118TH CONGRESS
1ST SESSION

S. _____

To amend titles XVIII and XIX of the Social Security Act to reform and improve mental health and substance use care under the Medicare and Medicaid programs, and for other purposes.

IN THE SENATE OF THE UNITED STATES

_____

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

A BILL

To amend titles XVIII and XIX of the Social Security Act to reform and improve mental health and substance use care under the Medicare and Medicaid programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Better Mental Health Care for Americans Act''.

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

TITLE I—MEDICARE PART B PROVISIONS

SEC. 101. PAYMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE FOR INHERENTLY COMPLEX EVALUATION AND MANAGEMENT VISITS RELATED TO INTEGRATED MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE.

(a) IN GENERAL.—Section 1848(b) of the Social Security Act (42 U.S.C. 1395w–4(b)) is amended by adding at the end the following new paragraph:

''(13) PAYMENT FOR INHERENTLY COMPLEX EVALUATION AND MANAGEMENT VISITS RELATED TO INTEGRATED MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE.—

''(A) IN GENERAL.—The Secretary shall establish a new HCPCS add–on code under the fee schedule established under this subsection for integrated mental health and substance use disorder care services (as defined in subparagraph (B)(i)) that are furnished on or after January 1, 2025, when furnished by an integrated care practitioner on the same date of service that a service in the HCPCS category of office and other outpatient evaluation and man-

agement services is furnished. Such add-on code may be similar to HCPCS code G2211.

''(B) DEFINITIONS.—In this paragraph:

''(i) INTEGRATED MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE SERVICES.—

''(I) IN GENERAL.—The term 'integrated mental health and substance use disorder care services' means services described in subclause (II) that are furnished by an integrated care practitioner.

''(II) SERVICES DESCRIBED.—The services described in this subclause are the following:

''(aa) Preventive services and screening for mental health and substance use disorders that the Secretary determines are—

''(AA) reasonable and necessary for the prevention or early detection of a mental health or substance use disorder;

"(BB) recommended with a grade of A or B by the United States Preventive Services Task Force or recommended in Health Resources and Services–supported guidelines for infants, children, adolescents, and women; and

"(CC) appropriate for individuals enrolled under this part.

"(bb) The routine use and tracking of quality measures appropriate for the measurement of the quality of care (including medication errors) related to behavioral health that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities.

"(cc) Short-term, evidence-based, culturally, and linguis-

tically appropriate therapeutic and psychosocial intervention integrated into the primary care practice, including through telehealth.

''(dd) Evidence-based treatment for mental health and substance use care integrated into the primary care practice, including through telehealth, or through referral.

''(ee) Care management, which can include establishing, implementing, revising or monitoring the care plan, coordinating with other professionals and agencies, and educating the individual or caregiver about the individual's condition, care plan, or prognosis.

''(ff) Other services determined by the Secretary.

''(ii) INTEGRATED CARE PRACTITIONER.—

''(I) IN GENERAL.—The term 'integrated care practitioner' means a primary care practitioner (as defined in section 1833(x)(2)(A)(i)) who has demonstrated the capacity to furnish integrated mental health and substance use disorder care services (as determined under subclause (II)).

''(II) DEMONSTRATING CAPACITY GUIDANCE; ATTESTATION.—For purposes of applying subclause (I) with respect to an integrated care practitioner demonstrating the capacity to furnish integrated mental health and substance use disorder care services, the Secretary shall issue guidance, not later than one year after the date of the enactment of this paragraph, describing requirements for demonstrating capacity to provide such services and establishing a process for the Secretary to receive an attestation that an integrated care practitioner has such capacity. Such guidance and attestation may not impose additional

burden on small practices (as defined for purposes of subsection (q)(11)) and practices located in rural areas.

''(C) PAYMENT.—

''(i) AMOUNT OF PAYMENT.—The fee schedule amount for integrated mental health and substance use disorder care services shall not be less than the fee schedule amount for services described by HCPCS code G2211 (or any successor or substantially similar code).

''(ii) ADD-ON SERVICES.—If, during the furnishing of an evaluation and management service to an individual by an integrated care practitioner, such practitioner also furnishes (or coordinates the furnishing of) integrated mental health and substance use disorder care services on the same date of service, payment shall also be made for such integrated mental health and substance used disorder care services even if the individual did not previously have a mental health or substance use disorder diagnosis.

"(iii) PAYMENT CONSIDERATIONS.—In carrying out this paragraph, the Secretary shall ensure that the amount of payment for integrated mental health and substance use disorder care services under this paragraph is sufficient to sustain effective and accessible integrated mental health and substance use disorder care under this part, as determined by evidence from practice expenses of those implementing effective integrated care as well as evidence of the resource needs of integrated care practitioners who furnish such services in mental health professional shortage areas (as designated under section 332(a)(1)(A) of the Public Health Service Act) and medically underserved areas.".

(b) EXEMPTION FROM BUDGET NEUTRALITY.—Section 1848(c)(2)(B)(iv) of the Social Security Act (42 U.S.C. 1395w–4(C)(2)(b)(iv)) is amended by adding at the end the following new subclause:

"(VII) Subsection (b)(13) shall not be taken into account in applying clause (ii)(II) for 2025.".

(c) WAIVER OF COINSURANCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(1) by striking ''and'' before ''(HH)''; and

(2) by inserting before the semicolon at the end the following: '', and (II) with respect to integrated mental health and substance use disorder care services (as defined in subparagraph (B)(i) of section 1848(b)(13)) that are furnished on or after January 1, 2025, the amounts paid shall be equal to 100 percent of the lesser of the actual charge for such services or the fee schedule amount provided under such section''.

SEC. 102. ENSURING ACCESS TO EARLY INTERVENTION IN MENTAL HEALTH CARE IN MEDICARE.

Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 101(c), is amended—

(1) by striking ''and'' before ''(II)''; and

(2) by inserting before the semicolon at the end the following: '', and (JJ) with respect to behavioral health integration services described by HCPCS codes 99492, 99493, 99494, 99484 , G2214, and G0323 (or any successor or substantially similar code) furnished on or after January 1, 2025, the

amounts paid shall be equal to 100 percent of the lesser of the actual charge for such services or the fee schedule amount provided under section 1848(b)''.

TITLE II—MEDICARE ADVANTAGE AND PART D PROVISIONS

SEC. 201. PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS UNDER MEDICARE ADVANTAGE AND PRESCRIPTION DRUG PLANS.

