

103<sup>D</sup> CONGRESS  
1<sup>ST</sup> SESSION

# S. RES. 107

To express the sense of the Senate that comprehensive and equitable mental health and substance abuse benefits should be included in any comprehensive health care bill passed by the Congress.

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## IN THE SENATE OF THE UNITED STATES

MAY 12 (legislative day, APRIL 19), 1993

Mr. WELLSTONE (for himself, Mr. SIMON, and Mr. INOUE) submitted the following resolution; which was referred to the Committee on Labor and Human Resources

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## RESOLUTION

To express the sense of the Senate that comprehensive and equitable mental health and substance abuse benefits should be included in any comprehensive health care bill passed by the Congress.

1       *Resolved,*

2       **SECTION 1. SENSE OF THE SENATE.**

3       It is the sense of the Senate that the model mental  
4 health and substance abuse services provisions described  
5 in this resolution should be considered in determining  
6 those mental health and substance abuse services to be  
7 included as part of any benefits package that is contained

1 in any comprehensive health care or health insurance re-  
2 form bill passed by the Congress.

3 **SEC. 2. MODEL SERVICES AND COMMISSION.**

4 (a) SERVICES.—The model services described in sec-  
5 tion 1 should include:

6 (1) IN GENERAL.—Mental health and substance  
7 abuse services described in this resolution, including  
8 all medically or psychologically necessary services re-  
9 lated to the prevention, diagnosis, treatment, and re-  
10 habilitation of mental illnesses and substance abuse  
11 disorders and the promotion of mental health.

12 (2) SERVICES.—To be included in coverage  
13 under this section, services must be provided as part  
14 of a continuum of care which includes—

15 (A) assessment, diagnosis, and referral  
16 services;

17 (B) crisis intervention services including—

18 (i) intervention services designed to  
19 facilitate entry into or continuation in  
20 treatment; and

21 (ii) hospital, nonhospital, or ambula-  
22 tory detoxification programs;

23 (C) outpatient services provided in a vari-  
24 ety of State-licensed settings, including hos-  
25 pitals, mental health or substance abuse clinics

1 or centers, office practices or school-based  
2 health services, including services ranging from  
3 brief counseling to day and evening treatment  
4 and family therapy, limited to the extent pro-  
5 vided according to a utilization review that is  
6 conducted at intervals determined appropriate  
7 by the Secretary of Health and Human Services  
8 (or the Federal entity responsible for the ad-  
9 ministration of the comprehensive program), to  
10 ensure that services are being appropriately  
11 utilized;

12 (D) partial hospitalization (such as day  
13 and evening treatment programs for seriously  
14 emotionally disturbed children and adolescents  
15 and seriously mentally ill adults, and other  
16 types of day programs);

17 (E) psychosocial rehabilitation services;

18 (F) pharmacotherapeutic interventions;

19 (G) residentially based treatment, includ-  
20 ing halfway house care and three quarter-way  
21 house care;

22 (H) inpatient care that includes services  
23 provided at hospitals, other inpatient facilities,  
24 community-based facilities, and residential  
25 treatment centers as clinically necessary, to the

1 extent provided according to a utilization review  
2 that is conducted at intervals determined appro-  
3 priate by the Secretary of Health and Human  
4 Services (or the Federal entity responsible for  
5 the administration of the comprehensive pro-  
6 gram), to ensure that adequate care is being  
7 provided in the least restrictive and most clini-  
8 cally appropriate setting for the needs of the  
9 patient; and

10 (I) care coordination services, including—

11 (i) the coordination and monitoring of  
12 mental health care and substance abuse  
13 services; and

14 (ii) the provision of transition man-  
15 agement from inpatient facilities to other  
16 community based care services (or vice  
17 versa) and assisting patients with identify-  
18 ing and gaining access to appropriate an-  
19 cillary services (such as housing assistance  
20 programs, dental care, education, and job  
21 placement and training).

22 (b) CARE COORDINATION.—

23 (1) OBJECTIVES OF CARE COORDINATION.—The  
24 objectives of the care coordination services described  
25 in subsection (a)(2)(I) shall be to ensure appropriate

1 comprehensive, continuous, and coordinated care the  
2 amount, duration, and scope of which shall be based  
3 on the clinical needs of the patient.

4 (2) ELIGIBILITY.—

5 (A) IN GENERAL.—Patients with a serious  
6 mental illness or a substance abuse disorder (as  
7 defined by the Secretary or responsible Federal  
8 entity) or who have encountered repeated treat-  
9 ment failures (as defined by the Federal entity  
10 responsible for the administration of the com-  
11 prehensive program) shall be eligible for care  
12 coordination services—

13 (i) on entry into a crisis intervention  
14 setting or inpatient service setting as de-  
15 scribed in subparagraphs (B) and (H) of  
16 subsection (a)(2); or

17 (ii) on referral by a qualified mental  
18 health or substance abuse treatment pro-  
19 fessional.

20 (B) EXEMPTION.—Patients who enter  
21 services described in subparagraph (B) or (H)  
22 of subsection (a)(2) may be exempt from care  
23 coordination services at the discretion of a  
24 qualified professional if the qualified profes-

1           sional determines that such services are not  
2           clinically indicated.

3           (C) PREVIOUS CONDITIONS.—Individuals  
4           whose previous condition entitled them to care  
5           coordination services under this section will be  
6           eligible for care coordination services after com-  
7           pletion of treatment or discharge from a pro-  
8           gram for a period of time to be determined by  
9           the Secretary or responsible Federal entity.

