

119TH CONGRESS
1ST SESSION

S. _____

To amend title XVIII of the Social Security Act to establish a demonstration program to promote collaborative treatment of mental and physical health comorbidities under the Medicare program.

IN THE SENATE OF THE UNITED STATES

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

A BILL

To amend title XVIII of the Social Security Act to establish a demonstration program to promote collaborative treatment of mental and physical health comorbidities under the Medicare program.

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.**

4 This Act may be cited as the “Mental and Physical
5 Health Care Comorbidities Act of 2025”.

1 **SEC. 2. ESTABLISHING A DEMONSTRATION PROGRAM TO**
2 **PROMOTE COLLABORATIVE TREATMENT OF**
3 **MENTAL AND PHYSICAL HEALTH**
4 **COMORBIDITIES UNDER THE MEDICARE PRO-**
5 **GRAM.**

6 Title XVIII of the Social Security Act (42 U.S.C.
7 1395 et seq.) is amended by inserting after section 1866G
8 the following new section:

9 **“SEC. 1866H. MENTAL AND PHYSICAL HEALTH**
10 **COMORBIDITIES COLLABORATIVE DEM-**
11 **ONSTRATION PROGRAM.**

12 “(a) IN GENERAL.—Consistent with the model de-
13 scribed in section 1115A(b)(2)(B)(xv) (relating to pro-
14 moting improved quality and reduced cost by developing
15 a collaborative of high-quality, low-cost health care institu-
16 tions), the Secretary shall conduct a demonstration pro-
17 gram (in this section referred to as the ‘program’) to test
18 and evaluate innovations implemented by eligible hospitals
19 (as defined in subsection (f)) in the furnishing of items
20 and services to applicable individuals (as defined in sub-
21 section (f)) with mental and physical health comorbidities
22 (and those at risk of developing such comorbidities), in-
23 cluding by addressing the adverse social determinants of
24 health that such individuals often experience.

1 “(b) ACTIVITIES UNDER PROGRAM.—Under the pro-
2 gram, the Secretary shall, in coordination with eligible
3 hospitals participating in the program—

4 “(1) identify, validate, and disseminate innova-
5 tive, effective evidence-based best practices and mod-
6 els that improve care and outcomes for applicable in-
7 dividuals with mental and physical health
8 comorbidities located in vulnerable communities, in-
9 cluding by addressing the social determinants of
10 health that adversely impact such individuals; and

11 “(2) assist in the identification of potential pay-
12 ment reforms under this title and title XIX that
13 could more broadly effectuate such improvements.

14 “(c) DURATION AND SCOPE.—The program con-
15 ducted under this section shall operate during the period
16 beginning on October 1, 2025, and ending no later than
17 September 30, 2030.

18 “(d) PROGRAM ELEMENTS.—

19 “(1) IN GENERAL.—An eligible hospital electing
20 to participate in the program shall enter into an
21 agreement with the Secretary for purposes of car-
22 rying out the activities described in subsection (b).
23 Such an agreement shall include the plan described
24 in paragraph (2), along with an annualized payment
25 arrangement as described in paragraph (3) to sup-

1 port implementation of such plan. Such agreement
2 shall include a requirement for the hospital to—

3 “(A) engage in the learning collaborative
4 established under subsection (e);

5 “(B) certify that all proposed innovations
6 under such plan will supplement and not sup-
7 plant existing activities, whether by augmenting
8 existing activities or initiating new activities;
9 and

10 “(C) remit payments made under such ar-
11 rangement to the Secretary if the Secretary de-
12 termines that such hospital has not complied
13 with the terms of such agreement.