(a) MEDICARE ADVANTAGE PLANS.—

(1) IN GENERAL.—Section 1852 of the Social Security Act (42 U.S.C. 1395w–22) is amended by adding at the end the following new subsection:

''(o) PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.—

''(1) IN GENERAL.—Each MA organization shall ensure that the benefit design of each MA plan offered by such organization meets the following requirements:

''(A) FINANCIAL REQUIREMENTS.—The financial requirements applicable to mental health or substance use disorder benefits covered by the plan may not exceed the predominant financial requirements applied to substan-

tially all medical benefits covered by the plan, including supplemental benefits, and there are no separate cost sharing requirements that are applicable only with respect to mental health and substance use disorder benefits.

''(B) TREATMENT LIMITATIONS.—The treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical benefits covered by the plan and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits, including supplemental benefits.

''(2) DETERMINATIONS OF MEDICAL NECESSITY.—

''(A) IN GENERAL.—Each MA organization shall ensure that any determination of medical necessity for mental health or substance use benefits under each MA plan offered by such organization that is not based on the application of a national or local coverage determination is consistent with generally accepted standards of mental health and substance use dis-

order care, as defined in paragraph. For any level of care determination with respect to mental health or substance use disorder benefits, coverage criteria are consistent with widely-used treatment guidelines only if they result in a level of care determination that is consistent with the determination that would have been made using the relevant widely-used treatment guidelines.

''(B) CRITERIA FOR MEDICAL NECESSITY DETERMINATIONS.—The criteria for determination of medical necessity with respect to mental health or substance use disorder benefits under an MA plan shall be made available in plain language to any individual upon request.

''(3) REPORTING ON APPLICATION OF NONQUANTITATIVE TREATMENT LIMITATIONS.—

''(A) COMPARATIVE ANALYSES OF DESIGN AND APPLICATION OF NONQUANTITATIVE TREATMENT LIMITS.—For 2025 and subsequent years, in the case of an MA organization that imposes nonquantitative treatment limitations (referred to in this paragraph as 'NQTLs') on mental health or substance use disorder benefits under an MA plan offered by

such organization, such organization shall be required to perform and document comparative analyses of the design and application of NQTLs on mental health and substance use disorder benefits under the plan and make available to the Secretary as provided under subparagraph (B), upon request, the comparative analyses and the following information:

''(i) The specific plan terms regarding the NQTLs and a description of all mental health or substance use disorder and medical benefits to which each such term applies in each respective benefits classification.

''(ii) The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical benefits.

''(iii) The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence, including utilization of decision support technology, artificial intelligence technology, machine-learning technology,

clinical decision-making technology, or any other technology specified by the Secretary, relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical benefits.

''(iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical benefits in the benefits classification.

''(v) The specific findings and conclusions reached by the MA organization with respect to the MA plan, including any results of the analyses described in this subparagraph that indicate that the plan is or is not in compliance with this subsection.

''(B) SUBMISSION TO SECRETARY UPON REQUEST.—An MA organization shall submit to the Secretary the comparative analyses de-

scribed in subparagraph (A) and the information described in clauses (i) through (v) of such subparagraph upon request by the Secretary. The Secretary shall request not fewer than 20 such analyses per year.

''(C) REPORT.—Not later than October 1, 2029, and biennially thereafter, the Secretary shall submit to Congress, and make publicly available, a report that contains the following:

''(i) A summary of the comparative analyses and information requested under subparagraph (B).

''(ii) The Secretary's conclusions as to whether each MA organization submitted sufficient information for the Secretary to review the comparative analyses and information requested for compliance with this subsection.

''(iii) The Secretary's conclusions as to whether each MA organization that submitted sufficient information for the Secretary to review was in compliance with this subsection.

''(4) DEFINITIONS.—In this subsection:

"(A) CLASSIFICATION OF BENEFITS.—The term 'classification of benefits' means the following:

"(i) INPATIENT.—Benefits under part A.

"(ii) OUTPATIENT.—Benefits furnished on an outpatient basis under part B.

"(iii) EMERGENCY CARE.—Benefits for emergency care covered under part B.

"(iv) PART B PRESCRIPTION DRUGS.—Benefits for drugs and biologicals covered under part B.

"(v) COVERED PART D DRUGS.—Benefits for covered part D drugs as defined in section 1860D–2(e).

"(vi) SUPPLEMENTAL.—Supplemental health care benefits as described in section 1852(a)(3).

"(B) EVIDENTIARY STANDARDS.—The term 'evidentiary standard' means factors or evidence a plan considers in designing and applying its medical management techniques, such as generally accepted standards of mental health and substance use disorder care, recog-

nized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

''(C) FINANCIAL REQUIREMENT.—The term 'financial requirement' includes deductibles, copayments, coinsurance, and maximum limitations on out-of-pocket expenses applicable under the plan.

''(D) GENERALLY ACCEPTED STANDARDS OF MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE.—The term 'generally accepted standards of mental health and substance use disorder care' means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, and addiction medicine and counseling, to ensure appropriate diagnosis, treatment, and ongoing management, for underlying mental health and substance use disorders, including

co-occurring conditions, to adequately meet the needs of patients. These standards are derived from valid, evidence–based sources such as peer–reviewed scientific studies and medical literature, consensus guidelines of nonprofit health care provider professional associations and specialty societies, including level of care criteria and clinical practice guidelines, and recommendations of Federal government agencies.

''(E) MENTAL HEALTH BENEFITS.—The term 'mental health benefits' means benefits with respect to items and services for mental health conditions as defined by the Secretary.

''(F) PREDOMINANT.—A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

''(G) SUBSTANCE USE DISORDER BENEFITS.—The term 'substance use disorder benefits' means benefits with respect to items and services for substance use disorders as defined by the Secretary.

''(H) SUBSTANTIALLY ALL.—A financial requirement or treatment limitation applies to substantially all medical benefits in a classifica-

tion if it applies to at least two-thirds of the benefits in that classification.

''(I) TREATMENT LIMITATION.—

''(i) IN GENERAL.—The term 'treatment limitation' means mechanisms to control utilization of services and expenditures such as limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Such term includes:

''(I) QUANTITATIVE TREATMENT LIMITATIONS.—Quantitative treatment limitations, including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

''(II) NONQUANTITATIVE TREATMENT LIMITATIONS.—Nonquantitative treatment limitations, including other limits on the access, scope, or duration of benefits for treatment under a plan or coverage not described in subclause (I), such as—

"(aa) medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

"(bb) for plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

"(cc) standards for provider admission to participate in a network, including reimbursement rates;

"(dd) refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);

"(ee) exclusions based on failure to complete a course of treatment; and

''(ff) restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

''(ii) EXCLUSIONS.—The term 'treatment limitation' does not include any exclusions from coverage of items or services for which payment is not made under part A or part B or any statutory limitations on coverage applicable under such parts.''.

