including facilitating treatment and medication adherence, in dealing with patient failures to adhere to medication or other therapy;

(7) listening to or receiving information with respect to the patient from the family or caregiver of such patient receiving mental illness treatment;

(8) communicating with family members of the patient, caregivers of patient, law enforcement, or others when the patient presents a serious and imminent threat of harm to self or others; and

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

(b) COORDINATION.—The Secretary of Health and Human Services shall carry out this section in coordination with the Director of the Office for Civil Rights within the Department of Health and Human Services.

(c) CONSISTENCY WITH GUIDANCE.—The Secretary of Health and Human Services shall ensure that the regulations under this section are consistent with the guidance entitled ''HIPAA Privacy Rule and Sharing Information Related to Mental Health'', issued by the Department of Health and Human Services on February 20, 2014.

SEC. 404. DEVELOPMENT AND DISSEMINATION OF MODEL TRAINING PROGRAMS.

(a) INITIAL PROGRAMS AND MATERIALS.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop and disseminate—

(1) a model program and materials for training health care providers (including physicians, emergency medical personnel, psychologists, counselors, therapists, behavioral health facilities and clinics, care managers, and hospitals) regarding the circumstances under which, consistent with the standards governing the privacy and security of individually identifiable health information promulgated by the Secretary under sections 262(a) and 264 of the Health Insurance Portability and Accountability Act of 1996, the protected health information of patients

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

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

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

(b) PERIODIC UPDATES.—The Secretary shall—

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

(2) disseminate the updated model programs and materials.

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

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

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

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

(f) FUNDING.—There are authorized to be appropriated to carry out this section $4,000,000 for fiscal year 2018, $2,000,000 for each of fiscal years 2019 and 2020, and $1,000,000 for each of fiscal years 2021 and 2022.

TITLE V—INCREASING ACCESS TO TREATMENT FOR SERIOUS MENTAL ILLNESS

SEC. 501. ASSERTIVE COMMUNITY TREATMENT GRANT PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

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

"SEC. 520M. ASSERTIVE COMMUNITY TREATMENT GRANT PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

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

''(1) to establish assertive community treatment programs for individuals with serious mental illness; or

''(2) to maintain or expand such programs.

''(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall be a State, county, city, tribe, tribal organization, mental health system, health care facility, or any other entity the Assistant Secretary deems appropriate.

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

''(d) ADDITIONAL ACTIVITIES.—The Assistant Secretary shall—

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

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

''(A) cost savings and public health outcomes such as mortality, suicide, substance abuse, hospitalization, and use of services;

''(B) rates of involvement with the criminal justice system of patients;

''(C) rates of homelessness among patients; and

''(D) patient and family satisfaction with program participation; and

''(2) provide appropriate information, training, and technical assistance to grant recipients under this section to help such recipients to establish, maintain, or expand their assertive community treatment programs.

''(e) AUTHORIZATION OF APPROPRIATIONS.—

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

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

SEC. 502. STRENGTHENING COMMUNITY CRISIS RESPONSE SYSTEMS.

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

"SEC. 520F. STRENGTHENING COMMUNITY CRISIS RESPONSE SYSTEMS.

''(a) IN GENERAL.—The Secretary shall award competitive grants—

''(1) to State and local governments and Indian tribes and tribal organizations to enhance community-based crisis response systems; or

''(2) to States to develop, maintain, or enhance a database of beds at inpatient psychiatric facilities, crisis stabilization units, and residential community mental health and residential substance use disorder treatment facilities, for individuals with serious mental illness, serious emotional disturbance, or substance use disorders.

''(b) APPLICATION.—

''(1) IN GENERAL.—To receive a grant or cooperative agreement under subsection (a), an entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

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

''(A) promoting integration and coordination between local public and private entities engaged in crisis response, including first responders, emergency health care providers, primary care providers, law enforcement, court systems, health care payers, social service providers, and behavioral health providers;

''(B) developing a plan for entering into memoranda of understanding with public and private entities to implement crisis response services;

''(C) expanding the continuum of community-based services to address crisis intervention and prevention; and

''(D) developing models for minimizing hospital readmissions, including through appropriate discharge planning.

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

tient psychiatric facilities and crisis stabilization units, and residential community mental health and residential substance use disorder treatment facilities to facilitate the identification and designation of facilities for the temporary treatment of individuals in mental or substance use disorder crisis.

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

''(1) includes information on inpatient psychiatric facilities, crisis stabilization units, and residential community mental health and residential substance use disorder facilities in the State involved, including contact information for the facility or unit;

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

''(3) enables searches of the database to identify available beds that are appropriate for the treat-

ment of individuals in mental or substance use disorder crisis.

''(d) EVALUATION.—An entity receiving a grant under subsection (a)(1) shall submit to the Secretary, at such time, in such manner, and containing such information as the Secretary may reasonably require, a report, including an evaluation of the effect of such grant on—

''(1) local crisis response services and measures of individuals receiving crisis planning and early intervention supports;

''(2) individuals reporting improved functional outcomes; and

''(3) individuals receiving regular followup care following a crisis.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $5,000,000 for the period of fiscal years 2018 through 2022.''.

SEC. 503. INCREASED AND EXTENDED FUNDING FOR ASSISTED OUTPATIENT GRANT PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

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

(1) in paragraph (1), by striking ''2018'' and inserting ''2022''; and

(2) in paragraph (2), by striking ''is authorized to be appropriated to carry out this section $15,000,000 for each of fiscal years 2015 through 2018'' and inserting ''are authorized to be appropriated to carry out this section $15,000,000 for each of fiscal years 2015 through 2017, $20,000,000 for fiscal year 2018, $19,000,000 for each of fiscal years 2019 and 2020, and $18,000,000 for each of fiscal years 2021 and 2022''.

SEC. 504. LIABILITY PROTECTIONS FOR HEALTH PROFESSIONAL VOLUNTEERS AT COMMUNITY HEALTH CENTERS.

