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AMERICAN PSYCHIATRIC ASSOCIATION
Government Relations

COMPARISON OF KEY PROVISIONS | Comprehensive Mental Health Reform Legislation

Helping Families in Mental Health Crisis Act of 2015 (H.R. 2646) – *As Passed in Subcommittee, Nov. 2015*	**Mental Health Reform Act of 2015 (S. 1945)**	**Mental Health Reform Act of 2016 (S. 2680)**
Bill Sponsors: Tim Murphy (R-PA) and Eddie Bernice Johnson (D-TX)	*Bill Sponsors: Bill Cassidy (R-LA), Chris Murphy (D-CT)*	*Bill Sponsors: Lamar Alexander (R-TN), Patty Murray (D-WA), Bill Cassidy (R-LA), and Chris Murphy (D-CT)*
SAMHSA Reform and Federal Coordination of MH/SUD Resources		
• New position of Assistant Secretary of Mental Health and Substance Use Disorders (ASMH) is created and housed within HHS, tasked with overseeing and coordinating MH/SUD activities (Sec. 101) • ASMH must be a psychiatrist or PhD psychologist (Sec. 101) • Among a number of duties, responsibilities, and priorities, the ASMH is explicitly tasked with coordinating mental health parity activities and identifying evidence-based best practices related to MH/SUD • All SAMHSA authorities, personnel and obligations are transferred to ASMH (Sec. 102)	• *Substantially similar duties, responsibilities, and priorities in the establishment of an Assistant Secretary for Mental Health and Substance Use Disorders (ASMH) as in H.R. 2646* • No transfer of SAMHSA authorities to the ASMH; the SAMHSA Administrator would report directly to the proposed ASMH	• More explicitly requires SAMHSA to collaborate with relevant federal departments and agencies, including DoD, VA, and the United States Interagency Council on Homelessness (Sec. 102) • Amends SAMHSA duties to more explicitly collaborate with states and other stakeholders to develop and support activities related to mental health workforce development (Sec. 102) • Directs Assistant Secretary for Planning and Evaluation (ASPE) to evaluate programs related to MH/SUD within HHS and provide recommendations to SAMHSA (Sec. 101) • Creates new SAMHSA position of Chief Medical Officer (CMO) that must have a doctoral degree in medicine or osteopathic medicine and is empowered to promote evidence-based best practices and participate in agency strategic planning (Sec. 103) • Directs the development of a strategic plan every four years to identify strategic priorities and objectives for SAMHSA, including ways to improve services to individuals with MH/SUD, and ensure programs provide effective and evidence-based diagnosis. The plan would take into consideration the review completed by ASPE and the report of the proposed Inter-Departmental Serious Mental Illness Coordinating Committee (Sec. 104) • Additional requirements for SAMHSA Center for Mental Health Services to collaborate with the

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		proposed CMO and the National Institute of Mental Health – and employ consistent methods to document criteria used for, and oversight of, grant-making (Sec. 106)
Mental Health Workforce		
• The ASMH is tasked with the development of a continuing "Nationwide Strategy" to increase the psychiatric workforce and recruit medical professionals for the treatment of individuals with SMI and SUD. Strategy would promote adoption of collaborative care models, and the necessary mental health workforce capacity for these models (Sec. 101)	• *Substantially similar to H.R. 2646* • Provision more explicitly includes non-physician mental health professionals. • Reauthorization of the Health Resources and Services Administration (HRSA) Mental Health and Behavioral Health Education Training Grants program, which was originally passed under the ACA and funded through the *Now is the Time* effort. While psychiatrists are eligible for funding under this grant program (currently, and through S.1945's proposed reauthorization), it prioritizes non-physician mental health practitioners over psychiatrist training. (Sec. 211)	• On a biennial basis, SAMHSA would prepare a report on activities and progress in meeting the agency's strategic priorities, including recruitment of a MH/SUD workforce, translation of research findings, and the integration of mental and physical health services (Sec. 105) • Proposes reauthorization of the HRSA Mental Health and Behavioral Health Education Training Grants program. ***Psychiatrists are prioritized in the awarding of grants under this section*** (Sec. 407) • Proposes SAMHSA to work with HRSA on a workforce development report to study national projections of the supply and demand of MH/SUD professionals and assessments of workforce capacity (Sec. 412) • ***New proposed demonstration grants program to strengthen the MH/SUD workforce*** for training in underserved community-based settings. Program would focus on training for medical residents to practice psychiatry and addiction medicine in areas that integrate primary care with MH/SUD services. Training for nurse practitioners and social workers are also included under these grants (Sec. 411).
Modifications to CSAP and CSAT		
• *No comparable provision*	• *No comparable provision*	• Updates nomenclature and clarifies duties of the Director of the Center for Substance Abuse Prevention (CSAP) by requiring (1) collaboration