(2) ENFORCEMENT.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w–27(g)(1)) is amended—

(A) in subparagraph (J), by striking ''or'' after the semicolon;

(B) by redesignating subparagraph (K) as subparagraph (L);

(C) by inserting after subparagraph (J), the following new subparagraph:

''(K) fails to comply with mental health parity requirements under section 1852(o) or applicable implementing regulations or guidance; or'';

(D) in subparagraph (L), as redesignated by subparagraph (B), by striking ''through (J)'' and inserting ''through (K)''; and

(E) in the flush matter following subparagraph (L), as so redesignated, by striking ''subparagraphs (A) through (K)'' and inserting ''subparagraphs (A) through (L)''.

(b) PRESCRIPTION DRUG PLANS.—Section 1860D–4 of the Social Security Act (42 U.S.C. 1395w–104) is amended by adding at the end the following new subsection:

''(c) PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.—The provisions of section 1852(o) (relating to parity in mental health and substance use disorder benefits) shall apply to PDP sponsors offering prescription drug plans in the same manner in which such provisions apply with respect to Medicare Advantage organizations offering MA–PD plans.''.

(c) REGULATIONS.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services shall issue regulations to carry out the amendments made by this section.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning after the date that is 2 years after the date of enact-

ment of this Act, regardless of whether regulations have been issued to carry out such amendments by such effective date.

(e) IMPLEMENTATION FUNDING.—For purposes of carrying out the provisions of, including the amendments made by, this section, there are appropriated, out of amounts in the Treasury not otherwise appropriated, to the Centers for Medicare & Medicaid Services Program Management Account, $10,000,000 for fiscal year 2024, which shall remain available until expended.

SEC. 202. BEHAVIORAL HEALTH MEASURES AND INCENTIVIZING BEHAVIORAL HEALTH CARE QUALITY.

Section 1853(o) of the Social Security Act (42 U.S.C. 1395w–23(o)) is amended by adding at the end the following new paragraph:

''(8) BEHAVIORAL HEALTH MEASURES.—

''(A) IN GENERAL.—For 2025 and biennially thereafter, the Secretary shall consider adding to the 5-star rating system behavioral health measures that measure the quality and outcomes of—

''(i) mental health or substance use disorder services; and

''(ii) items and services not described in clause (i) that are furnished to an individual with a mental health or substance use disorder.

''(B) CONSIDERATIONS.—In considering the addition of behavioral health measures under subparagraph (A), the Secretary shall—

''(i) consider measures for which data can be collected through encounter data or enrollee survey data submitted by MA organizations;

''(ii) consider measures endorsed by a consensus-based entity, as described in section 1890(a);

''(iii) consider measures that assess the quality and health outcomes of items and services described in subparagraph (A), including contraindicated or low-value care, furnished to individuals with a mental health or substance use disorder;

''(iv) consider measures that assess access to behavioral health treatment, including measures of wait times, distance standards, providers who are taking on new patients, and the proportion of behav-

ioral health providers who have not submitted a claim for a mental health or substance use disorder service during the past six months;

''(v) consider measures that assess the integration of behavioral health care and primary care services;

''(vi) consider measures that align with behavioral health measures—

''(I) used to assess performance in part A or part B; or

''(II) identified as part of the Core Set of Health Care Quality Measures for Adults as described in section 1139B; and

''(vii) consider measures that assess patient experience of care.''.

SEC. 203. PROVIDING INFORMATION ON BEHAVIORAL HEALTH COVERAGE TO PROMOTE INFORMED CHOICE.

Section 1851(d)(4) of the Social Security Act (42 U.S.C. 1395w–21(d)(4)) is amended by adding at the end the following new subparagraph:

''(F) BEHAVIORAL HEALTH INFORMATION.—For 2025 and subsequent plan years, to

the extent available, the following information with respect to the preceding plan year:

''(i) Information on access to in-network behavioral health providers, disaggregated by those who prescribe and those who offer mental health or substance use disorder services, including—

''(I) the average wait time (as defined by the Secretary) for an appointment for a new patient with an in-network provider for mental health or substance disorder services;

''(II) the total number and percentage of providers who have participation agreements with the organization who submitted at least one request for payment for a mental health or substance use disorder service during a 6 month period (or other period specified by the Secretary); and

''(III) the percentage of requests for payment for mental health or substance use disorder services that were submitted by—

''(aa) in-network providers; and

''(bb) out-of-network providers.

''(ii) Information on the number of denials of prior authorization requests or denials of payment for mental health or substance use disorder services compared to non-mental health and substance use disorder services overall, categorized by the type of denial and by the type of service, as defined by the Secretary, including—

''(I) the number and percent of such denials by the number of days to denial, the reason for denial, and the utilization of decision support technology, artificial intelligence technology, machine-learning technology, clinical decision-making technology, or any other technology specified by the Secretary; and

''(II) the number and percent of such denials with respect to a mental health or substance use disorder service compared to such denials with re-

spect to items and services for a similar physical health condition (such as depression compared to diabetes) by the number of days to denial, the reason for denial, and the utilization of decision support technology, artificial intelligence technology, machine-learning technology, clinical decision-making technology, or any other technology specified by the Secretary.''.

SEC. 204. REQUIRING MA ORGANIZATIONS TO MAINTAIN ACCURATE AND UPDATED PROVIDER DIRECTORIES.

(a) IN GENERAL.—Section 1852(c) of the Social Security Act (42 U.S.C. 1395w–22(c)) is amended—

(1) in paragraph (1)(C)—

(A) by striking ''plan, and any'' and inserting ''plan, any''; and

(B) by inserting the following before the period: '', and, in the case of a network-based MA plan (as defined in paragraph (3)(C)), the information described in paragraph (3)(A)(i)(II)''; and

(2) by adding at the end the following new paragraph:

''(3) PROVIDER DIRECTORY ACCURACY AND TRANSPARENCY.—

''(A) IN GENERAL.—For plan year 2025 and subsequent plan years, each MA organization offering a network-based MA plan shall do the following:

''(i) MAINTAIN AN ACCURATE PROVIDER DIRECTORY.—

''(I) IN GENERAL.—The MA organization shall, for each network-based MA plan offered by the organization, maintain an accurate provider directory—

''(aa) that includes the information described in subclause (II);

''(bb) which, not less frequently than 90 days, the organization verifies and, if applicable, updates the provider directory information of each provider;

''(cc) that provides, if the organization is unable to verify such information with respect to a provider, for the inclusion

along with the information in the directory with respect to such provider of a notification indicating that the information may not be up to date;

"(dd) that provides for the removal of a provider from such directory within 2 business days if the organization determines that the provider is no longer a participating provider; and

"(ee) that meets such other requirements as the Secretary may specify.

