

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.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

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

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

Sec. 1. Short title; table of contents.

2

- 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.
- Sec. 102. Ensuring access to early intervention in mental health care in Medicare.

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.
- Sec. 202. Behavioral health measures and incentivizing behavioral health care quality.
- Sec. 203. Providing information on behavioral health coverage to promote informed choice.
- Sec. 204. Requiring MA organizations to maintain accurate and updated provider directories.

TITLE III—MEDICAID AND CHIP

- Sec. 301. Enhanced payment under Medicaid for integrated mental health and substance use disorder care services.
- 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.
- Sec. 303. Uniform applicability to Medicaid of requirements for parity in mental health and substance use disorder benefits.
- Sec. 304. Requiring additional transparency on access to mental health and substance use disorder benefits through managed care.
- Sec. 305. Authority to defer or disallow a portion of Federal financial participation for failure to comply with managed care requirements.
- Sec. 306. Medicaid and CHIP audits.

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.
- Sec. 402. Measuring access and quality outcomes in mental health and substance use disorder care.
- Sec. 403. Reviewing the evidence for integrated mental health care for children.
- Sec. 404. Enhancing oversight of integrated mental health and substance use disorder care.

1 **TITLE I—MEDICARE PART B**
2 **PROVISIONS**

3 **SEC. 101. PAYMENT UNDER THE MEDICARE PHYSICIAN FEE**
4 **SCHEDULE FOR INHERENTLY COMPLEX**
5 **EVALUATION AND MANAGEMENT VISITS RE-**
6 **LATED TO INTEGRATED MENTAL HEALTH**
7 **AND SUBSTANCE USE DISORDER CARE.**

8 (a) IN GENERAL.—Section 1848(b) of the Social Se-
9 curity Act (42 U.S.C. 1395w-4(b)) is amended by adding
10 at the end the following new paragraph:

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

15 “(A) IN GENERAL.—The Secretary shall
16 establish a new HCPCS add-on code under the
17 fee schedule established under this subsection
18 for integrated mental health and substance use
19 disorder care services (as defined in subpara-
20 graph (B)(i)) that are furnished on or after
21 January 1, 2025, when furnished by an inte-
22 grated care practitioner on the same date of
23 service that a service in the HCPCS category of
24 office and other outpatient evaluation and man-

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

3 “(B) DEFINITIONS.—In this paragraph:

4 “(i) INTEGRATED MENTAL HEALTH
5 AND SUBSTANCE USE DISORDER CARE
6 SERVICES.—

7 “(I) IN GENERAL.—The term ‘in-
8 tegrated mental health and substance
9 use disorder care services’ means serv-
10 ices described in subclause (II) that
11 are furnished by an integrated care
12 practitioner.

13 “(II) SERVICES DESCRIBED.—
14 The services described in this sub-
15 clause are the following:

16 “(aa) Preventive services
17 and screening for mental health
18 and substance use disorders that
19 the Secretary determines are—

20 “(AA) reasonable and
21 necessary for the prevention
22 or early detection of a men-
23 tal health or substance use
24 disorder;

1 “(BB) recommended
2 with a grade of A or B by
3 the United States Preventive
4 Services Task Force or rec-
5 ommended in Health Re-
6 sources and Services-sup-
7 ported guidelines for infants,
8 children, adolescents, and
9 women; and

10 “(CC) appropriate for
11 individuals enrolled under
12 this part.

13 “(bb) The routine use and
14 tracking of quality measures ap-
15 propriate for the measurement of
16 the quality of care (including
17 medication errors) related to be-
18 havioral health that reflect con-
19 sensus among affected parties
20 and, to the extent feasible and
21 practicable, shall include meas-
22 ures set forth by one or more na-
23 tional consensus building entities.

24 “(cc) Short-term, evidence-
25 based, culturally, and linguis-

1 tically appropriate therapeutic
2 and psychosocial intervention in-
3 tegrated into the primary care
4 practice, including through tele-
5 health.

6 “(dd) Evidence-based treat-
7 ment for mental health and sub-
8 stance use care integrated into
9 the primary care practice, includ-
10 ing through telehealth, or
11 through referral.

12 “(ee) Care management,
13 which can include establishing,
14 implementing, revising or moni-
15 toring the care plan, coordinating
16 with other professionals and
17 agencies, and educating the indi-
18 vidual or caregiver about the in-
19 dividual’s condition, care plan, or
20 prognosis.

21 “(ff) Other services deter-
22 mined by the Secretary.

23 “(ii) INTEGRATED CARE PRACTI-
24 TIONER.—

1 “(I) IN GENERAL.—The term ‘in-
2 tegrated care practitioner’ means a
3 primary care practitioner (as defined
4 in section 1833(x)(2)(A)(i)) who has
5 demonstrated the capacity to furnish
6 integrated mental health and sub-
7 stance use disorder care services (as
8 determined under subclause (II)).

9 “(II) DEMONSTRATING CAPACITY
10 GUIDANCE; ATTESTATION.—For pur-
11 poses of applying subclause (I) with
12 respect to an integrated care practi-
13 tioner demonstrating the capacity to
14 furnish integrated mental health and
15 substance use disorder care services,
16 the Secretary shall issue guidance, not
17 later than one year after the date of
18 the enactment of this paragraph, de-
19 scribing requirements for dem-
20 onstrating capacity to provide such
21 services and establishing a process for
22 the Secretary to receive an attestation
23 that an integrated care practitioner
24 has such capacity. Such guidance and
25 attestation may not impose additional

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

4 “(C) PAYMENT.—

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

12 “(ii) ADD-ON SERVICES.—If, during
13 the furnishing of an evaluation and man-
14 agement service to an individual by an in-
15 tegrated care practitioner, such practi-
16 tioner also furnishes (or coordinates the
17 furnishing of) integrated mental health
18 and substance use disorder care services on
19 the same date of service, payment shall
20 also be made for such integrated mental
21 health and substance used disorder care
22 services even if the individual did not pre-
23 viously have a mental health or substance
24 use disorder diagnosis.

1 “(iii) PAYMENT CONSIDERATIONS.—

2 In carrying out this paragraph, the Sec-
3 retary shall ensure that the amount of pay-
4 ment for integrated mental health and sub-
5 stance use disorder care services under this
6 paragraph is sufficient to sustain effective
7 and accessible integrated mental health
8 and substance use disorder care under this
9 part, as determined by evidence from prac-
10 tice expenses of those implementing effec-
11 tive integrated care as well as evidence of
12 the resource needs of integrated care prac-
13 titioners who furnish such services in men-
14 tal health professional shortage areas (as
15 designated under section 332(a)(1)(A) of
16 the Public Health Service Act) and medi-
17 cally underserved areas.”.

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

22 “(VII) Subsection (b)(13) shall
23 not be taken into account in applying
24 clause (ii)(II) for 2025.”.

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

4 (1) by striking “and” before “(HH)”;

5 (2) by inserting before the semicolon at the end
6 the following: “, and (II) with respect to integrated
7 mental health and substance use disorder care serv-
8 ices (as defined in subparagraph (B)(i) of section
9 1848(b)(13)) that are furnished on or after January
10 1, 2025, the amounts paid shall be equal to 100 per-
11 cent of the lesser of the actual charge for such serv-
12 ices or the fee schedule amount provided under such
13 section”.

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

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

19 (1) by striking “and” before “(II)”;

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

1 amounts paid shall be equal to 100 percent of the
2 lesser of the actual charge for such services or the
3 fee schedule amount provided under section
4 1848(b)’’.