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

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

was made under paragraph (4)(C). The preceding sentence is subject to the provisions of this subsection.

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

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

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

''(C) The health care practitioner does not receive any compensation for the service from the individual or from any third-party payer (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program), except that the health care practitioner may receive repayment from the entity described in subsection (g)(4) for reasonable expenses incurred by the health care practitioner in the provision of the service to the individual.

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

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

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

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

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

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

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

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

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

''(D) Subsection (g)(1)(F) applies to a health care practitioner for purposes of this subsection only to the extent that, in providing health services to an individual, each of the conditions specified in paragraph (2) is met.

''(4)(A) Amounts in the fund established under subsection (k)(2) shall be available for transfer under subparagraph (C) for purposes of carrying out this subsection.

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

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

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

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

''(i) the Secretary may issue regulations for carrying out this subsection, and the Secretary may accept and consider applications submitted pursuant to paragraph (3)(B); and

''(ii) reports under paragraph (4)(B) may be submitted to the Congress.''.

TITLE VI—SUPPORTING INNOVATIVE AND EVIDENCE-BASED PROGRAMS

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

SEC. 601. ENCOURAGING INNOVATION AND EVIDENCE-BASED PROGRAMS.

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

(1) by redesignating subsection (d) as subsection (e); and

(2) by inserting after subsection (c) the following new subsection:

''(d) PROMOTING INNOVATION.—

''(1) IN GENERAL.—The Assistant Secretary, in coordination with the Laboratory, may award grants to States, local governments, Indian tribes or tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act), educational institutions, and non-profit organizations to develop evidence-based interventions, including culturally and linguistically appropriate services, as appropriate, for—

''(A) evaluating a model that has been scientifically demonstrated to show promise, but would benefit from further applied development, for—

''(i) enhancing the prevention, diagnosis, intervention, treatment, and recovery of mental illness, serious emotional disturbance, substance use disorders, and co-occurring disorders; or

''(ii) integrating or coordinating physical health services and mental and substance use disorder services; and

''(B) expanding, replicating, or scaling evidence-based programs across a wider area to enhance effective screening, early diagnosis,

intervention, and treatment with respect to mental illness, serious mental illness, and serious emotional disturbance, primarily by—

''(i) applying delivery of care, including training staff in effective evidence-based treatment; or

''(ii) integrating models of care across specialties and jurisdictions.

''(2) CONSULTATION.—In awarding grants under this paragraph, the Assistant Secretary shall, as appropriate, consult with the advisory councils described in section 502, the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism, as appropriate.

''(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated—

''(A) to carry out paragraph (1)(A), $7,000,000 for the period of fiscal years 2018 through 2020; and

''(B) to carry out paragraph (1)(B), $7,000,000 for the period of fiscal years 2018 through 2020.''.

SEC. 602. PROMOTING ACCESS TO INFORMATION ON EVIDENCE-BASED PROGRAMS AND PRACTICES.

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

"SEC. 544. PROMOTING ACCESS TO INFORMATION ON EVIDENCE-BASED PROGRAMS AND PRACTICES.

''(a) IN GENERAL.—The Assistant Secretary shall improve access to reliable and valid information on evidence-based programs and practices, including information on the strength of evidence associated with such programs and practices, related to mental and substance use disorders for States, local communities, nonprofit entities, and other stakeholders by posting on the website of the National Registry of Evidence-Based Programs and Practices on evidence-based programs and practices that have been reviewed by the Assistant Secretary pursuant to the requirements of this section.

''(b) NOTICE.—

''(1) PERIODS.—In carrying out subsection (a), the Assistant Secretary may establish an initial period for the submission of applications for evidence-based programs and practices to be posted publicly in accordance with subsection (a) (and may establish subsequent such periods). The Assistant Secretary

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

''(2) ADDRESSING GAPS.—Such notice may solicit applications for evidence-based practices and programs to address gaps in information identified by the Assistant Secretary, the Assistant Secretary for Planning and Evaluation, the Assistant Secretary for Financial Resources, or the National Mental Health and Substance Use Policy Laboratory, including pursuant to priorities identified in the strategic plan established under section 501(l).

''(c) REQUIREMENTS.—The Assistant Secretary shall establish minimum requirements for applications referred to in this section, including applications related to the submission of research and evaluation.

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

metrics used to evaluate applications and the resulting ratings publicly available.''.

SEC. 603. SENSE OF CONGRESS.

It is the sense of the Congress that the National Institute of Mental Health should conduct or support research on the determinants of self-directed and other violence connected to mental illness.

Subtitle B—Supporting the State Response to Mental Health Needs

SEC. 611. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT.

(a) FORMULA GRANTS.—Section 1911(b) of the Public Health Service Act (42 U.S.C. 300x(b)) is amended—

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

(2) by inserting before paragraph (2) (as so redesignated), the following:

''(1) providing community mental health services for adults with a serious mental illness and children with a serious emotional disturbance as defined in accordance with section 1912(c);''.

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

''(b) CRITERIA FOR PLAN.—In accordance with subsection (a), a State shall submit to the Secretary a plan that, at a minimum, satisfies the following criteria:

''(1) SYSTEM OF CARE.—The plan provides a description of the system of care of the State, including as follows:

''(A) COMPREHENSIVE COMMUNITY-BASED HEALTH SYSTEMS.—The plan shall—

''(i) identify the single State agency to be responsible for the administration of the program under the grant, including any third party who administers mental health services and is responsible for complying with the requirements of this part with respect to the grant;

''(ii) provide for an organized community-based system of care for individuals with mental illness, and describe available services and resources in a comprehensive system of care, including services for individuals with mental health and behavioral health co-occurring disorders;

''(iii) include a description of the manner in which the State and local entities will coordinate services to maximize

the efficiency, effectiveness, quality, and cost effectiveness of services and programs to produce the best possible outcomes (including health services, rehabilitation services, employment services, housing services, educational services, substance use disorder services, legal services, law enforcement services, social services, child welfare services, medical and dental care services, and other support services to be provided with Federal, State, and local public and private resources) with other agencies to enable individuals receiving services to function outside of inpatient or residential institutions, to the maximum extent of their capabilities, including services to be provided by local school systems under the Individuals with Disabilities Education Act;

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

viding comprehensive individualized treatment, or integrating mental and physical health services;

''(v) include a description of case management services;

''(vi) include a description of activities that seek to engage individuals with serious mental illness or serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication between individuals, families, caregivers, and treatment providers; and

''(vii) as appropriate to and reflective of the uses the State proposes for the block grant monies—

''(I) a description of the activities intended to reduce hospitalizations and hospital stays using the block grant monies;

''(II) a description of the activities intended to reduce incidents of suicide using the block grant monies; and

''(III) a description of how the State integrates mental health and primary care using the block grant monies.