"(II) INFORMATION DESCRIBED.—The information described in this subclause is the National Provider Identifier, name, address, specialty, telephone number, Internet website if available, availability (including whether the provider is accepting new patients), cultural and linguistic capabilities (including the languages offered by the provider or by a skilled medical interpreter who

provides interpretation services for the provider), and other information as determined appropriate by the Secretary for each provider with which such MA organization has an agreement for furnishing items and services covered under such plan.

''(ii) SUBMISSION OF PROVIDER DIRECTORY TO THE SECRETARY.—The MA organization shall submit to the Secretary the provider directory for each network-based MA plan offered by the organization in a manner specified by the Secretary.

''(B) POSTING OF PROVIDER DIRECTORY INFORMATION.—For plan year 2026 and subsequent plan years, the Secretary shall post the provider directory information submitted under subparagraph (A)(ii), in a machine readable file, on the internet website of the Centers for Medicare & Medicaid Services.

''(C) NETWORK-BASED MA PLAN DEFINED.—In this paragraph, the term 'network-based MA plan' means an MA plan that has a network of providers that have agreements with the MA organization offering the plan to fur-

nish items and services covered under such plan.''.

(b) ENFORCEMENT.—Section 1857(d) of the Social Security Act (42 U.S.C. 1395w–27(d)) is amended by adding at the end the following new paragraph:

''(7) AUDIT OF PROVIDER DIRECTORIES.—Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary, shall have the right to audit any provider directory under section 1852(c)(3)(A)(i) to determine whether such directory meets the requirements of such section.''.

(c) FUNDING.—In addition to amounts otherwise available, there is appropriated to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2023, out of any amounts in the Treasury not otherwise appropriated, $10,000,000, to remain available until expended, for purposes of carrying out the amendments made by this section.

TITLE III—MEDICAID AND CHIP

SEC. 301. ENHANCED PAYMENT UNDER MEDICAID FOR INTEGRATED MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE SERVICES.

Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(1) in subsection (a)(3)—

(A) in subparagraph (D), by inserting ''and'' after the semicolon;

(B) in subparagraph (F)(ii), by striking ''plus'' after the semicolon and inserting ''and''; and

(C) by inserting after subparagraph (F)(ii), the following:

''(G) for calendar quarters beginning on or after January 1, 2025, 100 percent of the amount determined for such quarter under subsection (cc); and''; and

(2) by adding the end the following:

''(cc) ENHANCED PAYMENT FOR INTEGRATED MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE SERVICES.—

''(1) IN GENERAL.—For purposes of subsection (a)(3)(G), in accordance with guidance issued not later than the date that is 180 days after the date of the enactment of this subsection by the Secretary to States, the amount determined under this subsection with respect to a State and calendar quarter is the amount by which—

''(A) the aggregate amount expended by the State during the calendar quarter for med-

ical assistance provided by a primary care practitioner (as defined in section 1833(x)(2)(A)(i)) for integrated mental health and substance use disorder care services described in section 1848(b)(13)(B) and such other items and services for the care of mental health and substance use conditions furnished by, or in coordination with, such primary care practitioner as the Secretary, in consultation with the State, may specify; exceeds

''(B) the quarterly average of the aggregate amounts expended by the State for medical assistance described in subparagraph (A) during the applicable base period for the calendar quarter involved.

''(2) APPLICABLE BASE PERIOD DEFINED.—

''(A) IN GENERAL.—For purposes of paragraph (1), the term 'applicable base period' means, with respect to a calendar quarter, the 5-year period that ends on the most recent base period end date.

''(B) BASE PERIOD END DATE DEFINED.—For purposes of subparagraph (A), the term 'base period end date' means—

''(i) December 31, 2024; and

"(ii) December 31 of every 5th year following 2024.".

SEC. 302. DEMONSTRATION PROJECT TO ENSURE MEDICAID-ENROLLED CHILDREN HAVE ACCESS TO INTEGRATED MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE SERVICES, INCLUDING PREVENTION AND EARLY INTERVENTION SERVICES.

(a) IN GENERAL.—Not later than the date that is 180 days after the date of the enactment of this section, the Secretary shall conduct a 54-month demonstration project for the purpose described in subsection (b) under which the Secretary shall—

(1) for the first 18-month period of such project, award planning grants described in subsection (c); and

(2) for the remaining 36-month period of such project, provide to each State selected under subsection (d) payments in accordance with subsection (e).

(b) PURPOSE.—The purpose described in this subsection is for each State that receives a planning grant under subsection (c) to ensure that every Medicaid-enrolled child in the State has access to integrated mental health and substance use disorder care services, including

prevention and early intervention services, so as to allow for the prevention, identification, and treatment of mental health and substance use conditions in primary care, children's hospitals, early care and education, schools, or other settings as appropriate (such as home visiting and early intervention programs for young children, foster care or other child welfare care settings, or workforce development programs and community centers for youth) (in this section collectively referred to as ''care settings''), through the following activities:

(1) Activities that support an ongoing assessment of the accessibility of integrated mental health and substance use disorder care services, including prevention and early intervention services, for Medicaid-enrolled children in the State that tracks progress toward the goal of all Medicaid-enrolled children (including infants and toddlers as well as transition-aged youth) having access to appropriate levels of services in care settings in which the children regularly engage, and that is conducted in partnership with such children and families, to ensure that the assessment reflects their perspective, experiences, and solutions.

(2) Activities that, taking into account the results of the assessment described in paragraph (1),

support the development, implementation, and maintenance of State infrastructure, such as technology and the physical structures necessary to physically co-locate integrated mental health and substance use disorder care services, including prevention and early intervention services, and a workforce to provide the types of support, training, and technical assistance needed in order to offer integrated mental health and substance use care services, including prevention and early intervention services, in care settings with which Medicaid-enrolled children and their families regularly interact, which are selected for integration based on the assessment of where such children and their families can access such services, and for which furnishing integrated mental health and substance use disorder care services, including prevention and early intervention services, will be sustainable under the State's planned activities.

(3) Increased reimbursement and improved incentives for care settings to sustainably implement and provide (either through direct delivery or coordination in the case of a care setting that is an early care or education program)—

(A) developmentally appropriate mental health promotive and preventive interventions

for Medicaid-enrolled children and their families, along with screening to identify psycho-social needs of such children who do not yet have a diagnosable mental health condition (consistent with the requirements for providing items and services described in section 1905(a)(4)(B) of the Social Security Act (42 U.S.C. 1396d(a)(4)(B))(relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r) of such Act (42 U.S.C. 1396d(r))) in accordance with the requirements of section 1902(a)(43) of such Act (42 U.S.C. 1396a(a)(43)) and the pediatric preventive care standards included in the essential health benefits required under section 1302(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(b)));

(B) evidence-based, person-centered, and culturally, linguistically, and developmentally appropriate interventions at the site of service, either in-person or virtually integrated, to address any identified family and child psycho-social needs, including developmentally appropriate assessment and diagnostic services, treat-

ment, care coordination, and dyadic intervention approaches; and

(C) referral to developmentally appropriate mental health and substance use specialty care providers and programs, community-based resources, or virtual or digital services to address risk factors or meet psycho- social needs that cannot be addressed in an integrated setting.