5 **TITLE II—MEDICARE ADVAN-**
6 **TAGE AND PART D PROVI-**
7 **SIONS**

8 **SEC. 201. PARITY IN MENTAL HEALTH AND SUBSTANCE USE**
9 **DISORDER BENEFITS UNDER MEDICARE AD-**
10 **VANTAGE AND PRESCRIPTION DRUG PLANS.**

11 (a) MEDICARE ADVANTAGE PLANS.—

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

15 “(o) PARITY IN MENTAL HEALTH AND SUBSTANCE
16 USE DISORDER BENEFITS.—

17 “(1) IN GENERAL.—Each MA organization
18 shall ensure that the benefit design of each MA plan
19 offered by such organization meets the following re-
20 quirements:

21 “(A) FINANCIAL REQUIREMENTS.—The fi-
22 nancial requirements applicable to mental
23 health or substance use disorder benefits cov-
24 ered by the plan may not exceed the predomi-
25 nant financial requirements applied to substan-

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

6 “(B) TREATMENT LIMITATIONS.—The
7 treatment limitations applicable to mental
8 health or substance use disorder benefits are no
9 more restrictive than the predominant treat-
10 ment limitations applied to substantially all
11 medical benefits covered by the plan and there
12 are no separate treatment limitations that are
13 applicable only with respect to mental health or
14 substance use disorder benefits, including sup-
15 plemental benefits.

16 “(2) DETERMINATIONS OF MEDICAL NECES-
17 SITY.—

18 “(A) IN GENERAL.—Each MA organization
19 shall ensure that any determination of medical
20 necessity for mental health or substance use
21 benefits under each MA plan offered by such
22 organization that is not based on the applica-
23 tion of a national or local coverage determina-
24 tion is consistent with generally accepted stand-
25 ards of mental health and substance use dis-

1 order care, as defined in paragraph. For any
2 level of care determination with respect to men-
3 tal health or substance use disorder benefits,
4 coverage criteria are consistent with widely-used
5 treatment guidelines only if they result in a
6 level of care determination that is consistent
7 with the determination that would have been
8 made using the relevant widely-used treatment
9 guidelines.

10 “(B) CRITERIA FOR MEDICAL NECESSITY
11 DETERMINATIONS.—The criteria for determina-
12 tion of medical necessity with respect to mental
13 health or substance use disorder benefits under
14 an MA plan shall be made available in plain
15 language to any individual upon request.

16 “(3) REPORTING ON APPLICATION OF NON-
17 QUANTITATIVE TREATMENT LIMITATIONS.—

18 “(A) COMPARATIVE ANALYSES OF DESIGN
19 AND APPLICATION OF NONQUANTITATIVE
20 TREATMENT LIMITS.—For 2025 and subse-
21 quent years, in the case of an MA organization
22 that imposes nonquantitative treatment limita-
23 tions (referred to in this paragraph as
24 ‘NQTLs’) on mental health or substance use
25 disorder benefits under an MA plan offered by

1 such organization, such organization shall be
2 required to perform and document comparative
3 analyses of the design and application of
4 NQTLs on mental health and substance use
5 disorder benefits under the plan and make
6 available to the Secretary as provided under
7 subparagraph (B), upon request, the compara-
8 tive analyses and the following information:

9 “(i) The specific plan terms regarding
10 the NQTLs and a description of all mental
11 health or substance use disorder and med-
12 ical benefits to which each such term ap-
13 plies in each respective benefits classifica-
14 tion.

15 “(ii) The factors used to determine
16 that the NQTLs will apply to mental
17 health or substance use disorder benefits
18 and medical benefits.

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

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

6 “(iv) The comparative analyses dem-
7 onstrating that the processes, strategies,
8 evidentiary standards, and other factors
9 used to apply the NQTLs to mental health
10 or substance use disorder benefits, as writ-
11 ten and in operation, are comparable to,
12 and are applied no more stringently than,
13 the processes, strategies, evidentiary stand-
14 ards, and other factors used to apply the
15 NQTLs to medical benefits in the benefits
16 classification.

17 “(v) The specific findings and conclu-
18 sions reached by the MA organization with
19 respect to the MA plan, including any re-
20 sults of the analyses described in this sub-
21 paragraph that indicate that the plan is or
22 is not in compliance with this subsection.

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

1 scribed in subparagraph (A) and the informa-
2 tion described in clauses (i) through (v) of such
3 subparagraph upon request by the Secretary.
4 The Secretary shall request not fewer than 20
5 such analyses per year.

6 “(C) REPORT.—Not later than October 1,
7 2029, and biennially thereafter, the Secretary
8 shall submit to Congress, and make publicly
9 available, a report that contains the following:

10 “(i) A summary of the comparative
11 analyses and information requested under
12 subparagraph (B).

13 “(ii) The Secretary’s conclusions as to
14 whether each MA organization submitted
15 sufficient information for the Secretary to
16 review the comparative analyses and infor-
17 mation requested for compliance with this
18 subsection.

19 “(iii) The Secretary’s conclusions as
20 to whether each MA organization that sub-
21 mitted sufficient information for the Sec-
22 retary to review was in compliance with
23 this subsection.

24 “(4) DEFINITIONS.—In this subsection:

1 “(A) CLASSIFICATION OF BENEFITS.—The
2 term ‘classification of benefits’ means the fol-
3 lowing:

4 “(i) INPATIENT.—Benefits under part
5 A.

6 “(ii) OUTPATIENT.—Benefits fur-
7 nished on an outpatient basis under part
8 B.

9 “(iii) EMERGENCY CARE.—Benefits
10 for emergency care covered under part B.

11 “(iv) PART B PRESCRIPTION
12 DRUGS.—Benefits for drugs and biologicals
13 covered under part B.

14 “(v) COVERED PART D DRUGS.—Ben-
15 efits for covered part D drugs as defined
16 in section 1860D-2(e).

17 “(vi) SUPPLEMENTAL.—Supplemental
18 health care benefits as described in section
19 1852(a)(3).

20 “(B) EVIDENTIARY STANDARDS.—The
21 term ‘evidentiary standard’ means factors or
22 evidence a plan considers in designing and ap-
23 plying its medical management techniques, such
24 as generally accepted standards of mental
25 health and substance use disorder care, recog-

1 nized medical literature, professional standards
2 and protocols (including comparative effective-
3 ness studies and clinical trials), published re-
4 search studies, treatment guidelines created by
5 professional medical associations or other third-
6 party entities, publicly available or proprietary
7 clinical definitions, and outcome metrics from
8 consulting or other organizations.

9 “(C) FINANCIAL REQUIREMENT.—The
10 term ‘financial requirement’ includes
11 deductibles, copayments, coinsurance, and max-
12 imum limitations on out-of-pocket expenses ap-
13 plicable under the plan.

14 “(D) GENERALLY ACCEPTED STANDARDS
15 OF MENTAL HEALTH AND SUBSTANCE USE DIS-
16 ORDER CARE.—The term ‘generally accepted
17 standards of mental health and substance use
18 disorder care’ means standards of care and clin-
19 ical practice that are generally recognized by
20 health care providers practicing in relevant clin-
21 ical specialties such as psychiatry, psychology,
22 and addiction medicine and counseling, to en-
23 sure appropriate diagnosis, treatment, and on-
24 going management, for underlying mental
25 health and substance use disorders, including

1 co-occurring conditions, to adequately meet the
2 needs of patients. These standards are derived
3 from valid, evidence-based sources such as
4 peer-reviewed scientific studies and medical lit-
5 erature, consensus guidelines of nonprofit
6 health care provider professional associations
7 and specialty societies, including level of care
8 criteria and clinical practice guidelines, and rec-
9 ommendations of Federal government agencies.

10 “(E) MENTAL HEALTH BENEFITS.—The
11 term ‘mental health benefits’ means benefits
12 with respect to items and services for mental
13 health conditions as defined by the Secretary.

14 “(F) PREDOMINANT.—A financial require-
15 ment or treatment limit is considered to be pre-
16 dominant if it is the most common or frequent
17 of such type of limit or requirement.

18 “(G) SUBSTANCE USE DISORDER BENE-
19 FITS.—The term ‘substance use disorder bene-
20 fits’ means benefits with respect to items and
21 services for substance use disorders as defined
22 by the Secretary.