10          (3) STANDARDS FOR CARE COORDINATION.—

11           (A) IN GENERAL.—To be covered under  
12           the provisions of this subsection, care coordina-  
13           tion services must be provided by a care coordi-  
14           nator that—

15                   (i) has successfully completed formal  
16                   training, or any other entry path deter-  
17                   mined appropriate by the State;

18                   (ii) is supervised by a health profes-  
19                   sional with licensing and field experience  
20                   requirements as determined appropriate by  
21                   the State; and

22                   (iii) for patients receiving services  
23                   from a Certified Employee Assistance Pro-  
24                   fessional (CEAP), has worked with a  
25                   CEAP in coordinating care.

1 (B) REQUIREMENTS.—Care coordination  
2 services shall be delivered pursuant to appro-  
3 priate State requirements that—

4 (i) provide for services according to an  
5 organizational plan developed by the State;

6 (ii) provide for the option of develop-  
7 ing different levels of care coordination  
8 services for subgroups;

9 (iii) provide for the establishment of  
10 care coordination guidelines that detail the  
11 levels of care coordination services pro-  
12 vided, and that, at a minimum, will iden-  
13 tify—

14 (I) the population targeted;

15 (II) the range of services offered;

16 and

17 (III) the maximum caseload size  
18 for each care coordination service  
19 level; and

20 (iv) establish safeguards to assure  
21 that care coordinators receive no financial  
22 benefits from treatment decisions or place-  
23 ments.

24 (4) REQUEST FOR DIFFERENT COORDINA-  
25 TOR.—Patients may ask for a different care coordi-

1 nator or refuse care coordination after having been  
2 offered such service.

3 (c) UTILIZATION REVIEW STANDARDS.—Utilization  
4 review for services provided pursuant to this section shall  
5 adhere to the following minimum standards:

6 (1) All utilization reviews shall be supervised by  
7 a physician, or other professional licensed in that  
8 State to provide the services under review.

9 (2) The utilization criteria to be applied shall  
10 be provided to patients and providers upon request  
11 and a written explanation of the basis for any denial  
12 of payment based upon such a review shall be pro-  
13 vided to the provider or patient upon request.

14 (3) Based on consultation with care coordina-  
15 tors, care providers, and patients, utilization review-  
16 ers shall make the final decision as to whether a pa-  
17 tient's benefits can be extended beyond its limits,  
18 subject to the appeals process.

19 (4) Based on consultation with care coordina-  
20 tors and patients, care providers shall make the final  
21 decision as to the appropriate course of treatment  
22 for a patient when treatment decisions are between  
23 utilization review intervals, subject to the appeals  
24 process.

1           (5) Utilization review and appeals shall be con-  
2           ducted promptly in order not to disrupt a course of  
3           treatment and providers shall not deny necessary  
4           care while a review or appeal is pending.

5           (6) During an appeal or alternative dispute res-  
6           olution under this subparagraph, providers shall  
7           have the right to be reviewed by an equivalent pro-  
8           fessional.

9           (7) The utilization review system may not per-  
10          mit any incentive or contingent fee arrangement  
11          based on the reduction or denial of services through  
12          utilization review.

13          (d) DUTIES OF SECRETARY.—The Secretary (or the  
14          Federal entity responsible for the administration of the  
15          comprehensive health care program) shall—

16                (1) authorize a mechanism for recognizing an  
17                approved care coordination plan that shall include  
18                timing intervals for utilization review and that is de-  
19                vised by the care coordinator with input from the  
20                utilization review professional, if there is one, the  
21                mental health or substance abuse treatment provider  
22                and the patient;

23                (2) devise a mechanism to review and monitor  
24                care coordination and utilization review guidelines;

1           (3) define an appeal and alternative dispute res-  
2           olution process by which care coordinators, care pro-  
3           viders and patients can appeal utilization review  
4           treatment decisions; and

5           (4) determine intervals for utilization review,  
6           and which services should be subject to review.

7           (e) COMMISSION ON MENTAL HEALTH AND SUB-  
8           STANCE ABUSE.—

9           (1) ESTABLISHMENT.—With respect to model  
10          services covered under this section the Secretary of  
11          Health and Human Services shall establish a Com-  
12          mission, under the auspices of the Substance Abuse  
13          and Mental Health Services Administration, in col-  
14          laboration with the National Institute of Mental  
15          Health, the National Institute on Drug Abuse, the  
16          National Institute on Alcohol Abuse and Alcoholism,  
17          and other appropriate agencies, to study, prepare  
18          and submit to the appropriate committees of Con-  
19          gress and to the Secretary a report containing fur-  
20          ther recommendations concerning the manner in  
21          which the benefits for mental disorders and sub-  
22          stance abuse treatment services should be modified  
23          to best meet the objectives of this Resolution.

24          (2) DUTIES.—The duties of the Commission es-  
25          tablished under paragraph (1) should include—

1 (A) studying changes in utilization pat-  
2 terns and costs which accompany the provision  
3 of mental health and substance abuse treatment  
4 benefits contained in this Resolution;

5 (B) making further recommendations on  
6 ways to create a continuum of care and encour-  
7 age the provision of care in the least restrictive,  
8 most clinically appropriate setting;

9 (C) developing a standard set of practices  
10 for care coordination services, including—

11 (i) the range of care coordination  
12 services that should be offered for a spe-  
13 cific target population;

14 (ii) the organizational structure in  
15 which care coordination services should be  
16 based;

17 (iii) the minimum training require-  
18 ments for care coordinators; and

19 (iv) standards for the clinical neces-  
20 sity of care coordination services; and

21 (D) studying peer care coordination and  
22 making recommendations regarding the devel-  
23 opment and implementation of peer care coordi-  
24 nation services.

1           (3) REPORT.—The Commission should make its  
2           first report not later than 1 year after the date of  
3           the enactment of any comprehensive health care bill  
4           and at 2 year intervals thereafter.

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