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ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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MEMORANDUM

April 2, 2014

To: **Committee on Energy and Commerce Democratic Members and Staff**

Fr: **Committee on Energy and Commerce Democratic Staff**

Re: **Hearing on "H.R. 3717, *the Helping Families in Mental Health Crisis Act*"**

On Thursday, April 3, 2014 at 10:30 a.m. in room 2322 of the Rayburn House Office Building, the Subcommittee on Health will hold a hearing on H.R. 3717, the Helping Families in Mental Health Crisis Act. H.R. 3717 is sponsored by Rep. Murphy (R-PA) and was introduced on December 12, 2013. We would call your attention to the following background information on mental illness and about this and related legislation.

I. BACKGROUND ON SERIOUS MENTAL ILLNESS

Serious mental illnesses include medical conditions such as major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, and borderline personality disorder.[1] These conditions are described as severe when they have a significant and persistent manifestation. Approximately 11.4 million adults in the United States live with a serious mental illness each year.[2]

Most violent acts are not committed by people living with a serious mental illness and most people living with a serious mental illness are not violent.[3] Research suggests that those

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[1] National Alliance on Mental Illness, *What is Mental Illness: Mental Illness Facts* (online at www.nami.org/template.cfm?section=about_mental_illness).

[2] Substance Abuse and Mental Health Services Administration, *Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings* (2010).

[3] Dr. Thomas Insel, Director, National Institute of Mental Health, National Institutes of Health, *Understanding Severe Mental Illness* (Jan. 11, 2011) (online at www.nimh.nih.gov/about/director/2011/understanding-severe-mental-illness.shtml).

living with schizophrenia with controlled psychotic symptoms are no more violent than the population living without a serious mental illness.[4] In fact, people living with a serious mental illness are 11 times more likely than the general population to be victims of violence.[5]

Individuals with serious mental illness can be treated effectively. According to the National Alliance on Mental Illness, "between 70 and 90 percent of individuals have significant reduction of symptoms and improved quality of life with a combination of pharmacological and psychosocial treatments and supports."[6] However, there are significant barriers to receiving treatment and recovering, including a shortage of treatment facilities, lack of access to a wide range of treatment and support services, and the stigma associated with serious mental illness and treatment. As a result, many individuals with serious mental illnesses are not receiving effective treatment or experience delays in treatment. On average, there is a 110-week delay between an initial episode of psychosis and the commencement of medical treatment.[7] For those individuals living with a serious mental illness, approximately 40% did not receive treatment in the past year.[8]

II. THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT AND THE AFFORDABLE CARE ACT IMPROVE ACCESS TO MENTAL HEALTH TREATMENT

A. The Mental Health Parity and Addiction Equity Act of 2008

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) provides important protections regarding equivalency of coverage for medical and surgical and mental health and substance use disorder services that will expand access to mental health treatment. The final regulation implementing MHPAEA went into effect on January 13, 2014, and generally applies to plan or policy years beginning on or after July 1, 2014.[9]

MHPAEA applies to large employers' insurance plans, Medicaid managed care, and the Children's Health Insurance Program and requires that financial requirements (such as

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[4] Dr. Linda A. Teplin et al., *Crime victimization in adults with severe mental illness,* Archives of General Psychiatry (Aug. 2005).

[5] *Id.*

[6] National Alliance on Mental Illness, *What is Mental Illness: Mental Illness Facts* (online at www.nami.org/template.cfm?section=about_mental_illness) (accessed Mar. 24, 2014).

[7] M. Marshall et al., *Association between duration of untreated psychosis and outcome in cohorts of first-episode patients*, Archives of General Psychiatry (Sept. 2005).

[8] Substance Abuse and Mental Health Services Administration, *20 percent of US adults experienced mental illness in the past year, report says* (Nov. 27, 2012) (online at www.samhsa.gov/newsroom/advisories/1211273220.aspx) (press release).