14 “(2) PROGRAM ELEMENTS.—An eligible hos-
15 pital electing to participate in the program shall sub-
16 mit a proposed plan and associated quality metrics
17 for review and approval by the Secretary. Such plan
18 and metrics shall, at a minimum, address—

19 “(A) the specific innovations addressing
20 mental and physical health comorbidities (as de-
21 fined in subsection (f)) and innovations ad-
22 dressing social determinants of health (as de-
23 fined in such subsection) that will be employed
24 and the evidence base supporting the proposed
25 approach;

1 “(B) the proposed target population of ap-
2 plicable individuals with respect to which such
3 innovations will be employed, including a de-
4 scription of the extent to which such population
5 consists of applicable individuals described in
6 subparagraph (A), (B), or (C) of subsection
7 (f)(1);

8 “(C) the evidence-based data supporting a
9 community’s status as a vulnerable community
10 through sources, such as Bureau of the Census
11 data and measures such as the Neighborhood
12 Deprivation Index or the Child Opportunity
13 Index;

14 “(D) community partners, such as non-
15 profit organizations, federally qualified health
16 centers, rural health clinics, and units of local
17 government (including law enforcement and ju-
18 dicial entities) that will participate in the imple-
19 mentation of such innovations;

20 “(E) how such innovations will address
21 mental and physical health comorbidities and
22 social determinants of health for the target pop-
23 ulation;

24 “(F) how such innovations may inform
25 changes in payment and other policies under

1 this title and title XIX (such as care coordina-
2 tion reimbursement, mental health homes, im-
3 provements to home and community-based serv-
4 ice portfolios, and coverage of supportive serv-
5 ices);

6 “(G) how such innovations might con-
7 tribute to a reduction in overall health care
8 costs, including under this title and title XIX
9 and for uninsured persons, through improve-
10 ments in population health, reductions in health
11 care utilization (such as inpatient admissions,
12 utilization of emergency departments, and
13 boarding of patients), and otherwise;

14 “(H) how such innovations can be expected
15 to improve the mental and physical health sta-
16 tus of minority populations;

17 “(I) how such innovations can be expected
18 to reduce other non-medical public expendi-
19 tures;

20 “(J) metrics to track care quality, im-
21 provement in outcomes, and the impact of such
22 innovations on health care and other public ex-
23 penditures;

24 “(K) how program outcomes will be as-
25 sessed and evaluated; and

1 “(L) how the hospital will collect and orga-
2 nize data and fully participate in the learning
3 collaborative established under subsection (e).

4 “(3) PARTICIPATION; PAYMENTS.—The Sec-
5 retary shall negotiate an annualized payment ar-
6 rangement with each eligible hospital participating
7 in the program. Such arrangement may include an
8 annual lump sum amount, capitated payment
9 amount, or such other arrangement as determined
10 appropriate by the Secretary, and which may include
11 an arrangement that includes financial risk for the
12 hospital, to support implementation of the innova-
13 tions specified in the plan described in paragraph
14 (2).

15 “(e) LEARNING COLLABORATIVE.—

16 “(1) IN GENERAL.—The Secretary shall estab-
17 lish a learning collaborative that shall convene eligi-
18 ble hospitals participating in the program and other
19 interested parties on a regular basis to report on
20 and share information regarding evidence-based in-
21 novations addressing mental and physical health
22 comorbidities, innovations addressing social deter-
23 minants of health, and associated metrics and out-
24 comes.

1 “(2) FOCUSED FORUMS.—The Secretary may
2 establish different focused forums within the collabo-
3 rative, such as ones that specifically address dif-
4 ferent geographic regions (such as urban and rural),
5 certain types of comorbidities, or as the Secretary
6 otherwise determines appropriate based on the types
7 of agreements entered into under subsection (d).

8 “(3) DISSEMINATION OF INFORMATION.—The
9 Secretary shall provide for the dissemination to
10 other health care providers and interested parties of
11 information on promising and effective activities.

12 “(f) DEFINITIONS.—For purposes of this section:

13 “(1) APPLICABLE INDIVIDUAL.—The term ‘ap-
14 plicable individual’ means an individual with mental
15 and physical health comorbidities who is—

16 “(A) a subsidy eligible individual (as de-
17 fined in section 1860D–14(a)(3)(A)) without
18 regard to clause (i) of such section;

19 “(B) enrolled under a State plan (or waiv-
20 er of such plan) under title XIX; or

21 “(C) uninsured.

