

1 **TITLE \_\_—IMPROVING INTEGRA-**  
 2 **TION, COORDINATION, AND**  
 3 **ACCESS TO CARE**

4 **SEC. \_\_01. SHORT TITLE OF TITLE; TABLE OF CONTENTS.**

5 (a) SHORT TITLE.—This title may be cited as the  
 6 “Mental Health Care Integration and Crisis Care Im-  
 7 provement Act”.

8 (b) TABLE OF CONTENTS.—The table of contents for  
 9 this title is as follows:

TITLE \_\_—IMPROVING INTEGRATION, COORDINATION, AND  
 ACCESS TO CARE

Sec. \_\_01. Short title of title; table of contents.

Subtitle A—Medicare Provisions

Sec. \_\_11. Guidance for expanding value-based arrangements and alternative payment models in Medicare.

Sec. \_\_12. Integration of behavioral health care for treatment of mental health and substance use disorders in the primary care setting.

Sec. \_\_13. Clarifying the eligibility for participation of peer support specialists in the furnishing of behavioral health integration services under the Medicare program.

Sec. \_\_14. Report on progress integrating behavioral health into primary care.

Sec. \_\_15. Incentives for behavioral health integration.

Sec. \_\_16. Payment for mobile crisis response intervention services under physician fee schedule.

Sec. \_\_17. Payment for crisis stabilization services under prospective payment system for hospital outpatient department services.

Subtitle B—Medicaid and CHIP Provisions

Sec. \_\_21. Guidance to States on supporting mental health and substance use disorder care integration with primary care in Medicaid and CHIP.

Sec. \_\_22. Guidance and technical assistance for States to support access to community social supports and services.

Sec. \_\_23. Supporting access to a continuum of crisis response services under Medicaid and CHIP.

Sec. \_\_24. Making permanent State option to provide qualifying community-based mobile crisis intervention services.

## 1     **Subtitle A—Medicare Provisions**

### 2     **SEC. \_11. GUIDANCE FOR EXPANDING VALUE-BASED AR-** 3                   **RANGEMENTS AND ALTERNATIVE PAYMENT** 4                   **MODELS IN MEDICARE.**

5           Not later than 18 months after the date of the enact-  
6     ment of this Act, the Secretary of Health and Human  
7     Services shall issue guidance to group practices, physi-  
8     cians, and practitioners on best practices for integrating  
9     behavioral health care within the primary care setting for  
10    the treatment of mental health and substance use dis-  
11    orders, including but not limited to depression, anxiety,  
12    and opioid use disorder. Such guidance may include the  
13    following, as determined appropriate by the Secretary:

14           (1) Use of the Collaborative Care Model or the  
15           Primary Care Behavioral Health Model for behav-  
16           ioral health integration.

17           (2) Having mental health providers co-located  
18           within a physician's practice with same-day visit  
19           availability.

20           (3) Incorporating the services of peer support  
21           specialists or other auxiliary personnel.

22           (4) Effectively coordinating care for individuals  
23           with behavioral health needs.

1           (5) Developing or maintaining referral relation-  
2           ships to other providers or community-based organi-  
3           zations.

4           (6) The use of telehealth to furnish mental  
5           health services.

6 **SEC. 12. INTEGRATION OF BEHAVIORAL HEALTH CARE**  
7                                   **FOR TREATMENT OF MENTAL HEALTH AND**  
8                                   **SUBSTANCE USE DISORDERS IN THE PRI-**  
9                                   **MARY CARE SETTING.**

10          Section 1115A(b)(2)(B) of the Social Security Act  
11          (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the  
12          end the following new clause:

13                               “(xxviii) Promoting ways to support  
14                               the adoption of behavioral health integra-  
15                               tion, such as the psychiatric Collaborative  
16                               Care Model, Primary Care Behavioral  
17                               Health Model, or other evidence-based  
18                               models, in the primary care setting for the  
19                               treatment of mental health and substance  
20                               use disorders that require regular follow-  
21                               up, such as depression, anxiety, and opioid  
22                               use disorder.”.

1 **SEC. \_\_13. CLARIFYING THE ELIGIBILITY FOR PARTICIPA-**  
2 **TION OF PEER SUPPORT SPECIALISTS IN THE**  
3 **FURNISHING OF BEHAVIORAL HEALTH INTE-**  
4 **GRATION SERVICES UNDER THE MEDICARE**  
5 **PROGRAM.**

6 Section 1848(i) of the Social Security Act (42 U.S.C.  
7 1395w-4(i)) is amended by adding at the end the fol-  
8 lowing new paragraph:

9 “(4) CLARIFYING ELIGIBILITY OF PEER SUP-  
10 PORT SPECIALISTS TO PARTICIPATE IN FURNISHING  
11 BEHAVIORAL HEALTH INTEGRATION SERVICES.—

12 “(A) IN GENERAL.—Not later than one  
13 year after the date of the enactment of this  
14 paragraph, the Secretary shall clarify that peer  
15 support specialists (as defined in subparagraph  
16 (B)) may participate in the furnishing of behav-  
17 ioral health integration services (as described in  
18 subsection (b)(12)(B)).

19 “(B) PEER SUPPORT SPECIALIST DE-  
20 FINED.—For purposes of subparagraph (A), the  
21 term ‘peer support specialist’ means an indi-  
22 vidual who is certified as qualified to furnish  
23 peer support services under a national certifi-  
24 cation process that meets State law require-  
25 ments or a State requirement process that is  
26 consistent with the National Practice Guidelines

1 for Peer Supporters and inclusive of the Sub-  
2 stance Abuse and Mental Health Services Ad-  
3 ministration Core Competencies for Peer Work-  
4 ers in Behavioral Health Settings as determined  
5 appropriate by the Secretary.

6 “(C) IMPLEMENTATION.—Notwithstanding  
7 any other provision of law, the Secretary may  
8 implement this paragraph by program instruc-  
9 tion or otherwise.”.

