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The Helping Families in Mental Health Crisis Reform Act of 2016 (Division B of P.L. 114-255)

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December 22, 2016

Congressional Research Service

7-5700

www.crs.gov

R44718

Summary

This report summarizes the Helping Families in Mental Health Crisis Reform Act of 2016, enacted on December 13, 2016, as Division B of the 21st Century Cures Act (P.L. 114-255). Division B comprises Title VI through Title XIV. The first five titles in Division B (Title VI – Title X) deal primarily with the Substance Abuse and Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services (HHS). SAMHSA is the federal agency with primary responsibility for increasing access to community-based services to prevent and treat mental disorders and substance use disorders. The next four titles in Division B (Title XI – Title XIV) deal with confidentiality of patient records, Medicaid, mental health parity, and criminal justice programs.

Title VI “Strengthening Leadership and Accountability”

Within Title VI, Subtitle A makes changes to HHS and SAMHSA’s leadership, structure, and responsibilities. Subtitle B creates new planning and evaluation requirements, changes reporting and accounting requirements for state-designated protection and advocacy systems, and requires a Government Accountability Office (GAO) report on programs funded by SAMHSA’s Protection and Advocacy for Individuals with Mental Illness grants. Subtitle C requires the HHS Secretary to establish an Interdepartmental Serious Mental Illness Coordinating Committee.

Title VII “Ensuring Mental and Substance Use Disorders Prevention, Treatment, and Recovery Programs Keep Pace with Science and Technology”

Title VII establishes within SAMHSA a “National Mental Health Policy Laboratory,” codifies SAMHSA’s existing National Registry of Evidence-based Programs and Practices (which was not previously explicitly authorized in statute), and authorizes appropriations for SAMHSA’s Programs of Regional and National Significance (for which authorizations of appropriations had expired).

Title VIII “Supporting State Prevention Activities and Responses to Mental Health and Substance Use Disorder Needs”

Title VIII focuses on SAMHSA’s two biggest programs: the Community Mental Health Services Block Grant (MHBG, \$533 million in FY2016) and the Substance Abuse Prevention and Treatment Block Grant (SABG, \$1.9 billion in FY2016). It makes various changes—some increasing flexibility, some imposing additional requirements, and some codifying current practice. It also requires a study on the formulas for distributing MHBG and SABG funds.

Title IX “Promoting Access to Mental Health and Substance Use Disorder Care”

Within Title IX, Subtitle A reauthorizes and modifies various programs and activities (most of which are administered by SAMHSA), codifies existing SAMHSA-administered programs and activities, authorizes new SAMHSA-administered programs and activities, and repeals statutory authorities for programs that have never been funded. Subtitle B focuses on the mental health and substance use disorder workforce—authorizing, reauthorizing, or amending several programs and activities, most of which are administered by the Health Resources and Services Administration (HRSA) within HHS. Subtitle C authorizes or reauthorizes SAMHSA-administered programs and activities focused on mental health on college campuses.

Title X “Strengthening Mental and Substance Use Disorder Care for Children and Adolescents”

Title X focuses on expanding access to community mental and behavioral health services for youth. It reauthorizes and modifies several SAMHSA-administered programs and activities. It also establishes several new grant programs.

Title XI “Compassionate Communication on HIPAA”

Title XI focuses on confidentiality of patient records and the circumstances under which health care providers (and other entities) may communicate with family members, caregivers, and law enforcement about individuals seeking or receiving treatment for mental disorders or substance use disorders. It requires dissemination of model programs for training health care providers, lawyers, and patients and their families on permitted disclosures.

Title XII “Medicaid Mental Health Coverage”

Title XII focuses on Medicaid. It includes a rule of construction related to same-day services. It requires studies and reports related to Medicaid managed care regulation and (separately) Medicaid’s Emergency Psychiatric Demonstration Project. It requires a letter from the Centers for Medicaid & Medicare Services to State Medicaid Directors regarding opportunities for innovation under the Social Security Act (SSA) Section 1115 waiver authority. It requires the use of an electronic visit verification system for personal care services and home health care services under Medicaid.

Title XIII “Mental Health Parity”

Title XIII focuses on mental health parity and (separately) eating disorders, as well as the application of parity to eating disorder benefits. It amends federal parity law to include provisions aimed at improving compliance and requires a GAO report on compliance. It authorizes activities to educate the public and health professionals about eating disorders.

Title XIV “Mental Health and Safe Communities”

Title XIV amends the authorizing legislation for several Department of Justice (DOJ) programs and one Department of Homeland Security (DHS) grant program. Broadly, the amendments made by Subtitle A expand the scope of these programs to allow funds to be used to assist people with mental illness, substance use problems, or co-occurring substance abuse and mental health issues. Subtitle B makes several changes to the Justice and Mental Health Collaboration program. The amendments largely expand the scope of the program, so grants may be used for additional purposes to help respond to people involved in the criminal justice system who have substance abuse, mental health, or co-occurring disorders.

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Introduction

The 21st Century Cures Act (P.L. 114-255) was signed into law on December 13, 2016, by President Barack Obama. On November 30, 2016, the House passed an amendment to the Senate amendment to H.R. 34, the 21st Century Cures Act, on a vote of 392 to 26. The bill was then sent to the Senate, where it was considered and passed, with only minor technical modification, on December 7, 2016, on a vote of 94 to 5.¹

The law consists of three divisions:

- Division A—21st Century Cures;
- Division B—Helping Families in Mental Health Crisis; and
- Division C—Increasing Choice, Access, and Quality in Health Care for Americans.

CRS has published a series of reports on this law, one on each division. This report provides information on Division B of the law.

Enactment of Division B is the culmination of a multiyear congressional effort dating back at least to December 2013, when the Helping Families in Mental Health Crisis Act of 2013 (H.R. 3717 in the 113th Congress) was introduced. In the 113th Congress, H.R. 3717 did not have a Senate companion (although other mental health bills were introduced in both chambers).

In the 114th Congress, the Helping Families in Mental Health Crisis Act of 2015 (H.R. 2646) was introduced in June 2015. It gained a Senate companion in August 2015, with the introduction of the Mental Health Reform Act of 2015 (S. 1945). The more recent Mental Health Reform Act of 2016 (S. 2680), introduced in March 2016, includes elements of the earlier S. 1945; the Mental Health Awareness and Improvement Act of 2015 (S. 1893), which passed the Senate in December 2015; and other bills that were smaller in scope.

The bulk of Division B represents a compromise between the Helping Families in Mental Health Crisis Act of 2015 (H.R. 2646 RFS) and the Mental Health Reform Act of 2016 (S. 2680 RS). Within the final title of Division B (Title XVI), Subtitle A represents a version of the Mental Health and Safe Communities Act of 2015 (H.R. 3722, S. 2002), and Subtitle B represents a version of the Comprehensive Justice and Mental Health Act of 2015 (H.R. 1854, S. 993).

This report provides a brief summary of each provision of the Helping Families in Mental Health Crisis Act (Division B of P.L. 114-255), by title and subtitle. Within each title (or subtitle), major provisions are organized by topic. In some cases, each topic corresponds with a section in the act. In other cases, multiple sections address the same topic or one section addresses multiple topics.

Throughout this report, clarity takes priority over consistency. For example, some summaries are more detailed than others where such detail is necessary to highlight important changes.

Technical edits to redesignating sections, subsections, paragraphs, et cetera are generally not noted. Edits to clarify meaning or replace outdated terminology are not provided in detail. For example, provisions throughout Division B replace the term “substance abuse” with the term “substance use disorder.” See below for a list of which CRS author covers which topics. The **Appendix** provides a list of abbreviations used throughout this report.

¹ The Congressional Budget Office’s (CBO) score of H.R. 34 (Rules Committee Print 114-67, as amended by Amendment Number 5) is available at <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr34amendment5.pdf>.

CRS Experts List

Erin Bagalman	Mental health and substance abuse generally (Titles VI, VII, VIII, and XIII)
Evelyne Baumrucker²	Medicaid provisions (Title XII)
Cliff Binder	Medicaid—Electronic Visit Verification System (Section 12006)
Elayne J. Heisler	Health care workforce, education, access to care (Titles IX and X)
Nathan James	Mental Health and Safe Communities; Justice and Mental Health Collaboration (Title XIV)
Don J. Jansen	Defense health (Section 14008)
C. Stephen Redhead	HIPAA privacy rule (Title XI)
Scott D. Szymendera	Veterans disability benefits (Section 14017)

Summary of Provisions

Division B begins before Title VI with the short title (Section 6000), “Helping Families in Mental Health Crisis Reform Act of 2016.”

Title VI—Strengthening Leadership and Accountability

Subtitle A—Leadership

Subtitle A makes changes to the leadership, organization, and responsibilities of the Substance Abuse and Mental Health Services Administration (SAMHSA), the agency within the Department of Health and Human Services (HHS) that has primary responsibility for increasing access to community-based services to prevent and treat mental disorders and substance use disorders.

Assistant Secretary for Mental Health and Substance Use

Subtitle A (Sections 6001 and 6002) replaces the position of SAMHSA Administrator with a newly established Assistant Secretary for Mental Health and Substance Use (ASMHSU), to be appointed by the President and subject to Senate confirmation (as was the case with the Administrator). It expands (and otherwise revises) the list of responsibilities to be carried out by the HHS Secretary, acting through the newly established ASMHSU (formerly the Administrator). For example, the revised list of responsibilities requires collaboration with other federal agencies, including the Secretaries of Defense and Veterans Affairs, and the Attorney General.

Subtitle A (Sections 6005 and 6006) requires the ASMHSU to develop and carry out a strategic plan, with specified contents, by the end of FY2018 and every four years thereafter. It changes the required contents of a biennial report concerning activities and progress; the ASMHSU must prepare the report, with specified contents, by the end of FY2020 and every two years thereafter. Both the strategic plan and the report on programs and activities must be submitted to specified congressional committees and posted on the agency website.

² Kirsten J. Colello authored the summaries included in this report; however, questions should be directed to Evelyne Baumrucker.

Chief Medical Officer

Subtitle A (Section 6003) establishes a new position of Chief Medical Officer, to be selected by the ASMHSU from among physicians with relevant experience, knowledge, and licensure. It specifies the duties of SAMHSA's Chief Medical Officer.

Authorizations for SAMHSA's Centers

Subtitle A (Section 6007) modifies the authorities for SAMHSA's Center for Mental Health Services, Center for Substance Abuse Prevention, and Center for Substance Abuse Treatment. Changes include increased requirements for collaboration (e.g., with relevant institutes of the National Institutes of Health [NIH]). Each center was, and remains, permanently authorized. Subtitle A (Section 6004) also provides permanent statutory authority for SAMHSA's Center for Behavioral Health Statistics and Quality (which was not previously authorized explicitly in statute) and specifies the responsibilities of its Director.

Advisory Councils and Peer Review Groups

Subtitle A (Sections 6008 and 6009) changes the membership requirements for SAMHSA's advisory councils and peer review groups. It includes the newly established Chief Medical Officer and the Directors of relevant NIH institutes as *ex officio* members of each advisory council. It requires that not less than half of appointed members of the advisory council for each of three centers—the Center for Mental Health Services, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment—shall have relevant clinical experience and training (i.e., a medical degree, a doctoral degree in psychology, or other specified advanced degree or certification). It also requires that not less than half of any peer review group reviewing a grant, contract, or cooperative agreement related to mental illness treatment shall have relevant experience and training, as specified. It requires the HHS Secretary, in consultation with the ASMHSU, to ensure broad geographic representation on peer review groups (to the extent possible).

Emergency Response and Technical Changes

Subtitle A (Section 6002) provides that funds made available for emergency response grants under Public Health Service Act (PHSA) Section 501 shall remain available through the end of the fiscal year following the fiscal year for which such amounts are appropriated, and makes numerous technical edits, such as updating terminology (e.g., replacing “illnesses” with “diseases or disorders”).

Subtitle B—Oversight and Accountability

Subtitle B creates new planning and evaluation requirements, changes reporting and accounting requirements for state-designated protection and advocacy systems, and requires a report by the Comptroller General on programs funded by SAMHSA's Protection and Advocacy for Individuals with Mental Illness (PAIMI) grants.

Planning and Evaluation

Subtitle B (Section 6021) requires the HHS Secretary, acting through the HHS Assistant Secretary for Planning and Evaluation (ASPE), to ensure efficient and effective planning and evaluation of programs and activities for the prevention and treatment of mental disorders and substance use disorders. It requires the ASPE, not later than 180 days after enactment, to develop an evaluation

strategy that identifies priority programs for evaluation. It specifies some contents of the evaluation strategy, requires consultation with others inside and outside HHS, and requires the ASPE to make recommendations to Congress and the HHS Secretary on improving the quality of relevant programs and activities.