22 “(2) ELIGIBLE HOSPITAL.—The term ‘eligible
23 hospital’ means a hospital that is—

24 “(A) a rural hospital with a dispropor-
25 tionate patient percentage of at least 35 percent

1 (as determined by the Secretary under section
2 1886(d)(5)(F)(vi)) or would have a dispropor-
3 tionate patient percentage of at least 35 percent
4 (as so determined) if the hospital were a sub-
5 section (d) hospital (or, a percentage of inpa-
6 tient days consisting of items and services fur-
7 nished to individuals entitled to benefits under
8 part A that exceeds 85 percent of all such days)
9 that is either a critical access hospital, a sole
10 community hospital (as defined in section
11 1886(d)(5)(D)(iii)), or a medicare-dependent,
12 small rural hospital (as defined in section
13 1886(d)(5)(G)(iv));

14 “(B) a large subsection (d) teaching and
15 tertiary hospital with more than 200 beds that
16 as of, or subsequent to July 1, 2020, has an av-
17 erage Medicare case mix index of at least 1.5,
18 an intern and resident-to-bed ratio of at least
19 0.25 percent (or at least 150 full-time equiva-
20 lent interns, residents, and fellows), and is ei-
21 ther a public hospital with a disproportionate
22 patient percentage of at least 35 percent (as de-
23 termined by the Secretary under section
24 1886(d)(5)(F)(vi)) or a nonprofit hospital with

1 a disproportionate patient percentage of at least
2 45 percent; or

3 “(C) a small subsection (d) urban safety
4 net hospital (as determined by the Secretary)
5 with less than 200 beds that is deemed to be
6 a disproportionate share hospital under section
7 1923(b).

8 “(3) INNOVATIONS ADDRESSING MENTAL AND
9 PHYSICAL HEALTH COMORBIDITIES.—The term ‘in-
10 novations addressing mental and physical health
11 comorbidities’ means innovations implemented by an
12 eligible hospital that seek to promote holistic care
13 and treatment of an applicable individual’s co-occur-
14 ring mental and physical health comorbidities, sup-
15 port early detection of such comorbidities, or prevent
16 their onset, including the following:

17 “(A) Implementation of interdisciplinary
18 integrative coordinated care team models, in-
19 cluding those that utilize mental health emer-
20 gency department in-reach staff (and other
21 emergency-department interventions), care co-
22 ordination staff and social services support, and
23 clinic-based services.

24 “(B) Integration of mental health services
25 into medical homes, coordinated care organiza-

1 tions, accountable care entities, and in-home
2 services.

3 “(C) Incorporation of mental health and
4 social risk screening into medical screening,
5 particularly in child and adolescent populations.

6 “(D) Preventing adverse impacts on men-
7 tal health resulting from physical health treat-
8 ments or medications, or on physical health re-
9 sulting from mental health treatments or medi-
10 cations, through cross disciplinary provider edu-
11 cation, quality metrics, and other mechanisms.

12 “(E) Improvements in electronic health
13 records and other technology platforms or net-
14 works to capture, track, and monitor mental
15 and physical health treatments and medications
16 provided across care settings and otherwise fa-
17 cilitate care coordination.

18 “(F) Piloting of reimbursement modifica-
19 tions that utilize site-neutral payments and that
20 address conflicts and disincentives related to
21 chronic care management and behavioral health
22 management and differential treatment of inpa-
23 tient and outpatient settings.

24 “(G) Mitigating the incidence of admission
25 and readmission into psychiatric inpatient set-

1 tings of chronically ill elderly patients through
2 methods such as active inpatient management,
3 variations in initial length of stay, enhanced
4 discharge planning, and psychosocial interven-
5 tions.

6 “(H) Delivering health behavior assess-
7 ments and interventions to improve physical
8 health outcomes for patients and aid in the
9 management of chronic health conditions.

10 “(I) In coordination with law enforcement
11 agencies and judicial entities, interventions tar-
12 geted at providing mental and physical health
13 services (including, as appropriate, substance
14 use disorder services) to individuals convicted of
15 criminal offenses for purposes of mitigating re-
16 cidivism.

17 “(4) INNOVATIONS ADDRESSING SOCIAL DETER-
18 MINANTS OF HEALTH.—The term ‘innovations ad-
19 dressing social determinants of health’ means inno-
20 vations implemented by an eligible hospital that seek
21 to address social determinants of health that nega-
22 tively impact the health outcomes of applicable indi-
23 viduals, including the following:

24 “(A) Improvements in electronic health
25 records to better integrate mental health, med-

1 ical care, and social care (such as screening for
2 social factors, facilitated or closed loop referral,
3 risk stratification, and shared records with com-
4 munity-based organizations).