''(B) MENTAL HEALTH SYSTEM DATA AND EPIDEMIOLOGY.—The plan shall contain an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children and presents quantitative targets and outcome measures for programs and services provided under this subpart.

''(C) CHILDREN'S SERVICES.—In the case of children with serious emotional disturbance (as defined in subsection (c)), the plan shall provide for a system of integrated social services, educational services, child welfare services, juvenile justice services, law enforcement services, and substance use disorder services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (such system to include services provided under the Individuals with Disabilities Education Act).

''(D) TARGETED SERVICES TO RURAL AND HOMELESS POPULATIONS.—The plan shall describe the State's outreach to and services for individuals who are homeless and how community-based services will be provided to individuals residing in rural areas.

''(E) MANAGEMENT SERVICES.—The plan shall—

''(i) describe the financial resources available, the existing mental health workforce, and workforce trained in treating individuals with co-occurring mental and substance use disorders;

''(ii) provide for the training of providers of emergency health services regarding mental health;

''(iii) describe the manner in which the State intends to expend the grant under section 1911 for the fiscal year involved; and

''(iv) describe the manner in which the State intends to comply with each of the funding agreements in this subpart and subpart III.

''(2) GOALS AND OBJECTIVES.—The plan establishes goals and objectives for the period of the plan, including targets and milestones that are intended to be met, and the activities that will be undertaken to achieve those targets.''.

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

''(c) BEST PRACTICES IN CLINICAL CARE MODELS.—A State shall expend not less than 10 percent of the amount the State receives for carrying out this subpart in each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset.''.

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

(1) by amending paragraph (1) to read as follows:

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

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

(2) in paragraph (2)—

(A) by striking ''subsection (a)'' and inserting ''paragraph (1)''; and

(B) by striking ''principle'' and inserting ''principal'';

(3) by amending paragraph (3) to read as follows:

''(3) WAIVER.—

''(A) IN GENERAL.—The Secretary may, upon the request of a State, waive the requirement established in paragraph (1) in whole or in part, if the Secretary determines that extraordinary economic conditions in the State in the fiscal year involved or in the previous fiscal year justify the waiver.

''(B) DATE CERTAIN FOR ACTION UPON REQUEST.—The Secretary shall approve or deny a request for a waiver under this paragraph not later than 120 days after the date on which the request is made.

''(C) APPLICABILITY OF WAIVER.—A waiver provided by the Secretary under this paragraph shall be applicable only to the fiscal year involved.''; and

(4) in paragraph (4)—

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

''(A) IN GENERAL.—

''(i) DETERMINATION AND REDUCTION.—The Secretary shall determine, in the case of each State, and for each fiscal year, whether the State maintained material compliance with the agreement made under paragraph (1). If the Secretary determines that a State has failed to maintain such compliance for a fiscal year, the Secretary shall reduce the amount of the allotment under section 1911 for the State, for the first fiscal year beginning after such determination is final, by an amount equal to the amount constituting such failure for the previous fiscal year about which the determination was made.

''(ii) ALTERNATIVE SANCTION.—The Secretary may by regulation provide for an

alternative method of imposing a sanction for a failure by a State to maintain material compliance with the agreement under paragraph (1) if the Secretary determines that such alternative method would be more equitable and would be a more effective incentive for States to maintain such material compliance.''; and

(B) in subparagraph (B)—

(i) by inserting after the subparagraph designation the following: ''SUBMISSION OF INFORMATION TO THE SECRETARY.—''; and

(ii) by striking ''subparagraph (A)'' and inserting ''subparagraph (A)(i)''.

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

(1) in paragraph (1), by striking ''1941'' and inserting ''1942(a)''; and

(2) in paragraph (5), by striking ''1915(b)(3)(B)'' and inserting ''1915(b)''.

Subtitle C—Strengthening Mental Health Care for Children and Adolescents

SEC. 621. TELEHEALTH CHILD PSYCHIATRY ACCESS GRANTS.

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

"SEC. 330M. TELEHEALTH CHILD PSYCHIATRY ACCESS GRANTS.

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

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

''(2) supporting the improvement of existing statewide child psychiatry access programs.

''(b) PROGRAM REQUIREMENTS.—

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

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

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

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

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

''(E) provide rapid statewide clinical telephone or telehealth consultations when requested between the pediatric mental health teams and pediatric primary care providers;

''(F) conduct training and provide technical assistance to pediatric primary care providers to support the early identification, diagnosis, treatment, and referral of children with behavioral health conditions or co-occurring intellectual and other developmental disabilities;

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

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

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

''(2) PEDIATRIC MENTAL HEALTH TEAMS.—In this subsection, the term 'pediatric mental health team' means a team of case coordinators, child and adolescent psychiatrists, and licensed clinical mental

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

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

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

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

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

''(f) AUTHORIZATION OF APPROPRIATIONS.—To carry this section, there are authorized to be appropriated $9,000,000 for the period of fiscal years 2018 through 2020.''.

SEC. 622. INFANT AND EARLY CHILDHOOD MENTAL HEALTH PROMOTION, INTERVENTION, AND TREATMENT.