Protection and Advocacy System Reporting and Accounting

The Protection and Advocacy for Individuals with Mental Illness Act of 1986 (PAIMI Act, P.L. 99-319, as amended) authorizes formula grants to state-designated protection and advocacy systems mandated to protect individuals with mental illness residing in care or treatment facilities from abuse, neglect, and violations of their civil rights. The PAIMI Act requires each protection and advocacy system to prepare an annual report on the system’s activities, accomplishments, and expenditures and to transmit the report to the HHS Secretary and the head of the state mental health agency. It also requires the HHS Secretary to provide a biennial report to the President, Congress, and the National Council on Disability describing the goals and outcomes of specified programs for individuals with disabilities; it requires the Secretary to include in each such report a separate statement containing specified information.

Subtitle B (Section 6022) requires each protection and advocacy system to make the annual report publicly available, in addition to transmitting the report to the Secretary and the head of the state mental health agency. It also specifies inclusion of additional information in the separate statement in the HHS Secretary’s biennial report. The separate statement must contain “a detailed accounting” of the protection and advocacy system’s spending, broken down by funding source: federal government, state government, local government, or a private entity.

GAO Report

Subtitle B (Section 6023) requires the Comptroller General, not later than 18 months after the date of enactment, to submit a report to specified congressional committees on programs funded by PAIMI grants. It requires the Comptroller General to consult with the HHS Secretary and the ASMHSU in conducting the evaluation, and it specifies the contents of the report.

Subtitle C—Interdepartmental Serious Mental Illness Coordinating Committee

Interdepartmental Serious Mental Illness Coordinating Committee

Subtitle C (Section 6031) requires the HHS Secretary (or a designee), not later than three months after enactment, to establish the “Interdepartmental Serious Mental Illness Coordinating Committee.” It requires the committee to produce a report—not later than one year after enactment and again five years after enactment—summarizing advances, evaluating federal programs, and making recommendations related to services for adults with serious mental illness and children with serious emotional disturbances. It specifies that the committee shall terminate six years after the date on which it is established; however, it also requires the HHS Secretary, upon submission of the committee’s second report, to make a recommendation to Congress as to whether operation of the committee should be extended. It includes requirements regarding committee membership, members’ terms, and the frequency of committee meetings. It allows the committee to establish working groups. It specifies that the provisions of the Federal Advisory Committee Act shall apply to the committee except as provided in the section.

Title VII—Ensuring Mental and Substance Use Disorders Prevention, Treatment, and Recovery Programs Keep Pace with Science and Technology

Title VII establishes within SAMHSA a “National Mental Health Policy Laboratory,” codifies SAMHSA’s National Registry of Evidence-based Programs and Practices (which was not previously explicitly authorized in statute), and authorizes appropriations for SAMHSA’s Programs of Regional and National Significance (for which authorizations of appropriations had expired).

National Mental Health Policy Laboratory

Prior to enactment of P.L. 114-255, SAMHSA’s Office of Policy, Planning, and Innovation, which was not explicitly authorized in statute, facilitated the adoption of evidence-based policies and practices to improve behavioral health services outcomes. Title VII (Section 7001) adds a new PHSA Section 501A establishing within SAMHSA a “National Mental Health Policy Laboratory,” to begin implementation not later than January 1, 2018. It requires the laboratory to carry out specified responsibilities, including “the authorities and activities that were in effect for the Office of Policy, Planning, and Innovation” before enactment of P.L. 114-255.

New PHSA Section 501A allows the laboratory, in carrying out its responsibilities, to give preference to some types of service delivery models (e.g., those that improve coordination between mental health care providers and physical health care providers). It requires the laboratory to consult with SAMHSA’s Chief Medical Officer, representatives of relevant NIH institutes, other federal agencies as appropriate, clinical and analytical experts in specified fields, and other individuals and agencies as determined appropriate by the ASMHSU.

New PHSA Section 501A allows the ASMHSU, in coordination with the laboratory, to award grants for (1) evaluating promising service delivery models and (2) expanding the use of evidence-based programs (as specified). It requires the ASMHSU, in awarding such grants, to consult with SAMHSA’s Chief Medical Officer, advisory councils, and relevant NIH institutes as appropriate. It authorizes to be appropriated \$7 million for the period of FY2018–FY2020 to carry out each of the two grant programs (i.e., \$14 million total).

National Registry of Evidence-based Programs and Practices

Prior to enactment of P.L. 114-255, SAMHSA maintained a searchable online database of evidence-based programs and practices for the prevention and treatment of mental disorders and substance use disorders. The database, called the National Registry of Evidence-based Programs and Practices (NREPP), was not explicitly authorized in statute. Title VII (Section 7002) adds a new PHSA Section 543A essentially codifying the NREPP (but not by name). New PHSA Section 543A requires the ASMHSU, as appropriate, to post on SAMHSA’s website “information on evidence-based programs and practices” for the purpose of improving stakeholders’ access to such information.

New PHSA Section 543A requires the ASMHSU to review applications before posting programs and practices on the website. It allows the ASMHSU to establish an application period and to prioritize the review of programs and practices to address gaps in information identified by the ASMHSU, the National Mental Health and Substance Use Policy Laboratory, or the ASPE. It requires the ASMHSU to provide notice of the application period in the *Federal Register*; the notice may solicit applications for programs and practices meeting criteria for priority review.

New PHSA Section 543A allows the ASMHSU to establish minimum requirements for applications and to use a rating system that takes into account the strength of evidence and the methodological rigor of the supporting research. It requires the ASMHSU to make publicly available the evaluation metrics and resulting ratings of applications.

Programs of Regional and National Significance

SAMHSA administers numerous grants and activities under authorities commonly known as Programs of Regional and National Significance (PRNS) in three areas: mental health, substance abuse treatment, and substance abuse prevention.³ Prior to enactment of P.L. 114-255, authorizations of appropriations for PRNS had expired; however, programs operating under their general authorities have continued to receive funding through the annual appropriations process.

Title VII (Sections 7003 through 7005) authorizes appropriations for mental health PRNS, substance abuse treatment PRNS, and substance abuse prevention PRNS. It authorizes to be appropriated \$395 million (rounded) annually for each of FY2018–FY2022 to carry out mental health PRNS. It authorizes to be appropriated \$334 million (rounded) annually for each of FY2018–FY2022 to carry out substance abuse treatment PRNS. It authorizes to be appropriated \$211 million (rounded) annually for each of FY2018–FY2022 to carry out substance abuse prevention PRNS. It also makes technical edits to the mental health, substance abuse treatment, and substance abuse prevention PRNS authorities.

Title VIII—Supporting State Prevention Activities and Responses to Mental Health and Substance Use Disorder Needs

Title VIII focuses on SAMHSA’s two biggest programs: the Community Mental Health Services Block Grant (MHBG, \$533 million in FY2016) and the Substance Abuse Prevention and Treatment Block Grant (SABG, \$1.9 billion in FY2016). The two block grants are authorized under PHSA Title XIX, Part B, Subpart I (MHBG) and Subpart II (SABG). Provisions in PHSA Title XIX, Part B, Subpart III also apply to the MHBG and the SABG.

Community Mental Health Services Block Grant (MHBG)

Each state may distribute MHBG funds to local government entities and nongovernmental organizations in accordance with a required state plan for providing comprehensive community mental health services for adults with serious mental illness and children with serious emotional disturbance (and subject to other federal requirements). Prior to enactment of P.L. 114-255, PHSA Section 1911(b) listed three purposes for which states may expend MHBG funds, each of which refers explicitly to the required state plan. Title VIII (Section 8001) adds a new purpose, which is placed first and is more general: “providing community mental health services for adults with a serious mental illness and children with a serious emotional disturbance” (as defined).

Title VIII (Section 8001) amends PHSA Section 1912(b), which lays out criteria for the state plan. It specifies that the state plan must be submitted to the HHS Secretary every two years. (The frequency was not previously specified in statute.) It preserves existing requirements for the

³ Under PHSA Title V Part B, the HHS Secretary is required to “address priority ... needs of regional and national significance” in mental health (PHSA Section 520A), substance abuse treatment (PHSA Section 509), and substance abuse prevention (PHSA Section 516); the HHS Secretary may do so “directly or through grants or cooperative agreements with States, political subdivisions of States, Indian tribes and tribal organizations, other public or private nonprofit entities.”

content of the state plan and adds several new requirements. For example, it requires the state plan to identify a “single State agency” responsible for administering the grant—something SAMHSA already requires of states but that was not previously in statute. Some of the new requirements focus on efficiency (or cost-efficiency), effectiveness, and quality of services.

Title VIII (Section 8001) also amends PHSA 1915(b), which requires states (as a condition of receiving MHBG funds) to maintain spending on community mental health services and allows the HHS Secretary to waive that requirement under certain circumstances. It adds a new provision giving the HHS Secretary 120 days to approve or deny a request for such a waiver; this provision parallels one already in place for the SABG. For a state that fails to maintain spending at required level (absent a waiver), it allows the state to request a negotiated agreement (to be approved by the HHS Secretary and carried out under guidelines issued by the HHS Secretary) rather than have its MHBG allotment reduced.

Title VIII (Section 8001) amends PHSA Section 1920 to require a state to expend at least 10% of its block grant funds each fiscal year (or at least 20% by the end of the succeeding fiscal year) to support evidence-based programs to address early serious mental illness. It also makes several technical edits and authorizes to be appropriated \$533 million (rounded) annually for each of FY2018–FY2022 to carry out the MHBG.

Substance Abuse Prevention and Treatment Block Grant (SABG)

Each state may distribute SABG funds to local government entities and nongovernmental organizations in accordance with a required state plan for providing substance use disorder prevention and treatment services (and subject to other federal requirements). Title VIII (Section 8002) amends PHSA Section 1932(b), which lays out criteria for the state plan. It preserves existing requirements for the content of the state plan and adds several new requirements. For example, it requires the state plan to identify a “single State agency” responsible for administering the grant—something SAMHSA already requires of states but that was not previously in statute. It adds a requirement for the state plan to include information on the need for substance use disorder prevention and services (and repeals PHSA Section 1929, which previously allowed the HHS Secretary to make an SABG grant to a state only if the state submitted a statement of needs).

Title VIII (Section 8002) amends PHSA Section 1930, which requires states (as a condition of receiving SABG funds) to maintain spending on substance use disorder services and allows the HHS Secretary to waive that requirement under certain circumstances. For a state that fails to maintain spending at required level (absent a waiver), it allows the state to request a negotiated agreement (to be approved by the HHS Secretary and carried out under guidelines issued by the HHS Secretary) rather than have its SABG allotment reduced. In addition, Title VIII (Section 8002) eliminates a separate maintenance of effort requirement related to tuberculosis and HIV.

Title VIII (Section 8002) amends PHSA Section 1928(b) by replacing a requirement for states to make available continuing education with a more detailed requirement for states to ensure opportunities for ongoing professional development, including specific topics (e.g., performance-based accountability). It preserves a requirement for states to improve the treatment referral process but strikes language in PHSA Section 1928(a) that requires such improvements “relative to fiscal year 1992.”

Title VIII (Section 8002) makes several technical edits and authorizes to be appropriated \$1.9 billion (rounded) annually for each of FY2018–FY2022 to carry out the SABG.

Public Health Emergencies

Title VIII (Section 8003) adds a new PHS Section 1957, which allows the HHS Secretary, in the case of a public health emergency, to offer a state flexibility in meeting deadlines or other requirements for the MHBG, the SABG, SAMHSA’s Projects for Assistance in Transition from Homelessness grant, or SAMHSA’s Protection and Advocacy for Individuals with Mental Illness grant.

Joint MHBG/SABG Applications

Title VIII (Section 8003) adds a new PHS Section 1958, which allows the HHS Secretary, acting through the ASMHSU, to permit a joint application for the MHBG and SABG; this section codifies the joint application SAMHSA already allows in practice.

Study of Block Grant Formulas

Each of the SAMHSA-administered block grants is distributed according to a formula that takes into account the population at risk, cost of services, and available resources. Title VIII (Section 8004) requires the HHS Secretary, acting through the ASMHSU, to conduct a study on the formulas for distributing MHBG and SABG funds and, not later than two years after enactment, to submit to specified congressional committees a report on the findings and recommendations of the study. Section 8004 specifies the contents of the study and requires that the study be conducted through a grant, contract, or agreement with a third party.

Title IX—Promoting Access to Mental Health and Substance Use Disorder Care

Subtitle A—Helping Individuals and Families

Changes to Existing Programs and Activities

Treatment Systems for Homeless

PHSA Section 506 authorizes a SAMHSA-administered program commonly known as Treatment Systems for Homeless. PHS Section 506 requires the HHS Secretary to award grants, contracts, and cooperative agreements to eligible entities, as specified, to provide mental health and substance abuse services to homeless individuals. The section specifies granting preferences, conditions for services provided under the grant, and terms of awards, among other factors.

Subtitle A (Section 9001) makes technical edits to PHS Section 506 (e.g., replacing “substance abuse” with “substance use disorder”). It authorizes to be appropriated \$41 million (rounded) annually for each of FY2018-FY2022.