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

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

3 “(I) TREATMENT LIMITATION.—

4 “(i) IN GENERAL.—The term ‘treat-
5 ment limitation’ means mechanisms to con-
6 trol utilization of services and expenditures
7 such as limits on the frequency of treat-
8 ment, number of visits, days of coverage,
9 or other similar limits on the scope or du-
10 ration of treatment. Such term includes:

11 “(I) QUANTITATIVE TREATMENT
12 LIMITATIONS.—Quantitative treat-
13 ment limitations, including limits on
14 the frequency of treatment, number of
15 visits, days of coverage, or other simi-
16 lar limits on the scope or duration of
17 treatment.

18 “(II) NONQUANTITATIVE TREAT-
19 MENT LIMITATIONS.—Nonquantitative
20 treatment limitations, including other
21 limits on the access, scope, or dura-
22 tion of benefits for treatment under a
23 plan or coverage not described in sub-
24 clause (I), such as—

1 “(aa) medical management
2 standards limiting or excluding
3 benefits based on medical neces-
4 sity or medical appropriateness,
5 or based on whether the treat-
6 ment is experimental or inves-
7 tigative;

8 “(bb) for plans with multiple
9 network tiers (such as preferred
10 providers and participating pro-
11 viders), network tier design;

12 “(cc) standards for provider
13 admission to participate in a net-
14 work, including reimbursement
15 rates;

16 “(dd) refusal to pay for
17 higher-cost therapies until it can
18 be shown that a lower-cost ther-
19 apy is not effective (also known
20 as fail-first policies or step ther-
21 apy protocols);

22 “(ee) exclusions based on
23 failure to complete a course of
24 treatment; and

1 “(ff) restrictions based on
2 geographic location, facility type,
3 provider specialty, and other cri-
4 teria that limit the scope or dura-
5 tion of benefits for services pro-
6 vided under the plan or coverage.

7 “(ii) EXCLUSIONS.—The term ‘treat-
8 ment limitation’ does not include any ex-
9 clusions from coverage of items or services
10 for which payment is not made under part
11 A or part B or any statutory limitations on
12 coverage applicable under such parts.”.

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

16 (A) in subparagraph (J), by striking “or”
17 after the semicolon;

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

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

22 “(K) fails to comply with mental health
23 parity requirements under section 1852(o) or
24 applicable implementing regulations or guid-
25 ance; or”;

1 (D) in subparagraph (L), as redesignated
2 by subparagraph (B), by striking “through (J)”
3 and inserting “through (K)”; and

4 (E) in the flush matter following subpara-
5 graph (L), as so redesignated, by striking “sub-
6 paragraphs (A) through (K)” and inserting
7 “subparagraphs (A) through (L)”.

8 (b) PRESCRIPTION DRUG PLANS.—Section 1860D–
9 4 of the Social Security Act (42 U.S.C. 1395w–104) is
10 amended by adding at the end the following new sub-
11 section:

12 “(c) PARITY IN MENTAL HEALTH AND SUBSTANCE
13 USE DISORDER BENEFITS.—The provisions of section
14 1852(o) (relating to parity in mental health and substance
15 use disorder benefits) shall apply to PDP sponsors offer-
16 ing prescription drug plans in the same manner in which
17 such provisions apply with respect to Medicare Advantage
18 organizations offering MA–PD plans.”.

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

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

1 ment of this Act, regardless of whether regulations have
2 been issued to carry out such amendments by such effec-
3 tive date.

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

11 **SEC. 202. BEHAVIORAL HEALTH MEASURES AND**
12 **INCENTIVIZING BEHAVIORAL HEALTH CARE**
13 **QUALITY.**

14 Section 1853(o) of the Social Security Act (42 U.S.C.
15 1395w–23(o)) is amended by adding at the end the fol-
16 lowing new paragraph:

17 “(8) BEHAVIORAL HEALTH MEASURES.—

18 “(A) IN GENERAL.—For 2025 and bienni-
19 ally thereafter, the Secretary shall consider add-
20 ing to the 5-star rating system behavioral
21 health measures that measure the quality and
22 outcomes of—

23 “(i) mental health or substance use
24 disorder services; and

1 “(ii) items and services not described
2 in clause (i) that are furnished to an indi-
3 vidual with a mental health or substance
4 use disorder.

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

8 “(i) consider measures for which data
9 can be collected through encounter data or
10 enrollee survey data submitted by MA or-
11 ganizations;

12 “(ii) consider measures endorsed by a
13 consensus-based entity, as described in sec-
14 tion 1890(a);

15 “(iii) consider measures that assess
16 the quality and health outcomes of items
17 and services described in subparagraph
18 (A), including contraindicated or low-value
19 care, furnished to individuals with a men-
20 tal health or substance use disorder;

21 “(iv) consider measures that assess
22 access to behavioral health treatment, in-
23 cluding measures of wait times, distance
24 standards, providers who are taking on
25 new patients, and the proportion of behav-

1 ioral health providers who have not sub-
2 mitted a claim for a mental health or sub-
3 stance use disorder service during the past
4 six months;

5 “(v) consider measures that assess the
6 integration of behavioral health care and
7 primary care services;

8 “(vi) consider measures that align
9 with behavioral health measures—

10 “(I) used to assess performance
11 in part A or part B; or

12 “(II) identified as part of the
13 Core Set of Health Care Quality
14 Measures for Adults as described in
15 section 1139B; and

16 “(vii) consider measures that assess
17 patient experience of care.”.

18 **SEC. 203. PROVIDING INFORMATION ON BEHAVIORAL**
19 **HEALTH COVERAGE TO PROMOTE INFORMED**
20 **CHOICE.**

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

24 “(F) BEHAVIORAL HEALTH INFORMA-
25 TION.—For 2025 and subsequent plan years, to

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

3 “(i) Information on access to in-net-
4 work behavioral health providers,
5 disaggregated by those who prescribe and
6 those who offer mental health or substance
7 use disorder services, including—

8 “(I) the average wait time (as de-
9 fined by the Secretary) for an ap-
10 pointment for a new patient with an
11 in-network provider for mental health
12 or substance disorder services;

13 “(II) the total number and per-
14 centage of providers who have partici-
15 pation agreements with the organiza-
16 tion who submitted at least one re-
17 quest for payment for a mental health
18 or substance use disorder service dur-
19 ing a 6 month period (or other period
20 specified by the Secretary); and

21 “(III) the percentage of requests
22 for payment for mental health or sub-
23 stance use disorder services that were
24 submitted by—

1 “(aa) in-network providers;
2 and

3 “(bb) out-of-network pro-
4 viders.

5 “(ii) Information on the number of
6 denials of prior authorization requests or
7 denials of payment for mental health or
8 substance use disorder services compared
9 to non-mental health and substance use
10 disorder services overall, categorized by the
11 type of denial and by the type of service,
12 as defined by the Secretary, including—

13 “(I) the number and percent of
14 such denials by the number of days to
15 denial, the reason for denial, and the
16 utilization of decision support tech-
17 nology, artificial intelligence tech-
18 nology, machine-learning technology,
19 clinical decision-making technology, or
20 any other technology specified by the
21 Secretary; and

22 “(II) the number and percent of
23 such denials with respect to a mental
24 health or substance use disorder serv-
25 ice compared to such denials with re-

1 spect to items and services for a simi-
2 lar physical health condition (such as
3 depression compared to diabetes) by
4 the number of days to denial, the rea-
5 son for denial, and the utilization of
6 decision support technology, artificial
7 intelligence technology, machine-learn-
8 ing technology, clinical decision-mak-
9 ing technology, or any other tech-
10 nology specified by the Secretary.”.

11 **SEC. 204. REQUIRING MA ORGANIZATIONS TO MAINTAIN**
12 **ACCURATE AND UPDATED PROVIDER DIREC-**
13 **TORIES.**

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

16 (1) in paragraph (1)(C)—

17 (A) by striking “plan, and any” and insert-
18 ing “plan, any”; and

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

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

1 along with the information in the
2 directory with respect to such
3 provider of a notification indi-
4 cating that the information may
5 not be up to date;

6 “(dd) that provides for the
7 removal of a provider from such
8 directory within 2 business days
9 if the organization determines
10 that the provider is no longer a
11 participating provider; and

12 “(ee) that meets such other
13 requirements as the Secretary
14 may specify.