(4) Improved regulatory oversight of policies governing the provision of services described in paragraph (3), including with respect to early and periodic screening, diagnostic, and treatment services referred to in such paragraph, mental health and substance use parity, network adequacy, essential health benefits referred to in such paragraph, Medicaid rate setting, scope of practice policies, and health professional shortage areas.

(5) Improved alignment between Medicaid and commercial health insurers to ensure that services described in paragraph (3) are supported by commercial health insurers, such as through the initiation of multi-payer collaboratives.

(6) Improved coordination among State and local agencies and other stakeholders that fund or provide primary care, children's hospitals, early care

and education, or other programs in care settings described in this subsection so as to include efforts to align policies to promote coordination of mental health and substance use services funded under such programs across care settings, including through the alignment of Medicaid with programs under the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.), the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.), the Family First Prevention Services Act (title VII of division E of the Bipartisan Budget Act of 2018 (Public Law 115–123; 132 Stat. 232)), the Stephanie Tubbs Jones Child Welfare Services Program under subpart 1 of part B of title IV of the Social Security Act (42 U.S.C. 621 et seq.), the MaryLee Allen Promoting Safe and Stable Families Program under subpart 2 of part B of title IV of the Social Security Act (42 U.S.C. 629 et seq.), home visiting programs, including the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) under section 511 of the Social Security Act (42 U.S.C. 711), and health, education, and social welfare programs funded under the American Rescue Plan Act of 2021 (Public Law 117–2; 135 Stat. 4)

and the Child Care Development Block Grant Act of 1990 (42 U.S.C. 9857 et seq.).

(7) Activities that include Medicaid-enrolled children and their families and caregivers as partners at all levels of decision-making, implementation, and evaluation, including engaging such children who are youth and their families directly as paraprofessional providers.

(c) PLANNING GRANTS.—

(1) IN GENERAL.—For the first 18-month period of the demonstration project, the Secretary shall award planning grants to States that apply for such grants, including to entities specified in subparagraphs (B) and (C) of subsection (h)(7). A State awarded a planning grant under this subsection shall use the grant to carry out the activities described in paragraph (2) for purposes of preparing and submitting an application to participate in the remaining 36-month period of the demonstration project in accordance with subsection (d).

(2) ACTIVITIES DESCRIBED.—Activities described in this paragraph are, with respect to a State awarded a planning grant under this subsection, each of the following:

(A) Activities that support the development of an initial assessment of the access needs of Medicaid-enrolled children in the State with respect to mental health and substance use services, to determine the types of support, training, incentives, and technical assistance that primary care, early care and education, or other programs provided in care settings described in subsection (b) and with which Medicaid-enrolled children and their families regularly engage need in order to offer integrated mental health and substance use disorder care services, including prevention and early intervention services, and which shall include engaging Medicaid-enrolled children and their families directly to ensure that the assessment builds toward solutions that meet their needs and reflect their perspectives, experiences, and solutions.

(B) Activities that, taking into account the results of the assessment described in subparagraph (A), support the development of State infrastructure, such as technology and the physical structures necessary to physically co-locate integrated mental health and substance use disorder care services, including prevention and

early intervention services, to provide the types of support, training, incentives, and technical assistance that primary care, early care and education, or other programs provided in care settings described in subsection (b) and with which Medicaid-enrolled children and their families regularly engage need in order to offer integrated mental health and substance use disorder care services, including prevention and early intervention services, to Medicaid-enrolled children, as well as activities that support ongoing engagement of Medicaid-enrolled children and their families in implementation and coordination with health insurers and with other child-serving agencies and stakeholders.

(3) FUNDING.—For purposes of awarding planning grants under paragraph (1), there is appropriated, out of any funds in the Treasury not otherwise appropriated, $100,000,000, to remain available until expended.

(d) POST-PLANNING STATES.—

(1) IN GENERAL.—For the remaining 36-month period of the demonstration project, the Secretary shall make payments in accordance with subsection (e) to all States that submit applications that meet

the requirements of paragraph (2) and carry out the activities described in that paragraph.

(2) APPLICATIONS; ACTIVITIES.—

(A) IN GENERAL.—A State seeking to be selected to participate in the remaining 36-month period of the demonstration project shall submit to the Secretary, at such time and in such form and manner as the Secretary requires, an application that includes such information, provisions, and assurances, as the Secretary may require, in addition to the following:

(i) A process for carrying out the ongoing assessment described in subsection (b)(1), taking into account the results of the initial assessment described in subsection (c)(2)(A).

(ii) A review of Medicaid reimbursement methodologies and other policies related to furnishing integrated mental health and substance use disorder care services, including prevention and early intervention services, to Medicaid-enrolled children that may create barriers to access. If the State uses multiple reimbursement methodologies under Medicaid for mental

health and substance use care (such as capitation, fee-for-service, value-based, and alternative payment programs), the State shall include in the application specific detailed information regarding how the State will verify that the combination of reimbursement methodologies employed by the State will result in improved access to integrated mental health and substance use disorder care services, including prevention and early intervention services, for Medicaid-enrolled children.

(iii) The development of a plan, taking into account activities carried out under subsection (c)(2)(B), that will result in long-term and sustainable access to integrated mental health and substance use disorder care services, including prevention and early intervention services, for Medicaid-enrolled children which includes the following:

(I) Specific activities to increase access to integrated mental health and substance use disorder care services, including prevention and early inter-

vention services, so as to allow for the prevention, identification, and treatment of mental health and substance use conditions in primary care, early care and education, or other programs provided in care settings described in subsection (b) and with which Medicaid-enrolled children and their families regularly engage.

(II) Strategies that will incentivize a racially and culturally diverse array of providers (including paraprofessionals) to obtain the necessary training, education, and support to deliver integrated care for the developmentally appropriate prevention, identification, assessment, diagnosis, and treatment of mental health and substance use conditions in Medicaid-enrolled children in primary care, early care and education, or other programs provided in care settings described in subsection (b) and with which Medicaid-enrolled children and their families regularly engage.

(III) Milestones and timeliness for implementing activities set forth in the plan, as determined by the Secretary.

(IV) Specific measurable targets for increasing equitable access to integrated mental health and substance use disorder care services, including prevention and early intervention services, for Medicaid-enrolled children.

(V) Specific measurable targets for increasing the workforce providing integrated mental health and substance use disorder care services, including prevention and early intervention services.