10 **SEC. \_14. REPORT ON PROGRESS INTEGRATING BEHAV-**  
11 **IORAL HEALTH INTO PRIMARY CARE.**

12 Section 1115A(g) of the Social Security Act (42  
13 U.S.C. 1315a(g)) is amended—

14 (1) by striking “CONGRESS.—Beginning in”  
15 and inserting “CONGRESS.—

16 “(1) IN GENERAL.—Subject to paragraph (2),  
17 beginning in”; and

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

20 “(2) REPORT ON PROGRESS INTEGRATING BE-  
21 HAVIORAL HEALTH INTO PRIMARY CARE.—In the  
22 case of the first report submitted under paragraph  
23 (1) on or after the date that is 1 year after the date  
24 of the enactment of this paragraph, such report shall  
25 include an analysis of the progress made by prac-

1 tices towards integrating behavioral health into pri-  
2 mary care, based on such progress under relevant  
3 demonstration programs under titles XVIII and  
4 XIX. As part of such analysis, the Secretary shall—

5 “(A) conduct and take into consideration  
6 surveys of—

7 “(i) a range of providers, including  
8 providers currently participating in such  
9 demonstration programs, providers who  
10 have previously participated in such dem-  
11 onstration programs and who are no longer  
12 participating (regardless of reason), and  
13 providers who serve underserved commu-  
14 nities and vulnerable populations (regard-  
15 less of whether they have ever participated  
16 in such demonstration programs), on ap-  
17 propriate outcome and integration meas-  
18 ures, including effectiveness of clinical as-  
19 sessment, screening, and therapeutic tools  
20 (inclusive of digital therapeutics) as well as  
21 clinical support tools; and

22 “(ii) patients on patient outcomes and  
23 experience;

24 “(B) establish a plan to develop additional  
25 outcome and integration measures , and clinical

1 assessment and screening tools in areas of need  
2 for use under such demonstration programs as  
3 identified by providers in surveys conducted  
4 pursuant to subparagraph (A); and

5 “(C) consider workforce needs and any po-  
6 tential barriers to implementation of such dem-  
7 onstration programs.”.

8 **SEC. 15. INCENTIVES FOR BEHAVIORAL HEALTH INTE-**  
9 **GRATION.**

10 (a) INCENTIVES.—

11 (1) IN GENERAL.—Section 1848(b) of the So-  
12 cial Security Act (42 U.S.C. 1395w-4(b)) is amend-  
13 ed by adding at the end the following new para-  
14 graph:

15 “(12) INCENTIVES FOR BEHAVIORAL HEALTH  
16 INTEGRATION.—

17 “(A) IN GENERAL.—For services described  
18 in subparagraph (B) that are furnished during  
19 2025, 2026, or 2027, instead of the payment  
20 amount that would otherwise be determined  
21 under this section for such year, the payment  
22 amount shall be equal to the applicable percent  
23 (as defined in subparagraph (C)) of such pay-  
24 ment amount for such year.

1           “(B) SERVICES DESCRIBED.—The services  
2 described in this subparagraph are services  
3 identified, as of January 1, 2022, by HCPCS  
4 codes 99484, 99492, 99493, 99494, and G2214  
5 (and any successor or similar codes as deter-  
6 mined appropriate by the Secretary).

7           “(C) APPLICABLE PERCENT.—In this  
8 paragraph, the term ‘applicable percent’ means,  
9 with respect to a service described in subpara-  
10 graph (A), the following:

11                   “(i) For services furnished during  
12 2025 , 175 percent.

13                   “(ii) For services furnished during  
14 2026, 150 percent.

15                   “(iii) For services furnished during  
16 2027, 125 percent.”.

17           (2) WAIVER OF BUDGET NEUTRALITY.—Section  
18 1848(c)(2)(B)(iv) of such Act (42 U.S.C. 1395w-  
19 4(c)(2)(B)(iv)) is amended—

20                   (A) in subclause (IV), by striking “and” at  
21 the end;

22                   (B) in subclause (V), by striking the period  
23 at the end and inserting “; and” and

24                   (C) by adding at the end the following new  
25 subclause:



1                   “(VI) the increase in payment  
2                   amounts as a result of the application  
3                   of subsection (b)(12) shall not be  
4                   taken into account in applying clause  
5                   (ii)(II) for 2025, 2026, or 2027.”.

6           (b) QUALITY MEASUREMENT.—

7                   (1) IN GENERAL.—Section 1833(z) of the So-  
8                   cial Security Act (42 U.S.C. 1395l(z)) is amended—

9                           (A) by redesignating paragraph (4) as  
10                          paragraph (5); and

11                           (B) by inserting after paragraph (3) the  
12                          following new paragraph:

13                           “(4) QUALITY MEASUREMENT RELATING TO  
14                          BEHAVIORAL HEALTH INTEGRATION.—

15                                   “(A) IN GENERAL.—The Secretary shall  
16                                   establish quality measurement reporting re-  
17                                   quirements for applicable physicians and practi-  
18                                   tioners (as defined in subparagraph (B)) with  
19                                   respect to the extent to which clinician practices  
20                                   are integrating behavioral health services and  
21                                   primary care services, in accordance with the  
22                                   succeeding provisions of this paragraph.

23                                   “(B) APPLICABLE PHYSICIANS AND PRAC-  
24                                   TITIONERS.—For purposes of this paragraph,  
25                                   the term ‘applicable physician or practitioner’

1 means, with respect to a year, a physician or a  
2 practitioner described in section 1842(b)(18)(C)  
3 who is participating in an eligible alternative  
4 payment entity for which the associated alter-  
5 native payment model involves the delivery of  
6 primary care services to beneficiaries who may  
7 have the need for mental health or substance  
8 use disorder services, as determined by the Sec-  
9 retary.