[9] U.S. Department of the Treasury, U.S. Department of Labor, and U.S. Department of Health and Human Services, *Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program;* 78 Fed. Reg. 219 (Nov. 13, 2013) (final rule).

deductibles and co-payments) and treatment limitations (such as number of visits) for mental health and substance use disorder services are “no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits.”[10]

The Affordable Care Act (ACA)[11] significantly expanded the protections in MHPAEA and health insurance coverage for mental health services.[12]

B. The Affordable Care Act

1. *Expanded Access to Treatment through the Affordable Care Act*

The ACA provides affordable and quality insurance coverage to tens of millions of Americans. The ACA also requires that all new individual and small group insurance plans cover mental health and substance use disorder services as one of ten Essential Health Benefits. Plans are required to cover these services at parity with medical and surgical benefits, significantly expanding access to these lifesaving services.[13] Individuals are now able to compare high-quality health insurance plans and purchase affordable coverage, often with the help of tax credits and cost-sharing reductions, through the federal and state Health Insurance Marketplaces set up through the ACA. A report by the American Mental Health Counselors Association found that 6.6 million uninsured adults with serious mental health and substance use conditions will be eligible for health insurance coverage -- including coverage for mental health and substance use conditions -- through these marketplaces.[14]

The ACA also gives states the ability to expand Medicaid coverage to individuals with incomes at or below 138% of the federal poverty level. The federal government will cover the full cost of this Medicaid expansion through 2016, and slowly decrease its matching rate to cover 90% of the cost to states by 2020.[15] States expanding their Medicaid programs must offer

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[10] Centers for Medicare and Medicaid Services, *The Mental Health Parity and Addiction Equity Act* (online at cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html) (accessed Mar. 24, 2014).

[11] The Affordable Care Act is comprised of two public laws, Pub. L. 111-148 and Pub. L. 111-152.

[12] *Supra* note 10.

[13] Healthcare.gov, *Essential Health Benefits* (online at www.healthcare.gov/glossary/essential-health-benefits/) (accessed Mar. 24, 2014); Centers for Medicare and Medicaid Services, *The Mental Health Parity and Addiction Equity Act* (online at cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html) (accessed Mar. 24, 2014).

[14] American Mental Health Counselors Association, *Dashed Hopes; Broken Promises; More Despair: How the Lack of State Participation in the Medicaid Expansion will Punish Americans with Mental Illness* (Feb. 2014).

[15] Kaiser Family Foundation, *Quick Take: Who Benefits from the ACA Medicaid Expansion?* (June 14, 2012) (online at kff.org/health-reform/fact-sheet/who-benefits-from-the-aca-medicaid-expansion/).

Essential Health Benefits -- including coverage for mental health and substance use conditions -- to newly-eligible beneficiaries and cover these services at parity with medical and surgical benefits.[16] Twenty-six states plus the District of Columbia have expanded or are in the process of expanding their Medicaid programs, and over 8.9 million Americans were determined eligible for Medicaid and CHIP between October 1, 2013 and January 31, 2014, with millions enrolling in coverage for the first time.[17]

However, over 20 states have not yet moved forward with Medicaid expansion.[18] As a result, an estimated 3.7 million uninsured adults with mental health and substance use conditions will be unable to obtain health insurance coverage through the ACA's Medicaid expansion. This includes nearly 800,000 individuals with a serious mental illness; over 1.5 million individuals suffering from serious psychological distress, such as panic, anxiety, and mood disorders; and nearly 1.4 million individuals dealing with a substance use disorder.[19]

Health insurance through the ACA stands to greatly benefit people with mental health and substance use conditions by making early treatment and prevention services more accessible, which will avert crisis situations from arising in the first place.[20]

2. *Medicaid Emergency Psychiatric Demonstration Program*

Current law prohibits the federal government from providing Medicaid matching funds for inpatient treatment of adults ages 21 to 64 in psychiatric institutions that have more than 16 beds, known as institutions for mental disease (IMDs). Section 2707 of the ACA authorizes a demonstration program providing Medicaid reimbursement to private IMDs for emergency inpatient psychiatric care.[21]

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[16] Healthcare.gov, *Essential Health Benefits* (online at www.healthcare.gov/glossary/essential-health-benefits/); Centers for Medicare and Medicaid Services, *The Mental Health Parity and Addiction Equity Act* (online at cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html).