15 “(II) INFORMATION DE-
16 SCRIBED.—The information described
17 in this subclause is the National Pro-
18 vider Identifier, name, address, spe-
19 cialty, telephone number, Internet
20 website if available, availability (in-
21 cluding whether the provider is ac-
22 cepting new patients), cultural and
23 linguistic capabilities (including the
24 languages offered by the provider or
25 by a skilled medical interpreter who

1 provides interpretation services for the
2 provider), and other information as
3 determined appropriate by the Sec-
4 retary for each provider with which
5 such MA organization has an agree-
6 ment for furnishing items and services
7 covered under such plan.

8 “(ii) SUBMISSION OF PROVIDER DI-
9 RECTORY TO THE SECRETARY.—The MA
10 organization shall submit to the Secretary
11 the provider directory for each network-
12 based MA plan offered by the organization
13 in a manner specified by the Secretary.

14 “(B) POSTING OF PROVIDER DIRECTORY
15 INFORMATION.—For plan year 2026 and subse-
16 quent plan years, the Secretary shall post the
17 provider directory information submitted under
18 subparagraph (A)(ii), in a machine readable
19 file, on the internet website of the Centers for
20 Medicare & Medicaid Services.

21 “(C) NETWORK-BASED MA PLAN DE-
22 FINED.—In this paragraph, the term ‘network-
23 based MA plan’ means an MA plan that has a
24 network of providers that have agreements with
25 the MA organization offering the plan to fur-

1 nish items and services covered under such
2 plan.”.

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

6 “(7) AUDIT OF PROVIDER DIRECTORIES.—Each
7 contract under this section shall provide that the
8 Secretary, or any person or organization designated
9 by the Secretary, shall have the right to audit any
10 provider directory under section 1852(c)(3)(A)(i) to
11 determine whether such directory meets the require-
12 ments of such section.”.

13 (c) FUNDING.—In addition to amounts otherwise
14 available, there is appropriated to the Centers for Medi-
15 care & Medicaid Services Program Management Account
16 for fiscal year 2023, out of any amounts in the Treasury
17 not otherwise appropriated, \$10,000,000, to remain avail-
18 able until expended, for purposes of carrying out the
19 amendments made by this section.

20 **TITLE III—MEDICAID AND CHIP**

21 **SEC. 301. ENHANCED PAYMENT UNDER MEDICAID FOR IN-** 22 **TEGRATED MENTAL HEALTH AND SUB-** 23 **STANCE USE DISORDER CARE SERVICES.**

24 Section 1903 of the Social Security Act (42 U.S.C.
25 1396b) is amended—

1 (1) in subsection (a)(3)—

2 (A) in subparagraph (D), by inserting
3 “and” after the semicolon;

4 (B) in subparagraph (F)(ii), by striking
5 “plus” after the semicolon and inserting “and”;
6 and

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

9 “(G) for calendar quarters beginning on or
10 after January 1, 2025, 100 percent of the
11 amount determined for such quarter under sub-
12 section (cc); and”; and

13 (2) by adding the end the following:

14 “(cc) ENHANCED PAYMENT FOR INTEGRATED MEN-
15 TAL HEALTH AND SUBSTANCE USE DISORDER CARE
16 SERVICES.—

17 “(1) IN GENERAL.—For purposes of subsection
18 (a)(3)(G), in accordance with guidance issued not
19 later than the date that is 180 days after the date
20 of the enactment of this subsection by the Secretary
21 to States, the amount determined under this sub-
22 section with respect to a State and calendar quarter
23 is the amount by which—

24 “(A) the aggregate amount expended by
25 the State during the calendar quarter for med-

1 “(ii) December 31 of every 5th year
2 following 2024.”.

3 **SEC. 302. DEMONSTRATION PROJECT TO ENSURE MED-**
4 **ICAID-ENROLLED CHILDREN HAVE ACCESS**
5 **TO INTEGRATED MENTAL HEALTH AND SUB-**
6 **STANCE USE DISORDER CARE SERVICES, IN-**
7 **CLUDING PREVENTION AND EARLY INTER-**
8 **VENTION SERVICES.**

9 (a) IN GENERAL.—Not later than the date that is
10 180 days after the date of the enactment of this section,
11 the Secretary shall conduct a 54-month demonstration
12 project for the purpose described in subsection (b) under
13 which the Secretary shall—

14 (1) for the first 18-month period of such
15 project, award planning grants described in sub-
16 section (c); and

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

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

1 prevention and early intervention services, so as to allow
2 for the prevention, identification, and treatment of mental
3 health and substance use conditions in primary care, chil-
4 dren’s hospitals, early care and education, schools, or
5 other settings as appropriate (such as home visiting and
6 early intervention programs for young children, foster care
7 or other child welfare care settings, or workforce develop-
8 ment programs and community centers for youth) (in this
9 section collectively referred to as “care settings”), through
10 the following activities:

11 (1) Activities that support an ongoing assess-
12 ment of the accessibility of integrated mental health
13 and substance use disorder care services, including
14 prevention and early intervention services, for Med-
15 icaid-enrolled children in the State that tracks
16 progress toward the goal of all Medicaid-enrolled
17 children (including infants and toddlers as well as
18 transition-aged youth) having access to appropriate
19 levels of services in care settings in which the chil-
20 dren regularly engage, and that is conducted in part-
21 nership with such children and families, to ensure
22 that the assessment reflects their perspective, experi-
23 ences, and solutions.

24 (2) Activities that, taking into account the re-
25 sults of the assessment described in paragraph (1),

1 support the development, implementation, and main-
2 tenance of State infrastructure, such as technology
3 and the physical structures necessary to physically
4 co-locate integrated mental health and substance use
5 disorder care services, including prevention and early
6 intervention services, and a workforce to provide the
7 types of support, training, and technical assistance
8 needed in order to offer integrated mental health
9 and substance use care services, including prevention
10 and early intervention services, in care settings with
11 which Medicaid-enrolled children and their families
12 regularly interact, which are selected for integration
13 based on the assessment of where such children and
14 their families can access such services, and for which
15 furnishing integrated mental health and substance
16 use disorder care services, including prevention and
17 early intervention services, will be sustainable under
18 the State's planned activities.

19 (3) Increased reimbursement and improved in-
20 centives for care settings to sustainably implement
21 and provide (either through direct delivery or coordi-
22 nation in the case of a care setting that is an early
23 care or education program)—

24 (A) developmentally appropriate mental
25 health promotive and preventive interventions

1 for Medicaid-enrolled children and their fami-
2 lies, along with screening to identify psycho-so-
3 cial needs of such children who do not yet have
4 a diagnosable mental health condition (con-
5 sistent with the requirements for providing
6 items and services described in section
7 1905(a)(4)(B) of the Social Security Act (42
8 U.S.C. 1396d(a)(4)(B))(relating to early and
9 periodic screening, diagnostic, and treatment
10 services defined in section 1905(r) of such Act
11 (42 U.S.C. 1396d(r))) in accordance with the
12 requirements of section 1902(a)(43) of such
13 Act (42 U.S.C. 1396a(a)(43)) and the pediatric
14 preventive care standards included in the essen-
15 tial health benefits required under section
16 1302(b) of the Patient Protection and Afford-
17 able Care Act (42 U.S.C. 18022(b));

18 (B) evidence-based, person-centered, and
19 culturally, linguistically, and developmentally
20 appropriate interventions at the site of service,
21 either in-person or virtually integrated, to ad-
22 dress any identified family and child psycho-so-
23 cial needs, including developmentally appro-
24 priate assessment and diagnostic services, treat-

1 ment, care coordination, and dyadic interven-
2 tion approaches; and

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

9 (4) Improved regulatory oversight of policies
10 governing the provision of services described in para-
11 graph (3), including with respect to early and peri-
12 odic screening, diagnostic, and treatment services re-
13 ferred to in such paragraph, mental health and sub-
14 stance use parity, network adequacy, essential health
15 benefits referred to in such paragraph, Medicaid rate
16 setting, scope of practice policies, and health profes-
17 sional shortage areas.