Criminal and Juvenile Justice Programs

PHSA Section 520G authorizes a SAMHSA-administered program commonly known as Criminal and Juvenile Justice Programs. PHS Section 520G requires the HHS Secretary to make grants to states, political subdivisions of states, Indian Tribes, and Tribal Organizations, directly or through agreements, for jail diversion programs (i.e., programs to divert individuals with mental illness from the criminal justice system to community-based services).

Subtitle A (Section 9002) amends PHS Section 520G to require the HHS Secretary to give special consideration, as appropriate, to entities supporting jail diversion services for veterans. It adds developing programs to divert individuals prior to booking or arrest as a permissible use of funds. It makes several technical edits (e.g., updating definitions). It authorizes to be appropriated \$4 million (rounded) annually for each of FY2018-FY2022.

Primary and Behavioral Health Care Integration

PHSA Section 520K authorizes a SAMHSA-administered program commonly known as Primary and Behavioral Health Care Integration. Prior to enactment of P.L. 114-255, PHS Section 520K required the HHS Secretary, acting through the SAMHSA Administrator, to fund demonstration projects to provide coordinated and integrated mental health and primary care services. Eligible entities were community-based mental health programs. The target population was adults with mental illnesses and co-occurring chronic diseases. It included various other requirements (e.g., application, allowable uses of funds, and reporting).

Subtitle A (Section 9003) replaces the text of PHS Section 520K to establish a similar program. It renames the section “Integration Incentive Grants and Cooperative Agreements.” Major differences include that it authorizes rather than requires these grants, does not reference the SAMHSA Administrator, and makes eligible entities state agencies in collaboration with qualified community programs. It expands the target population to include children and adolescents with serious emotional disturbance who have co-occurring physical health conditions or chronic diseases, adults with serious mental illness who have co-occurring physical health conditions or chronic diseases, and individuals with substance use disorders. It also includes various other requirements that differ from the prior program, such as its application procedures, reporting requirements, and the technical assistance that the HHS Secretary is authorized to provide. It authorizes to be appropriated \$52 million (rounded) annually for each of FY2018-FY2022.

Projects for Assistance in Transition from Homelessness

PHSA Title V, Part C (Sections 521-535) authorizes a SAMHSA-administered program commonly known as Projects for Assistance in Transition from Homelessness. The program awards formula grants to states to provide outreach, support services, and mental health and alcohol and drug treatment services to homeless individuals with serious mental illness (with or without co-occurring substance use disorders) or those who are at risk of becoming homeless. Prior to enactment of P.L. 114-255, PHS Title V, Part C, required the HHS Secretary, acting through specified NIH institutes, to provide technical assistance to eligible entities. It authorized the formula grant program for FY1991-FY1994 and authorized appropriations for FY2001-FY2003; however, the program has continued to receive funding through the annual appropriations process.

Subtitle A (Section 9004) amends PHS Section 521 to authorize the formula grants for FY2018-FY2022. It requires the ASMHSU, not later than two years after enactment, to conduct a study of the allotment formula and to submit a report to Congress. It requires the HHS Secretary to provide technical assistance acting through the ASMHSU (rather than NIH institutes). It defines the term “substance use disorder services” (by reference) and makes technical edits (e.g., replacing “substance abuse” with “substance use disorder”). It authorizes to be appropriated \$65 million (rounded) annually for each of FY2018-FY2022.

Garrett Lee Smith (GLS) Suicide Prevention Resource Center

PHSA Section 520C authorizes a SAMHSA-administered program commonly known as the Garrett Lee Smith (GLS) Suicide Prevention Resource Center. Prior to enactment of P.L. 114-255, PHSA Section 520C authorized four additional centers that were never funded. Subtitle A (Section 9008) amends PHSA Section 520C to require the HHS Secretary, acting through the ASMHSU, to establish one technical assistance center focused on suicide prevention (i.e., the one existing center). It expands the existing program’s focus from youth suicides to suicides among all ages, particularly high-risk groups. It requires the HHS Secretary, not later than two years after enactment, to submit to Congress a report on the activities carried out by the center. It authorizes to be appropriated \$6 million (rounded) annually for each of FY2018–FY2022 for the center.

GLS Youth Suicide Prevention State Grants

PHSA Section 520E authorizes a SAMHSA-administered program commonly known as the GLS Youth Suicide Prevention State Grants. Prior to enactment of P.L. 114-255, PHSA Section 520E required the HHS Secretary, acting through the SAMHSA Administrator, to award grants or cooperative agreements for statewide or tribal strategies targeting suicide prevention among youth. It specified that each state may receive only one grant or cooperative agreement. It authorizes appropriations through FY2007 and specified funding preferences that would be applied if less than \$3.5 million was appropriated in any given fiscal year. Congress has continued to provide funding for the program in annual appropriations acts.

Subtitle A (Section 9008) amends PHSA Section 520E in several places. It adds a requirement that the HHS Secretary consider the need of the applicant (e.g., rates of suicide) in awarding grants. It renews a reporting requirement by making the report due to congressional committees not later than two years after enactment. It eliminates the requirement that was previously in effect if the program’s appropriation was less than \$3.5 million in any fiscal year. It makes technical edits (e.g., replacing “substance abuse” with “substance use disorder”). It authorizes to be appropriated \$30 million annually for each of FY2018-FY2022.

Evidence-Based Practices for Older Adults

PHSA Section 520A authorizes SAMHSA’s mental health programs of regional and national significance. PHSA Section 520A(e) requires the HHS Secretary to establish programs for the purpose of disseminating and applying findings of other programs (as specified). Subtitle A (Section 9012) amends PHSA Section 520A(e) to require the HHS Secretary to provide technical assistance to grantees and to disseminate to non-grantees information about evidence-based practices for preventing and treating mental disorders (including those with co-occurring substance use disorders) among geriatric populations.

National Violent Death Reporting System

Under the authority in PHSA Title III, the Centers for Disease Control and Prevention (CDC) administers the National Violent Death Reporting System, which includes surveillance data from 42 states on violent deaths that have occurred (e.g., homicides and suicides). Subtitle A (Section 9013) encourages the HHS Secretary, acting through the CDC Director, to improve the National Violent Death Reporting System by including additional states. It specifies that reporting to this system is voluntary for states.

Assisted Outpatient Treatment for Individuals with Serious Mental Illness

The Protecting Access to Medicare Act (PAMA, P.L. 113-93) Section 224 authorizes a SAMHSA-administered program commonly known as Assisted Outpatient Treatment for Individuals with Serious Mental Illness. Prior to enactment of P.L. 114-255, PAMA Section 224 required the HHS Secretary to establish a four-year pilot program to award no more than 50 grants each year to eligible entities to support implementation of new assisted outpatient treatment programs for individuals with serious mental illness. It limited grant amounts to not exceed \$1 million in each year. It authorized to be appropriated \$15 million annually for each of FY2015-FY2018.

Subtitle A (Section 9014) amends PAMA Section 224 to extend the program's authorization through FY2022. It authorizes to be appropriated \$15 million annually for each of FY2015-FY2017, \$20 million for FY2018, \$19 million annually for each of FY2019-FY2020, and \$18 million annually for each of FY2021-FY2022.

Sober Truth on Preventing Underage Drinking

PHSA Section 519B authorizes a SAMHSA-administered program commonly known as the Sober Truth on Preventing Underage Drinking Act (STOP Act). Prior to enactment of P.L. 114-255, PHSA Section 519B authorized a range of activities aimed at reducing underage drinking. It authorized to be appropriated separate amounts for each activity annually through FY2010, including (among other activities) (1) \$1 million to support an Interagency Coordinating Committee on the Prevention of Underage Drinking and an annual report on state underage drinking prevention and enforcement activities; (2) \$1 million for a National Media Campaign to Prevent Underage Drinking; (3) \$5 million for "enhancement grants" aimed at maximizing the effectiveness of community-wide approaches to preventing and reducing underage drinking; and (4) \$6 million for research on underage drinking. For each of the listed activities, Subtitle A (Section 9016) authorizes to be appropriated the same amount annually for each of FY2018-FY2022. Subtitle A (Section 9016) adds a new PHSA Section 519B(d), which allows the ASMHSU to award grants to support implementation of practices for reducing the prevalence of underage drinking.

Codification of Existing Programs and Activities

Suicide Prevention Lifeline

Prior to enactment of P.L. 114-255, SAMHSA funded the National Suicide Prevention Lifeline (1-800-273-8255), which was not explicitly authorized in statute but operated under SAMHSA's mental health programs of regional and national significance (PHSA Section 520A). The National Suicide Prevention Lifeline provides confidential, free, 24-hour-a-day, 365-day-a-year support for people who are in crisis or experiencing emotional distress. Subtitle A (Section 9005) adds a new PHSA Section 520E-3 requiring the HHS Secretary to maintain the existing National Suicide Prevention Lifeline authorized under Section 520A. It authorizes appropriations of \$7 million (rounded) annually for each of FY2018-FY2022.

National Helpline

Prior to enactment of P.L. 114-255, SAMHSA funded the National Helpline, also known as the Treatment Referral Routing Service, which was not explicitly authorized in statute. The National Helpline provides a confidential, free, 24-hour-a-day, 365-day-a-year referrals to local treatment facilities, support groups, and community-based organizations to individuals and family members

facing mental and/or substance use disorders. Subtitle A (Section 9006) creates a new PHSA Section 520E-4 requiring the HHS Secretary, acting through the ASMHSU, to maintain the existing Treatment and Referral Routing Services. It specifies the protocol that the Secretary should follow including the contact included in the routing service, how information is made available, and how information is removed from the routing service. It also states that nothing in the new section prevents the ASMHSU from using any unobligated amounts to maintain the Routing Service.

New Programs and Activities

Strengthening Community Crisis Response Systems

Prior to enactment of P.L. 114-255, PHSA Section 520F authorized a grant program that had not been funded. It required the HHS Secretary to award grants to support the designation of hospitals and health centers as emergency mental health centers (as defined). It specified eligible entities, application procedures, permissible uses of funds, and a required evaluation. It authorized appropriations through FY2003.

Subtitle A (Section 9007) replaces PHSA Section 520F with new language that requires the HHS Secretary to award competitive grants (1) to states, localities, Indian Tribes, and Tribal Organizations to enhance community-based crisis response systems (as defined); or (2) to states to develop, maintain, or enhance a database of beds at specified inpatient behavioral health treatment facilities. It specifies application procedures, defines the requirements of a database of inpatient beds, and requires an evaluation. It authorizes to be appropriated \$13 million (rounded) for the period of FY2018-FY2022 to carry out the program.

Adult Suicide Prevention

Subtitle A (Section 9009) authorizes the ASMHSU to award five-year grants to eligible entities as described for suicide prevention efforts amongst adults aged 25 and older, as specified. It requires the ASMHSU to evaluate grant activities and provide appropriate information, training, and technical assistance to grantees. It authorizes to be appropriated \$30 million for the period of FY2018-FY2022 to carry out the program.

Assertive Community Treatment

Subtitle A (Section 9015) adds a new PHSA Section 520M requiring the ASMHSU to award grants to support assertive community treatment programs for individuals with serious mental illness. Assertive community treatment is designed to support community living for individuals with the most severe functional impairments associated with mental illness. Such individuals tend to need services from multiple providers (e.g., physicians and social workers) and multiple systems (e.g., social services, housing services, and health care). In the assertive community treatment model, a multidisciplinary team is available around the clock to deliver a wide range of services in an individual's home or other community settings. Subtitle A (Section 9015) specifies the entities eligible for these grants and required "additional activities," including a report to Congress and technical assistance for grantees. It authorizes to be appropriated \$5 million for the period of FY2018-FY2022, of which no more than 5% of funds are to be used for carrying out the specified "additional activities."

Mental Health Awareness Training

Prior to enactment of P.L. 114-255, PHSA Section 520J authorized a grant program that had not been funded. It required the HHS Secretary to award grants to train emergency services personnel to identify and appropriately respond to individuals with mental illness (among other purposes). It authorized appropriations through FY2003. Subtitle A (Section 9010) makes a number of changes to PHSA Section 520J, including expanding the permissible uses of funds to include recognizing mental illness, resources available for individuals with mental illness, and safely de-escalating crisis situations involving individuals with mental illness. It authorizes to be appropriated \$15 million (rounded) annually for each of FY2018-FY2022.

Repeals of Unfunded Programs and Activities

Subtitle A (Section 9017) repeals the authorizations for several grant programs that have never received funding:

- PHSA Section 514,⁴ “Methamphetamine and Amphetamine Treatment Initiative”
- PHSA Section 514A, “Early Intervention Services for Children and Adolescents”
- PHSA Section 517, “Prevention, Treatment, And Rehabilitation Model Projects for High Risk Youth”
- PHSA Section 519A, “Grants for Strengthening Families”
- PHSA Section 519C, “Services for Individuals with Fetal Alcohol Syndrome”
- PHSA Section 519E, “Prevention of Methamphetamine and Inhalant Abuse and Addiction”
- PHSA Section 520B, “National Centers of Excellence for Depression”
- PHSA Section 520D, “Services for Youth Offenders”
- PHSA Section 520H, “Improving Outcomes for Children and Adolescents Through Services Integration Between Child Welfare and Mental Health Services.”