[17] Centers for Medicare and Medicaid Services, *Medicaid & CHIP: January 2014 Monthly Applications and Eligibility Determinations Report* (Feb. 28, 2014) (online at medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/January-2014-Enrollment-Report.pdf).

[18] Kaiser Family Foundation, *Status of State Action on the Medicaid Expansion Decision* (Mar. 26, 2014) (online at http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/).

[19] American Mental Health Counselors Association, *Dashed Hopes; Broken Promises; More Despair: How the Lack of State Participation in the Medicaid Expansion will Punish Americans with Mental Illness* (Feb. 2014).

[20] *Id.*

[21] Centers for Medicare and Medicaid Services, *Report to Congress on the Evaluation of the Medicaid Emergency Psychiatric Demonstration* (Dec. 1, 2013).

Twenty-seven private IMDs in 11 states and the District of Columbia are participating in the demonstration, which began in 2012 and is scheduled to end in December 2015, with a final evaluation report available in September 2016. In its December 2013 report to Congress, the Centers for Medicare and Medicaid Services (CMS) states: "[W]e do not have enough data to recommend expanding the demonstration at this time; given the limited data, however, we recommend that the demonstration continue through the end of the current authorization, December 31, 2015, to allow a fuller evaluation of its effects."[22]

Proponents of eliminating the IMD exclusion expect that the demonstration will increase the number of inpatient beds, lead states to reallocate savings to improving community-based services, reduce psychiatric boarding in emergency rooms, decrease hospital readmissions, and decrease overall Medicaid costs.[23]

3. *Health Homes*

Section 2703 of the ACA gives states the option to create Health Homes to coordinate care for individuals with chronic conditions in the Medicaid program. Eligible individuals who have one serious and persistent mental health condition, two chronic conditions (including mental health, substance abuse, asthma, diabetes, heart disease, and being overweight), or one chronic condition with risk for a second.

Health Homes will provide services such as comprehensive care management, health promotion, transitional and follow-up care, patient and family support, and referrals to community and social support services. CMS will provide an enhanced Medicaid matching rate of 90% for Home Health services.[24]

CMS has approved Health Home state plan amendments in 14 states. Another 11 states and the District of Columbia have submitted state plan amendments to CMS for approval.[25]

III. SUMMARY OF H.R. 3717, HELPING FAMILIES IN MENTAL HEALTH CRISIS ACT

A. TITLE I – Assistant Secretary of Mental Health

This title creates a new Assistant Secretary for Mental Health and Substance Use Disorders position within the Department of Health and Human Services (HHS). The Assistant Secretary

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[22] *Id.*
[23] *Id.*
[24] Centers for Medicare and Medicaid Services, *Health Homes* (online at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html) (accessed Mar. 24, 2014).
[25] Centers for Medicare and Medicaid Services, *State Home Health CMS Proposal Status* (Mar. 2014) (online at www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-MAP_v31.pdf).

would be a Senate-confirmed position and report directly to the Secretary of HHS. Among other duties, the Assistant Secretary would carry out any HHS function to improve treatment and related services, prevention services, and protection of legal rights of/for individuals with mental illnesses and substance use disorders; supervise the Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA); and oversee and coordinate all HHS programs and activities related to the prevention, treatment, or rehabilitation of/for mental health and substance use disorders. The legislation creates a National Mental Health Policy Laboratory within the Office of the Assistant Secretary tasked with identifying and implementing policy changes "likely to have the most significant impact on mental health services," among other responsibilities. The title authorizes funding out of the amounts appropriated to carry out the Community Mental Health Services Block Grant (MHBG) -- not more than 5 percent -- to support the Assistant Secretary's office. It establishes an Interagency Severe Mental Illness Coordinating Committee of Federal and non-Federal members to support the Assistant Secretary in carrying out his/her duties. This title also authorizes a grant program for assisted outpatient treatment (AOT) and for tele-psychiatry and primary care physician training.