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

''SEC. 399Z–2. INFANT AND EARLY CHILDHOOD MENTAL HEALTH PROMOTION, INTERVENTION, AND TREATMENT.

''(a) GRANTS.—The Secretary shall—

''(1) award grants to eligible entities, including human services agencies, to develop, maintain, or enhance infant and early childhood mental health promotion, intervention, and treatment programs, including—

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

disorders including serious emotional disturbance; and

''(B) multigenerational therapy and other services that support the caregiving relationship; and

''(2) ensure that programs funded through grants under this section are evidence-informed or evidence-based models, practices, and methods that are, as appropriate, culturally and linguistically appropriate, and can be replicated in other appropriate settings.

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

''(1) ELIGIBLE CHILD.—The term 'eligible child' means a child from birth to not more than 5 years of age who—

''(A) is at risk for, shows early signs of developing, or has been diagnosed with a mental disorder, including serious emotional disturbance; and

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

ise but would benefit from further applied development.

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

''(A) is accredited or approved by a State mental health or education agency, as applicable, to provide for children from infancy to 5 years of age, mental health promotion, intervention, or treatment services that are evidence-based or that have been scientifically demonstrated to show promise but would benefit from further applied development; and

''(B) provides programs described in subsection (a) that are evidence-based or that have been scientifically demonstrated to show promise but would benefit from further applied development.

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

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

''(1) Provide age-appropriate mental health promotion and early intervention services or mental disorder treatment services, which may include specialized programs, for eligible children at significant risk of developing, showing early signs of, or having been diagnosed with a mental disorder, including serious emotional disturbance. Such services may include social and behavioral services as well as multigenerational therapy and other services ?that support the caregiving relationship.

''(2) Provide training for health care professionals with expertise in infant and early childhood mental health care with respect to appropriate and relevant integration with other disciplines such as primary care clinicians, early intervention specialists, child welfare staff, home visitors, early care and education providers, and others who work with young children and families.

''(3) Provide mental health consultation to personnel of early care and education programs (including licensed or regulated center-based and home-based child care, home visiting, preschool special education and early intervention programs) who work with children and families.

''(4) Provide training for mental health clinicians in infant and early childhood promising and evidence-based practices and models for mental health treatment and early intervention, including with regard to practices for identifying and treating mental and behavioral disorders of infants and children resulting from exposure or repeated exposure to adverse childhood experiences or childhood trauma.

''(5) Provide age-appropriate assessment, diagnostic, and intervention services for eligible children, including early mental health promotion, intervention, and treatment services.

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

''(f) AUTHORIZATION OF APPROPRIATIONS.—To carry this section, there are authorized to be appropriated $20,000,000 for the period of fiscal years 2018 through 2022.''.

SEC. 623. NATIONAL CHILD TRAUMATIC STRESS INITIATIVE.

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

(1) in subsection (a), by striking ''developing programs'' and all that follows and inserting the following: ''developing and maintaining programs that provide for—

''(1) the continued operation of the National Child Traumatic Stress Initiative (referred to in this section as the 'NCTSI'), which includes a coordinating center, that focuses on the mental, behavioral, and biological aspects of psychological trauma response; and

''(2) the development of knowledge with regard to evidence-based practices for identifying and treating mental disorders, behavioral disorders, and physical health conditions of children and youth resulting from witnessing or experiencing a traumatic event.'';

(2) in subsection (b)—

(A) by striking ''subsection (a) related'' and inserting ''subsection (a)(2) (related'';

(B) by striking ''treating disorders associated with psychological trauma'' and inserting ''treating mental, behavioral, and biological dis-

orders associated with psychological trauma)''; and

(C) by striking ''mental health agencies and programs that have established clinical and basic research'' and inserting ''universities, hospitals, mental health agencies, and other programs that have established clinical expertise and research'';

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

(4) by inserting after subsection (b), the following:

''(c) CHILD OUTCOME DATA.—The NCTSI coordinating center shall collect, analyze, report, and make publicly available NCTSI-wide child treatment process and outcome data regarding the early identification and delivery of evidence-based treatment and services for children and families served by the NCTSI grantees.

''(d) TRAINING.—The NCTSI coordinating center shall facilitate the coordination of training initiatives in evidence-based and trauma-informed treatments, interventions, and practices offered to NCTSI grantees, providers, and partners.

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

in the dissemination of evidence-based and trauma-informed interventions, treatments, products, and other resources to appropriate stakeholders.

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

(5) in subsection (g) (as so redesignated), by striking ''with respect to centers of excellence are distributed equitably among the regions of the country'' and inserting ''are distributed equitably among the regions of the United States'';

(6) in subsection (i) (as so redesignated), by striking ''recipient may not exceed 5 years'' and inserting ''recipient shall not be less than 4 years, but shall not exceed 5 years''; and

(7) in subsection (j) (as so redesignated), by striking ''$50,000,000'' and all that follows through ''2006'' and inserting ''$46,887,000 for each of fiscal years 2017 through 2021''.

TITLE VII—GRANT PROGRAMS AND PROGRAM REAUTHORIZATION

Subtitle A—Garrett Lee Smith Memorial Act Reauthorization

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

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

(1) by striking the section heading and inserting ''**SUICIDE PREVENTION TECHNICAL ASSISTANCE CENTER.**'';

(2) in subsection (a), by striking ''and in consultation with'' and all that follows through the period at the end of paragraph (2) and inserting ''shall establish a research, training, and technical assistance resource center to provide appropriate information, training, and technical assistance to States, political subdivisions of States, federally recognized Indian tribes, tribal organizations, institutions of higher education, public organizations, or private nonprofit organizations regarding the prevention of suicide among all ages, particularly among groups that are at high risk for suicide.'';

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

(4) by redesignating subsection (d) as subsection (b);

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

(A) by striking the subsection heading and inserting ''RESPONSIBILITIES OF THE CENTER.'';

(B) in the matter preceding paragraph (1), by striking ''The additional research'' and all that follows through ''nonprofit organizations for'' and inserting ''The center established under subsection (a) shall conduct activities for the purpose of'';

(C) by striking ''youth suicide'' each place such term appears and inserting ''suicide'';

(D) in paragraph (1)—

(i) by striking ''the development or continuation of'' and inserting ''developing and continuing''; and

(ii) by inserting ''for all ages, particularly among groups that are at high risk for suicide'' before the semicolon at the end;

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

high risk for suicide'' before the semicolon at the end;

(F) in paragraph (3), by inserting ''and tribal'' after ''statewide'';

(G) in paragraph (5), by inserting ''and prevention'' after ''intervention'';

(H) in paragraph (8), by striking ''in youth'';

(I) in paragraph (9), by striking ''and behavioral health'' and inserting ''health and substance use disorder''; and

(J) in paragraph (10), by inserting ''conducting'' before ''other''; and

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

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $5,988,000 for each of fiscal years 2017 through 2021.