(iv) A process for reporting the information required under subsection (f)(1), including information to assess the effectiveness of the efforts of the State during the period of the demonstration project under this subsection and ensure the sustainability of such efforts after the conclusion of the demonstration project.

(v) The expected financial impact of the demonstration project on the State.

(vi) A description of funding sources available to the State to expand access to integrated mental health and substance use disorder care services, including prevention and early intervention services in the State, including health care, public health, education, and social service funding opportunities.

(vii) A preliminary plan for how the State will sustain access to integrated mental health and substance use disorder care services, including prevention and early intervention services, for Medicaid-enrolled children after the demonstration project, including maintenance of incentives and enhanced reimbursement rates.

(viii) A description of how the State will coordinate the goals of the demonstration project with any waiver granted (or submitted by the State and pending) pursuant to section 1115 of the Social Security Act (42 U.S.C. 1315) for the delivery of mental health and substance use serv-

ices under Medicaid, as applicable, and with State plans under the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.), the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.), the Family First Prevention Services Act (title VII of division E of the Bipartisan Budget Act of 2018 (Public Law 115–123; 132 Stat. 232)), the Stephanie Tubbs Jones Child Welfare Services Program under subpart 1 of part B of title IV of the Social Security Act (42 U.S.C. 621 et seq.), the MaryLee Allen Promoting Safe and Stable Families Program under subpart 2 of part B of title IV of the Social Security Act (42 U.S.C. 629 et seq.), home visiting programs, including the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) under section 511 of the Social Security Act (42 U.S.C. 711), and health, education, and social welfare programs funded under the American Rescue Plan Act of 2021 (Public Law 117–2; 135 Stat. 4) and the Child

Care Development Block Grant Act of 1990 (42 U.S.C. 9857 et seq.).

(B) CONSULTATION.—In completing an application under subparagraph (A), a State shall consult with relevant stakeholders, including Medicaid managed care plans, primary and specialty health care provider organizations, Medicaid-enrolled children and their families, and other child-serving State and local agencies and stakeholders, and include in the application a description of such consultation.

(C) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States with respect to preparing and submitting an application that meets the requirements of subparagraphs (A) and (B).

(e) PAYMENTS.—

(1) IN GENERAL.—For each quarter occurring during the remaining 36-month period of the demonstration project, the Secretary shall pay each State that submits an application that meets the requirements of subsection (d) (2) and carries out the activities described in that subsection, an amount equal to 80 percent of the qualified sums expended by the State for such quarter.

(2) QUALIFIED SUMS DEFINED.—For purposes of paragraph (1), the term ''qualified sums'' means, with respect to a State and a quarter, the amount equal to the amount (if any) by which—

(A) the sums expended by the State during such quarter that are attributable to—

(i) furnishing integrated mental health and substance use disorder care services, including prevention and early intervention services, to Medicaid-enrolled children;

(ii) the development or enabling of State infrastructure, such as technology and the physical structures necessary to physically co-locate integrated mental health and substance use disorder care services, including prevention and early intervention services, delivered in or coordinated through primary care, early care and education, or other programs provided in care settings described in subsection (b) and with which Medicaid-enrolled children and their families regularly engage; and

(iii) the development of a workforce to provide the types of support, training, and

technical assistance needed in order to offer integrated mental health and substance use care services, including prevention and early intervention services, in primary care, early care and education, or other programs provided in care settings described in subsection (b) and with which Medicaid-enrolled children and their families regularly engage; exceeds

(B) ¼ of the average annual amount expended by the State for the most recent 5-fiscal year period for medical assistance for mental health or substance use disorder care services for Medicaid-enrolled children in a primary care, children's hospitals, school, early care and education, or other developmentally appropriate care setting, as determined by the Secretary.

(3) NON-DUPLICATION OF PAYMENT.—No payment made under this subsection with respect to medical assistance furnished to a Medicaid-enrolled child shall be duplicative of any payment made to a provider participating under the State Medicaid program for the same services so furnished to the same child.

(f) REPORTS.—

(1) STATE REPORTS.—Each State that receives payments under subsection (e) during the remaining 36-month period of the demonstration project shall submit to the Secretary, in accordance with detailed, specific guidance that is issued by the Secretary not later than the first day of such period, and that includes information on how to estimate and reconcile State expenditures to carry out the demonstration project during such period, quarterly reports, with respect to expenditures for which payment is made to the State under subsection (e), on the following:

(A) The specific activities with respect to which payment under such subsection was provided.

(B) The number of primary care, children's hospitals, schools, and early care and education programs that delivered or coordinated integrated mental health and substance use disorder care services, including prevention and early intervention services, to Medicaid-enrolled children during such period and their geographic distribution, compared to the estimated number that would have otherwise delivered such services in the absence of the dem-

onstration project, including disaggregated data on the race, ethnicity, and gender of providers.

(C) The number of Medicaid-enrolled children who received integrated mental health and substance use disorder care services, including prevention and early intervention services during such period compared to the estimated number of such children who would have otherwise received such services in the absence of the demonstration project, including disaggregated data on the race, ethnicity, gender, age (ensuring that children birth to 5 as well as transition-aged youth are adequately served), sexual orientation, primary language, income, and disability status of the children.

(D) Such other data or information as determined by the Secretary.

(2) CMS REPORTS.—

(A) INITIAL REPORT.—Not later than October 1, 2026, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, submit to Congress an initial report

on the activities carried out by States under the planning grants made under subsection (c), and actions taken by the Administrator of the Centers for Medicare & Medicaid Services to improve oversight of such activities.

(B) INTERIM REPORT.—Not later than October 1, 2028, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, submit to Congress an interim report on activities carried out under the demonstration project and actions taken by the Administrator of the Centers for Medicare & Medicaid Services to improve oversight of such activities and the extent to which States have achieved the stated goals submitted in their applications. Such report shall include a description of the strengths and limitations of the demonstration project and a plan for the sustainability of the project.

(C) FINAL REPORT.—Not later than October 1, 2030, the Administrator of the Centers for Medicare & Medicaid Services shall, in con-

sultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, submit to Congress a final report providing updates on the matters reported in the interim report required by subparagraph (B) and that includes—

(i) a description of any changes made with respect to the demonstration project after the submission of such interim report; and

(ii) an evaluation of the demonstration project.

(g) IMPLEMENTATION FUNDING.—There is appropriated, out of any funds in the Treasury not otherwise appropriated, $5,000,000 to the Administrator of the Centers for Medicare & Medicaid Services for purposes of implementing this section, to remain available until expended.

(h) DEFINITIONS.—In this section:

(1) CHILDREN'S HOSPITALS.—The term ''children's hospitals'' has the meaning given that term in section 340E(g)(2) of the Public Health Service Act (42 U.S.C. 256e(g)(2).