A modified version of the AOT grant program was included in Section 224 of the Medicare Sustainable Growth Rate (SGR) patch, H.R. 4302, the Protecting Access to Medicare Act of 2014.[26] Section 224 authorizes the Secretary of HHS to make grant awards of up to $1 million to no more than 50 grantees that have AOT laws in their states to help them implement these laws. States will use these grants to assist individuals with serious mental illness who are subject to court-ordered treatment and assess treatment outcomes. The bill authorizes $15 million for each of fiscal years 2015 through 2018 for such grants.

This title, along with other provisions in the legislation, reverses efforts to coordinate the administration and oversight of mental health and substance abuse activities at SAMHSA; minimizes the role of the SAMHSA Administrator; and could potentially reduce Federal funding made available to States for community mental health services. While it may be beneficial to improve coordination of mental health and substance use activities across HHS and other parts of the Federal government, this legislation does not advance the most appropriate and efficient mechanism to accomplish this goal. It does not adequately coordinate the roles of the SAMHSA Administrator, Office of National Drug Control Policy, and other Federal entities/officials and it significantly undercuts SAMHSA's core funding and authority.

B. TITLE II – Federally Qualified Behavioral Health Clinics

This title includes a modified version of H.R. 1263, the Excellence in Mental Health Act, authored by Rep. Matsui (D-CA) and Rep. Lance (R-NJ) of a 10-state, 5-year demonstration project to "improve the provision of behavioral health services provided by certified community behavioral health clinics," paid for with a prospective payment system (PPS) using enhanced Medicaid reimbursement.

[26] H.R. 4302 has passed the House and the Senate and is awaiting presidential action.

A further modified version of this demonstration was included in Section 223 of the SGR patch, H.R. 4302, the Protecting Access to Medicare Act of 2014.[27] Section 223 creates a new type of mental health provider called a "certified community behavioral health clinic," which is intended to coordinate care across settings and providers to ensure seamless transitions for patients across the provision of acute, chronic, and behavioral health services. It allows up to eight states to take part in a two-year demonstration program to receive enhanced matching funds for mental health services provided by such clinics in Medicaid (and paid using a PPS). The Secretary shall award planning grants for the demonstration program by January 1, 2016, and by September 1, 2017 shall select the states to participate in the two-year demonstration. The Secretary shall annually report to Congress on the impact of the demonstration, starting no later than one year after the date on which the first State is selected for the demonstration. The demonstration project provides grant funds for planning, provider development, reports, and PPS rate development. CBO estimated the total cost of the demonstration to be $1.1 billion over the remaining of fiscal year 2014 through fiscal year 2024.[28] The Secretary shall report to Congress by December 31, 2021 as to whether the demonstration programs should be continued, expanded, modified, or terminated.

C. TITLE III – HIPAA and FERPA Caregivers[29]

This title makes changes to current Health Insurance Portability and Accountability Act (HIPAA) provisions as they relate to provider disclosure of protected health information to family members and individuals who assume primary responsibility" of patients with "severe mental illness." It creates a definition of "severe mental illness" that is both overly broad and includes all individuals with schizophrenia, schizoaffective disorder, manic-depressive disorder, or major depression, and does not reference the severity of the condition or the status of treatment.