10 “(C) QUALITY REPORTING BY SELECTED  
11 PHYSICIANS AND PRACTITIONERS.—With re-  
12 spect to each year beginning on or after the  
13 date that is one year after one or more meas-  
14 ures are first specified under subparagraph (D),  
15 an applicable physician or practitioner shall  
16 submit to the Secretary data on quality meas-  
17 ures specified under such subparagraph. Such  
18 data shall be submitted in a form and manner,  
19 and at a time, specified by the Secretary for  
20 purposes of this subparagraph.

21 “(D) QUALITY MEASURES.—

22 “(i) IN GENERAL.—Subject to clause  
23 (ii), any measure specified by the Secretary  
24 under this subparagraph must have been

1 endorsed by the entity with a contract  
2 under section 1890(a).

3 “(ii) EXCEPTION.—In the case of a  
4 specified area or medical topic determined  
5 appropriate by the Secretary for which a  
6 feasible and practical measure has not  
7 been endorsed by the entity with a contract  
8 under section 1890(a), the Secretary may  
9 specify a measure that is not so endorsed  
10 as long as due consideration is given to  
11 measures that have been endorsed or  
12 adopted by a consensus organization iden-  
13 tified by the Secretary.

14 “(E) IMPLEMENTATION.—The Secretary  
15 may use quality measures developed pursuant  
16 to this paragraph in—

17 “(i) the shared savings program under  
18 section 1899; and

19 “(ii) the Primary Care First Model,  
20 the Accountable Care Organization Real-  
21 izing Equity, Access, and Community  
22 Health (ACO REACH) Model, and any  
23 other alternative payment model (as de-  
24 fined in paragraph (3)(C)) as determined  
25 appropriate by the Secretary.”.

1           (2) CONFORMING AMENDMENT RELATING TO  
2           CONVENING MULTI-STAKEHOLDER GROUPS.—Section  
3           1890(b)(7)(B)(i)(I) of the Social Security Act (42  
4           U.S.C. 1395aaa(b)(7)(B)(i)(I)) is amended by in-  
5           serting “1833(z)(4),” after “1833(t)(17),”.

6           (c) TECHNICAL ASSISTANCE FOR THE ADOPTION OF  
7           BEHAVIORAL HEALTH INTEGRATION.—

8           (1) IN GENERAL.—Not later than January 1,  
9           2024, the Secretary of Health and Human Services  
10          shall enter into contracts or agreements with appro-  
11          priate entities to offer technical assistance to pri-  
12          mary care practices that are seeking to adopt behav-  
13          ioral health integration models in such practices.

14          (2) BEHAVIORAL HEALTH INTEGRATION MOD-  
15          ELS.—For purposes of paragraph (1), behavioral  
16          health integration models include the Collaborative  
17          Care Model (with services identified as of January  
18          1, 2022, by HCPCS codes 99492, 99493, 99494,  
19          and G2214 (and any successor codes)), the Primary  
20          Care Behavioral Health model (with services identi-  
21          fied as of January 1, 2022, by HCPCS code 99484  
22          (and any successor code)), and other models identi-  
23          fied by the Secretary.

24          (3) FUNDING.—In addition to amounts other-  
25          wise available, there is appropriated to the Secretary

1 of Health and Human Services for each of fiscal  
2 years 2023 through 2027, out of any money in the  
3 Treasury not otherwise appropriated, such sums as  
4 are necessary, to remain available until expended,  
5 for purposes of carrying out this subsection.

6 **SEC. \_\_16. PAYMENT FOR MOBILE CRISIS RESPONSE INTER-**  
7 **VENTION SERVICES UNDER PHYSICIAN FEE**  
8 **SCHEDULE.**

9 Section 1848(b) of the Social Security Act (42 U.S.C.  
10 1395w-4(b)), as amended by section \_\_05, is amended by  
11 adding at the end the following new paragraph:

12 “(13) MOBILE CRISIS RESPONSE TEAM SERV-  
13 ICES.—

14 “(A) IN GENERAL.—Beginning January 1,  
15 2025, the Secretary shall, subject to the suc-  
16 ceeding provisions of this paragraph, make a  
17 single global payment (as determined by the  
18 Secretary under subparagraph (C)) under this  
19 section for mobile crisis response team services  
20 (as defined in subparagraph (B)) furnished by  
21 a physician (as defined in section 1861(r)(1)),  
22 physician assistant or nurse practitioner (as de-  
23 fined in section 1861(aa)(5)(A)), clinical nurse  
24 specialist (as defined in section  
25 1861(aa)(5)(B)), clinical social worker (as de-

1            fined in section 1861(hh)(1)), or clinical psy-  
2            chologist (as defined by the Secretary for pur-  
3            poses of section 1861(ii)).

4            “(B) DEFINITION OF MOBILE CRISIS RE-  
5            SPONSE TEAM SERVICES.—In this paragraph,  
6            the term ‘mobile crisis response team services’  
7            means physicians’ services that are furnished  
8            outside of a hospital, other facility setting, or  
9            physician office to an individual experiencing a  
10           mental health or substance use disorder crisis  
11           to—

12                    “(i) provide screening and assessment  
13                    for the individual’s mental health or sub-  
14                    stance use disorder crisis;

15                    “(ii) support the de-escalation of the  
16                    individual’s mental health or substance use  
17                    disorder crisis;

18                    “(iii) facilitate or support subsequent  
19                    referral to health, social, and other serv-  
20                    ices, as determined appropriate by the Sec-  
21                    retary; or

22                    “(iv) otherwise address the individ-  
23                    ual’s pressing behavioral health needs, as  
24                    determined appropriate by the Secretary.