''(d) REPORT.—Not later than 2 years after the date of enactment of the Helping Families in Mental Health Crisis Act of 2016, the Secretary shall submit to Congress a report on the activities carried out by the center established under subsection (a) during the year involved, including the potential effects of such activities, and the

States, organizations, and institutions that have worked with the center.''.

SEC. 702. YOUTH SUICIDE EARLY INTERVENTION AND PREVENTION STRATEGIES.

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

(1) in paragraph (1) of subsection (a) and in subsection (c), by striking ''substance abuse'' each place such term appears and inserting ''substance use disorder'';

(2) in subsection (b)(2)—

(A) by striking ''each State is awarded only 1 grant or cooperative agreement under this section'' and inserting ''a State does not receive more than 1 grant or cooperative agreement under this section at any 1 time''; and

(B) by striking ''been awarded'' and inserting ''received''; and

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

''(m) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $35,427,000 for each of fiscal years 2017 through 2021.''.

SEC. 703. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES ON CAMPUS.

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

(1) in the section heading, by striking ''**AND BEHAVIORAL HEALTH**'' and inserting ''**HEALTH AND SUBSTANCE USE DISORDER**'';

(2) in subsection (a)—

(A) by striking ''Services,'' and inserting ''Services and'';

(B) by striking ''and behavioral health problems'' and inserting ''health or substance use disorders''; and

(C) by striking ''substance abuse'' and inserting ''substance use disorders'';

(3) in subsection (b)—

(A) in the matter preceding paragraph (1), by striking ''for—'' and inserting ''for one or more of the following:''; and

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

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

''(2) The operation of hotlines.

''(3) Preparing informational material.

''(4) Providing outreach services to notify students about available mental health and substance use disorder services.

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

''(6) Supporting the training of students, faculty, and staff to respond effectively to students with mental health and substance use disorders.

''(7) Creating a network infrastructure to link colleges and universities with health care providers who treat mental health and substance use disorders.'';

(4) in subsection (c)(5), by striking ''substance abuse'' and inserting ''substance use disorder'';

(5) in subsection (d)—

(A) in the matter preceding paragraph (1), by striking ''An institution of higher education desiring a grant under this section'' and inserting ''To be eligible to receive a grant under this section, an institution of higher education'';

(B) in paragraph (1)—

(i) by striking ''and behavioral health'' and inserting ''health and substance use disorder''; and

(ii) by inserting ‘‘, including veterans whenever possible and appropriate,’’ after ‘‘students’’; and

(C) in paragraph (2), by inserting ‘‘, which may include, as appropriate and in accordance with subsection (b)(7), a plan to seek input from relevant stakeholders in the community, including appropriate public and private entities, in order to carry out the program under the grant’’ before the period at the end;

(6) in subsection (e)(1), by striking ‘‘and behavioral health problems’’ and inserting ‘‘health and substance use disorders’’;

(7) in subsection (f)(2)—

(A) by striking ‘‘and behavioral health’’ and inserting ‘‘health and substance use disorder’’; and

(B) by striking ‘‘suicide and substance abuse’’ and inserting ‘‘suicide and substance use disorders’’; and

(8) in subsection (h), by striking ‘‘$5,000,000 for fiscal year 2005’’ and all that follows through the period at the end and inserting ‘‘$6,488,000 for each of fiscal years 2017 through 2021.’’.

Subtitle B—Other Provisions

SEC. 711. NATIONAL SUICIDE PREVENTION LIFELINE PROGRAM.

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

"SEC. 520E–4. NATIONAL SUICIDE PREVENTION LIFELINE PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall maintain the National Suicide Prevention Lifeline Program (referred to in this section as the 'Program'), authorized under section 520A and in effect prior to the date of enactment of the Helping Families in Mental Health Crisis Act of 2016.

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

''(1) coordinating a network of crisis centers across the United States for providing suicide prevention and crisis intervention services to individuals seeking help at any time, day or night;

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

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

''(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $7,198,000 for each of fiscal years 2017 through 2021.''.

SEC. 712. WORKFORCE DEVELOPMENT STUDIES AND REPORTS.

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Assistant Secretary for Mental Health and Substance Use, in consultation with the Administrator of the Health Resources and Services Administration, shall conduct a study and publicly post on the appropriate Internet website of the Department of Health and Human Services a report on the mental health and substance use disorder workforce in order to inform Federal, State, and local efforts related to workforce enhancement.

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

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

substance use disorder health workers, including the number of individuals practicing in fields deemed relevant by the Secretary;

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

(C) information on trends within the mental health and substance use disorder provider workforce, including the number of individuals entering the mental health workforce over the next five years;

(D) information on the gaps in workforce development for mental health providers and professionals, including those who serve pediatric, adult, and geriatric patients; and

(E) any additional information determined by the Assistant Secretary for Mental Health and Substance Use, in consultation with the Administrator of the Health Resources and Services Administration, to be relevant to the mental health and substance use disorder provider workforce.

SEC. 713. MINORITY FELLOWSHIP PROGRAM.

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

"PART K—MINORITY FELLOWSHIP PROGRAM

"SEC. 597. FELLOWSHIPS.