This title undermines patient privacy and could discourage patients from seeking needed treatment. This unprecedented redefinition of HIPPA's privacy protections would unnecessarily stigmatize individuals seeking treatment for mental illness despite the fact that experts have indicated to the Committee that these individuals are no more violent than the general population. HIPAA already allows providers to disclose private information if it "is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public" or for a variety of law enforcement purposes. HIPPA also gives providers broad discretion to share information with family members and caregivers if it would aid an individual's treatment, even in some cases in which the individual explicitly objects to such disclosures. Providers are often misinformed about their obligations under HIPAA and have failed to disclose information

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[27] H.R. 4302 has passed the House and the Senate and is awaiting presidential action.

[28] Congressional Budget Office, *Cost Estimate for the Protecting Access to Medicare Act of 2014* (Mar. 26, 2014) (online at http://www.cbo.gov/sites/default/files/cbofiles/attachments/House%20introduced%20Protecting%20Access%20to%20Medicare%20Act%20of%202014,%20March%2026,%202014.pdf).

[29] HIPAA comments are included in this memo. FERPA is outside of E&C's jurisdiction.

which they are legally permitted to disclose. The HHS Office of Civil Rights has taken steps to improve provider education, which is essential to balancing the privacy rights of patients and the need for effective treatment.

D. TITLE IV – Department of Justice Reforms

This title is outside of E&C's jurisdiction.

E. TITLE V – Medicare and Medicaid Reforms

This section restricts state Medicaid programs from prohibiting payment for a mental health or primary care service provided at clinics (as defined in Title II of this bill) when the mental health service was received on the same day as the primary care service or vice versa. CMS now pays a global rate for all services provided on a given day. This provision would allow unbundling of the payment for the services, potentially increasing costs and utilization.

It eliminates the IMD exclusion in Medicaid by authorizing federal matching payment for services provided in an inpatient psychiatric residential treatment facility or psychiatric residential treatment facility for individuals ages 22 to 64. Since this section does not include a maintenance of effort requirement, it could allow states to simply shift costs to the federal government for services already being provided, and is likely to have a significant cost.

This section also requires states to pay for mental health items/services provided by a primary care physician for consultation with a psychologist or psychiatrist through qualified telehealth technology (as defined in the bill). Currently, states can choose to pay for telehealth services—this provision requires all states to do so. This could include a broad range of mental health disorders, and it is possible that not all disorders could be adequately diagnosed via telehealth.

It prohibits state Medicaid programs from excluding coverage for drugs used for the treatment of a mental health disorder, including major depression, bipolar (manic-depressive) disorder, panic disorder, obsessive compulsive disorder, schizophrenia, and schizoaffective disorder. This provision seems to protect broad classes of drugs that are used to treat a wide range of mental health conditions. For example Adderall used for attention deficit hyperactivity disorder would be considered a drug to used treat a mental health condition, but may not be what the legislation intends to protect.

While this title does not make permanent the inclusion of antipsychotics and antidepressant drugs as protected drug classes by which a Medicare Part D plan must provide all drugs within those classes, it does prohibit the Secretary from allowing Medicare Part D plans to exclude or to otherwise limit access to antidepressants or antipsychotic through prior authorization or utilization management.

F. TITLE VI – Research by the National Institute of Mental Health

This title authorizes the appropriation of $40 million for each of fiscal years 2015 through 2019 in funding for the National Institute of Mental Health (NIMH) -- beyond amounts currently available for the Institute -- for research on: (1) the determinants of self- and other directed-violence in mental illness; and (2) the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. This specific authorization of appropriations for NIMH research does not follow the standard authorization convention of just having a single, agency-wide authorization for the National Institutes of Health (NIH).