18 (5) Improved alignment between Medicaid and
19 commercial health insurers to ensure that services
20 described in paragraph (3) are supported by com-
21 mercial health insurers, such as through the initi-
22 ation of multi-payer collaboratives.

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

1 and education, or other programs in care settings
2 described in this subsection so as to include efforts
3 to align policies to promote coordination of mental
4 health and substance use services funded under such
5 programs across care settings, including through the
6 alignment of Medicaid with programs under the Ele-
7 mentary and Secondary Education Act of 1965 (20
8 U.S.C. 6301 et seq.), the Individuals with Disabil-
9 ities Education Act (20 U.S.C. 1400 et seq.), the
10 Family First Prevention Services Act (title VII of
11 division E of the Bipartisan Budget Act of 2018
12 (Public Law 115–123; 132 Stat. 232)), the Steph-
13 anie Tubbs Jones Child Welfare Services Program
14 under subpart 1 of part B of title IV of the Social
15 Security Act (42 U.S.C. 621 et seq.), the MaryLee
16 Allen Promoting Safe and Stable Families Program
17 under subpart 2 of part B of title IV of the Social
18 Security Act (42 U.S.C. 629 et seq.), home visiting
19 programs, including the Maternal, Infant, and Early
20 Childhood Home Visiting Program (MIECHV)
21 under section 511 of the Social Security Act (42
22 U.S.C. 711), and health, education, and social wel-
23 fare programs funded under the American Rescue
24 Plan Act of 2021 (Public Law 117–2; 135 Stat. 4)

1 and the Child Care Development Block Grant Act of
2 1990 (42 U.S.C. 9857 et seq.).

3 (7) Activities that include Medicaid-enrolled
4 children and their families and caregivers as part-
5 ners at all levels of decision-making, implementation,
6 and evaluation, including engaging such children
7 who are youth and their families directly as para-
8 professional providers.

9 (c) PLANNING GRANTS.—

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

21 (2) ACTIVITIES DESCRIBED.—Activities de-
22 scribed in this paragraph are, with respect to a
23 State awarded a planning grant under this sub-
24 section, each of the following:

1 (A) Activities that support the development
2 of an initial assessment of the access needs of
3 Medicaid-enrolled children in the State with re-
4 spect to mental health and substance use serv-
5 ices, to determine the types of support, train-
6 ing, incentives, and technical assistance that
7 primary care, early care and education, or other
8 programs provided in care settings described in
9 subsection (b) and with which Medicaid-enrolled
10 children and their families regularly engage
11 need in order to offer integrated mental health
12 and substance use disorder care services, in-
13 cluding prevention and early intervention serv-
14 ices, and which shall include engaging Med-
15 icaid-enrolled children and their families di-
16 rectly to ensure that the assessment builds to-
17 ward solutions that meet their needs and reflect
18 their perspectives, experiences, and solutions.

19 (B) Activities that, taking into account the
20 results of the assessment described in subpara-
21 graph (A), support the development of State in-
22 frastructure, such as technology and the phys-
23 ical structures necessary to physically co-locate
24 integrated mental health and substance use dis-
25 order care services, including prevention and

1 early intervention services, to provide the types
2 of support, training, incentives, and technical
3 assistance that primary care, early care and
4 education, or other programs provided in care
5 settings described in subsection (b) and with
6 which Medicaid-enrolled children and their fam-
7 ilies regularly engage need in order to offer in-
8 tegrated mental health and substance use dis-
9 order care services, including prevention and
10 early intervention services, to Medicaid-enrolled
11 children, as well as activities that support ongo-
12 ing engagement of Medicaid-enrolled children
13 and their families in implementation and co-
14 ordination with health insurers and with other
15 child-serving agencies and stakeholders.

16 (3) FUNDING.—For purposes of awarding plan-
17 ning grants under paragraph (1), there is appro-
18 priated, out of any funds in the Treasury not other-
19 wise appropriated, \$100,000,000, to remain avail-
20 able until expended.

21 (d) POST-PLANNING STATES.—

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

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

3 (2) APPLICATIONS; ACTIVITIES.—

4 (A) IN GENERAL.—A State seeking to be
5 selected to participate in the remaining 36-
6 month period of the demonstration project shall
7 submit to the Secretary, at such time and in
8 such form and manner as the Secretary re-
9 quires, an application that includes such infor-
10 mation, provisions, and assurances, as the Sec-
11 retary may require, in addition to the following:

12 (i) A process for carrying out the on-
13 going assessment described in subsection
14 (b)(1), taking into account the results of
15 the initial assessment described in sub-
16 section (c)(2)(A).

17 (ii) A review of Medicaid reimburse-
18 ment methodologies and other policies re-
19 lated to furnishing integrated mental
20 health and substance use disorder care
21 services, including prevention and early
22 intervention services, to Medicaid-enrolled
23 children that may create barriers to access.
24 If the State uses multiple reimbursement
25 methodologies under Medicaid for mental

1 health and substance use care (such as
2 capitation, fee-for-service, value-based, and
3 alternative payment programs), the State
4 shall include in the application specific de-
5 tailed information regarding how the State
6 will verify that the combination of reim-
7 bursement methodologies employed by the
8 State will result in improved access to inte-
9 grated mental health and substance use
10 disorder care services, including prevention
11 and early intervention services, for Med-
12 icaid-enrolled children.

13 (iii) The development of a plan, tak-
14 ing into account activities carried out
15 under subsection (c)(2)(B), that will result
16 in long-term and sustainable access to inte-
17 grated mental health and substance use
18 disorder care services, including prevention
19 and early intervention services, for Med-
20 icaid-enrolled children which includes the
21 following:

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

1 vention services, so as to allow for the
2 prevention, identification, and treat-
3 ment of mental health and substance
4 use conditions in primary care, early
5 care and education, or other programs
6 provided in care settings described in
7 subsection (b) and with which Med-
8 icaid-enrolled children and their fami-
9 lies regularly engage.

10 (II) Strategies that will
11 incentivize a racially and culturally di-
12 verse array of providers (including
13 paraprofessionals) to obtain the nec-
14 essary training, education, and sup-
15 port to deliver integrated care for the
16 developmentally appropriate preven-
17 tion, identification, assessment, diag-
18 nosis, and treatment of mental health
19 and substance use conditions in Med-
20 icaid-enrolled children in primary
21 care, early care and education, or
22 other programs provided in care set-
23 tings described in subsection (b) and
24 with which Medicaid-enrolled children
25 and their families regularly engage.

1 (III) Milestones and timeliness
2 for implementing activities set forth in
3 the plan, as determined by the Sec-
4 retary.

5 (IV) Specific measurable targets
6 for increasing equitable access to inte-
7 grated mental health and substance
8 use disorder care services, including
9 prevention and early intervention serv-
10 ices, for Medicaid-enrolled children.

11 (V) Specific measurable targets
12 for increasing the workforce providing
13 integrated mental health and sub-
14 stance use disorder care services, in-
15 cluding prevention and early interven-
16 tion services.

17 (iv) A process for reporting the infor-
18 mation required under subsection (f)(1),
19 including information to assess the effec-
20 tiveness of the efforts of the State during
21 the period of the demonstration project
22 under this subsection and ensure the sus-
23 tainability of such efforts after the conclu-
24 sion of the demonstration project.

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

3 (vi) A description of funding sources
4 available to the State to expand access to
5 integrated mental health and substance use
6 disorder care services, including prevention
7 and early intervention services in the
8 State, including health care, public health,
9 education, and social service funding op-
10 portunities.

11 (vii) A preliminary plan for how the
12 State will sustain access to integrated
13 mental health and substance use disorder
14 care services, including prevention and
15 early intervention services, for Medicaid-
16 enrolled children after the demonstration
17 project, including maintenance of incen-
18 tives and enhanced reimbursement rates.