(2) INTEGRATED MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE SERVICES.—The term ''mental health and substance use disorder care services'' has the meaning given that term in section 1848(b)(13)(B) of the Social Security Act and includes prevention and early intervention services and such other items and services for the care of mental health and substance use conditions furnished by, or in coordination with, a primary care practitioner as the Secretary, in consultation with a State, may specify.

(3) MEDICAID.—The term ''Medicaid'' means the program for grants to States for medical assistance programs established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(4) SECRETARY.—Except as otherwise specified, the term ''Secretary'' means the Secretary of Health and Human Services.

(5) STATE.—The term ''State'' has the meaning given that term in section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) for purposes of titles XIX and XXI of such Act, and for purposes of

(6) MEDICAID-ENROLLED CHILD.—The term ''Medicaid-enrolled child'' means, with respect to a

State, a child enrolled under the State plan approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) or under a waiver of such plan.

(7) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(8) STATE.—The term ''State'' means—

(A) each of the 50 States and the District of Columbia;

(B) the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands; and

(C) to the extent the Secretary determines appropriate, may include an Indian Tribe, Tribal organization, or Urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)).

SEC. 303. UNIFORM APPLICABILITY TO MEDICAID OF REQUIREMENTS FOR PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

(a) FEE-FOR-SERVICE AND ALTERNATIVE BENEFIT PLANS.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) by striking ''and'' at the end of paragraph (86);

(B) by striking the period at the end of paragraph (87) and inserting ''; and''; and

(C) by inserting after paragraph (87) the following new paragraph:

''(88) provide for ensuring that the requirements for parity in mental health and substance use disorder benefits under subsection (uu) are complied with regardless of the payment model or arrangement under which medical assistance is provided, including when medical assistance under the State plan or under a waiver of such plan is provided through an alternative benefit plan under section 1937.''; and

(2) by adding at the end the following new subsection:

''(uu) PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.—For purposes of subsection (a)(88), the requirements under this subsection are the following:

''(1) IN GENERAL.—Regardless of whether a State plan or waiver of pays for medical assistance on a fee-for-service basis, capitated payment basis,

through the use of 1 or more alternative payment models, or any combination thereof, the State shall ensure that the financial requirements and treatment limitations applicable to coverage of mental health or substance use disorder services provided under such plan or under a waiver of such plan comply with the requirements of section 2726(a) of the Public Health Service Act in the same manner as such requirements or limitations apply to a group health plan under such section.

''(2) DEEMED COMPLIANCE.—Coverage with respect to an individual described in section 1905(a)(4)(B) and covered under the State plan or waiver under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), shall be deemed to satisfy the requirements of paragraph (1).''.

(b) MANAGED CARE ORGANIZATIONS AND PAYMENT ARRANGEMENTS.—

(1) IN GENERAL.—Section 1932(b)(8) of the Social Security Act (42 U.S.C. 1396u–2(b)(8)) is amended to read as follows:

''(8) COMPLIANCE WITH CERTAIN MATERNITY, PARITY IN MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS, AND OTHER COVERAGE REQUIREMENTS.—

''(A) IN GENERAL.—Each medicaid managed care organization shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply and are effective with respect to a health insurance issuer that offers group health insurance coverage.

''(B) PARITY IN MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS.—The financial requirements and treatment limitations applicable to coverage of mental health or substance use disorder services provided under the State plan or under a waiver of such plan through a medicaid managed care organization, a prepaid inpatient health plan (as defined by the Secretary), a prepaid ambulatory health plan (as defined by the Secretary), or a primary care case manager under section 1905 (consistent with section 1905(t)(2)), shall comply with the requirements of section 2726(a) of the Public Health Service Act in the same manner

as such requirements or limitations apply to a group health plan under such section.

''(C) DEEMED COMPLIANCE.—In applying subparagraphs (A) and (B) with respect to requirements under paragraph (8) of section 2726(a) of the Public Health Service Act, a medicaid managed care organization, a prepaid inpatient health plan (as defined by the Secretary), a prepaid ambulatory health plan (as defined by the Secretary), or a primary care case manager under section 1905 (consistent with section 1905(t)(2)) shall be treated as in compliance with such requirements if the medicaid managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan, or primary care case manager under section 1905 is in compliance with subpart K of part 438 of title 42, Code of Federal Regulations, and section 438.3(n) of such title, or any successor regulation.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by subsections (a) and (b) shall take effect on the first day of the first calendar quarter that begins on or after the date

that is 3 years after the date of enactment of this Act.

(2) DELAY IF STATE LEGISLATION NEEDED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(d) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services for purposes of carrying out this section and the amendments made by this

section, $10,000,000 for fiscal year 2024, to remain available until expended.

SEC. 304. REQUIRING ADDITIONAL TRANSPARENCY ON ACCESS TO MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS THROUGH MANAGED CARE.

(a) BIANNUAL ASSESSMENT.—Section 1932(b) of the Social Security Act (42 U.S.C. 1396u–2(b)) is amended by adding at the end the following new paragraph:

"(9) TRANSPARENCY ON ACCESS TO MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.—

"(A) IN GENERAL.—Each managed care organization, prepaid inpatient health plan (as defined by the Secretary), and prepaid ambulatory health plan (as defined by the Secretary), with a contract with a State to enroll individuals who are eligible for medical assistance under the State plan under this title or under a waiver of such plan and to provide coverage under the contract for mental health services or substance use disorder services, disaggregated, biannually shall assess and report to the State, in such manner that the report is publicly available on a website, the following:

''(i) The average wait times during the reporting period by level of acuity and site of care for adult and child patients for a new patient visit in an outpatient setting (including intensive outpatient, eating disorder, residential treatments, or other appointments as the Secretary specifies) from a provider of mental health services or substance use disorder services.

''(ii) The total number and average percentage of network providers that provide mental health services or substance use disorder services and are accepting as new patients individuals who are enrollees of such organization or plan at any point during the reporting period.

''(iii) The proportion of mental health services or substance use disorder services and prescription drugs during the reporting period that are denied payment under the State plan under this title or a waiver on the basis of prior authorization or medical necessity (or for any other reason that is not based on an enrollee's eligibility for medical assistance under the State plan

under this title or a waiver) in comparison to medical and surgical services and prescription drugs that are denied payment on the same bases during the reporting period.

''(iv) The total number and percentage of providers during the reporting period who have participation agreements with the organization who submitted at least 1 request for payment for a mental health or substance use disorder service.