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		with NIDA, NIAAA, and States to promote research that may improve delivery and effectiveness of substance abuse activities; (2) cooperation with CDC to disseminate educational materials about substance abuse and communicable diseases; (3) assistance to states in preventing illicit drug use; and (4) consistent documentation of criteria when awarding grants (Sec. 106) • Similarly updates nomenclature and clarifies duties of the Director of the Center for Substance Abuse Treatment (CSAT) (Sec. 106)
Mental Health Parity Enforcement		
• Requires federal departments responsible for enforcement of parity to annually report to Congress on investigations conducted in the previous year and the results of said investigations (Sec. 103) • Requires GAO to report on the extent to which insurance plans comply with MHPAEA (Sec. 801)	• *Includes parity provisions from H.R. 2646* • In addition: S. 1945 establishes new and detailed disclosure and reporting requirements, allows for randomized audits by HHS, and provides a new process for parity complaints to be filed by the public.	• With the exception of a narrow provision dealing with eating disorders, APA's understanding is that negotiations continue regarding mental health parity enforcement provisions – potentially including proposals that would offer health plans additional guidance and direct a federal action plan to ensure compliance.
HIPAA		
• Permits certain disclosures of protected health information of individuals with serious mental illness to caregivers by licensed health professionals. Disclosure must meet a number of tests to be permissible under HIPAA (Sec. 401) • Information disclosed must be limited to certain relevant categories. Therapy notes are explicitly excluded (Sec. 401) • Requires the development and dissemination of model training programs for clinicians, other professionals, and family members	• Provides some limited guidance to help health professionals determine the "best interests" of the patient for purposes of disclosure of protected health information (Sec. 501, 502) • Requires the development and dissemination of model training programs for clinicians, other professionals, and family members regarding the circumstances under which protected health information may be disclosed (Sec. 503)	• Proposes creation of resources to educate individuals about permitted uses and disclosures of protected health information (including model training programs as included in S. 1945) (Sec. 601, 602)

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regarding the circumstances under which protected health information may be disclosed (Sec. 404, 405)		
Modifications to 42 CFR Part 2 (confidentiality of addiction treatment records)		
• This provision would create an exception to Part 2 requirements within Accountable Care Organizations, health information exchanges, health homes, and other integrated care arrangements that involve the exchange of electronic health records. (Sec. 403) • *As background:* 42 CFR Part 2 (or "Part 2") is federal regulation that generally limits disclosure of health records from addiction treatment providers to circumstances of (1) direct written consent by the patient, (2) emergency, or (3) court order.	• Permits annually-provided blanket consent for the disclosure and re-disclosure of Part 2-covered addiction records within accountable care organizations, health information exchanges, health homes, or other integrated care arrangements (Sec. 504)	• In light of proposed regulation from SAMHSA, the bill does not make modifications to confidentiality of addiction treatment records. Proposal calls for the Secretary of HHS to convene relevant stakeholders to determine the impact of such regulations on patient care, health outcomes, and privacy, not later than 1 year after regulations are finalized. (Sec. 603)
Interagency/Inter-Departmental Serious Mental Illness Coordinating Committee (ISMICC)		
• Establishes the ISMICC to assist the ASMH with carrying out his or her duties. ISMICC is tasked with annually updating Congress on advances in SMI research, monitoring federal activities related to SMI, and developing and updating an annual Strategic Plan for conduct and support of SMI research. ISMICC is explicitly required to report on the progress and activities of the proposed Nationwide Strategy. (Sec. 301)	• *Substantially similar to H.R. 2646*	• Establishes the Inter-Departmental Serious Mental Illness Coordinating Committee charged with submitting a report to Congress in one year (and every 5 years thereafter) addressing advances in SMI research and public health impacts of programs related to SMI. The Secretary of HHS would determine whether this Committee should continue after it submits the first report. Of the non-federal members, a psychiatrist is not explicitly required to be on the Committee. Terminates the Committee 6 years after the date it is first established. (Sec. 109)

