

110TH CONGRESS  
1ST SESSION

# H. R. 4232

To improve mental and substance use health care.

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IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 15, 2007

Mr. KENNEDY (for himself and Mr. RAMSTAD) introduced the following bill;  
which was referred to the Committee on Energy and Commerce

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## A BILL

To improve mental and substance use health care.

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; FINDINGS.**

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Improving the Quality of Mental and Substance Use  
6 Health Care Act of 2007”.

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

Sec. 1. Short title; table of contents; findings.

Sec. 2. Evidence-based mental and substance use health care.

Sec. 3. Improved coordination of care.

Sec. 4. Information technology for mental health and substance use health care  
providers.

Sec. 5. Council on the Mental Health and Substance Use Health Care Work-  
force.

Sec. 6. Funding of research through national centers of excellence.

- Sec. 7. Patient-centered care.
- Sec. 8. Uniform methodologies for reimbursing behavioral health claims.
- Sec. 9. Study on use of public mental health and addiction services by individuals with private health coverage.
- Sec. 10. High-quality mental health and substance use health care Medicaid demonstration project.
- Sec. 11. Medicaid requirement for State repeal of laws denying health benefits coverage based on intoxication.

1           (c) FINDINGS.—The Congress finds the following:

2                   (1) In its study, “Improving the Quality of  
3           Health Care for Mental and Substance-Use Condi-  
4           tions”, the Institute of Medicine found that each  
5           year, more than 33,000,000 Americans use health  
6           care services for their mental problems and illnesses,  
7           and for conditions resulting from their use of alco-  
8           hol, inappropriate use of prescription medications,  
9           or, less often, illegal drugs. In the United States,  
10          mental and substance use illnesses (which often  
11          occur together) are the leading cause of death and  
12          disability for women, the highest for men ages 15 to  
13          44, and the second highest for all men.

14                   (2) Effective treatments for these medical ill-  
15          nesses exist, but multiple barriers prevent many  
16          from receiving them. The consequences of these bar-  
17          riers are serious for these individuals and their fami-  
18          lies, for their employers and the workforce, for the  
19          Nation’s economy, and for the Nation’s education,  
20          welfare, and justice systems. The Institute of Medi-  
21          cine further found that a comprehensive approach is

1 needed to remedy this issue that addresses the dis-  
2 tinguishing characteristics of mental and substance  
3 use health care in the United States.

4 (3) The Institute of Medicine recommended a  
5 multifaceted and comprehensive strategy to improve  
6 the quality of mental and substance use health care  
7 in the United States and thereby ensure that—

8 (A) individual patient preferences, needs,  
9 and values prevail in the face of residual stig-  
10 ma, discrimination, and coercion into treatment;

11 (B) the necessary infrastructure exists to  
12 produce scientific evidence more quickly and  
13 promote its application in patient care;

14 (C) multiple providers' care of the same  
15 patient is coordinated;

16 (D) emerging information technology re-  
17 lated to health care benefits people with mental  
18 or substance use problems and illnesses;

19 (E) the health care workforce has the edu-  
20 cation, training, and capacity to deliver high-  
21 quality care for mental and substance use con-  
22 ditions; and

23 (F) government programs, employers, and  
24 other group purchasers of health care for men-  
25 tal and substance use conditions use their dol-



1 including interventions for various age and eth-  
2 nic groups;

3 (B) recommend procedure and payment  
4 codes and definitions for such evidence-based  
5 interventions and tools for their use in adminis-  
6 trative datasets under part C of title XI of the  
7 Social Security Act and recommend standards  
8 for health data collection relating to such inter-  
9 ventions;

10 (C) identify on an annual basis priority  
11 areas for research on—

12 (i) the development of new evidence-  
13 based preventive, diagnostic, and thera-  
14 peutic interventions;

15 (ii) comparative effectiveness and cost  
16 effectiveness of existing interventions and  
17 new evidence-based interventions; and

18 (iii) how best to translate new evi-  
19 dence-based findings into practice in com-  
20 munity-based clinical settings.

21 (D) recommend to the Director of the Na-  
22 tional Institute of Mental Health, the Director  
23 of the National Institute on Drug Abuse, the  
24 Director of the National Institute on Alcohol  
25 Abuse and Alcoholism, and other Federal offi-

1           cials methods to coordinate the conduct or sup-  
2           port of research described in subparagraph (C);

3           (E) collect, synthesize, and disseminate in-  
4           formation on research concerning evidence-  
5           based strategies for promoting the use of evi-  
6           dence-based preventive, diagnostic, and thera-  
7           peutic interventions;

8           (F) provide guidance on effective mental  
9           and substance use interventions to Federal  
10          agencies that provide or support such interven-  
11          tions, including the Centers for Medicare &  
12          Medicaid Services, the Substance Abuse and  
13          Mental Health Services Administration, the  
14          Agency for Healthcare Research and Quality,  
15          the Centers for Disease Control and Prevention,  
16          the Health Resources and Services Administra-  
17          tion, the Department of Defense, the Depart-  
18          ment of Veterans Affairs, the Indian Health  
19          Service, and the Bureau of Prisons; and

20          (G) periodically assess the progress of  
21          agencies described in subparagraph (F) in im-  
22          plementing such interventions.