G. TITLE VII – Community Mental Health Services Block Grant Reform

This title transfers the MHBG authority from SAMSHA to the new Assistant Secretary and includes several new requirements for states to be eligible for MHBG funds, including a requirement that they: (1) have in effect laws that provide for involuntary inpatient or outpatient treatment of an individual that as a result of mental illness, is a danger to self or others, "is persistently or acutely disabled, or is gravely disabled and in need of treatment;" (2) have an AOT law on the books that meets several criteria; (3) address the integration of mental and physical health services in their plans outlining use of MHBG funds; and (4) report additional data regarding comprehensive mental health services in the respective State and public health outcomes for people with serious mental illness. States would also be permitted to carryover unused MHBG balances. This title also redirects 5 percent of appropriated MHBG funding to support the implementation of evidence-based models of care through the National Mental Health Laboratory (established under Title I). And it requires the Assistant Secretary to enter into an agreement with the Institute of Medicine (or other appropriate entity) to evaluate the combined paperwork burden of community mental health centers meeting criteria prior to enactment of the legislation and the clinics certified under Title II of the legislation.

This title strips block grant authority away from SAMHSA and separates the administration and oversight of block grants for mental health and substance use disorders, which will undo several steps SAMHSA and States have taken to increase efficiency and streamline the block grant process. The title also establishes Federal standards for involuntary treatment -- including AOT -- which traditionally are set by individual States and would jeopardize continued MHBG funding in several States (unless they pass laws to change current standards). The reduction in MHBG funding, particularly in this difficult fiscal climate, is also troubling.

H. TITLE VIII – Behavioral Health Awareness Program

This title directs the Secretary of Education, together with the Assistant Secretary, to undertake a national awareness campaign targeting elementary and high school students -- as well as other youth -- to: (1) reduce the stigma associated with serious mental illness; (2) assist these students and young adults in responding to the signs of serious mental illness; and (3) improve the understanding among these students and young adults of the importance of seeking treatment for serious mental illness or a behavioral health disorder.

I. TITLE IX – Behavioral Health Information Technology

This title allows behavioral and mental health providers to receive incentive payments for the meaningful use of health information technology and creates a new mechanism for reporting patient safety issues associated with electronic health records.

J. TITLE X – Expanding Access to Care Through Health Care Professional Volunteerism

This title extends liability protection under the Federal Tort Claims Act (FTCA) currently available to community health center (health center) employees, contractors, and officers to volunteer physicians at health centers and community mental health centers, including clinics certified under Title II. This title does not address FTCA coverage for employees of community mental health centers, who are not currently eligible for such coverage.

K. TITLE XI – SAMHSA Reauthorization and Reforms

This title reauthorizes SAMHSA's programs of regional and national significance (PRNS) authority for mental health at 60% of the currently-appropriated level; but it could also restrict SAMHSA's ability to undertake new activities that address pressing mental health and substance use needs utilizing these authorities, and terminate any programs and activities established pursuant to these authorities unless they are explicitly authorized (or are otherwise required by statute) by the end of fiscal year 2014. The title modifies the SAMHSA Administrator's and the Center for Mental Health Services authorities to shift mental health responsibilities -- but not those related to substance abuse -- to the Assistant Secretary. It would transfer SAMHSA's specific behavioral health data collection authority to the Assistant Secretary. It requires that at least half of the members of any peer review group established to review proposals or grants related to mental illness -- and for the agency's advisory councils -- are physicians or clinical psychologists.

The title also requires the SAMHSA Administrator to provide a list of peer review group members to Congress prior to awarding any grant, cooperative agreement, or contract reviewed by the group; and notify Congress before awarding any PRNS grant, cooperative agreement, or contract. It precludes the Administrator of SAMHSA from supporting any program for the diagnosis and treatment mental health and substance use disorders unless the supported activities rely on evidence-based practices.

This title reauthorizes the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program but seeks an 85% reduction in funding authorized for PAIMI activities, restricts their ability to pursue class action lawsuits or to investigate and seek legal remedies outside of individual cases of abuse or neglect, and prohibits them from lobbying, even with private funds. This title also reauthorizes programs with broad bipartisan support, such as the Garrett Lee Smith Suicide Prevention Program, Comprehensive Community Health Services for Children With Serious Emotional Disturbances Program, and the National Child Traumatic Stress Network.