Sense of Congress Prioritizing American Indians and Alaska Native Youth Within Suicide Prevention Programs

Subtitle A (Section 9011) presents findings related to suicide among American Indian and Alaska Native youth and expresses the sense of Congress that the HHS Secretary, in carrying out programs for suicide prevention and intervention, “should prioritize programs and activities for populations with disproportionately high rates of suicide, such as American Indian and Alaska Natives.”

⁴ The PHSA has two sections 514; this refers to the one codified at 42 U.S.C. §290bb-9.

Subtitle B—Strengthening the Health Care Workforce

Changes to Existing Programs and Activities

Mental and Behavioral Health Training Grants

PHSA Section 756 authorizes a program commonly known as Mental and Behavioral Health Training Grants, which is administered by the Health Resources and Services Administration (HRSA). It allows the HHS Secretary to award grants to eligible entities to support student recruitment, education, and clinical experiences in mental and behavioral health.

Prior to enactment of P.L. 114-255, PHSA Section 756(a) eligible entities included (1) social work programs offering a bachelor's degree or higher, as specified; (2) psychology programs offering a master's degree or higher, as specified; (3) accredited educational or professional training programs in specified disciplines that are establishing or expanding field placements in child and adolescent mental health; and (4) state-licensed mental health organizations paying for preservice or in-service training of paraprofessionals in child and adolescent mental health. Subtitle B (Section 9021) amends PHSA Section 756(a) to (among other changes) eliminate bachelor's degree programs in social work and master's degree programs in psychology from the list of eligible entities; make the descriptions of eligible social work programs and psychology programs more parallel; add occupational therapy to the list of eligible disciplines; specify that psychiatric nursing may include master's and doctoral-level training; and eliminate the focus on child and adolescent mental health as a requirement (but retain it as an included or preferred focus area).

Subtitle B (Section 9021) also struck language regarding penalties imposed on institutions that violate the terms of their grant agreements and added language requiring eligible institutions to demonstrate their ability to recruit and place students in areas with high need and high demand populations. It also added language specifying granting priorities and requiring a new report to Congress that will include certain specified elements.

Prior to enactment of P.L. 114-255, PHSA Section 756 authorized appropriations through FY2013; however, Congress has continued to provide funding for the program in annual appropriations acts. Subtitle B (Section 9021) authorizes to be appropriated \$50 million (allocated amongst the programs as specified) annually for each of FY2018-FY2022.

National Health Service Corps

PHSA Section 331 authorizes a HRSA-administered program commonly known as the National Health Service Corps (NHSC) to provide primary health services in health professional shortage areas. In addition, it authorizes the HHS Secretary to provide scholarships and loan repayments to corps members in exchange for providing primary health services in such areas. PHSA Section 338B requires the HHS Secretary to establish the NHSC loan repayment program, which provides loan repayment services to trained health professionals, including psychiatrists. Subtitle B (Section 9023) requires the HRSA Administrator to clarify that child and adolescent psychiatrists are eligible for the NHSC loan repayment program.

Minority Fellowship Program

The SAMHSA-administered Minority Fellowship Program provides grants to professional associations (e.g., the American Psychiatric Association and the American Nurses Association) to offer stipends to minority doctoral students who are studying for degrees in a mental or

behavioral health profession. The program is an agency-wide initiative that is not explicitly authorized; instead, it operates under the general authorities for mental health, substance abuse prevention, and substance abuse treatment programs of regional and national significance (PHSA Sections 509, 516, and 520A).

Subtitle B (Section 9023) provides explicit authorization for the Minority Fellowship Program. It adds a new PHSA Section 597 requiring the HHS Secretary to maintain a “Minority Fellowship Program” to award fellowships, which may include stipends, for post-baccalaureate training for mental health professionals in the fields of psychiatry, nursing, social work, marriage and family therapy, mental health counseling, and substance use disorder and addiction counseling. It authorizes to be appropriated \$13 million (rounded) annually for each of FY2018-FY2022.

Liability Protections for Health Professional Volunteers at Community Health Centers

PHSA Section 224 provides certain health care entities (such as health centers funded under PHSA Section 330 and free clinics) with liability protection from medical malpractice claims under the Federal Tort Claims Act (FTCA, 42 U.S.C. §233). FTCA coverage applies to the entities’ employees, board members, and certain contractors; however, it does not extend to health care providers who volunteer their services at health centers or free clinics.

Subtitle B (Section 9025) adds a new subsection (q) to PHSA Section 224 to extend federal malpractice liability coverage to health care professional volunteers by deeming them to be employees of the Public Health Service in certain cases. To be deemed to be an employee of the Public Health Service under this provision, volunteers who are providing specified services at health centers would be required to meet specified requirements, as would the entities where they are volunteering. Section 9025 also requires the U.S. Attorney General, in consultation with the HHS Secretary, to provide an annual report that estimates the cost of claims incurred by the individuals deemed eligible for FTCA coverage by this subsection. It requires the Secretary to transfer the amount estimated in the required report to the Treasury by December 31, for each fiscal year, beginning October 1, 2017. The provision also permits the HHS Secretary to issue regulations to carry out the new subsection and to report to Congress. This authority will sunset on October 1, 2022.

New Programs and Activities

Training Demonstration Program

PHSA Title VII authorizes several HRSA-administered health workforce programs, including some that target training the behavioral health workforce specifically (e.g., the Mental and Behavioral Health Training Grants authorized by PHSA Section 756 described above).

Subtitle B (Section 9022) adds a new PHSA Section 760, requiring the HHS Secretary to establish a demonstration program that awards five-year grants to eligible entities to (1) support training in underserved community-based settings that integrate primary care and mental and substance use disorder treatment for psychiatry residents and fellows, nurse practitioners, physician assistants, and social workers, and (2) establish, maintain, or improve academic units or programs that provide training for students or faculty in the ability to recognize, diagnose, and treat mental and substance use disorders or develop evidence-based practice or recommendations for curricula content standards. Subtitle B (Section 9022) also specifies acceptable use of grant funds, eligible entities, granting priority, required studies and reports. It authorizes to be

appropriated \$10 million annually for each of FY2018-FY2022 to carry out the demonstration program

Workforce Reports

HRSA administers the National Center for Health Workforce Analysis (42 U.S.C. §294q), which regularly examines the health workforce and makes its analyses and reports publicly available. HRSA released its projections on the supply and demand for behavioral health practitioners from 2013-2025 in November 2016.⁵

Subtitle B (Section 9026) requires the HRSA Administrator, in consultation with the ASMHSU, not later than two years after enactment, to conduct and make publicly available a study on the mental health and substance use disorder workforce that contains certain specified elements.

Subtitle B (Section 9026) also requires the U.S. Comptroller General to conduct a study on peer-support specialist programs in up to 10 states that receive SAMHSA funding for peer-support specialist programs. It specifies the contents of the study, the committees that will receive the study, and specifies that the study is to be completed not later than two years after enactment.

Subtitle C—Mental Health on Campus Improvement

Changes to Existing Programs and Activities

Garrett Lee Smith Youth Suicide Prevention Campus Grants

PHSA Section 520E-2 authorizes the SAMHSA-administered program commonly known as Garrett Lee Smith Youth Suicide Prevention Campus grants. It allows the HHS Secretary, acting through the Director of SAMHSA's Center for Mental Health Services and in consultation with the Secretary of Education, to award grants to institutions of higher education to enhance services for students with mental disorders and substance use disorders, as specified.

Subtitle C (Section 9031) amends PHSA Section 520E-2 to expand the grant purposes and permissible uses of funds, to change the application requirements, to authorize the HHS Secretary to provide technical assistance to grantees, and to update terminology. Prior to enactment of P.L. 114-255, PHSA Section 520E-2 authorized appropriations through FY2007; however, Congress has continued to provide funding for the program in annual appropriations acts. Subtitle C (Section 9031) authorizes to be appropriated \$7 million annually for each of FY2018-FY2022 to carry out this section.

New Programs and Activities

College Campus Task Force

Subtitle C (Section 9032) requires the HHS Secretary to establish a College Campus Task Force to discuss mental and behavioral health concerns on college campuses. It specifies the task force members who are representatives from each federal agency that has jurisdiction over, or is

⁵ Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis, *National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025*, Rockville, MD, November 2016, <http://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/behavioral-health2013-2025.pdf>.

affected by, mental health and education policies and projects, including the Departments of Education, HHS, and Veterans Affairs, and others as determined appropriate. It also specifies the task force's required duties and meeting frequency. The section also requires the Secretary to sponsor an annual conference on mental and behavioral health on college campuses. Finally, Section 9032 authorizes to be appropriated \$1 million for the period of FY2018-FY2022.

National Public Education Campaign

Subtitle C (Section 9033) adds a new PHSA Section 549 requiring the HHS Secretary, acting through the ASMHSU in collaboration with the CDC Director, to convene an interagency, public-private sector working group composed of representatives of certain specified groups. The working group will plan, establish, and begin coordinating a public education campaign, as specified, focused on mental and behavioral health on the campuses of institutions of higher education, as defined. New PHSA Section 549 specifies the elements required in the working group's plan. It authorizes to be appropriated of \$1 million for the period of FY2018-FY2022.

Title X—Strengthening Mental Health and Substance Use Disorder Care for Children and Adolescents

Changes to Existing Grant Programs

Children's Mental Health Services

PHSA Title V, Part E (Sections 561–565), authorizes a SAMHSA-administered program commonly known as Children's Mental Health Services. PHSA Title V, Part E, requires the HHS Secretary to award grants to support “comprehensive community mental health services for children with a serious emotional disturbance.” It specifies reporting requirements, technical assistance requirements, and the ages of children to be served, among other factors.

Title X (Section 10001) amends the purpose of the grants to include efforts to identify and serve children at risk. It changes requirements for grantee reporting (such that a copy of the report must be provided to the state) and requirements for the HHS Secretary to provide technical assistance (such that the technical assistance is not limited to grant recipients). It also makes technical edits. It authorizes to be appropriated \$119 million annually for each of FY2018-FY2022 to carry out the program.

Children and Families

PHSA Section 514 authorizes a SAMHSA-administered program commonly known as Children and Families.⁶ PHSA Section 514 requires the HHS Secretary to award grants, contracts, or cooperative agreements to support substance use disorder services for children and adolescents. Eligible entities include public and private nonprofit entities, including Native Alaskan entities and Indian tribes and tribal organizations. PHSA Section 514 requires the HHS Secretary to give priority to applicants meeting specified criteria (e.g., providing gender-specific and culturally appropriate treatment).

Title X (Section 10003) amends PHSA Section 514 to specify definitions for Indian Tribes or Tribal Organizations and Indian Health Service facilities. It expands the grants' purposes to

⁶ The PHSA has two 514 sections; this refers to the one codified at 42 U.S.C. §290bb-7.

include early identification of children and adolescents who are at risk of substance use disorders, substance use disorder treatment services for children, and assistance in obtaining treatment services to pregnant and parenting women with substance use disorders. It also amends granting priority and makes technical edits. It authorizes to be appropriated \$30 million (rounded) annually for each of FY2018-FY2022.

National Child Traumatic Stress Initiative

PHSA Section 582 authorizes a SAMHSA-administered program commonly known as the National Child Traumatic Stress Initiative (NCTSI).⁷ PHSA Section 582 requires the HHS Secretary to award grants, contracts, or cooperative agreements for the purpose of developing programs to improve behavioral health services for children and youth exposed to traumatic events. Eligible entities include public and nonprofit private entities, as well as Indian tribes and tribal organizations. PHSA Section 582 requires the HHS Secretary to prioritize mental health agencies and programs meeting specified criteria; to ensure equitable distribution across geographic regions and among urban and rural areas; and to require each applicant to submit an evaluation plan (as specified). It limits the duration of awards to a maximum of five years.

Title X (Section 10004) amends PHSA Section 582 to make a series of changes to the NCTSI. It expands the purpose of the awards to include providing for the continued operation of the NCTSI, and it expands the types of entities to be given priority to include universities and hospitals. It adds new subsections requiring the NCTSI coordinating center to (1) collect, analyze, report, and make public NCTSI-wide data; (2) facilitate the coordination of training initiatives; and (3) collaborate with the Secretary in disseminating information to stakeholders. It adds another new subsection requiring the HHS Secretary to ensure that NCTSI applications are reviewed by appropriate experts. It establishes a minimum award duration of four years, while retaining the existing maximum duration of five years. It authorizes to be appropriated \$47 million (rounded) annually for each of FY2018-FY2022 to carry out the NCTSI grant program.