23          (3) CONSULTATION.—In carrying out this sec-  
24          tion, the Commission shall—

1 (A) seek consultation from leading public  
2 and private State and national authorities, and  
3 consolidate evidence, opinions, and findings of  
4 these authorities as they see fit; and

5 (B) ensure that interested parties have op-  
6 portunities to provide input before the Commis-  
7 sion makes recommendations or decisions.

8 (4) MEMBERSHIP.—The Commission shall be  
9 composed of not fewer than 15 and not more than  
10 20 members, who shall be appointed by the Presi-  
11 dent from among experts in evidence-based mental  
12 and substance use health care. Such members shall  
13 include—

14 (A) researchers;

15 (B) practitioners from various specialties,  
16 professions, and practice settings;

17 (C) mental health and substance abuse  
18 health care consumers; and

19 (D) health care payers.

20 (5) TERMS.—

21 (A) IN GENERAL.—Each member of the  
22 Commission shall be appointed for a term of 4  
23 years, except as provided in subparagraphs (B)  
24 and (C).

1           (B) TERMS OF INITIAL APPOINTEES.—As  
2           designated by the President at the time of ap-  
3           pointment, of the members of the Commission  
4           first appointed,  $\frac{1}{4}$  shall each be appointed for  
5           terms of 1, 2, and 3 years and the remainder  
6           shall be appointed for a term of 4 years.

7           (C) VACANCIES.—Any member appointed  
8           to fill a vacancy occurring before the expiration  
9           of the term for which the member's predecessor  
10          was appointed shall be appointed only for the  
11          remainder of that term. A member may serve  
12          after the expiration of that member's term until  
13          a successor has taken office.

14          (b) CMS ANNUAL REPORT.—The Administrator of  
15          the Centers for Medicare & Medicaid Services shall report  
16          annually to the Congress on the extent to which the Med-  
17          icaid program under title XIX of the Social Security Act  
18          provides coverage of evidence-based interventions identi-  
19          fied by the Commission, including—

20                (1) a list of those interventions not so covered  
21                and the reasons why they are not covered;

22                (2) a justification for each evidence-based inter-  
23                vention that is not so covered; and

24                (3) a list of evidence-based interventions that  
25                can be covered only with statutory change.

1 (c) CONSTRUCTION REGARDING APPLICATION.—  
2 Nothing in this section shall be construed as requiring,  
3 as a condition of payment under the Medicaid program  
4 under title XIX of the Social Security Act, that an inter-  
5 vention must be an evidence-based practice.

6 (d) PROMPT DEVELOPMENT AND IMPLEMENTATION  
7 OF CLAIMS PROCESSING AND DATA CODES.—The Sec-  
8 retary, acting through the Administrator of the Centers  
9 for Medicare & Medicaid Services, shall establish, or enter  
10 into an agreement with, one or more entities for the pur-  
11 pose of developing, as soon as practicable after the date  
12 of the enactment of this Act, codes that should be applied  
13 to claims processing and health data collection activities  
14 as recommended by the Commission pursuant to sub-  
15 section (a)(2)(B).

16 (e) DEFINITION.—In this section, the term “interven-  
17 tion” means a preventive, diagnostic, or therapeutic action  
18 with respect to a mental health or substance use disease  
19 process.

20 **SEC. 3. IMPROVED COORDINATION OF CARE.**

21 (a) INTERAGENCY COLLABORATIVE GROUP.—

22 (1) ESTABLISHMENT.—The Secretary shall con-  
23 vene an interagency collaborative group (in this sec-  
24 tion referred to as the “interagency collaborative  
25 group”) to provide for the coordination at the clin-

1 ical and programmatic level of mental health and  
2 substance use services and primary care services,  
3 funded in whole or in part through the Department  
4 of Health and Human Services, the Department of  
5 Justice, the Department of Veterans Affairs, the De-  
6 partment of Defense, and the Department of Edu-  
7 cation, using one or more evidence-based coordina-  
8 tion models, such as the following:

9 (A) Formal agreements between mental  
10 health, substance use, and primary care pro-  
11 viders.

12 (B) Case management of mental health,  
13 substance use, and primary care.