1                   “(C) DETERMINATION OF SINGLE GLOBAL  
2 PAYMENT.—

3                   “(i) IN GENERAL.—The Secretary  
4 shall determine an appropriate global pay-  
5 ment for mobile crisis response team serv-  
6 ices under the fee schedule under this sec-  
7 tion to account for the work, practice ex-  
8 penses, and malpractice expenses involved  
9 in furnishing physicians’ services that  
10 would typically be furnished to an indi-  
11 vidual experiencing a mental health or sub-  
12 stance use disorder crisis to accomplish the  
13 objectives described in clauses (i) through  
14 (iv) of subparagraph (B) (as identified by  
15 the Secretary).

16                   “(ii) RELATIVE VALUES.—In deter-  
17 mining work, practice expenses, and mal-  
18 practice expenses under clause (i), the Sec-  
19 retary shall account for differences in  
20 work, practice expenses, and malpractice  
21 expenses between furnishing physicians’  
22 services identified in clause (i) in a physi-  
23 cian office and the work, practice expenses,  
24 and malpractice expenses involved in fur-  
25 nishing such services at the site at which

1 at individual is experiencing a mental or  
2 substance use disorder crisis, including po-  
3 tential practice expenses associated with  
4 transportation to such site.

5 “(iii) ENSURING NO DUPLICATE PAY-  
6 MENT.—The Secretary shall ensure that if  
7 a physician or practitioner receives pay-  
8 ment for mobile crisis response team serv-  
9 ices under this paragraph, additional pay-  
10 ment is not made under this section for  
11 physicians’ services identified in clause (i)  
12 that are furnished to the same individual  
13 by the same physician or practitioner on  
14 the same day on which such mobile crisis  
15 response team services are furnished.

16 “(D) REQUIREMENTS FOR PHYSICIANS  
17 AND PRACTITIONERS RECEIVING PAYMENT.—In  
18 order to receive payment for mobile crisis re-  
19 sponse team services, a physician or practi-  
20 tioner who submits a claim for payment for  
21 such services must document, in a form and  
22 manner determined appropriate by the Sec-  
23 retary, that the physician or practitioner fur-  
24 nishing such services and any auxiliary per-  
25 sonnel (as defined in section 410.26(a)(1) of



1 title 42, Code of Federal Regulations, or any  
2 successor regulation) furnishing such services  
3 under the supervision of the physician or practi-  
4 tioner—

5 “(i) are trained in trauma-informed  
6 care, de-escalation strategies, and harm re-  
7 duction;

8 “(ii) are capable of coordinating with  
9 emergency response systems, crisis inter-  
10 vention hotlines, and hospitals furnishing  
11 crisis stabilization services (as defined in  
12 section 1833(t)(23)); and

13 “(iii) meet other criteria determined  
14 appropriate by the Secretary to ensure  
15 quality of care and program integrity.

16 “(E) ADDITIONAL CLARIFICATION.—The  
17 Secretary shall allow for auxiliary personnel (as  
18 defined in section 410.26(a)(1) of title 42, Code  
19 of Federal Regulations, or any successor regula-  
20 tion), including peer support specialists (as de-  
21 fined in subsection (i)(4)(B)), to furnish mobile  
22 crisis response team services under the super-  
23 vision of a physician or practitioner billing for  
24 such services under this section.”.

1 **SEC. \_\_17. PAYMENT FOR CRISIS STABILIZATION SERVICES**  
2 **UNDER PROSPECTIVE PAYMENT SYSTEM FOR**  
3 **HOSPITAL OUTPATIENT DEPARTMENT SERV-**  
4 **ICES.**

5 (a) IN GENERAL.—Section 1833(t) of the Social Se-  
6 curity Act (42 U.S.C. 1395l(t)) is amended—

7 (1) in paragraph (1)(B)—

8 (A) in clause (iv), by striking “and” at the  
9 end;

10 (B) in clause (v), by striking the period at  
11 the end and inserting “; and”; and

12 (C) by adding at the end the following new  
13 clause:

14 “(vi) includes crisis stabilization serv-  
15 ices (as defined in paragraph (23)) fur-  
16 nished on or after January 1, 2025.”; and

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

19 “(23) CRISIS STABILIZATION SERVICES.—

20 “(A) CRISIS STABILIZATION SERVICES DE-  
21 FINED.—In this subsection, the term ‘crisis sta-  
22 bilization services’ means applicable items and  
23 services (as defined in subparagraph (B)) that  
24 are furnished to an eligible individual who is ex-  
25 periencing a mental health or substance use dis-

1 order crisis, subject to the requirements under  
2 subparagraph (C).

3 “(B) APPLICABLE ITEMS AND SERVICES  
4 DEFINED.—

5 “(i) IN GENERAL.—For purposes of  
6 subparagraph (A), the term ‘applicable  
7 items and services’ means items and serv-  
8 ices described in clause (ii) that are—

9 “(I) covered under this part; and

10 “(II)(aa) reasonable and nec-  
11 essary for the diagnosis and active  
12 treatment of the individual’s mental  
13 health or substance use disorder con-  
14 dition; or

15 “(bb) reasonably expected to sup-  
16 port the de-escalation of the individ-  
17 ual’s mental health or substance use  
18 disorder crisis.

19 “(ii) ITEMS AND SERVICES DE-  
20 SCRIBED.—The following items and serv-  
21 ices are described in this clause:

22 “(I) Observation services and su-  
23 pervised care for individuals in severe  
24 distress for up to 23 consecutive  
25 hours.

1                   “(II) Screening for suicide risk,  
2 including comprehensive suicide risk  
3 assessments and planning when clini-  
4 cally indicated.

5                   “(III) Screening for violence risk,  
6 including comprehensive violence risk  
7 assessments and planning when clini-  
8 cally indicated.

9                   “(IV) Assessment of immediate  
10 physical health needs and delivery of  
11 care for physical health needs that are  
12 within the capability of the hospital.

13                   “(V) Such other items and serv-  
14 ices as the Secretary determines ap-  
15 propriate.