''(B) SUBMISSION TO SECRETARY.—A State shall submit information reported to the State under subparagraph (A), including stratifying reporting by race, ethnicity, disability, primary language, age, sexual orientation, and gender identity, to help identify health inequities where applicable, to the Secretary in such form and manner as the Secretary shall specify.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 2 years after the date of enactment of this section.

SEC. 305. AUTHORITY TO DEFER OR DISALLOW A PORTION OF FEDERAL FINANCIAL PARTICIPATION FOR FAILURE TO COMPLY WITH MANAGED CARE REQUIREMENTS.

(a) STATE PLAN AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 303(a)(1), is amended—

(1) in paragraph (87), by striking ''and'' after the semicolon;

(2) in paragraph (88)(D), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (88)(D), the following new paragraph:

''(89) in the case of a State that adopts the option to use managed care as described in section 1932, provide that the State shall comply with the requirements of section 1932.''.

(b) APPLICATION TO MANAGED CARE CONTRACTS.—Section 1903(m)(2) of the Social Security Act (42 U.S.C. 1396b(m)) is amended—

(1) in subparagraph (A), in the matter preceding clause (i), by striking ''and (G)'' and inserting ''(G), and (I)''; and

(2) by adding at the end the following new subparagraph:

''(I) For a violation of any requirement described in subparagraph (A), including a violation of the requirements of section 1932, as applicable under clause (xii) of such subparagraph and paragraph (89) of section 1902(a), rather than disallowing the full amount of a payment under this title to a State for expenditures incurred by the State as described in subparagraph (A), the Secretary may defer or disallow a portion of a payment to the State. In determining the amount deferred or disallowed under this subparagraph, the Secretary may consider factors such as the degree, duration, and recurrence of noncompliance. A State may receive a reconsideration of a decision by the Secretary under this subparagraph to disallow payment in the manner described in section 1116(e).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 2 years after the date of enactment of this section and shall apply to contracts for rating periods beginning on or after such date.

SEC. 306. MEDICAID AND CHIP AUDITS.

(a) REGULAR AUDITS.—Beginning with fiscal year 2025, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall audit State Medicaid programs and State Children's Health In-

surance Programs for purposes of assessing State enforcement of the requirements relating to parity in mental health and substance use disorder benefits (including with respect to compliance with such parity requirements in the case of any mental health or substance use disorder benefits that are separately managed or financed under a ''carve-out'' model) applicable under subsections (a)(88) and (uu) of section 1902 of the Social Security Act (42 U.S.C. 1396a) (as added by section 303(a), section 1932(b)(8) of such Act (42 U.S.C. 1396u–2(b)(8)), section 1937(b)(6) of such Act (42 U.S.C. 1396u–7(b)(6)), and section 2103(c)(7) of such Act (42 U.S.C. 1397cc(c)(7)), and related regulations.

(b) ROTATIONAL PROCEDURE; PUBLICATION.—The Secretary may carry out the audits required by subsection (a) using a rotational approach among States over a 3-year period, and shall make the results of such audits publicly available on a searchable website.

(c) PUBLICATION OF ENFORCEMENT ACTIONS.—The Secretary shall publish (and update on at least an annual basis) on a public website of the Department of Health and Human Services a report that specifies the actions taken by the Secretary to enforce violations of the mental health and substance use disorder parity requirements under the Medicaid and CHIP programs described in sub-

section (a). The Secretary may publish such information separately or include the information in the 1 or more published audit reports required by subsection (b) that correspond to each such violation.

(d) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services for each fiscal year beginning with fiscal year 2025, $5,000,000 to carry out this section.

TITLE IV—OTHER PROVISIONS

SEC. 401. ENSURING MULTI-PAYER ALIGNMENT ON PAYMENT AND MEASUREMENT OF QUALITY OF CARE AND HEALTH OUTCOMES RELATED TO INTEGRATED MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE.

Not later than April 1, 2024, the Administrator of the Centers for Medicare & Medicaid Services shall convene an advisory working group that includes representatives of issuers of group and individual health insurance coverage, mental health and substance use disorder programs and advocacy organizations, individuals and families receiving integrated care services, and State Medicaid Directors, for purposes of making recommendations for administrative and legislative changes to facilitate multi-payer alignment on payment and measurement of quality

of care and health outcomes with respect to advancing the provision of integrated mental health and substance use disorder care in a manner that does not violate antitrust or other applicable laws. The recommendations of the working group shall include recommendations for measurable, ongoing benchmarks to assess the extent to which payment and measurement of the quality of care and health outcomes are aligned across health care payers.

SEC. 402. MEASURING ACCESS AND QUALITY OUTCOMES IN MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE.

(a) IN GENERAL.—Not later than October 1, 2024, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Administrator of the Health Resource Services Administration, the Director of the Agency for Healthcare Research and Quality, and the Assistant Secretary for Mental Health and Substance Use, develop and implement a plan to improve measurement of the extent to which children and adults have access to integrated mental health and substance use disorder care in primary care and the quality and effectiveness of the care provided, which shall be implemented in quality measurement programs under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the Medicaid program under title

XIX of such Act (42 U.S.C. 1396 et seq.), and group health plans and health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)).

(b) MEASURE DEVELOPMENT.—The Director of the Agency for Healthcare Research and Quality shall conduct measure development where necessary to ensure that the plan developed under subsection (a) may be fully implemented, including measures of patient experience outcomes, structural measures of practice transformation toward evidence-based integrated care, and measures of access and unmet need provided by local, State, or Federal agencies.

SEC. 403. REVIEWING THE EVIDENCE FOR INTEGRATED MENTAL HEALTH CARE FOR CHILDREN.

Not later than October 1, 2024, the Director of the Agency for Healthcare Research and Quality shall review the evidence, for consideration by the United States Preventive Services Task Force, for interventions for children who are at risk of developing a mental health condition to prevent internalizing and externalizing mental health problems, and for screening to identify family and child psychosocial needs, segmented by developmental stage as appropriate.

SEC. 404. ENHANCING OVERSIGHT OF INTEGRATED MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE.

(a) IN GENERAL.—Not later than October 1, 2024, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, develop and implement a plan to improve oversight and enforcement of requirements relating to the provision of integrated mental health and substance use disorder care under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.), and group health plans and health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)), including requirements relating to—

(1) coverage of preventive health services without cost-sharing under section 2713 of the Public Health Service Act (42 U.S.C. 300gg–13);

(2) early and periodic screening, diagnosis, and treatment for mental health and substance use disorders;

(3) mental health and substance use parity;

(4) network adequacy, including quantitative measures of network access that take into account integration in primary care and schools, racial equity, and virtual care;

(5) essential health benefits (as defined in section 1302(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(b))); and

(6) Medicaid rate setting.

(b) PATIENT INPUT.—In developing and implementing the plan under subsection (a), the Administrator shall seek input from patients with mental health and substance use conditions.