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Assisted Outpatient Treatment (AOT) and Assertive Community Outreach Efforts		
• Reauthorizes the voluntary AOT implementation grant program passed in the bipartisan March 2014 SGR patch legislation. Raises the authorized annual funding amount from $15M to $20M. (Sec. 205) • Provides more flexible requirements for proposed state AOT provisions, providing a 2% block grant bonus for states that have an AOT law on the books. Provision is intended to incentivize states to adopt AOT laws without jeopardizing block grant funding (Sec. 206) • Establishes as a condition for block grant eligibility that states have active evidence-based "assertive outreach and engagement services" targeting specific populations (Sec. 206)	• *Contains reauthorization of voluntary AOT grant program as proposed in H.R. 2646* • *Contains substantially similar condition for block grant eligibility that states have active evidence-based assertive outreach and engagement services*	• *No comparable provision*
National Mental Health Policy Laboratory (NMHPL)		
• Establishes the NMHPL under supervision of ASMH with broad powers of collecting information from grantees under federal mental health programs and disseminating evidence-based practices and delivery models. (Sec. 201) • Director of NMHPL is empowered to set standards for grant programs administered under ASMH. (Sec. 201) • Proposed specific staffing requirements for NMHPL; for example, at least 20% of staff must be psychiatrists. (Sec. 201)	• *Duties of NMHPL similar to H.R. 2646. Proposed NMHPL under H.R. 2646 includes broader powers over grant program standards.* • Provides general guidance about the types of clinical and research professionals who shall staff NMHPL (Sec. 201)	• *No comparable provision, though concept of NMHPL influences duties and responsibilities of proposed SAMHSA Office of Policy, Planning and Innovation*

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Explicit Authorization for the SAMHSA Minority Fellowship Program		
• The program would be explicitly authorized in statute and its authorized funding would be set at $6M for FY 2016-2020. (Sec. 207)	• *Substantially similar to H.R. 2646 but includes higher proposed funding level at $10M annually for FY 2017-2022. (Sec. 209)*	• *No comparable provision*
Telepsychiatry Grants		
• Establishes new grant program under which 10 states are provided funding for training PCPs in the use of standardized behavioral health screening tools, best practices, and implementing the CCM. (Sec. 208) • States must use this grant funding for the payment of consultation provided by a psychiatrist or psychologist through qualified telehealth technology. States must also match at least 20% of funding in order to be eligible. (Sec. 208)	• Establishes a grant program to support the creation or expansion of state child psychiatry access programs (e.g., MCPAP). These programs include pediatric mental health teams (including child and adolescent psychiatrists) who provide rapid telephone consultations when requested, among other activities. Proposes annual authorization of $25m for FY2017 and such sums as necessary for FY2018-2021 (Sec. 207)	• While the framework of the proposed child and adolescent psychiatric access program provision is substantially similar to S.1945, the provision does not have a new authorization – instead, the Secretary of HHS may award grants through existing telehealth programs.
Liability Protection for Mental Healthcare Professional Volunteers		
• Adds liability protections similar to those provided for Public Health Service employees for healthcare professionals who volunteer at community mental health centers (Sec. 207)	• *Substantially similar to H.R. 2646*	• *No comparable provision*
Medicaid: Same Day Billing and IMD Exclusion		
• Partially raises the Medicaid exclusion for reimbursement of care at Institutes for Mental Disease (the "IMD exclusion") for psychiatric hospitals and acute care units within state psychiatric hospitals that have an average length of stay of less than 30 days. (Sec. 501, 503) • *[Provision removed that would address same*	• Partial raise of the IMD exclusion applies to psychiatric hospitals with an average length of stay of 20 days or less. Does not include Medicaid reimbursement for psychiatric rehabilitation treatment centers (Sec. 601) • Mandates that states allow for same day Medicaid billing of psychiatric and primary care services when furnished at community mental	• *No comparable provision, pending consideration of Medicare and Medicaid provisions by the Senate committee of jurisdiction (i.e., Senate Finance Committee)*