16                   “(C) REQUIREMENTS FOR PAYMENT.—In  
17 order to receive payment for crisis stabilization  
18 services under this subsection, a hospital must  
19 document, in a form and manner determined  
20 appropriate by the Secretary, that—

21                   “(i) the hospital accepts referrals,  
22 within the capability of the hospital, for  
23 crisis stabilization services;

24                   “(ii) the hospital is capable of pro-  
25 viding referrals for health, social, and

1 other services and supports, as needed,  
2 that are not provided as part of crisis sta-  
3 bilization services;

4 “(iii) the unit of the hospital that fur-  
5 nishes crisis stabilization services is staffed  
6 at all times (24 hours a day, 7 days a  
7 week, 365 days a year) with a multidisci-  
8 plinary team, which may include providers  
9 such as a psychiatrist or psychiatric nurse  
10 practitioner (who may be available by tele-  
11 health for such staffing purposes), reg-  
12 istered nurses, practitioners legally author-  
13 ized to furnish such services under State  
14 law (or the State regulatory mechanism  
15 provided by State law) of the State in  
16 which the services are furnished, and peer  
17 support specialists (as defined in sub-  
18 section (i)(4)(B)); and

19 “(iv) the unit of the hospital that fur-  
20 nishes crisis stabilization services is capa-  
21 ble—

22 “(I) of timely communication  
23 with emergency response systems, cri-  
24 sis intervention hotlines, and physi-  
25 cians and practitioners furnishing mo-

1           bile crisis response team services (as  
2           defined in section 1848(b)(13)); and

3                           “(II) within the capacity of the  
4           hospital, of accepting referrals of indi-  
5           viduals from such entities for crisis  
6           stabilization services.”.

7           (b) REPORT ON MEDICARE COVERAGE OF CRISIS  
8           STABILIZATION FACILITY SERVICES.—Not later than 18  
9           months after the date of the enactment of this Act, the  
10          Secretary of Health and Human Services (referred to in  
11          this subsection as the “Secretary”) shall submit to the  
12          Committee on Finance of the Senate and the Committee  
13          on Energy and Commerce and the Committee on Ways  
14          and Means of the House of Representatives a report on  
15          policy issues for consideration in relation to providing  
16          Medicare coverage of crisis stabilization services (as de-  
17          fined in section 1833(t)(23) of the Social Security Act,  
18          as added by subsection (a)), when furnished by crisis sta-  
19          bilization facilities that are not eligible to enroll in the  
20          Medicare program as a subsection (d) hospital (as defined  
21          in section 1886(d)(1)(B) of such Act (42 U.S.C.  
22          1395ww(d)(1)(B))). Such report may include an assess-  
23          ment of the following:

24                           (1) Considerations relating to licensure and ac-  
25                           creditation of such facilities by States and accredita-

1       tion organizations to ensure care quality and pro-  
2       gram integrity.

3           (2) Considerations relating to the development  
4       of payment rates for such facilities, including collec-  
5       tion of data on the costs that such facilities incur in  
6       furnishing crisis stabilization services.

7           (3) Considerations relating to any program in-  
8       tegrity risks associated with crisis stabilization facili-  
9       ties and potential measures that could be imple-  
10      mented to mitigate those risks.

11          (4) Other considerations determined appro-  
12      priate by the Secretary.

## 13       **Subtitle B—Medicaid and CHIP** 14                                   **Provisions**

### 15   **SEC. \_\_21. GUIDANCE TO STATES ON SUPPORTING MENTAL** 16                                   **HEALTH AND SUBSTANCE USE DISORDER** 17                                   **CARE INTEGRATION WITH PRIMARY CARE IN** 18                                   **MEDICAID AND CHIP.**

19       (a) ANALYSIS REGARDING CARE INTEGRATION.—  
20   Not later than 18 months after the date of enactment of  
21   this Act, the Secretary of Health and Human Services  
22   shall conduct an analysis of Medicaid and CHIP regarding  
23   clinical outcomes among different models of integration of  
24   mental health or substance use disorder care within the  
25   primary care setting. Such analysis shall—

1           (1) consider different models for how mental  
2 health or substance use disorder care is delivered  
3 and integrated within the primary care setting, in-  
4 cluding when providers operating in an integrated  
5 model are physically located in the same practice or  
6 building, when at least 1 provider in an integrated  
7 care model is available via telehealth, and when pri-  
8 mary care or mental health or substance use dis-  
9 order health providers seek education and consulta-  
10 tion from other providers through electronic modali-  
11 ties; and

12           (2) evaluate—

13                 (A) the use of different payment meth-  
14 odologies, such as bundled payments and value-  
15 based payment arrangements; and

16                 (B) the use and quality of enhanced care  
17 coordination or case management for mental  
18 health and substance use disorder care.

19           (b) GUIDANCE.—Not later than 12 months after the  
20 Secretary of Health and Human Services completes the  
21 analysis required under subsection (a), the Secretary shall  
22 issue guidance to States on supporting integration of men-  
23 tal health or substance use disorder care within the pri-  
24 mary care setting under Medicaid and CHIP. Such guid-



1 ance shall be informed by the analysis required under sub-  
2 section (a) and, at minimum, shall do the following:

3 (1) Provide an overview of State options for  
4 adopting and expanding value-based payment ar-  
5 rangements and alternative payment models, includ-  
6 ing accountable care organizations and other shared  
7 savings programs, that integrate mental health or  
8 substance use disorder care within the primary care  
9 setting.

10 (2) Describe opportunities for States to use and  
11 align existing authorities and resources to finance  
12 integration of mental health or substance use dis-  
13 order care within the primary care setting, including  
14 with respect to the use of electronic health records  
15 in mental health and substance use disorder care  
16 settings.

17 (3) Describe strategies to support integration of  
18 mental health or substance use disorder care within  
19 the primary care setting through the use of non-clin-  
20 ical professionals and paraprofessionals, including  
21 trained peer support specialists.