19 (viii) A description of how the State
20 will coordinate the goals of the demonstra-
21 tion project with any waiver granted (or
22 submitted by the State and pending) pur-
23 suant to section 1115 of the Social Secu-
24 rity Act (42 U.S.C. 1315) for the delivery
25 of mental health and substance use serv-

1 ices under Medicaid, as applicable, and
2 with State plans under the Elementary and
3 Secondary Education Act of 1965 (20
4 U.S.C. 6301 et seq.), the Individuals with
5 Disabilities Education Act (20 U.S.C.
6 1400 et seq.), the Family First Prevention
7 Services Act (title VII of division E of the
8 Bipartisan Budget Act of 2018 (Public
9 Law 115–123; 132 Stat. 232)), the Steph-
10 anie Tubbs Jones Child Welfare Services
11 Program under subpart 1 of part B of title
12 IV of the Social Security Act (42 U.S.C.
13 621 et seq.), the MaryLee Allen Promoting
14 Safe and Stable Families Program under
15 subpart 2 of part B of title IV of the So-
16 cial Security Act (42 U.S.C. 629 et seq.),
17 home visiting programs, including the Ma-
18 ternal, Infant, and Early Childhood Home
19 Visiting Program (MIECHV) under sec-
20 tion 511 of the Social Security Act (42
21 U.S.C. 711), and health, education, and
22 social welfare programs funded under the
23 American Rescue Plan Act of 2021 (Public
24 Law 117–2; 135 Stat. 4) and the Child

1 Care Development Block Grant Act of
2 1990 (42 U.S.C. 9857 et seq.).

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

12 (C) TECHNICAL ASSISTANCE.—The Sec-
13 retary shall provide technical assistance to
14 States with respect to preparing and submitting
15 an application that meets the requirements of
16 subparagraphs (A) and (B).

17 (e) PAYMENTS.—

18 (1) IN GENERAL.—For each quarter occurring
19 during the remaining 36-month period of the dem-
20 onstration project, the Secretary shall pay each
21 State that submits an application that meets the re-
22 quirements of subsection (d) (2) and carries out the
23 activities described in that subsection, an amount
24 equal to 80 percent of the qualified sums expended
25 by the State for such quarter.

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

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

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

12 (ii) the development or enabling of
13 State infrastructure, such as technology
14 and the physical structures necessary to
15 physically co-locate integrated mental
16 health and substance use disorder care
17 services, including prevention and early
18 intervention services, delivered in or coordi-
19 nated through primary care, early care and
20 education, or other programs provided in
21 care settings described in subsection (b)
22 and with which Medicaid-enrolled children
23 and their families regularly engage; and

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

1 technical assistance needed in order to
2 offer integrated mental health and sub-
3 stance use care services, including preven-
4 tion and early intervention services, in pri-
5 mary care, early care and education, or
6 other programs provided in care settings
7 described in subsection (b) and with which
8 Medicaid-enrolled children and their fami-
9 lies regularly engage; exceeds

10 (B) $\frac{1}{4}$ of the average annual amount ex-
11 pended by the State for the most recent 5-fiscal
12 year period for medical assistance for mental
13 health or substance use disorder care services
14 for Medicaid-enrolled children in a primary
15 care, children's hospitals, school, early care and
16 education, or other developmentally appropriate
17 care setting, as determined by the Secretary.

18 (3) NON-DUPLICATION OF PAYMENT.—No pay-
19 ment made under this subsection with respect to
20 medical assistance furnished to a Medicaid-enrolled
21 child shall be duplicative of any payment made to a
22 provider participating under the State Medicaid pro-
23 gram for the same services so furnished to the same
24 child.

25 (f) REPORTS.—

1 (1) STATE REPORTS.—Each State that receives
2 payments under subsection (e) during the remaining
3 36-month period of the demonstration project shall
4 submit to the Secretary, in accordance with detailed,
5 specific guidance that is issued by the Secretary not
6 later than the first day of such period, and that in-
7 cludes information on how to estimate and reconcile
8 State expenditures to carry out the demonstration
9 project during such period, quarterly reports, with
10 respect to expenditures for which payment is made
11 to the State under subsection (e), on the following:

12 (A) The specific activities with respect to
13 which payment under such subsection was pro-
14 vided.

15 (B) The number of primary care, chil-
16 dren’s hospitals, schools, and early care and
17 education programs that delivered or coordi-
18 nated integrated mental health and substance
19 use disorder care services, including prevention
20 and early intervention services, to Medicaid-en-
21 rolled children during such period and their ge-
22 ographic distribution, compared to the esti-
23 mated number that would have otherwise deliv-
24 ered such services in the absence of the dem-

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

3 (C) The number of Medicaid-enrolled chil-
4 dren who received integrated mental health and
5 substance use disorder care services, including
6 prevention and early intervention services dur-
7 ing such period compared to the estimated
8 number of such children who would have other-
9 wise received such services in the absence of the
10 demonstration project, including disaggregated
11 data on the race, ethnicity, gender, age (ensur-
12 ing that children birth to 5 as well as transi-
13 tion-aged youth are adequately served), sexual
14 orientation, primary language, income, and dis-
15 ability status of the children.

16 (D) Such other data or information as de-
17 termined by the Secretary.

18 (2) CMS REPORTS.—

19 (A) INITIAL REPORT.—Not later than Oc-
20 tober 1, 2026, the Administrator of the Centers
21 for Medicare & Medicaid Services shall, in con-
22 sultation with the Director of the Agency for
23 Healthcare Research and Quality and the As-
24 sistant Secretary for Mental Health and Sub-
25 stance Use, submit to Congress an initial report

1 on the activities carried out by States under the
2 planning grants made under subsection (c), and
3 actions taken by the Administrator of the Cen-
4 ters for Medicare & Medicaid Services to im-
5 prove oversight of such activities.

6 (B) INTERIM REPORT.—Not later than Oc-
7 tober 1, 2028, the Administrator of the Centers
8 for Medicare & Medicaid Services shall, in con-
9 sultation with the Director of the Agency for
10 Healthcare Research and Quality and the As-
11 sistant Secretary for Mental Health and Sub-
12 stance Use, submit to Congress an interim re-
13 port on activities carried out under the dem-
14 onstration project and actions taken by the Ad-
15 ministrator of the Centers for Medicare & Med-
16 icaid Services to improve oversight of such ac-
17 tivities and the extent to which States have
18 achieved the stated goals submitted in their ap-
19 plications. Such report shall include a descrip-
20 tion of the strengths and limitations of the
21 demonstration project and a plan for the sus-
22 tainability of the project.

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

1 sultation with the Director of the Agency for
2 Healthcare Research and Quality and the As-
3 sistant Secretary for Mental Health and Sub-
4 stance Use, submit to Congress a final report
5 providing updates on the matters reported in
6 the interim report required by subparagraph
7 (B) and that includes—

8 (i) a description of any changes made
9 with respect to the demonstration project
10 after the submission of such interim re-
11 port; and

12 (ii) an evaluation of the demonstra-
13 tion project.

14 (g) IMPLEMENTATION FUNDING.—There is appro-
15 priated, out of any funds in the Treasury not otherwise
16 appropriated, \$5,000,000 to the Administrator of the Cen-
17 ters for Medicare & Medicaid Services for purposes of im-
18 plementing this section, to remain available until ex-
19 pended.

20 (h) DEFINITIONS.—In this section:

21 (1) CHILDREN’S HOSPITALS.—The term “chil-
22 dren’s hospitals” has the meaning given that term in
23 section 340E(g)(2) of the Public Health Service Act
24 (42 U.S.C. 256e(g)(2)).