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day Medicaid billing of psychiatric and primary care. Potential for reinsertion into bill at a later stage].	health centers or federally qualified health centers.	
Medicare Discharge Planning		
• Requires the Secretary of HHS to develop additional guidelines and standards related to the discharge planning process of psychiatric hospitals and psychiatric units. (Sec. 503)	• *Substantially similar to H.R. 2646*	• *No comparable provision, pending consideration of Medicare and Medicaid provisions by Senate committee of jurisdiction (i.e., Senate Finance Committee)*
Proposed NIMH Funding Increase		
• Provides NIMH with an authorized funding increase of $40M annually for the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative and for research into the determinants of self and other-directed violence (Sec. 601)	• *Substantially similar to H.R. 2646*	• *No comparable provision*
SAMHSA Grant Peer Review and Advisory Council Requirements		
• New requirements that half of the members of a program or grant peer review group, as well as an advisory council, be physicians or clinical psychologists. • Includes new requirements that any research concerning an intervention be based on scientific controls and standards related to whether the intervention reduces symptoms and improves outcomes (Sec. 702, 703)	• *Substantially similar to H.R. 2646* • Does not include requirements that grant peer review be based on scientific controls and standards	• Relevant advisory councils would include the new CMO as well as the Directors of NIMH, NIDA, and NIAAA (Sec. 107) • Not less than half of SAMHSA Center for Mental Health Services advisory council members must have a medical degree, doctorate in psychology, or advanced degree in nursing or social work • *Substantially similar peer review to S. 1945* (Sec. 108)
MH/SUD Innovation and Demonstration Grants		
• The ASMH is authorized to award grants to state and local governments and other organizations for expanding models of care	• *Substantially similar grant programs as proposed in H.R. 2646*	• Directs the SAMHSA Administrator to award grants, in coordination with the Office of Policy, Planning, and Innovation (whose Office responsibilities were

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that have been scientifically demonstrated to show promise but would benefit from further research. Authorizes up to 5% of non-block grant SAMHSA funding to carry out the section (Sec. 202) • The ASMH is authorized to award grants to similar entities for the purpose of expanding evidence-based programs to advance mental healthcare with priority for applied delivery and integration of care. Authorizes up to 10% of certain non-block grant SAMHSA funding to carry out this section (Sec. 203).	• Grants would have specific authorizations of appropriations (not SAMHSA block grant set-asides as proposed in H.R. 2646)	clarified in the same section), to state, tribal, local governments, and other organizations for evaluation of models that have shown promise but would benefit from further research. Grants may also be used to expand or scale evidence-based programs across a wider area to enhance screening and early diagnosis through integrated models of care. (Sec. 201) • SAMHSA Administrator would also consult, as appropriate, with the new CMO, NIMH, NIDA, or NIAAA (Sec. 201) • Grants would have specific authorization of appropriations in an amount as such sums may be necessary (Sec. 201)
National Health Service Corp (NHSC) Loan Repayment for Child and Adolescent Psychiatrists		
• Provides explicit eligibility for child and adolescent psychiatrists to participate in NHSC including eligibility for loan repayment (Sec. 207)	• *Substantially similar to H.R. 2646. Broader application to all pediatric subspecialty physicians.*	• *No comparable provision*
Modifications to Block Grants		
• Five (5) percent of the Community Mental Health Services Block Grant would be set aside for the Secretary of HHS, acting through the National Institute of Mental Health, to translate evidence-based interventions into systems of care. Suggested models include the Recovery After Initial Schizophrenia Episode project and the North American Prodrome Longitudinal Study. (Sec. 206)	• *Substantially similar to H.R. 2646.* • Reauthorization of SAMHSA block grant at the current appropriation level, among other SAMHSA program reauthorizations (Sec. 206 and Sec. 803, 804, 805, and 806)	• Adds new explicit purpose of Community Mental Health Services Block Grant that would provide community mental health services for adults with SMI and children with serious emotional disturbances (Sec. 301) • Revises criteria for state plans of comprehensive community mental health services by requiring that the plan identify the state agency responsible for administration of the program under the grant and provide for an organized community-based system of care (Sec. 301)