22 (4) Provide examples of specific strategies and  
23 models designed to support integration of mental  
24 health or substance use disorder care within the pri-  
25 mary care setting for differing age groups, including

1 children, young adults, and individuals over the age  
2 of 65.

3 (5) Describe options for assessing the clinical  
4 outcomes of differing models and strategies for inte-  
5 gration of mental health or substance use disorder  
6 care within the primary care setting.

7 (6) Describe best practices for supporting suc-  
8 cessful integration of mental health or substance use  
9 disorder care within the primary care setting for in-  
10 dividuals eligible for assistance under Medicaid or  
11 CHIP.

12 (c) INTEGRATION OF MENTAL HEALTH AND SUB-  
13 STANCE USE DISORDER CARE WITHIN THE PRIMARY  
14 CARE SETTING.—For purposes of subsections (a) and (b),  
15 integration of mental health and substance use disorder  
16 care within the primary care setting may include (and  
17 shall not be limited to, including when furnished via tele-  
18 health, when appropriate)—

19 (1) adherence to the collaborative care model or  
20 primary care behavioral health model for behavioral  
21 health integration;

22 (2) use of behavioral health integration models  
23 primarily intended for pediatric populations with  
24 non-severe mental health needs that are focused on  
25 prevention and early detection and intervention

1 methods through a multidisciplinary collaborative be-  
2 havioral health team approach co-managed with pri-  
3 mary care, to include same-day access to family-fo-  
4 cused mental health treatment services;

5 (3) having mental health or substance use dis-  
6 order providers physically co-located in a primary  
7 care setting with same-day visit availability;

8 (4) implementing or maintaining enhanced care  
9 coordination or targeted case management which in-  
10 cludes regular interactions between and within care  
11 teams;

12 (5) providing mental health and substance use  
13 disorder screening and follow-up assessments, inter-  
14 ventions, or services within the same practice or fa-  
15 cility as a primary care or physical service setting;

16 (6) the use of assertive community treatment  
17 that is integrated with or facilitated by a primary  
18 care practice; and

19 (7) delivery of integrated primary care and  
20 mental health and substance use disorder care in  
21 home or community-based settings for individuals  
22 who choose and are able to receive care in such set-  
23 tings, as authorized under subsections (b), (c), (i),  
24 (j), and (k) of section 1915 of the Social Security  
25 Act (42 U.S.C. 1396n), under a waiver under sec-

1       tion 1115 of such Act (42 U.S.C. 1315), or under  
2       section 1937, 1945, or 1945A of such Act (42  
3       U.S.C. 1396u-7, 1396w-4, 1396w-4a).

4 **SEC. 22. GUIDANCE AND TECHNICAL ASSISTANCE FOR**  
5                   **STATES TO SUPPORT ACCESS TO COMMUNITY**  
6                   **SOCIAL SUPPORTS AND SERVICES.**

7       (a) GUIDANCE.—Not later than 18 months after the  
8       date of enactment of this Act, the Secretary of Health and  
9       Human Services shall provide guidance to encourage and  
10      support collaboration and coordination between States,  
11      Medicaid managed care organizations, prepaid inpatient  
12      health plans, prepaid ambulatory health plans, and com-  
13      munity-based organizations, when appropriate, in pro-  
14      viding beneficiaries with connections to social supports  
15      and other non-medical services that affect or improve  
16      health outcomes, particularly mental health and substance  
17      use disorder health outcomes. Such guidance shall include  
18      the following:

19           (1) A description of common components and  
20      key considerations for agreements between Medicaid  
21      managed care organizations, prepaid inpatient  
22      health plans, prepaid ambulatory health plans, and  
23      community-based organizations with respect to pro-  
24      viding beneficiaries such connections.

1           (2) Considerations for complying with applica-  
2           ble requirements and restrictions under the Health  
3           Insurance Portability and Accountability Act of  
4           1996 (42 U.S.C. 1320d–2 note), including the pri-  
5           vacy, security, and breach notification regulations  
6           promulgated under section 264(c) of such Act, and  
7           part 2 of title 42, Code of Federal Regulations.

8           (3) Information on financing and allowable re-  
9           imbursement, rate setting, and funding parameters  
10          for the coordination with and provision of non-med-  
11          ical services under Medicaid and CHIP.

12          (4) Measurement of health outcomes of bene-  
13          ficiaries using allowable data sharing agreements be-  
14          tween States, Medicaid managed care organizations,  
15          prepaid inpatient health plans, prepaid ambulatory  
16          health plans, and community-based organizations.

17          (5) Strategies to incorporate non-clinical profes-  
18          sionals and paraprofessionals, such as trained peer  
19          support specialists, in care teams and care coordina-  
20          tion efforts.

21          (6) Strategies to develop and encourage States  
22          to use value-based payment financing mechanisms to  
23          improve health outcomes and encourage collabora-  
24          tions between Medicaid managed care organizations,

1 prepaid inpatient health plans, prepaid ambulatory  
2 health plans, and community-based organizations.

3 (7) Strategies for States to help Medicaid man-  
4 aged care organizations, prepaid inpatient health  
5 plans, and prepaid ambulatory health plans identify  
6 social needs of beneficiaries, which may include food  
7 services, housing support services, employment sup-  
8 ports, and transportation support, and to connect  
9 beneficiaries to social supports provided by commu-  
10 nity-based organizations.

11 (b) TECHNICAL ASSISTANCE.—The Secretary of  
12 Health and Human Services shall provide technical assist-  
13 ance to States to support activities related to the guidance  
14 provided under subsection (a). Such support may include  
15 direct one-on-one technical assistance, peer-to-peer learn-  
16 ing, affinity group facilitation, cross-industry convenings,  
17 webinars, and other supports that advance collaborations  
18 between Medicaid managed care organizations, prepaid in-  
19 patient health plans, prepaid ambulatory health plans, and  
20 community-based organizations.