This title could result in the termination of many successful SAMHSA programs established pursuant to PRNS authorities, such as the minority fellowship program and Project AWARE (Advancing Wellness and Resilience in Education). Termination of programs established pursuant to PRNS authorities without redistribution of funding for these activities to other SAMHSA areas would translate to a loss of approximately 35% of SAMHSA's mental health budget and 25% of SAMHSA's substance use budget, based upon fiscal year 2014-enacted levels. The reduction to and restrictions on uses of PAIMI funding will impede the ability for State protection and advocacy systems to protect the rights of individuals through activities that ensure the enforcement of the constitution and federal and state laws and the ability for these entities to leverage their expertise and utilize private funding to weigh in on relevant federal, state, and local policies. While the inclusion of medical and clinical psychology perspectives on peer review groups and advisory councils seems reasonable, a rigid requirement for members with this expertise may not be feasible and may minimize the opportunity for important interdisciplinary perspectives. Requiring written notice to Congress before awarding any grants would be an atypical and overly burdensome task.

IV. RELEVANT COMMITTEE PROCEEDINGS AND LEGISLATION

A. Relevant Committee Proceedings

During the 113th Congress, the Subcommittee on Oversight and Investigations has held three hearings and one forum focusing on mental health issues, addressing mental health and gun violence, examining privacy issues surrounding the HIPAA, conducting oversight of SAMHSA, and examining the shortage of psychiatric hospital beds and overcrowding in emergency departments.[30]

B. Other Relevant Legislation: H.R. 2910, Gun Violence and Reduction Act of 2013

Rep. Waxman introduced gun violence legislation that includes a title to improve access to mental health services. Title II of this bill includes mental health provisions and focuses on preventing the rare instances when individuals with serious mental illness escalate and commit violent acts; however, the provisions are applicable and would benefit all individuals with mental illness.

Specifically, title II of this bill expands access to mental health services; establishes a new SAMHSA program to develop and implement continuing education training curricula targeted to health professionals to identify, refer, and treat individuals with serious mental

[30] House Committee on Energy and Commerce, *Forum on After Newtown: A National Conversation on Violence and Severe Mental Illness* (Mar. 5, 2013); House Committee on Energy and Commerce, *Hearing on Does HIPAA Help or Hinder Patient Care and Public Safety* (Apr. 25, 2013); House Committee on Energy and Commerce, *Hearing on Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill* (May 20, 2013); House Committee on Energy and Commerce, *Hearing on Where Have All the Patient Gone? Examining the Psychiatric Bed Shortage* (March 26, 2014).

illness; increases funding for scholarships and loan repayments for mental health professionals through the National Health Service Corps; provides support for training programs for school and emergency services personnel to identify and respond to signs of mental health and substance use disorders; provides support for programs designed to integrate mental health services into primary care settings; and expands the mission of the NIMH to specifically address research on serious mental illness. It also reauthorizes several programs, including the Garrett Lee Smith Memorial Act; the National Child Traumatic Stress Initiative; and the Health Resources and Services Administration Mental and Behavioral Health Education and Training Program to train psychologists, social workers, and child and adolescent mental health providers.

It directs the Secretary of HHS to issue guidance on the requirements of HIPAA to ensure that HIPAA training for covered entities -- including doctors, hospitals, and clinics -- includes a clear explanation of the circumstances under which health care providers are permitted or required to disclose protected health information for individuals with a mental health disorder.

It directs the Government Accountability Office to conduct a study on the availability of inpatient beds for the treatment of mental health disorders, including the impact of the Medicaid IMD exclusion on individuals with serious mental illness and on states. It revises the annual reporting requirements for the SAMHSA MHBG and state block grant for the prevention and treatment of substance use disorders to both better account for the use of block grant dollars and better measure the quality and impact of the services provided. Finally, it provides that the provisions of MHPAEA are to be construed to ensure full parity between both medical and surgical benefits and mental health and substance use disorder benefits, including full parity at all levels of medically appropriate treatment and with respect to applicable medical management techniques.

V. WITNESSES

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