1 (2) INTEGRATED MENTAL HEALTH AND SUB-
2 STANCE USE DISORDER CARE SERVICES.—The term
3 “mental health and substance use disorder care serv-
4 ices” has the meaning given that term in section
5 1848(b)(13)(B) of the Social Security Act and in-
6 cludes prevention and early intervention services and
7 such other items and services for the care of mental
8 health and substance use conditions furnished by, or
9 in coordination with, a primary care practitioner as
10 the Secretary, in consultation with a State, may
11 specify.

12 (3) MEDICAID.—The term “Medicaid” means
13 the program for grants to States for medical assist-
14 ance programs established under title XIX of the
15 Social Security Act (42 U.S.C. 1396 et seq.).

16 (4) SECRETARY.—Except as otherwise speci-
17 fied, the term “Secretary” means the Secretary of
18 Health and Human Services.

19 (5) STATE.—The term “State” has the mean-
20 ing given that term in section 1101(a)(1) of the So-
21 cial Security Act (42 U.S.C. 1301(a)(1)) for pur-
22 poses of titles XIX and XXI of such Act, and for
23 purposes of

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

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

4 (7) SECRETARY.—The term “Secretary” means
 5 the Secretary of Health and Human Services.

6 (8) STATE.—The term “State” means—

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

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

13 (C) to the extent the Secretary determines
 14 appropriate, may include an Indian Tribe, Trib-
 15 al organization, or Urban Indian organization
 16 (as such terms are defined in section 4 of the
 17 Indian Health Care Improvement Act (25
 18 U.S.C. 1603)).

19 **SEC. 303. UNIFORM APPLICABILITY TO MEDICAID OF RE-**
 20 **QUIREMENTS FOR PARITY IN MENTAL**
 21 **HEALTH AND SUBSTANCE USE DISORDER**
 22 **BENEFITS.**

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

1 (1) in subsection (a)—

2 (A) by striking “and” at the end of para-
3 graph (86);

4 (B) by striking the period at the end of
5 paragraph (87) and inserting “; and”; and

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

8 “(88) provide for ensuring that the require-
9 ments for parity in mental health and substance use
10 disorder benefits under subsection (uu) are complied
11 with regardless of the payment model or arrange-
12 ment under which medical assistance is provided, in-
13 cluding when medical assistance under the State
14 plan or under a waiver of such plan is provided
15 through an alternative benefit plan under section
16 1937.”; and

17 (2) by adding at the end the following new sub-
18 section:

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

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

1 through the use of 1 or more alternative payment
2 models, or any combination thereof, the State shall
3 ensure that the financial requirements and treat-
4 ment limitations applicable to coverage of mental
5 health or substance use disorder services provided
6 under such plan or under a waiver of such plan com-
7 ply with the requirements of section 2726(a) of the
8 Public Health Service Act in the same manner as
9 such requirements or limitations apply to a group
10 health plan under such section.

11 “(2) DEEMED COMPLIANCE.—Coverage with re-
12 spect to an individual described in section
13 1905(a)(4)(B) and covered under the State plan or
14 waiver under section 1902(a)(10)(A) of the services
15 described in section 1905(a)(4)(B) (relating to early
16 and periodic screening, diagnostic, and treatment
17 services defined in section 1905(r)) and provided in
18 accordance with section 1902(a)(43), shall be
19 deemed to satisfy the requirements of paragraph
20 (1).”.

21 (b) MANAGED CARE ORGANIZATIONS AND PAYMENT
22 ARRANGEMENTS.—

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

1 “(8) COMPLIANCE WITH CERTAIN MATERNITY,
2 PARITY IN MENTAL HEALTH OR SUBSTANCE USE
3 DISORDER BENEFITS, AND OTHER COVERAGE RE-
4 QUIREMENTS.—

5 “(A) IN GENERAL.—Each medicaid man-
6 aged care organization shall comply with the re-
7 quirements of subpart 2 of part A of title
8 XXVII of the Public Health Service Act insofar
9 as such requirements apply and are effective
10 with respect to a health insurance issuer that
11 offers group health insurance coverage.

12 “(B) PARITY IN MENTAL HEALTH OR SUB-
13 STANCE USE DISORDER BENEFITS.—The finan-
14 cial requirements and treatment limitations ap-
15 plicable to coverage of mental health or sub-
16 stance use disorder services provided under the
17 State plan or under a waiver of such plan
18 through a medicaid managed care organization,
19 a prepaid inpatient health plan (as defined by
20 the Secretary), a prepaid ambulatory health
21 plan (as defined by the Secretary), or a primary
22 care case manager under section 1905 (con-
23 sistent with section 1905(t)(2)), shall comply
24 with the requirements of section 2726(a) of the
25 Public Health Service Act in the same manner

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

3 “(C) DEEMED COMPLIANCE.—In applying
4 subparagraphs (A) and (B) with respect to re-
5 quirements under paragraph (8) of section
6 2726(a) of the Public Health Service Act, a
7 medicaid managed care organization, a prepaid
8 inpatient health plan (as defined by the Sec-
9 retary), a prepaid ambulatory health plan (as
10 defined by the Secretary), or a primary care
11 case manager under section 1905 (consistent
12 with section 1905(t)(2)) shall be treated as in
13 compliance with such requirements if the med-
14 icaid managed care organization, prepaid inpa-
15 tient health plan, prepaid ambulatory health
16 plan, or primary care case manager under sec-
17 tion 1905 is in compliance with subpart K of
18 part 438 of title 42, Code of Federal Regula-
19 tions, and section 438.3(n) of such title, or any
20 successor regulation.”.

21 (c) EFFECTIVE DATE.—

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

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

3 (2) DELAY IF STATE LEGISLATION NEEDED.—

4 In the case of a State plan for medical assistance
5 under title XIX of the Social Security Act (42
6 U.S.C. 1396 et seq.) which the Secretary of Health
7 and Human Services determines requires State legis-
8 lation (other than legislation appropriating funds) in
9 order for the plan to meet the additional require-
10 ments imposed by the amendments made by sub-
11 section (a), the State plan shall not be regarded as
12 failing to comply with the requirements of such title
13 solely on the basis of its failure to meet these addi-
14 tional requirements before the first day of the first
15 calendar quarter beginning after the close of the
16 first regular session of the State legislature that be-
17 gins after the date of the enactment of this Act. For
18 purposes of the previous sentence, in the case of a
19 State that has a 2-year legislative session, each year
20 of such session shall be deemed to be a separate reg-
21 ular session of the State legislature.

22 (d) FUNDING.—Out of any funds in the Treasury not
23 otherwise appropriated, there is appropriated to the Sec-
24 retary of Health and Human Services for purposes of car-
25 rying out this section and the amendments made by this

1 section, \$10,000,000 for fiscal year 2024, to remain avail-
2 able until expended.

3 **SEC. 304. REQUIRING ADDITIONAL TRANSPARENCY ON AC-**
4 **CESS TO MENTAL HEALTH AND SUBSTANCE**
5 **USE DISORDER BENEFITS THROUGH MAN-**
6 **AGED CARE.**

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

10 “(9) TRANSPARENCY ON ACCESS TO MENTAL
11 HEALTH AND SUBSTANCE USE DISORDER BENE-
12 FITS.—

13 “(A) IN GENERAL.—Each managed care
14 organization, prepaid inpatient health plan (as
15 defined by the Secretary), and prepaid ambula-
16 tory health plan (as defined by the Secretary),
17 with a contract with a State to enroll individ-
18 uals who are eligible for medical assistance
19 under the State plan under this title or under
20 a waiver of such plan and to provide coverage
21 under the contract for mental health services or
22 substance use disorder services, disaggregated,
23 biennially shall assess and report to the State,
24 in such manner that the report is publicly avail-
25 able on a website, the following:

1 “(i) The average wait times during
2 the reporting period by level of acuity and
3 site of care for adult and child patients for
4 a new patient visit in an outpatient setting
5 (including intensive outpatient, eating dis-
6 order, residential treatments, or other ap-
7 pointments as the Secretary specifies) from
8 a provider of mental health services or sub-
9 stance use disorder services.