21 (c) DEFINITIONS.—In this section:

22 (1) BENEFICIARY.—The term “beneficiary”  
23 means an individual who is enrolled in a State plan  
24 or under a waiver in Medicaid or CHIP under a fee-  
25 for-service model, an alternative payment model (in-

1 including a payment model specified by the Secretary  
2 under section 1115A(e) of the Social Security Act  
3 (42 U.S.C. 1316a(e)) for implementation on a na-  
4 tionwide basis), or through a Medicaid managed care  
5 organization, prepaid inpatient health plan, or pre-  
6 paid ambulatory health plan.

7 (2) **COMMUNITY-BASED ORGANIZATION.**—The  
8 term “community-based organization” means an or-  
9 ganization, including a governmental organization,  
10 such as a county or local organization, a local or re-  
11 gional nonprofit organization, a nongovernmental or-  
12 ganization, or a tribal organization, that provides in-  
13 dividuals with non-medical services and other social  
14 supports that may include food services, housing  
15 services, employment supports, and transportation  
16 support.

17 **SEC. 23. SUPPORTING ACCESS TO A CONTINUUM OF CRI-**  
18 **SIS RESPONSE SERVICES UNDER MEDICAID**  
19 **AND CHIP.**

20 (a) **GUIDANCE.**—Not later than 18 months after the  
21 date of enactment of this Act, the Secretary, in coordina-  
22 tion with the Administrator of the Centers for Medicare  
23 & Medicaid Services and the Assistant Secretary for Men-  
24 tal Health and Substance Use, shall issue guidance to

1 States regarding Medicaid and CHIP that includes the fol-  
2 lowing:

3 (1) Establishes, in consultation with health care  
4 providers and stakeholders with expertise in mental  
5 health and substance use disorder crisis response  
6 services, recommendations for an effective con-  
7 tinuum of crisis response services that—

8 (A) includes crisis call centers and 988 cri-  
9 sis services hotlines, mobile crisis teams, crisis  
10 response services delivered in home, community,  
11 residential facility, and hospital settings, and  
12 coordination with follow-on mental health and  
13 substance use disorder services, such as inten-  
14 sive outpatient and partial hospitalization pro-  
15 grams, as well as connections to social services  
16 and supports;

17 (B) promotes access to appropriate and  
18 timely mental health and substance use disorder  
19 crisis response services in the least restrictive  
20 setting appropriate to an individual's needs;  
21 and

22 (C) promotes culturally competent, trau-  
23 ma-informed care, and crisis de-escalation.

24 (2) Outlines the Federal authorities through  
25 which States may finance and enhance under Med-



1       icaid and CHIP the availability of crisis response  
2       services across each stage of the continuum of crisis  
3       response services.

4           (3) Addresses how States under Medicaid and  
5       CHIP may support the ongoing implementation of  
6       crisis call centers and 988 crisis services hotlines  
7       and how Medicaid administrative funding, including  
8       enhanced matching, and the Medicaid Information  
9       Technology Architecture 3.0 framework, may be  
10      used to establish or enhance regional or statewide  
11      crisis call centers, including 988 crisis services hot-  
12      lines, that coordinate in real time.

13          (4) Identifies how States under Medicaid and  
14      CHIP may support access to crisis response services  
15      that are responsive to the needs of children, youth,  
16      and families, including through CHIP health serv-  
17      ices initiatives, behavioral disorder-specific crisis re-  
18      sponse, trained peer support services, and estab-  
19      lishing or enhancing crisis call centers that are  
20      youth-focused.

21          (5) Identifies policies and practices to meet the  
22      need for crisis response services with respect to dif-  
23      fering patient populations, including urban, rural,  
24      and frontier communities, differing age groups, cul-  
25      tural and linguistic minorities, individuals with co-

1 occurring mental health and substance use disorder  
2 crises, and individuals with disabilities.

3 (6) Identifies policies and practices to promote  
4 evidence-based suicide risk screenings and assess-  
5 ments.

6 (7) Identifies strategies to facilitate timely pro-  
7 vision of crisis response services, including how  
8 States can enable access to crisis response services  
9 without requiring a diagnosis, the use of presump-  
10 tive eligibility at different stages of the continuum of  
11 crisis response services, the use of telehealth to de-  
12 liver crisis response services, strategies to make cri-  
13 sis response services available 24/7 in medically un-  
14 derserved regions, and best practices used by States  
15 and health providers for maximizing capacity to de-  
16 liver crisis response services, such as identifying and  
17 repurposing available beds, space, and staff for crisis  
18 response services.

19 (8) Describes best practices for coordinating  
20 Medicaid and CHIP funding with other payors and  
21 sources of Federal funding for mental health and  
22 substance use disorder crisis response services, and  
23 best practices for Medicaid and CHIP financing  
24 when the continuum of crisis response services  
25 serves individuals regardless of payor.

1           (9) Describes best practices for establishing ef-  
2           fective connections with follow-on mental health and  
3           substance use disorder services, as well as with so-  
4           cial services and supports.

5           (10) Describes best practices for coordinating  
6           and financing a continuum of crisis response services  
7           through Medicaid managed care organizations, pre-  
8           paid inpatient health plans, prepaid ambulatory  
9           health plans, and fee-for-service delivery systems, in-  
10          cluding when States carve-out from delivery through  
11          Medicaid managed care organizations, prepaid inpa-  
12          tient health plans, prepaid ambulatory health plans,  
13          or fee-for-service systems, mental health or sub-  
14          stance use disorder benefits or a subset of such serv-  
15          ices.

16          (11) Identifies strategies and best practices for  
17          measuring and monitoring utilization of, and out-  
18          comes related to, crisis response services.