5 “(B) Personnel-supported ‘wrap around’
6 services for at-risk individuals with mental and
7 physical health comorbidities (such as nutrition
8 and diet counseling, social services referral, res-
9 piratory therapy, medical-legal assistance, fi-
10 nancial counseling, consumer education, phar-
11 macy education, asthma education, and referral
12 to food resources such as referral to the SNAP
13 program, the WIC program, a food bank, case
14 management assistance, employment or edu-
15 cation support, intimate partner violence, and
16 behavioral health support).

17 “(C) Home and community-based services
18 that provide collaborative care to address men-
19 tal and physical health comorbidities through
20 health behavior services, nutrition support,
21 medication management, transitional care, tele-
22 health, mobile integrated health care, para-
23 medic-based home visitation, or utilization of
24 community health workers.

1 “(D) Hospital-based interventions (such as
2 same day primary care services, skilled nursing
3 interventions, substance use disorder and be-
4 havioral health treatment coordination of care,
5 collaborative care models, discharge planning
6 and medication reconciliation, long-term care
7 management, and post-traumatic injury man-
8 agement).

9 “(5) INDIVIDUAL WITH MENTAL AND PHYSICAL
10 HEALTH COMORBIDITIES.—The term ‘individual
11 with mental and physical health comorbidities’
12 means an individual who is challenged by serious
13 mental illness or serious emotional disturbance as
14 well as 1 or more of the following conditions or char-
15 acteristics:

16 “(A) Has or is at risk for one or more
17 chronic conditions (as defined by the Sec-
18 retary).

19 “(B) High-risk pregnancy.

20 “(C) History of high utilization of acute
21 care services.

22 “(D) Frail elderly (defined by impairments
23 in activities of daily living).

24 “(E) Disability, including traumatic brain
25 injury.

1 “(F) Critical illness or injury requiring
2 long-term recovery.

3 “(6) VULNERABLE COMMUNITY.—The term
4 ‘vulnerable community’ means a geographic area
5 served by an eligible hospital characterized by a pop-
6 ulation that has a statistically significant number of
7 individuals with mental and physical health
8 comorbidities, indicators of poor population health
9 status, low-income status, or status as a USDA-rec-
10 ognized food desert.

11 “(g) EVALUATION AND REPORT.—Not later than 1
12 year after the date of completion of the program under
13 this section, the Secretary shall submit to Congress a re-
14 port containing an evaluation of the activities supported
15 by the program. Such report shall include the following:

16 “(1) A description of each such activity, includ-
17 ing—

18 “(A) the target population of such activity;

19 “(B) how such activity addressed the ad-
20 verse social determinants of health in such pop-
21 ulation; and

22 “(C) the role of community-based organi-
23 zations and other community partners (such as
24 nonprofits and units of local government) in
25 such activity.

1 “(2) Evidence showing whether and how each
2 such activity advanced any of the following objec-
3 tives:

4 “(A) Improved access to care.

5 “(B) Improved quality of care.

6 “(C) Improved health outcomes.

7 “(D) Amelioration of disparities in care.

8 “(E) Improved care coordination.

9 “(F) Reduction in health care costs (in-
10 cluding such reductions under this title and
11 title XIX and such reductions occurring for un-
12 insured individuals).

13 “(G) Reduction in health care utilization
14 (including with respect to inpatient admissions,
15 utilization of emergency departments, and room
16 and board provided to individuals).

17 “(H) Reduction in non-medical public ex-
18 penditures.

19 “(I) Changes in patient and provider satis-
20 faction with care delivery.

21 “(J) Reductions in involvement with the
22 justice system, including reductions in recidi-
23 vism.

24 “(3) A description of the metrics used to track
25 the implementation and results of each such activity.

1 “(4) Recommendations for any legislation or
2 administrative action the Secretary determines ap-
3 propriate.

4 “(h) FUNDING.—Any funds appropriated under sec-
5 tion 1115A(f) shall be available to the Secretary without
6 further appropriation for the purposes of carrying out this
7 section.”.