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

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

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

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

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

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

''(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $12,669,000 for each of fiscal years 2017, 2018, and 2019 and $13,669,000 for each of fiscal years 2020 and 2021.''.

SEC. 714. CENTER AND PROGRAM REPEALS.

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

SEC. 715. NATIONAL VIOLENT DEATH REPORTING SYSTEM.

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

Participation in the system by the States shall be voluntary.

SEC. 716. SENSE OF CONGRESS ON PRIORITIZING NATIVE AMERICAN YOUTH AND SUICIDE PREVENTION PROGRAMS.

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

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

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

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

(b) SENSE OF CONGRESS.—It is the sense of Congress that the Secretary of Health and Human Services, in carrying out programs for Native American youth and suicide prevention programs for youth suicide intervention, should prioritize programs and activities for individuals who have a high risk or disproportional burden of suicide, such as Native Americans.

SEC. 717. PEER PROFESSIONAL WORKFORCE DEVELOPMENT GRANT PROGRAM.

(a) IN GENERAL.—For the purposes described in subsection (b), the Secretary of Health and Human Services shall award grants to develop and sustain behavioral health paraprofessional training and education programs, including through tuition support.

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

(1) to increase the number of behavioral health paraprofessionals, including trained peers, recovery coaches, mental health and addiction specialists, prevention specialists, and pre-masters-level addiction counselors; and

(2) to help communities develop the infrastructure to train and certify peers as behavioral health paraprofessionals.

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

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

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

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

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

SEC. 718. NATIONAL HEALTH SERVICE CORPS.

(a) DEFINITIONS.—

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

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

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

program in medicine, osteopathic medicine, dentistry, behavioral and mental health, or other health profession''.

SEC. 719. ADULT SUICIDE PREVENTION.

(a) GRANTS.—

(1) AUTHORITY.—The Assistant Secretary for Mental Health and Substance Use (referred to in this section as the ''Assistant Secretary'') may award grants to eligible entities in order to implement suicide prevention efforts amongst adults 25 and older.

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

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

(4) NATURE OF ACTIVITIES.—The grants awarded under paragraph (1) shall be used to implement programs that—

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

(B) implement evidence-based practices to treat individuals who are at suicide risk, including appropriate followup services; and

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

(b) ADDITIONAL ACTIVITIES.—The Assistant Secretary shall—

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

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

(3) provide appropriate information, training, and technical assistance to eligible entities that receive a grant under this section, in order to help such entities to meet the requirements of this section, including assistance with—

(A) selection and implementation of evidence-based interventions and frameworks to prevent suicide, such as the Zero Suicide framework; and

(B) other activities as the Assistant Secretary determines appropriate.

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

(d) AUTHORIZATION OF APPROPRIATIONS.—

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

(2) USE OF CERTAIN FUNDS.—Of the funds appropriated to carry out this section in any fiscal year, the lesser of 5 percent of such funds or $500,000 shall be available to the Assistant Secretary for purposes of carrying out subsection (b).

SEC. 720. CRISIS INTERVENTION GRANTS FOR POLICE OFFICERS AND FIRST RESPONDERS.

(a) IN GENERAL.—The Assistant Secretary for Mental Health and Substance Use may award grants to entities such as law enforcement agencies and first responders—

(1) to provide specialized training to law enforcement officers, corrections officers, paramedics, emergency medical services workers, and other first responders (including village public safety officers (as defined in section 247 of the Indian Arts and

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

(A) to recognize individuals who have mental illness and how to properly intervene with individuals with mental illness; and

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

(2) to establish collaborative law enforcement and mental health programs, including behavioral health response teams and mental health crisis intervention teams comprised of mental health professionals, law enforcement officers, and other first responders, as appropriate, to provide on-site, face-to-face, mental and behavioral health care services during a mental health crisis, and to connect the individual in crisis to appropriate community-based treatment services in lieu of unnecessary hospitalization or further involvement with the criminal justice system.

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

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

SEC. 721. DEMONSTRATION GRANT PROGRAM TO TRAIN HEALTH SERVICE PSYCHOLOGISTS IN COMMUNITY-BASED MENTAL HEALTH.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a grant program under which the Assistant Secretary of Mental Health and Substance Use Disorders may award grants to eligible institutions to support the recruitment, education, and clinical training experiences of health services psychology students, interns, and postdoctoral residents for education and clinical experience in community mental health settings.

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

(1) are focused on the development and implementation of interdisciplinary training of psychology graduate students and postdoctoral fellows in providing mental and behavioral health services to address substance use disorders, serious emotional disturbance, and serious illness, as well as developing

faculty and implementing curriculum to prepare psychologists to work with underserved populations; and

(2) demonstrate an ability to train health service psychologists in psychiatric hospitals, forensic hospitals, community mental health centers, community health centers, federally qualified health centers, or adult and juvenile correctional facilities.

(c) PRIORITIES.—In selecting grant recipients under this section, the Secretary shall give priority to eligible institutions in which training focuses on the needs of individuals with serious mental illness, serious emotional disturbance, justice-involved youth, and individuals with or at high risk for substance use disorders.

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

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

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

''(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $12,000,000 for the period of fiscal years 2018 through 2022.''.

SEC. 723. CUTGO COMPLIANCE.

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

TITLE VIII—MENTAL HEALTH PARITY

SEC. 801. ENHANCED COMPLIANCE WITH MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE REQUIREMENTS.

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

''(6) COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—

''(A) IN GENERAL.—Not later than 6 months after the date of enactment of the Helping Families in Mental Health Crisis Act of 2016, the Inspector General of the Department of Health and Human Services, in coordination with the Secretary, the Secretary of Labor, or the Secretary of the Treasury, shall issue a compliance program guidance document to help improve compliance with this section.