New Grant Programs

Pediatric Mental Health Care Access Grants

Title X (Section 10002) adds a new PHSA Section 330M, which requires the HHS Secretary, acting through the HRSA Administrator and in coordination with other relevant federal agencies, to award grants to support the development and improvement of “statewide or regional pediatric mental health care telehealth access programs” (as specified). Such programs are networks of teams—composed of mental health professionals including child psychiatrists and psychologists—that provide support to pediatric primary care practices through the use of telehealth consultations and by other means. Eligible entities for the grants include states, local governments, and Indian tribes and organizations. Grantees are required to (1) submit an evaluation of the activities carried out with the funds they receive and (2) provide nonfederal matching funds equal to at least 20% of the grant amount. In addition, Title X (Section 10002) permits the Secretary to coordinate with other agencies to ensure that funding opportunities are available to support broadband access for health providers. It authorizes to be appropriated \$9 million for the period FY2018-FY2020 to carry out the grant program.

⁷ The PHSA has two 582 sections; this refers to the one codified at 42 U.S.C. §290hh-1.

Screening and Treatment for Maternal Depression

Title X (Section 10005) creates a new PHSA Section 317L-1, which requires the HHS Secretary to award grants to states to establish, improve, or maintain programs for depression screening, assessment, and treatment services for women who are pregnant or who have given birth within the preceding 12 months. It specifies that such programs should use culturally and linguistically appropriate services. It also specifies the application procedures, awarding priorities, and acceptable uses of funds. It authorizes to be appropriated \$5 million annually for each of FY2018-FY2022 to carry out the program.

Infant and Early Childhood Mental Health Promotion, Intervention, and Treatment

Title X (Section 10006) adds a new PHSA Section 399Z-2, which requires the HHS Secretary to award grants to develop, maintain, or enhance programs for infant and early childhood mental health promotion, intervention, and treatment. The program targets children up to age 12 who are at risk for, show early signs of, or have been diagnosed with a serious mental illness (including a serious emotional disturbance) and who would benefit from specified programs. Eligible entities are human services agencies or nonprofit institutions meeting specified criteria. Grantees must provide nonfederal matching funds equal to at least 10% of the grant amount. Title X (Section 10006) also specifies characteristics of the programs to be supported, eligible entities, application requirements, and allowable uses of funds. It authorizes to be appropriated \$20 million for the period FY2018-FY2022 to carry out the grant program.

Title XI—Compassionate Communication on HIPAA

The HIPAA Privacy Rule,⁸ administered by the HHS Office for Civil Rights (OCR), permits a health care provider to disclose protected health information (PHI) to family, friends, or others directly involved in an individual's care (or payment related to that care) as long as the individual does not object to the disclosure or the provider reasonably infers, based on professional judgment, that the individual would not object.⁹ If the individual objects, the provider is prohibited from sharing any PHI with the individual's caregivers.

The Privacy Rule also addresses situations in which the individual is not present, or the opportunity to agree or object “cannot practicably be provided because of the individual's incapacity or an emergency circumstance.” Under such circumstances a health care provider may share the individual's PHI with family, friends, or others directly involved in the individual's care if, based on professional judgment, the provider determines that disclosure is in the “best interests” of the individual.¹⁰

On February 20, 2014, HHS released a guidance document (“HIPAA Privacy Rule and Sharing Information Related to Mental Health”) that provides answers to several frequently asked questions about the circumstances under which the Privacy Rule permits a health care provider to disclose a mentally ill individual's PHI. In addition to disclosures to family and friends, the guidance covers disclosures to law enforcement pursuant to administrative requests and court

⁸ 45 C.F.R. Part 164, Subpart E.

⁹ 45 C.F.R. 164.510(b)(2).

¹⁰ 45 C.F.R. 164.510(b)(3).

orders,¹¹ as well as disclosures to family, law enforcement, and others to avert a serious and imminent threat to the health or safety of the individual or others.¹²

Other federal law and regulations—commonly referred to as the “Part 2 regulations”—protect the privacy of patient records at federally assisted alcohol and drug treatment programs.¹³ The Part 2 regulations restrict the use and disclosure of any patient information that directly identifies a patient as an alcohol or drug abuser, or that links the patient to the alcohol or drug treatment facility (or provider). Such information may not be disclosed without the patient’s prior written consent, except in a few specified circumstances. On February 9, 2016, HHS published a proposed rule updating the Part 2 regulations to facilitate the electronic exchange of substance abuse treatment records.¹⁴

Sense of Congress

Title XI (Section 11001) includes a series of congressional findings regarding the prevalence of individuals with serious mental illness, including schizophrenia, bipolar disorder, and major depression, and the impact of serious mental illness on chronic physical illness and premature death. Congress also finds that confusion exists regarding the permissible uses and disclosures of patient information under the HIPAA Privacy Rule, which may hinder communication with caregivers. The section concludes with a sense-of-Congress statement that more clarity is needed regarding the circumstances under which the HIPAA Privacy Rule permits health care professionals to communicate with caregivers of adults with serious mental illness.

Confidentiality of Records

Title XI (Section 11002) requires the Secretary, not later than one year after finalizing the proposed changes to the Part 2 regulations, to convene stakeholders to determine the effect of the regulations on patient care, outcomes, and privacy.

Clarification of Permitted Uses and Disclosures of Protected Health Information

Title XI (Section 11003) requires OCR, not later than one year after enactment, to issue guidance clarifying the circumstances—consistent with the HIPAA privacy standards—under which health care providers (and other HIPAA-covered entities) may communicate with family members, caregivers, and law enforcement about individuals seeking or receiving treatment for mental health or substance use disorders.

Development and Dissemination of Model Training Programs

Title XI (Section 11004) requires the Secretary, not later than one year after enactment, to develop, disseminate, and periodically update model programs for training health care providers, lawyers, and patients and their families on the permitted uses and disclosures of PHI of

¹¹ 45 C.F.R. 164.512(f).

¹² 45 C.F.R. 164.512(j).

¹³ PHSA Section 543, 42 U.S.C. § 290dd–2. The implementing regulations are codified at 42 C.F.R. Part 2.

¹⁴ Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, “Confidentiality of Substance Use Disorder Patient Records; Proposed Rule,” 81 *Federal Register* 6987, February 9, 2016.

individuals seeking or receiving treatment for mental health or substance use disorders, consistent with the HIPAA privacy and security standards. The Secretary must coordinate with OCR, ASMHSU, HRSA, and other relevant agencies. In addition, the Secretary must solicit input from relevant associations, medical societies, and licensing boards. The section authorizes to be appropriated \$4 million for FY2018, \$2 million annually for FY2019 and FY2020, and \$1 million annually for FY2021 and FY2022 to fund the model training programs.

Title XII—Medicaid Mental Health Coverage

Same-Day Service Rule of Construction

Medicaid is a joint federal-state program that finances the delivery of primary and acute medical services, as well as long-term services and supports, for certain low-income individuals, including children, pregnant women, adults, individuals with disabilities, and people aged 65 and older. In order for states to participate in Medicaid, the federal government requires them to cover certain mandatory populations and benefits, but the federal government allows states to cover other optional populations and services. This flexibility results in substantial variation among the states' Medicaid programs. For instance, some states prohibit Medicaid payment for more than one encounter a day per Medicaid patient at community health centers and/or federally qualified health centers, even though the Medicaid patient could have multiple appointments in one day (i.e., medical, dental, or mental health).

Title XII (Section 12001) addresses Medicaid's same-day services prohibition. It establishes a rule of construction which states that nothing under Social Security Act (SSA) Title XIX (Medicaid) prohibits separate payment under Medicaid state plans (or under a waiver of the plan) for a mental health service or a primary care service furnished to an individual on the same day because the service is (1) a primary care service furnished to an individual at a facility on the same day as a mental health service is furnished at the facility, or (2) a mental health service furnished to an individual at a facility on the same day as a primary care service is furnished at the facility.

Study and Report Related to Medicaid Managed Care Regulation

Title XII (Section 12002) requires the HHS Secretary, acting through the CMS Administrator, to conduct a study on Medicaid coverage of mental health treatment for adults aged 22 through 64 in Institutions for Mental Diseases (IMDs) that are provided through a Medicaid managed-care organization or a prepaid inpatient health plan. It requires the study to include certain specified information, such as the extent to which states, the District of Columbia, and the five territories (i.e., Puerto Rico, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and the Virgin Islands) are providing capitated payments to such organizations or plans for IMD services; data on the number of individuals receiving such services, as well as length of stay; how organizations or plans determine services through IMDs in lieu of other benefits; and the extent to which services through IMDs affect capitated payments. It also requires the HHS Secretary to submit to Congress a report on the study no later than three years after enactment.

Guidance on Opportunities for Innovation

SSA Section 1115 provides the HHS Secretary with broad authority to waive certain statutory requirements for states to conduct research and demonstration projects that further the goals of Medicaid and CHIP. States use the Section 1115 waiver demonstration authority to cover non-Medicaid and CHIP services, limit benefit packages, cap program enrollment, and test delivery

system reforms, among other purposes. CMS has encouraged states to use the Section 1115 waiver authority, along with other opportunities for state innovation available through various statutory authorities (e.g., the Center for Medicare & Medicaid Innovation, Home and Community Based Waivers approved under one or more of the Section 1915 waiver authorities and/or Section 1332 waivers for state innovation), to pursue delivery system transformation initiatives focused on integrating physical and behavioral health services, among other program changes. Through the use of these authorities (alone or in combination), states have sought to engage in delivery system reforms that improve access, patient care, and population health while reducing health care costs.

Title XII (Section 12003) requires, no later than one year after enactment, the CMS Administrator to issue a State Medicaid Director letter regarding opportunities to design innovative service delivery systems, including systems for providing community-based services, for adults with a serious mental illness or children with a serious emotional disturbance who receive Medicaid. The letter should include opportunities for demonstration projects under the SSA Section 1115 waiver authority to improve care for such individuals.

Study and Report on Medicaid Emergency Psychiatric Demonstration Project

Medicaid's IMD exclusion limits the circumstances under which federal Medicaid matching funds are available for inpatient mental health care. Two exceptions to the IMD exclusion are, at state option, Medicaid coverage of (1) services provided to individuals older than 65 in IMDs and (2) inpatient psychiatric hospital services to children under age 21 (or in certain circumstances under the age of 22). However, even with the IMD exclusion, states may receive federal Medicaid matching funding for inpatient mental health services for individuals aged 21 through 64 outside of an IMD.

Section 2707 of the Patient Protection and Affordable Care Act (ACA, P.L. 110-148 as amended) established the Medicaid Emergency Psychiatric Demonstration project, in which eligible states provide Medicaid payments to certain IMDs for services provided to Medicaid enrollees, aged 21 through 64, who require medical assistance to stabilize a psychiatric emergency medical condition. To participate in the demonstration, an IMD must (1) not be publicly owned or operated and (2) be subject to the Emergency Medical Treatment and Active Labor Act (EMTALA, P.L. 99-272). The HHS Secretary selected 11 states and the District of Columbia to participate in the demonstration, which began July 1, 2012. The three-year demonstration was projected to expire on January 1, 2016. However, in August 2016, it was discontinued because the CMS's Office of the Actuary was unable to certify budget neutrality, which was a statutory requirement for the demonstration.

Title XII (Section 12004) requires the HHS Secretary, acting through the CMS Administrator, to collect certain specified information from each state that has participated in the demonstration project. This information includes data on number of IMDs (and beds within these institutions) that receive payment under Medicaid through the demonstration, compared with the statewide total of IMDs (and beds within these institutions); any reduction in expenditures under the Medicaid program or other spending on health care for individuals under the demonstration; data on forensic psychiatric hospitals and beds throughout the state; disproportionate share hospital payments that IMDs received during the period July 1, 2012, through June 30, 2015, and the extent to which the demonstration reduced such payments; data on facilities or sites where individuals with mental health are treated; and utilization of hospital emergency departments during the demonstration project. It requires the HHS Secretary, no later than two years after enactment, to submit a report to Congress that summarizes and analyzes such information, either as part of the reporting requirements under ACA Section 2707(f) or separately.

Providing EPSDT Services to Children in IMDs

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a required Medicaid benefit that provides health screenings and services for most children under the age of 21. Under EPSDT, states are required to provide all medically necessary Medicaid services (e.g., preventive, dental, mental health, developmental, laboratory tests and specialty services) to ameliorate health conditions identified through a health care screening without benefit limits.

Title XII (Section 12005) amends SSA Section 1905(a)(16) to ensure that EPSDT services are available to individuals under age 21 in an inpatient psychiatric hospital setting, regardless of whether such services are furnished by the mental health provider. It applies to Medicaid items and services furnished on or after January 1, 2019.

Electronic Visit Verification System for Personal Care Services and Home Health Care Services

Federal Medicaid law requires states to cover certain populations and benefits, but states have discretion to cover other optional populations and services. Medicaid benefits can include long-term service and support (LTSS) coverage for certain beneficiaries. LTSS, health and related services provided to individuals who need assistance due to a physical, cognitive, or mental disability or condition, can be both optional and mandatory benefits. Personal care services (PCS) and home health care service (HHCS) are LTSS that help enable certain Medicaid beneficiaries to live independently by assisting with medical and nonmedical support services. Prior to the passage of H.R. 34, states were required to provide HHCS services to some beneficiaries and may have used waiver and state plan authorities to also provide PCS and HHCS to other Medicaid populations.