19          (b) TECHNICAL ASSISTANCE CENTER.—

20           (1) IN GENERAL.—Not later than 18 months  
21          after the date of enactment of this Act, the Sec-  
22          retary of Health and Human Services, in coordina-  
23          tion with the Administrator of the Centers for Medi-  
24          care & Medicaid Services and the Assistant Sec-  
25          retary for Mental Health and Substance Use, shall

1 establish a technical assistance center to help States  
2 under Medicaid and CHIP design, implement, or en-  
3 hance a continuum of crisis response services for  
4 children, youth, and adults. Such technical assist-  
5 ance shall, at least in part, provide support to States  
6 in—

7 (A) leveraging the Federal authorities  
8 through which Medicaid and CHIP may finance  
9 mental health and substance use disorder crisis  
10 response services;

11 (B) coordinating Medicaid and CHIP  
12 funds with other sources of Federal funding for  
13 mental health and substance use disorder crisis  
14 response services; and

15 (C) adopting the best practices and strate-  
16 gies identified in the guidance issued under sub-  
17 section(a).

18 (2) COMPENDIUM OF BEST PRACTICES.—The  
19 Secretary of Health and Human Services shall de-  
20 velop and maintain a publicly available compendium  
21 of best practices for the successful operation under  
22 Medicaid and CHIP of a continuum of crisis re-  
23 sponse services. The Secretary shall update the in-  
24 formation available through the compendium at least  
25 annually.

1 (c) PLANNING GRANTS FOR STATES TO DEVELOP  
2 UNDER MEDICAID AND CHIP A CONTINUUM OF CRISIS  
3 RESPONSE SERVICE.—

4 (1) IN GENERAL.—Not later than 1 year after  
5 the date on which the Secretary of Health and  
6 Human Services issues guidance under subsection  
7 (a), the Secretary shall award grants to all States  
8 that submit timely, complete applications for such  
9 grants which meet such requirements as the Sec-  
10 retary shall establish, for the purpose of preparing  
11 and submitting a crisis plan described in paragraph  
12 (3) in order to establish or enhance a continuum of  
13 crisis response services under Medicaid and CHIP  
14 which incorporates best practices and strategies  
15 identified in the guidance issued under subsection  
16 (a).

17 (2) REQUIRED ACTIVITIES.—A State awarded a  
18 grant under this subsection shall use the grant  
19 funds to do the following:

20 (A) Assess the need for crisis response  
21 services for children, youth, and adults in the  
22 State who are eligible for assistance under Med-  
23 icaid or CHIP.

24 (B) Identify State legal and regulatory  
25 barriers to providing mental health and sub-

1           stance use disorder crisis response services  
2           under the State programs under Medicaid and  
3           CHIP that the State will seek to address to  
4           support improved access to a continuum of cri-  
5           sis response services under such programs.

6           (C) Identify how the State will leverage  
7           Federal authorities under the State programs  
8           under Medicaid and CHIP to finance mental  
9           health and substance use disorder crisis serv-  
10          ices, and coordinate such financing with other  
11          sources of Federal funds as appropriate, to im-  
12          plement and expand access to mental health  
13          and substance use disorder crisis response serv-  
14          ices under such programs.

15          (D) Consult with stakeholders in order to  
16          support access to culturally competent and  
17          trauma-informed care under the State pro-  
18          grams under Medicaid and CHIP, and to iden-  
19          tify and address the needs of underserved com-  
20          munities in the State.

21          (E) Identify strategies to support access to  
22          needed follow-on mental health and substance  
23          use disorder services, including by increasing  
24          access to community-based mental health and  
25          substance use disorder care providers.

1 (F) Identify strategies to measure and  
2 monitor crisis response services access, utiliza-  
3 tion, and outcomes.

4 (G) Such other activities as the Secretary  
5 may approve to support the design, implemen-  
6 tation, or enhancement under Medicaid and  
7 CHIP of a continuum of crisis response serv-  
8 ices.

9 (3) CRISIS PLAN.—Not later than 18 months  
10 after the date on which a State is awarded a grant  
11 under this subsection, the State shall submit to the  
12 Secretary a plan for implementing or enhancing  
13 under Medicaid and CHIP a continuum of crisis re-  
14 sponse services. Such plan shall describe, at a min-  
15 imum, the results of the required activities carried  
16 out under paragraph (2), including the results of the  
17 needs assessment described in subparagraph (A) of  
18 such paragraph, how the State will ensure that the  
19 plan is implemented, and how the State will measure  
20 over time the State's progress in carrying out the  
21 plan.

22 **[(d) PLANNING GRANT AND TECHNICAL ASSIST-**  
23 **ANCE FUNDING.—]**

1 **SEC. 24. MAKING PERMANENT STATE OPTION TO PRO-**  
2 **VIDE QUALIFYING COMMUNITY-BASED MO-**  
3 **BILE CRISIS INTERVENTION SERVICES.**

4 Section 1947 of the Social Security Act (42 U.S.C.  
5 1396w-6) is amended—

6 (1) in subsection (a), by striking “during the 5-  
7 year period”;

8 (2) in subsection (c), by striking “occurring  
9 during the period described in subsection (a) that a  
10 State” and inserting “in which a State provides  
11 medical assistance for qualifying community-based  
12 mobile crisis intervention services under this section  
13 and”; and

14 (3) in subsection (d)(2)—

15 (A) in subparagraph (A), by striking “for  
16 the fiscal year preceding the first fiscal quarter  
17 occurring during the period described in sub-  
18 section (a)” and inserting “for the fiscal year  
19 preceding the first fiscal quarter in which the  
20 State provides medical assistance for qualifying  
21 community-based mobile crisis intervention  
22 services under this section”; and

23 (B) in subparagraph (B), by striking “oc-  
24 ccurring during the period described in sub-  
25 section (a)” and inserting “occurring during a  
26 fiscal quarter”.