''(B) EXAMPLES ILLUSTRATING COMPLIANCE AND NONCOMPLIANCE.—

''(i) IN GENERAL.—The compliance program guidance document required under this paragraph shall provide illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986 based on investigations of violations of such sections, including—

''(I) examples illustrating requirements for information disclosures and nonquantitative treatment limitations; and

''(II) descriptions of the violations uncovered during the course of such investigations.

''(ii) NONQUANTITATIVE TREATMENT LIMITATIONS.—To the extent that any example described in clause (i) involves a

finding of compliance or noncompliance with regard to any requirement for non-quantitative treatment limitations, the example shall provide sufficient detail to fully explain such finding, including a full description of the criteria involved for medical and surgical benefits and the criteria involved for mental health and substance use disorder benefits.

''(iii) ACCESS TO ADDITIONAL INFORMATION REGARDING COMPLIANCE.—In developing and issuing the compliance program guidance document required under this paragraph, the Inspector General of the Department of Health and Human Services may—

''(I) enter into interagency agreements with the Inspector General of the Department of Labor and the Inspector General of the Department of the Treasury to share findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security

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

''(II) enter into an agreement with a State to share information on findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986.

''(C) RECOMMENDATIONS.—The compliance program guidance document shall include recommendations to avoid violations of this section and encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. Such internal controls may include a compliance checklist with illustrative examples of nonquantitative treatment limitations on mental health and substance use disorder benefits, which may fail to comply with this section in relation to nonquantitative treatment limitations on medical and surgical benefits.

''(D) UPDATING THE COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—The compliance program guidance document shall be updated

every 2 years to include illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986.''.

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

''(7) ADDITIONAL GUIDANCE.—

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

''(B) DISCLOSURE.—

''(i) GUIDANCE FOR PLANS AND ISSUERS.—The guidance issued under this

paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use for disclosing information to ensure compliance with the requirements under this section (and any regulations promulgated pursuant to this section).

''(ii) DOCUMENTS FOR PARTICIPANTS, BENEFICIARIES, CONTRACTING PROVIDERS, OR AUTHORIZED REPRESENTATIVES.—The guidance issued under this paragraph may include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use to provide any participant, beneficiary, contracting provider, or authorized representative, as applicable, with documents containing information that the health plans or issuers are required to disclose to participants, beneficiaries, contracting providers, or authorized representatives to ensure compliance

with this section, any regulation issued pursuant to this section, or any other applicable law or regulation, including information that is comparative in nature with respect to—

"(I) nonquantitative treatment limitations for both medical and surgical benefits and mental health and substance use disorder benefits;

"(II) the processes, strategies, evidentiary standards, and other factors used to apply the limitations described in subclause (I); and

"(III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and mental health and substance use disorder benefits.

"(C) NONQUANTITATIVE TREATMENT LIMITATIONS.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other fac-

tors that group health plans and health insurance issuers offering group or individual health insurance coverage may use regarding the development and application of nonquantitative treatment limitations to ensure compliance with this section (and any regulations promulgated pursuant to this section), including—

''(i) examples of methods of determining appropriate types of nonquantitative treatment limitations with respect to both medical and surgical benefits and mental health and substance use disorder benefits, including nonquantitative treatment limitations pertaining to—

''(I) medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;

''(II) limitations with respect to prescription drug formulary design; and

''(III) use of fail-first or step therapy protocols;

''(ii) examples of methods of determining—

''(I) network admission standards (such as credentialing); and

''(II) factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;

''(iii) examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of nonquantitative treatment limitations;

''(iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans or issuers in performing a nonquantitative treatment limitation analysis;

''(v) examples of how specific evidentiary standards may be used to determine whether treatments are considered experimental or investigative;

''(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;

''(vii) examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for individuals with a serious mental illness and types of medical management techniques;

''(viii) examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship between the covered mental health or substance use disorder benefit and a traditional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment; and

''(ix) additional illustrative examples of methods, processes, strategies, evidentiary standards, and other factors for which the Secretary determines that addi-

tional guidance is necessary to improve compliance with this section.

''(D) PUBLIC COMMENT.—Prior to issuing any final guidance under this paragraph, the Secretary shall provide a public comment period of not less than 60 days during which any member of the public may provide comments on a draft of the guidance.''.

(c) IMPROVING COMPLIANCE.—

(1) IN GENERAL.—In the case that the Secretary of Health and Human Services, the Secretary of Labor, or the Secretary of the Treasury determines that a group health plan or health insurance issuer offering group or individual health insurance coverage has violated, at least 5 times, section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), or section 9812 of the Internal Revenue Code, the appropriate Secretary shall audit plan documents for such health plan or issuer in the plan year following the Secretary's determination in order to help improve compliance with such section.

(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to limit the authority,

as in effect on the day before the date of enactment of this Act, of the Secretary of Health and Human Services, the Secretary of Labor, or the Secretary of the Treasury to audit documents of health plans or health insurance issuers.

SEC. 802. ACTION PLAN FOR ENHANCED ENFORCEMENT OF MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE.

(a) PUBLIC MEETING.—

(1) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall convene a public meeting of stakeholders described in paragraph (2) to produce an action plan for improved Federal and State coordination related to the enforcement of mental health parity and addiction equity requirements.

(2) STAKEHOLDERS.—The stakeholders described in this paragraph shall include each of the following:

(A) The Federal Government, including representatives from—

(i) the Department of Health and Human Services;

(ii) the Department of the Treasury;

(iii) the Department of Labor; and

(iv) the Department of Justice.

(B) State governments, including—

(i) State health insurance commissioners;

(ii) appropriate State agencies, including agencies on public health or mental health; and

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

(C) Representatives from key stakeholder groups, including—

(i) the National Association of Insurance Commissioners;

(ii) health insurance providers;

(iii) providers of mental health and substance use disorder treatment;

(iv) employers; and

(v) patients or their advocates.

(b) ACTION PLAN.—Not later than 6 months after the public meeting under subsection (a), the Secretary of Health and Human Services shall finalize the action plan described in such subsection and make it plainly available

on the Internet website of the Department of Health and Human Services.