10 “(ii) The total number and average
11 percentage of network providers that pro-
12 vide mental health services or substance
13 use disorder services and are accepting as
14 new patients individuals who are enrollees
15 of such organization or plan at any point
16 during the reporting period.

17 “(iii) The proportion of mental health
18 services or substance use disorder services
19 and prescription drugs during the report-
20 ing period that are denied payment under
21 the State plan under this title or a waiver
22 on the basis of prior authorization or med-
23 ical necessity (or for any other reason that
24 is not based on an enrollee’s eligibility for
25 medical assistance under the State plan

1 under this title or a waiver) in comparison
2 to medical and surgical services and pre-
3 scription drugs that are denied payment on
4 the same bases during the reporting pe-
5 riod.

6 “(iv) The total number and percent-
7 age of providers during the reporting pe-
8 riod who have participation agreements
9 with the organization who submitted at
10 least 1 request for payment for a mental
11 health or substance use disorder service.

12 “(B) SUBMISSION TO SECRETARY.—A
13 State shall submit information reported to the
14 State under subparagraph (A), including strati-
15 fying reporting by race, ethnicity, disability, pri-
16 mary language, age, sexual orientation, and
17 gender identity, to help identify health inequi-
18 ties where applicable, to the Secretary in such
19 form and manner as the Secretary shall speci-
20 fy.”.

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

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

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

8 (1) in paragraph (87), by striking “and” after
9 the semicolon;

10 (2) in paragraph (88)(D), by striking the period
11 at the end and inserting “; and”; and

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

14 “(89) in the case of a State that adopts the op-
15 tion to use managed care as described in section
16 1932, provide that the State shall comply with the
17 requirements of section 1932.”.

18 (b) APPLICATION TO MANAGED CARE CONTRACTS.—
19 Section 1903(m)(2) of the Social Security Act (42 U.S.C.
20 1396b(m)) is amended—

21 (1) in subparagraph (A), in the matter pre-
22 ceding clause (i), by striking “and (G)” and insert-
23 ing “(G), and (I)”; and

24 (2) by adding at the end the following new sub-
25 paragraph:

1 “(I) For a violation of any requirement described in
2 subparagraph (A), including a violation of the require-
3 ments of section 1932, as applicable under clause (xii) of
4 such subparagraph and paragraph (89) of section
5 1902(a), rather than disallowing the full amount of a pay-
6 ment under this title to a State for expenditures incurred
7 by the State as described in subparagraph (A), the Sec-
8 retary may defer or disallow a portion of a payment to
9 the State. In determining the amount deferred or dis-
10 allowed under this subparagraph, the Secretary may con-
11 sider factors such as the degree, duration, and recurrence
12 of noncompliance. A State may receive a reconsideration
13 of a decision by the Secretary under this subparagraph
14 to disallow payment in the manner described in section
15 1116(e).”.

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

21 **SEC. 306. MEDICAID AND CHIP AUDITS.**

22 (a) REGULAR AUDITS.—Beginning with fiscal year
23 2025, the Secretary of Health and Human Services (re-
24 ferred to in this section as the “Secretary”) shall audit
25 State Medicaid programs and State Children’s Health In-

1 surance Programs for purposes of assessing State enforce-
2 ment of the requirements relating to parity in mental
3 health and substance use disorder benefits (including with
4 respect to compliance with such parity requirements in the
5 case of any mental health or substance use disorder bene-
6 fits that are separately managed or financed under a
7 “carve-out” model) applicable under subsections (a)(88)
8 and (uu) of section 1902 of the Social Security Act (42
9 U.S.C. 1396a) (as added by section 303(a), section
10 1932(b)(8) of such Act (42 U.S.C. 1396u–2(b)(8)), sec-
11 tion 1937(b)(6) of such Act (42 U.S.C. 1396u–7(b)(6)),
12 and section 2103(c)(7) of such Act (42 U.S.C.
13 1397cc(c)(7)), and related regulations.

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

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

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

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

10 **TITLE IV—OTHER PROVISIONS**

11 **SEC. 401. ENSURING MULTI-PAYER ALIGNMENT ON PAY-** 12 **MENT AND MEASUREMENT OF QUALITY OF** 13 **CARE AND HEALTH OUTCOMES RELATED TO** 14 **INTEGRATED MENTAL HEALTH AND SUB-** 15 **STANCE USE DISORDER CARE.**

16 Not later than April 1, 2024, the Administrator of
17 the Centers for Medicare & Medicaid Services shall con-
18 vene an advisory working group that includes representa-
19 tives of issuers of group and individual health insurance
20 coverage, mental health and substance use disorder pro-
21 grams and advocacy organizations, individuals and fami-
22 lies receiving integrated care services, and State Medicaid
23 Directors, for purposes of making recommendations for
24 administrative and legislative changes to facilitate multi-
25 payer alignment on payment and measurement of quality

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

9 **SEC. 402. MEASURING ACCESS AND QUALITY OUTCOMES IN**
10 **MENTAL HEALTH AND SUBSTANCE USE DIS-**
11 **ORDER CARE.**

12 (a) IN GENERAL.—Not later than October 1, 2024,
13 the Administrator of the Centers for Medicare & Medicaid
14 Services shall, in consultation with the Administrator of
15 the Health Resource Services Administration, the Director
16 of the Agency for Healthcare Research and Quality, and
17 the Assistant Secretary for Mental Health and Substance
18 Use, develop and implement a plan to improve measure-
19 ment of the extent to which children and adults have ac-
20 cess to integrated mental health and substance use dis-
21 order care in primary care and the quality and effective-
22 ness of the care provided, which shall be implemented in
23 quality measurement programs under the Medicare pro-
24 gram under title XVIII of the Social Security Act (42
25 U.S.C. 1395 et seq.), the Medicaid program under title

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

5 (b) MEASURE DEVELOPMENT.—The Director of the
6 Agency for Healthcare Research and Quality shall conduct
7 measure development where necessary to ensure that the
8 plan developed under subsection (a) may be fully imple-
9 mented, including measures of patient experience out-
10 comes, structural measures of practice transformation to-
11 ward evidence-based integrated care, and measures of ac-
12 cess and unmet need provided by local, State, or Federal
13 agencies.

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

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

1 **SEC. 404. ENHANCING OVERSIGHT OF INTEGRATED MEN-**
2 **TAL HEALTH AND SUBSTANCE USE DIS-**
3 **ORDER CARE.**

4 (a) IN GENERAL.—Not later than October 1, 2024,
5 the Administrator of the Centers for Medicare & Medicaid
6 Services shall, in consultation with the Director of the
7 Agency for Healthcare Research and Quality and the As-
8 sistant Secretary for Mental Health and Substance Use,
9 develop and implement a plan to improve oversight and
10 enforcement of requirements relating to the provision of
11 integrated mental health and substance use disorder care
12 under the Medicare program under title XVIII of the So-
13 cial Security Act (42 U.S.C. 1395 et seq.), the Medicaid
14 program under title XIX of such Act (42 U.S.C. 1396 et
15 seq.), and group health plans and health insurance cov-
16 erage (as such terms are defined in section 2791 of the
17 Public Health Service Act (42 U.S.C. 300gg–91)), includ-
18 ing requirements relating to—

19 (1) coverage of preventive health services with-
20 out cost-sharing under section 2713 of the Public
21 Health Service Act (42 U.S.C. 300gg–13);

22 (2) early and periodic screening, diagnosis, and
23 treatment for mental health and substance use dis-
24 orders;

25 (3) mental health and substance use parity;

1 (4) network adequacy, including quantitative
2 measures of network access that take into account
3 integration in primary care and schools, racial eq-
4 uity, and virtual care;

5 (5) essential health benefits (as defined in sec-
6 tion 1302(b) of the Patient Protection and Afford-
7 able Care Act (42 U.S.C. 18022(b))); and

8 (6) Medicaid rate setting.

9 (b) PATIENT INPUT.—In developing and imple-
10 menting the plan under subsection (a), the Administrator
11 shall seek input from patients with mental health and sub-
12 stance use conditions.