Expenditures for Medicaid PCS benefits have increased rapidly. The Department of Health and Human Services Office of Inspector General (OIG) has issued a number of reports documenting increasing federal PCS expenditures and raised concerns about state and federal PCS oversight. Nationally, HHCS expenditures have increased more slowly, whereas they have increased in some states and other areas, raising concerns about fraud and abuse.

Electronic visit verification (EVV) systems use telephone and computer-based processes to electronically verify and document that a remote activity occurred and when it began and ended. Most EVV systems work similarly by identifying the location of the service provider (by telephone or global positioning satellite location) and the time services began and ended. By communicating with an EVV system, Medicaid PCS and HHCS providers can confirm and document that a PCS or HHCS worker arrived at a scheduled appointment and delivered the necessary services.

Title XII (Section 12006) requires states to require Medicaid PCS and HHCS providers to use EVV systems by January 1, 2019, for PCS and by January 1, 2023, for HHCS or their Federal Medical Assistance Percentage (FMAP) rate—the percentage rate the federal government matches state Medicaid expenditures—will be reduced.

Table 1 displays the percentage reduction that would be applied to a state's quarterly FMAP payment if a state does not implement an EVV requirement for Medicaid PCS providers. **Table 2** displays the FMAP reduction on states if they do not implement an EVV requirement for Medicaid HHCS providers.

Table 1. FMAP Reduction for Noncompliance with Requirement for Medicaid PCS Providers to use Electronic Visit Verification Systems

Calendar Quarter in Which a State was Noncompliant with EVV System Requirement	FMAP Percentage Point Reduction
2019-2020	0.25%
2021	0.5%
2022	0.75%
2023 and each year thereafter	1.0%

Source: CRS summary of P.L. 114-255 Section 12006, Electronic Visit Verification System Required for Personal Care Services and Home Health Care Services under Medicaid.

Table 2. FMAP Reduction for Noncompliance with Requirement for Medicaid HHCS Providers to use Electronic Visit Verification Systems

Calendar Quarter in Which a State was Noncompliant with EVV System Requirement	FMAP Percentage Point Reduction
2023-2024	0.25%
2025	0.5%
2026	0.75%
2027 and each year thereafter	1.0%

Source: CRS summary of P.L. 114-255 Section 12006, Electronic Visit Verification System Required for Personal Care Services and Home Health Care Services under Medicaid.

In implementing the Section 12006 requirement for Medicaid PCS and HHCS EVVs, states are required to consult with agencies and entities that provide PCS and HHCS under the state plan or a waiver. Such consultation is intended to ensure that the EVV systems would be minimally burdensome, account for existing best practices and EVVs in use in the state, and comply with the Health Insurance Portability and Accountability Act of 1986 (HIPAA, P.L. 104-191) privacy and security requirements (as defined in Section 3009 of the Public Health Service Act).

In addition, subject to guidance provided by the HHS Secretary, in implementing the Section 12006 EVV requirement, states are required to have a stakeholder process that obtains input from beneficiaries, family caregivers, individuals who furnish PCS and HHCS, and other stakeholders. States also are required to ensure that individuals who provide PCS and/or HHCS under the state Medicaid plan or a waiver are provided training in the operation of PCS and HHCS EVVs.

States that already required providers to use EVV systems for both PCS and HHCS prior to enactment of P.L. 114-255 are exempt from the requirement to have an EVV, as long as the states continued to require providers to use those EVV systems.

States that can demonstrate to the HHS Secretary they made good faith efforts—by attempting to adopt technology or through encountering unavoidable system delays—to implement a requirement for PCS and HHCS providers to use EVV systems may have a one-year exemption from the required FMAP reductions (for PCS, calendar year 2019; for HHCS, calendar year 2023).

Title XII (Section 12006) defines PCS and HHCS EVVs as systems that capture the type of service performed, person receiving the service, date of the service, location of the service, person providing the service, and time the service begins and ends. It defines HHCS as those provided under Social Security Act Section 1905(a)(7) and PCS as services approved under a state Medicaid plan or other Social Security Act authorities (Social Security Act Sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), or under an 1115 waiver).

Title XII (Section 12006) authorizes the HHS Secretary to pay states that require PCS and HHCS providers to use EVVs operated by the state, or by a contractor on behalf of the state, 90% of the EVV system design, development, or installation costs and 75% of the EVV system operation and maintenance costs. States that require PCS and HHCS providers to use EVV systems not operated by the state, or by a contractor on behalf of the state, will not receive these federal payments.

By January 1, 2018, Title XII (Section 12006) requires the HHS Secretary to collect and disseminate to states PCS and HHCS EVV system best practices. These include (1) training for individuals who provide PCS and HHCS under a state Medicaid plan or waiver on the operation of PCS and HHCS EVVs and the prevention of PCS and HHCS fraud, and (2) providing notice and educational materials to family caregivers and beneficiaries on the use of PCS and HHCS EVVs and other means to prevent fraud.

Under the Fair Labor Standards Act to Domestic Service (29 C.F.R Part 552), Title XII (Section 12006) does not establish an employer-employee relationship between PCS or HHCS agencies or entities and the individuals under contract to the agencies or entities to furnish PCS or HHCS.

In addition, Title XII (Section 12006) does not require the use of a particular or uniform EVV to be used by all agencies or entities that provide PCS or HHCS under a state Medicaid plan or waiver. It does not limit PCS or HHCS provided under a state plan or waiver, or limit provider selection, constrain beneficiary selection of caregivers, or impede the manner in which PCS and HHCS are delivered. It does not prohibit a state from establishing quality measures in implementing a requirement for the use of a PCS and HHCS EVV system.

Title XIII—Mental Health Parity

Title XIII includes provisions related to mental health parity and provisions related to eating disorders, as well as one provision applying mental health parity to eating disorder benefits.

Mental Health Parity

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, P.L. 110-343, Title V, Subtitle B, as amended) requires covered group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Medicaid and the Children’s Health Insurance Program are neither group health plans nor issuers of health insurance; however, the Social Security Act requires Medicaid-managed care organizations, Medicaid alternative benefit plans, and health plans provided under the State Children’s Health Insurance Program to comply with certain requirements of MHPAEA.

MHPAEA is codified in three parts of federal statute: (1) PHS Act Section 2726, related to health insurance; (2) the Employee Retirement Income Security Act (ERISA) Section 712, related to employer-sponsored health insurance; and (3) the Internal Revenue Code (IRC) Section 9812,

related to taxes on health insurance premiums. Enforcement of MHPAEA is the joint responsibility of the Departments of HHS, Labor, and Treasury.

Compliance

Prior to enactment of P.L. 114-255, PHSA Section 2726(a) addressed MHPAEA's general requirements in five paragraphs: (1) aggregate lifetime limits, (2) annual limits, (3) financial requirements and treatment limitations, (4) availability of plan information, and (5) out-of-network providers. Title XIII (Section 13001) adds the sixth and seventh paragraphs to PHSA Section 2726(a).

New paragraph (6) requires the Secretaries of HHS, Labor, and Treasury (in consultation with the Inspectors General of their respective departments) to issue a compliance program guidance document to help improve compliance with MHPAEA. The compliance program guidance document is to be issued not later than one year after enactment and updated every two years. New paragraph (6) also specifies the contents of the compliance program guidance document (e.g., illustrative examples of compliance and noncompliance and recommendations).

New paragraph (7) requires the Secretaries of HHS, Labor, and Treasury to issue, not later than one year after enactment, guidance to help group health plans and health insurance issuers offering group or individual health insurance coverage satisfy MHPAEA requirements, including disclosure requirements. It requires the HHS Secretary to provide a public comment period (not less than 60 days) on the draft guidance before issuing the final guidance. New paragraph (7) also specifies the contents of the guidance (e.g., clarifying information and illustrative examples of methods for disclosing information to ensure compliance).

Title XIII (Section 13001) requires the Secretaries of HHS, Labor, and Treasury to solicit public feedback on how the disclosure request process can be improved (not later than six months after enactment); to make such feedback publicly available (not later than 12 months after enactment); and to share such feedback with the National Association of Insurance Commissioners.

Finally, Title XIII (Section 13001) requires the Secretary of HHS, Labor, or Treasury, upon determining that a group health plan or health insurance issuer has violated MHPAEA at least five times, to audit plan documents for a health plan or issuer in the plan year following the determination. It provides that the requirement should not be construed to limit the Secretaries' authority (as in effect the day before enactment) to audit documents of health plans or issuers.

Action Plan

Title XIII (Section 13002) requires the HHS Secretary, not later than six months after enactment, to convene a public meeting of stakeholders (as specified) to produce an action plan for improved federal and state coordination related to enforcement of MHPAEA and state parity laws. It requires the HHS Secretary to finalize the action plan and make it available on the HHS website not later than six months after the conclusion of the public meeting. It also specifies the contents of the action plan (e.g., recommendations to Congress regarding the need for additional legal authority).

Report on Investigations

Title XIII (Section 13003) requires the Assistant Secretary of Labor of the Employee Benefits Security Administration (in collaboration with the Administrator of the Centers for Medicare & Medicaid Services and the Secretary of the Treasury), not later than one year after enactment and annually thereafter for the subsequent five years, to submit to specified congressional committees

a report summarizing the results of all closed federal investigations with a finding of any serious violation of MHPAEA in the preceding 12-month period. It also specifies the contents of the report, which shall not include individually identifiable data.

GAO Report

Title XIII (Section 13004) requires the Comptroller General (in consultation with the Secretaries of HHS, Labor, and Treasury), not later than three years after enactment, to submit to specified congressional committees a report detailing MHPAEA compliance among group health plans, health insurance issuers, Medicaid-managed care organizations, and health plans provided under the State Children’s Health Insurance Program that are subject to MHPAEA requirements. It also specifies the contents of the report.

Application to Eating Disorder Benefits

Title XIII (Section 13007) applies MHPAEA requirements to eating disorder benefits provided by a group health plan or a health insurance issuer offering group or individual health insurance coverage. That is, *if* such a plan or issuer provides coverage of eating disorder benefits, it must do so consistent with MHPAEA requirements.

Eating Disorders

Information and Awareness

Title XIII (Section 13005) allows the HHS Secretary to advance public awareness on a range of topics related to eating disorders. It allows the HHS Secretary, acting through the Director of the Office of Women’s Health, to update specified contents on the National Women’s Health Information Center website and (in coordination with the Secretary of Education) to incorporate publicly available information into obesity prevention programs developed by the Office of Women’s Health.

Health Professional Training

Title XIII (Section 13006) allows the HHS Secretary to “facilitate the identification of model programs and materials” for teaching health professionals effective strategies for preventing eating disorders and caring for patients with eating disorders (including identification, early intervention, referral, and treatment).

Of note, PHSA Section 399Z authorizes similar activities, which are not currently funded. PHSA Section 399Z requires the HHS Secretary, acting through the CDC Director in collaboration with the HRSA Administrator and the heads of other agencies, to develop and carry out a program to educate and train health professionals to better identify, assess, counsel, refer, and educate patients (and their families) with obesity or an eating disorder or at risk of becoming obese or developing an eating disorder.

Title XIV—Mental Health and Safe Communities

Subtitle A—Mental Health and Safe Communities

Provisions in Subtitle A fall into four categories: (1) changes to existing grant programs, (2) changes to existing initiatives and (non-grant) programs, (3) new grant programs, and (4) changes to new initiatives and (non-grant) programs.

Changes to Existing Grant Programs

Subtitle A amends the authorizing legislation for several Department of Justice (DOJ) programs and one Department of Homeland Security (DHS) grant program. Broadly, the amendments made by Subtitle A expand the scope of these programs to allow funds to be used to assist people with mental illness, substance use problems, or co-occurring substance abuse and mental health issues.

The Edward Byrne Memorial Justice Assistance Grant Program

The Edward Byrne Memorial Justice Assistance Grant (JAG) program (42 U.S.C §§3750 – 3758) is a formula grant program administered by DOJ. JAG provides funding to state and local governments for initiatives, technical assistance, training, personnel, equipment, supplies, contractual support, and criminal justice information systems in one or more of seven purpose areas: (1) law enforcement programs; (2) prosecution and court programs; (3) prevention and education programs; (4) corrections and community corrections programs; (5) drug treatment programs; (6) planning, evaluation, and technology improvement programs; and (7) crime victim and witness programs (other than compensation)

Subtitle A adds an eighth purpose area to the JAG program so funds can be used for “mental health programs and related law enforcement and corrections programs, including behavioral programs and crisis intervention teams.”

The Community Oriented Policing Services (COPS) Program

The Community Oriented Policing Services (COPS) program (42 U.S.C §3796dd) is a competitive grant program administered by DOJ. The COPS program provides funding to state and local law enforcement to support programs that promote community policing and law enforcement operations. COPS grants may be used for a litany of purposes, including hiring or rehiring community policing officers; procuring equipment, technology, or support systems; and establishing school-based partnerships between local law enforcement agencies and local school systems.