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		• State plans would also include a description of how services will be coordinated to maximize efficiency, including specific outcomes. The state would also include a description of how it is integrating mental health and primary health care (Sec. 301) • Under the Block Grant for the Prevention and Treatment of Substance Use Disorders, mental health nomenclature is updated. In addition, a funding agreement for a grant would require the state to offer ongoing professional development on evidence-based practices, data collection requirements, among other training (Sec. 302) • A state plan under either block grant must describe the existing mental health workforce and workforce trained in treating co-occurring substance use and mental health disorders (Sec. 301, 302) • Directs the Secretary of HHS to study the distribution of funds under the block grants and evaluate whether the distributions accurately meet state needs (Sec. 304)
Other Authorizations and Reauthorizations		
• Reauthorizations of the Garrett Lee Smith Memorial Act, which established federal funding to states, tribes, and colleges to implement young adult suicide prevention programs (Sec. 208) • Authorization of 5% set-aside of certain non-block grant funding for law enforcement crisis intervention training grants (Sec. 208)	• Replaces SAMHSA's Primary and Behavioral Health Care Initiative with a new state grant program for statewide integration of primary and behavioral evidence-based health services. Defines integrated care team as specifically including primary care physicians and board-certified psychiatrists, among other relevant clinicians and staff. (Title III) • Explicitly reauthorizes the national suicide prevention lifeline program. (Sec. 212)	***Unless otherwise indicated, all proposed items in this section are authorized "as such sums as may be necessary"*** • Reauthorizes priority mental health needs of regional and national significance grant program (PRNS) (Sec. 203) • Updates nomenclature of grants to address treatment, recovery, and transition for homeless individuals and provides reauthorization of appropriations (Sec. 401, Sec. 404) • Updates nomenclature of grants for jail diversion programs and reauthorizes the program (Sec. 402) • Proposed reauthorization of Primary and Behavioral

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		Health Care Initiative grant program (PCBHI) substantially similar to S.1945 with notable refinements (Sec. 403) • Explicitly reauthorizes the national suicide prevention lifeline program (Sec. 405) (*Substantially similar to S. 1945*) • Reauthorizes programs for children with serious emotional disturbances (Sec. 501) *Substantially similar to S. 1945*) • Authorizes grants for substance use disorder treatment and early intervention services for children and adolescents (Sec. 503) • Authorizes residential treatment grant programs for pregnant and parenting women (Sec. 504) • Authorizes grants ($10M per FY 2017-2021) to address emerging drug abuse issues, including for the improvement of drug treatment services and recovery support services, with priority for entities serving rural areas (Sec. 305) • Authorizes grants to raise awareness of, and education and training for, eating disorders (Sec. 409, 410) • Authorizes SAMHSA program to provide grants to eligible states for the establishment of real-time internet-based psychiatric bed registries (Sec. 410) • Authorizes grant program related to depression screening and treatment (including psychiatric consultation) for pregnant and postpartum women that tracks very closely with the APA-supported *Bringing Postpartum Depression Out of the Shadows Act* (Sec. 505) • Authorizes grants to eligible entities to develop, maintain, or enhance infant and early childhood mental health prevention, intervention, and treatment programs (Sec. 506)

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Other Notable Provisions	***Other Notable Provisions***	***Other Notable Provisions***
• Modifies permitted third party disclosures under the FERPA (Sec. 402) • Improves Medicare/Medicaid coverage of psychiatric medications (Sec. 502) • Modifies the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program (Sec. 711-715) • *[Provision removed that would repeal the 190 day lifetime limit on Medicare inpatient psychiatric hospital coverage. Potential for reinsertion into bill at a later stage.]* • *[Provision removed that would extend Medicare/Medicaid HIT incentives to currently ineligible mental health clinicians and facilities. Potential for reinsertion into bill at a later stage.]* • *[Provision removed to extend Excellence in Mental Health Act demonstration project by increasing eligible states and lengthening number of years. Potential for reinsertion into bill at later stage.]*		• Directs Secretary of HHS to establish and maintain a National Treatment Referral Routing Service to assist individuals and families in locating MH/SUD treatment providers (Sec. 406) • Includes entirety of S.1893, the Mental Health Awareness and Improvement Act of 2015. Among other provisions, this legislation reauthorizes the Garrett Lee Smith Memorial Act and the National Child Traumatic Stress Network • Includes provisions related to opioid misuse and abuse such as certain requirements for labeling in the context of new opioid drug applications, requiring CDC to release best practices related to opioid prescribing, among other provisions (Title VIII) • Strikes a handful of SAMHSA authorizations that have not received appropriations in several years