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

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

(2) identify specific strategic objectives regarding how the various Federal and State agencies charged with enforcement of mental health parity and addiction equity requirements will collaborate to improve enforcement of such requirements;

(3) provide a timeline for implementing the action plan; and

(4) provide specific examples of how such objectives may be met, which may include—

(A) providing common educational information and documents to patients about their rights under Federal or State mental health parity and addiction equity requirements;

(B) facilitating the centralized collection of, monitoring of, and response to patient complaints or inquiries relating to Federal or State mental health parity and addiction equity requirements, which may be through the development and administration of a single, toll-free

telephone number and an Internet website portal;

(C) Federal and State law enforcement agencies entering into memoranda of understanding to better coordinate enforcement responsibilities and information sharing, including whether such agencies should make the results of enforcement actions related to mental health parity and addiction equity requirements publicly available; and

(D) recommendations to the Secretary and Congress regarding the need for additional legal authority to improve enforcement of mental health parity and addiction equity requirements, including the need for additional legal authority to ensure that nonquantitative treatment limitations are applied, and the extent and frequency of the applications of such limitations, both to medical and surgical benefits and to mental health and substance use disorder benefits in a comparable manner.

SEC. 803. REPORT ON INVESTIGATIONS REGARDING PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, and annually thereafter for the subsequent 5 years, the Administrator of the Centers for Medicare & Medicaid Services, in collaboration with the Assistant Secretary of Labor of the Employee Benefits Security Administration and the Secretary of the Treasury, shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report summarizing the results of all closed Federal investigations completed during the preceding 12-month period with findings of any serious violation regarding compliance with mental health and substance use disorder coverage requirements under section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section 9812 of the Internal Revenue Code of 1986.

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

(1) The number of open or closed Federal investigations conducted during the covered reporting period.

(2) Each benefit classification examined by any such investigation conducted during the covered reporting period.

(3) Each subject matter, including compliance with requirements for quantitative and nonquantitative treatment limitations, of any such investigation conducted during the covered reporting period.

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

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

SEC. 804. GAO STUDY ON PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

Not later than 3 years after the date of enactment of this Act, the Comptroller General of the United States, in consultation with the Secretary of Health and Human

Services, the Secretary of Labor, and the Secretary of the Treasury, shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report detailing the extent to which group health plans or health insurance issuers offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, medicaid managed care organizations with a contract under section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)), and health plans provided under the State Children's Health Insurance Program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) comply with section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section 9812 of the Internal Revenue Code of 1986, including—

(1) how nonquantitative treatment limitations, including medical necessity criteria, of such plans or issuers comply with such sections;

(2) how the responsible Federal departments and agencies ensure that such plans or issuers comply with such sections, including an assessment of how the Secretary of Health and Human Services

has used its authority to conduct audits of such plans to ensure compliance;

(3) a review of how the various Federal and State agencies responsible for enforcing mental health parity requirements have improved enforcement of such requirements in accordance with the objectives and timeline described in the action plan under section 605; and

(4) recommendations for how additional enforcement, education, and coordination activities by responsible Federal and State departments and agencies could better ensure compliance with such sections, including recommendations regarding the need for additional legal authority.

SEC. 805. INFORMATION AND AWARENESS ON EATING DISORDERS.

(a) INFORMATION.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') may—

(1) update information, related fact sheets, and resource lists related to eating disorders that are available on the public Internet website of the National Women's Health Information Center sponsored by the Office on Women's Health, to include—

(A) updated findings and current research related to eating disorders, as appropriate; and

(B) information about eating disorders, including information related to males and females;

(2) incorporate, as appropriate, and in coordination with the Secretary of Education, information from publicly available resources into appropriate obesity prevention programs developed by the Office on Women's Health; and

(3) make publicly available (through a public Internet website or other method) information, related fact sheets and resource lists, as updated under paragraph (1), and the information incorporated into appropriate obesity prevention programs, as updated under paragraph (2).

(b) AWARENESS.—The Secretary may advance public awareness on—

(1) the types of eating disorders;

(2) the seriousness of eating disorders, including prevalence, comorbidities, and physical and mental health consequences;

(3) methods to identify, intervene, refer for treatment, and prevent behaviors that may lead to the development of eating disorders;

(4) discrimination and bullying based on body size;

(5) the effects of media on self-esteem and body image; and

(6) the signs and symptoms of eating disorders.

SEC. 806. EDUCATION AND TRAINING ON EATING DISORDERS.

The Secretary of Health and Human Services may facilitate the identification of programs to educate and train health professionals and school personnel in effective strategies to—

(1) identify individuals with eating disorders;

(2) provide early intervention services for individuals with eating disorders;

(3) refer patients with eating disorders for appropriate treatment;

(4) prevent the development of eating disorders; or

(5) provide appropriate treatment services for individuals with eating disorders.

SEC. 807. GAO STUDY ON PREVENTING DISCRIMINATORY COVERAGE LIMITATIONS FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS AND SUBSTANCE USE DISORDERS.

Not later than 2 years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress and make publicly available a report detailing Federal oversight of group health plans and health insurance coverage offered in connection with such plans (as such terms are defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91), including Medicaid managed care plans under section 1903 of the Social Security Act (42 U.S.C. 1396b), to ensure compliance of such plans and coverage with sections 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and 9812 of the Internal Revenue Code of 1986 (in this section collectively referred to as the ''parity law''), including—

(1) a description of how Federal regulations and guidance consider nonquantitative treatment limitations, including medical necessity criteria and application of such criteria to medical, surgical, and primary care, of such plans and coverage in ensuring compliance by such plans and coverage with the parity law;

(2) a description of actions that Federal departments and agencies are taking to ensure that such plans and coverage comply with the parity law; and

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

SEC. 808. CLARIFICATION OF EXISTING PARITY RULES.

If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage for eating disorder benefits, including residential treatment, such group health plan or health insurance issuer shall provide such benefits consistent with the requirements of section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section 9812 of the Internal Revenue Code of 1986.

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