Subtitle A allows COPS grants to be used for providing specialized training to law enforcement officers on interacting with people who have mental health problems and recognizing people with mental illnesses; establishing collaborative programs that help law enforcement agencies address the mental health, behavioral, and substance abuse problems of people they encounter; providing specialized training to corrections officers to help them recognize people with mental illness; and enhancing the ability of corrections officers to address the mental health of individuals incarcerated in prison and jails.

The Mental Health Courts Program

Under the Mental Health Courts program (42 U.S.C §§3796ii – 3796ii-7), grants may be awarded to states, state courts, local courts, units of local government, and Indian tribal governments for

several purposes: providing continuing judicial supervision over offenders with mental illness, a mental handicap, or a co-occurring mental illness and substance use problem, who are charged with misdemeanors or nonviolent offenses; the coordinated delivery of services, which includes specialized training for law enforcement and judicial personnel to identify and address the needs of mentally ill offenders; voluntary mental health treatment that carries with it the possibility of dismissal of charges or reduced sentencing upon successful completion of treatment; centralized case management involving the consolidation of all of a mentally ill defendants' cases and the coordination of all mental health treatment plans and social services; and continuing supervision of treatment plan compliance by an offender and continuity of psychiatric care at the end of the supervision period.

Subtitle A allows grants under the Mental Health Courts program to be used to provide “court-ordered assisted outpatient treatment when the court has determined such treatment to be necessary.”

This subtitle adds definitions of “court-ordered assisted outpatient treatment” and “eligible patient” to the authorizing legislation for the Mental Health Courts program.

Subtitle A also allows DOJ to award grants under this program to states, units of local government, territories, Indian tribes, and nonprofit organizations for developing, implementing, or expanding pretrial service programs to improve the identification and outcomes of individuals with mental illness. Specifically, grants may be used for addressing behavioral health needs and risk screening of defendants; using validated methods to assess the risk of defendants and presenting the results to the court; reviewing defendants who cannot comply with the conditions of pretrial release; evaluating pretrial release programs; supervising defendants who are granted pretrial release; and collecting data and conducting risk assessment.

This subtitle allows DOJ to award grants for expanding behavioral health screening and assessment in state and local criminal justice systems. Specifically, grants may be used for promoting the use of risk and needs assessment instruments to gauge individuals' criminogenic risk and the substance abuse and mental health needs; initiatives to match individuals with programs that address their risk and needs factors; implementing methods for identifying individuals most in need of coordinated supervision and treatment; and coordination between criminal justice agencies, judicial systems, and service providers to determine how to best allocate treatment and intensive supervision services.

Subtitle A also puts in place requirements regarding supplanting, applications, grant distribution, and evaluation reports. This subtitle also creates a series of grant accountability requirements, which include requiring DOJ to audit grantees and outlining penalties for grantees with unresolved audit findings, prohibiting DOJ from awarding grants to nonprofit organizations that hold funds in offshore accounts for the purpose of avoiding taxes, placing limits on grantee conference expenditures, and requiring DOJ to take steps to limit duplicative grants to the same entity.

The Justice and Mental Health Collaboration Program

Grants under the Justice and Mental Health Collaboration program (42 U.S.C. §3797aa) may be used by state, local, and tribal governments to provide mental health and other treatment services for mentally ill adults or juvenile offenders who are overseen collaboratively by a criminal or juvenile justice agency or a mental health court and a mental health agency. Specifically, grants under the program may be used to, among other things, create or expand mental health courts or other court-based programs for preliminarily qualified offenders; offer specialized training to criminal and juvenile justice and mental health professionals on identifying the symptoms of

people who might benefit from participating in a mental health court; offer law enforcement or campus security personnel training in procedures to identify and respond to incidents involving individuals with mental illnesses; and establish and expand cooperative efforts to promote public safety through the use of effective intervention with mentally ill offenders.

Subtitle A allows grants under the Justice and Mental Health Collaboration program to be made to state, local, and tribal governments or nonprofit organizations to develop, implement, or expand programs that provide high-intensity, community-based services for individuals with mental illness who are involved with the criminal justice system with the intent of preventing future incarcerations. Specifically, grants may be used to establish multidisciplinary teams that address treatment protocols for individuals with mental illness involved in the criminal justice system; programs that involve criminal justice agencies and service providers who work together to provide recovery-oriented “24/7 wraparound services”; services such as “integrated evidence based practices for the treatment of co-occurring mental health and substance-related disorders, assertive outreach and engagement, community-based service provision at participants’ residence or in the community, psychiatric rehabilitation, recovery oriented services, services to address criminogenic risk factors, and community tenure”; payments to licensed service treatment providers providing treatment to offenders participating in the program; and training to promote “high-fidelity practice principles and technical assistance to support effective and continuing integration with criminal justice agency partners.” This subtitle also puts in place requirements regarding supplanting and applications for these grants.

Subtitle A reauthorizes appropriations for this program at \$50 million annually for each of FY2017-FY2021.

The Adult and Juvenile Offender State and Local Offender Reentry Demonstration Program

Under the Adult and Juvenile Offender State and Local Offender Reentry Demonstration program (42 U.S.C. §3797w), grant funds may be used within seven broad purpose areas: (1) educational, literacy, vocational, and job placement services; (2) substance abuse treatment and services, including programs that start in placement and continue through the community; (3) programs that provide comprehensive supervision and offer services in the community, including programs that provide housing assistance and mental and physical health services; (4) programs that focus on family integration during and after placement for both offenders and their families; (5) mentoring programs that start in placement and continue into the community; (6) programs that provide victim-appropriate services, including those that promote the timely payment of restitution by offenders and those that offer services (such as security or counseling) to victims when offenders are released; (7) and programs that protect communities from dangerous offenders, including developing and implementing the use of risk assessment tools to determine when offenders should be released from prison.

In addition to the current preference requirements, Subtitle A requires DOJ to give priority consideration to applications for funding under the Adult and Juvenile Offender State and Local Offender Reentry Demonstration program that best “provide mental health treatment and transitional services for those with mental illnesses or with co-occurring disorders, including housing placement or assistance” or that best “target offenders with histories of homelessness, substance abuse, or mental illness, including prerelease assessment of the housing status of the offender and behavioral health needs of the offenders with clear coordination with mental health, substance abuse, and homelessness service systems to achieve stable and permanent housing outcomes with appropriate service.”

The Drug Court Discretionary Grant Program

Under the Drug Court Discretionary Grant program (42 U.S.C §§3797u – 3797u-8), funds are awarded to states, state courts, local courts, units of local government, and tribal governments for drug courts that involve continuing judicial supervision over nonviolent offenders who have substance use problems; coordinate with the state or local prosecutor; integrate the administration of other sanctions and services, including mandatory periodic testing for the use of controlled substances; provide substance abuse treatment; allow diversion, probation, or other supervised release involving the possibility of prosecution, confinement, or incarceration based on noncompliance with program requirements or failure to show satisfactory progress; and have offender management and aftercare services. DOJ is also authorized to provide training and technical assistance to drug court programs.

Subtitle A allows individuals with co-occurring substance abuse and mental health problems to participate in courts funded by the Drug Court Discretionary Grant program. The act also allows training and technical assistance provided by DOJ to include training for drug court personnel on identifying and addressing co-occurring substance abuse and mental health problems.

Offender Reentry Mentoring Grants

Under the Offender Reentry Mentoring Grants program (42 U.S.C §17531), funds may be awarded to nonprofit organizations and Indian tribes to provide mentoring and other transitional services for offenders being released into the community. Grants may be used to provide mentoring services to adult and juvenile offenders during incarceration, through transition back to the community, and post-release; transitional services to assist in the reintegration of offenders into the community; and training regarding offender and victims issues.

Subtitle A allows mentoring grants to be used for mental health care as a part of transitional services for inmates returning to the community.

The Matching Grant Program for School Security

Under the Matching Grant Program for School Security (42 U.S.C §§3797a – 3797e) the COPS Office is authorized to award grants to state, local, and tribal governments for the purpose of improving security at schools and on school grounds. Grant funds may be used for installing deterrent measures, including metal detectors, security assessments, security training of personnel and students, coordination with local law enforcement, and any other measure that the COPS Office believes may provide a significant improvement in security.

Subtitle A allows grants under this program to be used for developing and operating crisis intervention teams, which may include coordination with law enforcement agencies and specialized training for school officials in responding to mental health crises.

The Residential Substance Abuse Treatment Program

DOJ's Residential Substance Abuse Treatment (RSAT) program (42 U.S.C §§3796ff – 3796ff-4, 3793(a)(17)) is a formula grant program that assists state and local governments in developing and implementing residential substance abuse treatment programs in state and local correctional facilities.

Subtitle A allows RSAT grants to be used for developing and implementing specialized residential substance abuse treatment programs that identify and provide appropriate treatment to inmates with co-occurring substance abuse *and* mental health problems.

Staffing for Adequate Fire and Emergency Response Program

Under the Staffing for Adequate Fire and Emergency Response (SAFER) program (15 U.S.C. §2229a), the Federal Emergency Management Agency (FEMA) makes grants to fire departments for hiring new firefighters. The grants are to be used to increase the number of firefighters to help communities meet industry minimum standards and attain 24-hour staffing.

Subtitle A allows SAFER grants to be used for providing “specialized training to paramedics, emergency medical service workers, and other first responders to recognize individuals who have mental illness and how to properly intervene with individuals with mental illness, including strategies for verbal de-escalation of crises.”

Changes to Existing Initiatives and Programs

Subtitle A makes changes to a couple of existing DOJ initiatives and programs to help law enforcement agencies respond to active shooters and to collect more data on how people with mental illness interact with the criminal justice system.

VALOR

DOJ’s Preventing Violence Against Law Enforcement and Ensuring Officer Resilience and Survivability Initiative (VALOR) provides training to law enforcement personnel on how to survive violent encounters, especially ambush situations.

Subtitle A allows DOJ to provide safety training and technical assistance to local law enforcement agencies, including active-shooter response training, through VALOR.

Collecting Data on Crimes Committed by People with Mental Illness

The Federal Bureau of Investigation (FBI), through its Uniform Crime Reporting program, collects and publishes data on offenses known to the police, the circumstances of reported homicides, law enforcement officers killed and assaulted in the line of duty, and hate crimes. The FBI announced in December 2015 that it is planning to expand the data it collects through the UCR program to go beyond justifiable homicides to include data on instances where a law enforcement officer causes serious injury or death to civilians.¹⁵

Subtitle A requires DOJ to promulgate or revise regulations within 90 days of enactment so that information submitted to DOJ regarding homicides; law enforcement officers killed, seriously injured, and assaulted; or individuals killed or seriously injured by law enforcement officers includes data on the involvement of mental illness with regard to such incidents.

New Grant Programs

Subtitle A authorizes two new grant programs to improve the criminal justice system’s response to people with substance abuse, mental health, or co-occurring disorders.

¹⁵ Kimberly Kind, “FBI to Sharply Expand System for Tracking Fatal Police Shootings,” *Washington Post*, December 8, 2015.

The Mental Health and Drug Treatment Alternative to Incarceration Program

Subtitle A repeals the authorization for the Prosecution Drug Treatment Alternative to Prison program and replaces it with a Mental Health and Drug Treatment Alternative to Incarceration program. Under the program, DOJ may award grants to state, local, and tribal governments and nonprofit organizations to develop, implement, or expand treatment alternatives for nonviolent or low-level drug offenders who come into contact with or enter the criminal justice system and have a history of or current substance abuse disorder, mental illness, or both and who have been approved for participation in the program by the relevant authorities. Specifically, grants may be used for pre-booking treatment alternatives to incarceration—including law enforcement training on substance use disorders, mental illness, and co-occurring disorders or specialized units to respond to calls involving people with substance abuse, mental illness, and co-occurring disorders—or post-booking treatment alternatives to incarceration—including pretrial services related to substance abuse, mental illness, and co-occurring disorders; specialized probation; treatment and rehabilitation programs; and problem-solving courts (e.g., drug courts, mental health courts, or veterans treatment courts).

This subtitle establishes a series of requirements regarding applications, supplanting, admission and monitoring of program participants, reporting, and the geographic distribution of grants. This subtitle also establishes a series of grant accountability requirements for the program, which include requiring DOJ to audit grantees and outlining penalties for grantees with unresolved audit findings, prohibiting DOJ from awarding grants to nonprofit organizations that hold funds in offshore accounts for the purpose of avoiding taxes, placing limits on grantee conference expenditures, and requiring DOJ to take steps to limit duplicative grants to the same entity.

National Criminal Justice and Mental Health Training and Technical Assistance Center

Subtitle A authorizes DOJ to make grants to national nonprofit organizations with experience in providing broad, national-level training and technical assistance on issues related to mental health, crisis intervention, criminal justice systems, and law enforcement, for the purpose of establishing of a National Criminal Justice and Mental Health Training and Technical Assistance Center. Funds may be used to, among other purposes, provide law enforcement officers with training on how to work with people with mental illness; provide training and technical assistance to mental health providers and criminal justice agencies on diversion, incarceration, and reentry programs for people with mental illness; develop suicide prevention and crisis intervention training for criminal justice agencies; and disseminate best practices, policy standards, and research findings relating to the provision of mental health services.

This subtitle also puts in place a series of grant accountability requirements for this program, which include requiring DOJ to audit grantees and outlining penalties for grantees with unresolved audit findings, prohibiting DOJ from awarding grants to nonprofit organizations that hold funds in offshore accounts for the purpose of avoiding taxes, placing limits on grantee conference expenditures, and requiring DOJ to take steps to limit duplicative grants to the same entity.

New Initiatives and Programs

Subtitle A establishes a federal drug and mental health court pilot program and requires the Government Accountability Office (GAO) to study the cost of incarcerating people with mental illness.

Federal Drug and Mental Health Courts

Subtitle A requires DOJ to establish a pilot program to determine the effectiveness of diverting nonviolent or low-level drug offenders with mental illness, a mental handicap, or a co-occurring mental health and substance abuse disorder from prosecution, probation, or incarceration and placing them in a drug or mental health court. The pilot program is to be conducted in one or more federal judicial districts during FY2017 through FY2021.

The subtitle places a series of criteria on the drug and mental health courts, including requirements that the courts provide continuing judicial supervision; mandatory periodic substance abuse testing; substance abuse treatment for participants with a need for it; community supervision with the possibility of prosecution, confinement, or incarceration for noncompliance with program requirements; outpatient or inpatient mental health treatment that carries with it the possibility of dismissal of charges or reduced sentencing upon successful completion of treatment; programmatic offender management, including case management and aftercare services, such as relapse prevention, health care, education, vocational training, and job and housing placement; and continuing supervision of treatment plan compliance for a term not to exceed the maximum allowable sentence or probation period for the relevant offense, and to the extent practicable, continuity of psychiatric care after the end of the supervision period.

The subtitle also requires DOJ, before establishing a drug or mental health court, to obtain the approval of the U.S. Attorney and chief judge in the judicial district in which the court would be established and determine that the judicial district has adequate behavioral health systems for treatment, including substance abuse and mental health treatment.

The subtitle requires the Administrative Office of the U.S. Courts and the U.S. Probation and Pretrial Services Office to assist DOJ with operating a drug or mental health court.

Report on the Cost of Incarcerating People with Serious Mental Illness

Subtitle A requires GAO to submit a report to Congress detailing the cost of imprisonment for individuals with serious mental illness within 12 months of enactment.

Mental Health Training for Federal Uniformed Services

Subtitle A (Section 14008) requires the Secretaries of Defense, Homeland Security, Health and Human Services, and Commerce to provide the uniformed services with (1) specialized and comprehensive training in procedures to identify and respond appropriately to incidents involving individuals with mental illnesses, (2) computerized information systems or technological improvements to provide timely information to federal law enforcement personnel, other branches of the uniformed services, and criminal justice system personnel to improve the federal response to mentally ill individuals, and (3) cooperative efforts to promote public safety through the use of effective intervention with respect to mentally ill individuals encountered by members of the uniformed services. These actions are to be accomplished not later than 180 days after the date of enactment.

Codification of Due Process for Determinations by Secretary of Veterans Affairs of Mental Capacity of Beneficiaries

Under current Department of Veterans Affairs regulations, the VA has the authority to determine the competency status of a person receiving VA benefits.¹⁶ Regulations define an incompetent person as “one who because of injury or disease lacks the mental capacity to contract or to manage his or her own affairs, including disbursement of funds without limitation.”¹⁷ The VA may appoint a fiduciary to receive benefits on behalf of a beneficiary determined to be incompetent. In addition, the VA will refer the name of any beneficiary determined to be incompetent to the National Instant Criminal Background Check System (NICS), thus legally prohibiting the beneficiary from purchasing or owning any firearm or ammunition under the Gun Control Act of 1968, as amended.¹⁸

Current VA regulations provide certain due process rights to beneficiaries determined to be incompetent, including the right to be notified of the VA’s competency decision and reasons for the decision and the right to challenge this decision in a hearing in which the beneficiary may present evidence and be represented by counsel.¹⁹

Subtitle A (Section 14017) creates a new section of Title 38 of the *U.S. Code* that codifies into the law the due process protections currently afforded by regulation to beneficiaries determined to be incompetent. Specifically, this section provides that the VA may not determine a beneficiary to be incompetent unless it provides the beneficiary with the following:

- a notice of the determination and supporting evidence;
- an opportunity to request a hearing;
- an opportunity to present evidence, including evidence from a medical professional or other person, as to the beneficiary’s capacity to manage his or her VA benefits; and
- the right to be represented by counsel or another person at the hearing and to bring a medical professional or other person to provide testimony at the hearing.

Subtitle B—Comprehensive Justice and Mental Health

Subtitle B makes several changes to the Justice and Mental Health Collaboration program. The amendments largely expand the scope of the program so grants may be used for additional purposes to help respond to people involved in the criminal justice system who have substance abuse, mental health, or co-occurring disorders.

The Justice and Mental Health Collaboration Program

Grants under the Justice and Mental Health Collaboration program (42 U.S.C. §3797aa) may be used by state, local, and tribal governments to provide mental health and other treatment services for mentally ill adults or juvenile offenders who are overseen collaboratively by a criminal or

¹⁶ 38 C.F.R. §3.353.

¹⁷ 38 C.F.R. §3.353(a).

¹⁸ 18 U.S.C. §§922(d)4 and (g)(4). The Brady Handgun Violence Prevention Act [18 U.S.C. §922(t)] requires that any federal firearms licensee check the status of a potential firearm or ammunition buyer through NICS before selling or transferring a firearm or ammunition to that person.

¹⁹ 38 C.F.R. §§3.103 and 3.353(d).

juvenile justice agency or a mental health court and a mental health agency. Specifically, grants under the program may be used, among other things, to create or expand mental health courts or other court-based programs for preliminarily qualified offenders; offer specialized training to criminal and juvenile justice and mental health professionals on identifying the symptoms of people who might benefit from participating in a mental health court; offer law enforcement or campus security personnel training in procedures to identify and respond to incidents involving individuals with mental illnesses; and establish and expand cooperative efforts to promote public safety through the use of effective intervention with mentally ill offenders.

Subtitle B allows grants under the Justice and Mental Health Collaboration program to be awarded to state, local, and tribal governments for “sequential intercept mapping,” which involves convening mental health and criminal justice stakeholders to develop an understanding of how people with mental illness flow through the criminal justice system and to identify opportunities to improve responses to people with mental illness and develop strategies to address gaps in services. This process may serve as the beginning for a strategic plan to improve public health and safety outcomes. Grants may also be used to implement the strategic plan developed through the sequential intercept mapping process.

In addition, Subtitle B allows grants under this program to be used for screening inmates held in correctional facilities for mental illness; providing mental health and substance abuse treatment for inmates with an identified need; developing, implementing, and enhancing post-release plans that coordinate health, housing, medical, employment, and other appropriate services for eligible inmates; increasing the availability of mental health and substance abuse treatment; developing alternatives to solitary confinement and segregated housing and provide mental health treatment to inmates who are placed in solitary confinement or segregated housing; and training correctional employees on how to identify and properly respond to incidents involving inmates with mental illness or co-occurring mental illness and substance abuse disorders.

Further, Subtitle B allows grants under this program to be used to provide training to law enforcement personnel, either through a training academy or another training modality, on how to identify and respond to incidents involving people with mental health disorders or co-occurring mental health and substance abuse disorders.

For frequent users of crisis services, Subtitle B allows grants awarded under the program to be used to develop or support multidisciplinary teams that coordinate, implement, and administer community-based crisis responses and long-term plans; provide training on how to respond appropriately to their unique issues; develop or support treatment alternatives to hospital and jail admissions; or develop protocols and systems to provide coordinated assistance.

Subtitle B requires DOJ to give preferential consideration to applicants under the Justice and Mental Health Collaboration program if they propose to use evidence-based interventions for reducing recidivism or use validated risk assessment instruments to target offenders with a high or moderate risk of recidivism and need for treatment and services.

Subtitle B amends the definition of a “preliminarily qualified offender” under this program to mean an adult or a juvenile accused of an offense who has previously been or currently is diagnosed by a qualified mental health professional as having a mental illness or a co-occurring mental illness and substance abuse disorders and manifests obvious signs of this diagnosis during arrest or confinement before any court. A “preliminarily qualified offender” must be approved for participation in a program by the relevant officials, must not pose a risk of violence to any person in the program or public, and must not be charged with or convicted of a serious sex offense or any offense related to the sexual exploitation of children, homicide, or assault with the intent to commit homicide. In the case of a veterans treatment court, a “preliminarily qualified offender”

must be diagnosed with, or manifest obvious signs of, mental illness or co-occurring mental illness and substance abuse disorders and have been unanimously approved for participation in the court program by relevant officials. This subtitle requires the relevant officials, when considering whether to designate someone as a “preliminarily qualified offender,” to take into account whether the defendant’s participation in the program would pose a substantial risk of violence to the community; the criminal history of the defendant and the severity of the offense for which the defendant is charged; the views of any victims; the extent to which the defendant would benefit from participating in the program; cost savings that could be realized by the defendant participating in the program; and whether the defendant meets all of the eligibility criteria for participation in the program.

In addition, Subtitle B establishes a series of grant accountability requirements for any grant made under the Justice and Mental Health Collaboration program, which include requiring DOJ to audit grantees and outlining penalties for grantees with unresolved audit findings, prohibiting DOJ from awarding grants to nonprofit organizations that hold funds in offshore accounts for the purpose of avoiding taxes, placing limits on grantee conference expenditures, and requiring DOJ to take steps to limit duplicative grants to the same entity.

Training for Federal Criminal Justice Agencies

Within one year of enactment, Subtitle B requires DOJ to provide direction and guidance regarding training programs for first responders and tactical units of federal law enforcement agencies, the Bureau of Prisons, the Administrative Office of the U.S. Courts, and other appropriate agencies. In particular, DOJ is to provide guidance regarding procedures to identify and appropriately respond to incidents involving people with mental illness and the establishment of, or improvement to, computerized information systems of federal criminal justice agencies to help improve their responses to incidents involving people with mental illness.

Report on Responding to the Needs of People with Mental Illness

Subtitle B requires GAO, in coordination with DOJ, and within one year of enactment, to submit to Congress a report on the practices that federal first responders, tactical units, and corrections officers are trained to use to respond to people with mental illness; procedures to properly identify and respond to the needs of people with mental illness; the application of best practices in a criminal justice setting to better address the needs of people with mental illness; and recommendations on how DOJ can expand and improve information sharing and dissemination of best practices.

Appendix. List of Abbreviations

ACA: Patient Protection and Affordable Care Act (P.L. 110-148, as amended)

ASMHSU: Assistant Secretary for Mental Health and Substance Use

ASPE: Assistant Secretary for Planning and Evaluation

CDC: Centers for Disease Control and Prevention

CHIP: Children’s Health Insurance Program

CMS: Centers for Medicare & Medicaid Services

COPS: Community Oriented Policing Services

CRS: Congressional Research Service

DHS: Department of Homeland Security

DOJ: Department of Justice

EMTALA: Emergency Medical Treatment and Labor Act (P.L. 99-272)

EPSDT: Early and Periodic Screening, Diagnosis and Treatment

ERISA: Employee Retirement Income Security Act

EVV: Electronic visit verification

FBI: Federal Bureau of Investigation

FMAP: Federal Medical Assistance Percentage

FTCA: Federal Tort Claims Act

GAO: Government Accountability Office

GLS: Garrett Lee Smith

HHCS: Home health care service

HHS: Department of Health and Human Services

HIPAA: Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)

HRSA: Health Resources and Services Administration

IMD: Institutions for Mental Diseases

IRC: Internal Revenue Code

JAG: Edward Byrne Memorial Justice Assistance Grant

LTSS: Long-term services and supports

MHBG: Community Mental Health Services Block Grant

MHPAEA: Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343, Title V, Subtitle B)

NCTSI: National Child Traumatic Stress Initiative

NHSC: National Health Service Corps

NICS: National Instant Criminal Background Check System

NIH: National Institutes of Health
NREPP: National Registry of Evidence-based Programs and Practices
NVDRS: National Violent Death Reporting System
OCR: Office for Civil Rights
OIG: Office of Inspector General
PAIMI: Protection and Advocacy for Individuals with Mental Illness
PAMA: Protecting Access to Medicare Act (P.L. 113-93)
PCS: Personal care services
PHI: Protected health information
PHSA: Public Health Service Act
PRNS: Programs of Regional and National Significance
RSAT: Residential substance abuse treatment
SABG: Substance Abuse Prevention and Treatment Block Grant
SAFER: Staffing for Adequate Fire and Emergency Response
SAMHSA: Substance Abuse and Mental Health Services Administration
SSA: Social Security Act
STOP: Sober Truth on Preventing Underage Drinking Act (P.L. 109-422)
VA: Department of Veterans Affairs
VALOR: Preventing Violence Against Law Enforcement and Ensuring Officer Resilience and Survivability Initiative

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