14 (C) Co-location of mental health, substance  
15 use, and primary care providers.

16 (D) Delivery of mental health, substance  
17 use, and primary care in integrated practices.

18 (2) DUTIES.—The interagency collaborative  
19 group shall—

20 (A) develop a plan for government agencies  
21 to implement the recommendations made by the  
22 Commission for Evidence-Based Mental and  
23 Substance Use Health Care;

1 (B) coordinate with States and appropriate  
2 public stakeholders to foster interagency col-  
3 laboration at the State and local level;

4 (C) make recommendations to the Presi-  
5 dent and the Congress to break down barriers  
6 to coordination of existing Federal programs  
7 funding mental health and substance use serv-  
8 ices and to allow for more effective integration  
9 of such programs across agencies and pro-  
10 grams;

11 (D) assess progress toward such coordina-  
12 tion through development and monitoring of  
13 performance measures of coordination; and

14 (E) report to the Congress biannually on  
15 the status of such coordination.

16 (3) COMPOSITION.—The interagency collabo-  
17 rative group shall include the following members:

18 (A) The Secretary of Health and Human  
19 Services (or the Secretary's designee).

20 (B) The Attorney General (or the Attorney  
21 General's designee).

22 (C) The Secretary of Veterans Affairs (or  
23 such Secretary's designee).

24 (D) The Secretary of Defense (or such  
25 Secretary's designee).

1                   (E) The Secretary of Education (or such  
2                   Secretary's designee).

3                   (4) MEETINGS.—The interagency collaborative  
4                   group shall meet not less than quarterly.

5                   (5) STAFF AND SUPPORT.—The Secretary shall  
6                   provide, without the requirement for reimbursement,  
7                   staff and other administrative support necessary for  
8                   the operation of the interagency collaborative group.

9                   (b) COORDINATED DELIVERY OF CARE.—The Fed-  
10                  eral agencies participating in the interagency collaborative  
11                  group shall modify internal policies and practices, to the  
12                  extent practicable and consistent with legal authority, in  
13                  order to implement one or more of the evidence-based co-  
14                  ordination models referred to in subsection (a)(1).

15                  (c) NO EFFECT ON HIPAA PRIVACY RULES.—Noth-  
16                  ing in this section shall be construed to alter the applica-  
17                  tion of rules promulgated under section 264(c) of the  
18                  Health Insurance Portability and Accountability Act of  
19                  1996.

20                  (d) GAO REPORT.—Not later than 2 years after the  
21                  date of the enactment of this Act, the Comptroller General  
22                  of the United States shall conduct a study and submit a  
23                  report to the Congress on the implementation of this sec-  
24                  tion.

1 (e) CLARIFICATION OF MEDICAID REIMBURSEMENT  
2 OPTIONS.—The Secretary shall provide, by regulation, for  
3 a change in the rules under title XIX of the Social Secu-  
4 rity Act relating to reimbursement for primary care serv-  
5 ices and mental health and substance use services to the  
6 same patient on the same day so as to permit payment  
7 for the legitimate provisions of both types of services on  
8 the same day to a patient.

9 **SEC. 4. INFORMATION TECHNOLOGY FOR MENTAL HEALTH**  
10 **AND SUBSTANCE USE HEALTH CARE PRO-**  
11 **VIDERS.**

12 (a) DEVELOPMENT AND IMPLEMENTATION OF  
13 PLAN.—The Secretary, acting through the National Coor-  
14 dinator for Health Information Technology and the Ad-  
15 ministrator of the Substance Abuse and Mental Health  
16 Services Administration, shall develop and implement a  
17 plan for ensuring that activities of the Department of  
18 Health and Human Services to promote the use of infor-  
19 mation technology by health care providers include pro-  
20 motion of information technology that is accessible and  
21 pertinent to mental health and substance use health care  
22 providers and consumers.

23 (b) CONTENTS OF PLAN.—The plan developed under  
24 subsection (a) shall address—

1           (1) how the development of an electronic health  
2 information infrastructure, including the awarding  
3 of grants and contracts to promote the use of elec-  
4 tronic health records (EHRs), personal health  
5 records (PHRs), regional health information organi-  
6 zations (RHIOs), and other forms of health informa-  
7 tion technology, and the establishment of data  
8 standards, will ensure that the needs of mental and  
9 substance use health care providers and consumers  
10 are met with particular emphasis on the privacy con-  
11 cerns of consumers;

12           (2) how financial incentives that are generally  
13 made available for the development of such infra-  
14 structure for health care providers can be provided  
15 to individual mental health and substance use clini-  
16 cians and organizations (and particularly publicly-  
17 funded providers) for investments in information  
18 technology to enable them to participate on a full  
19 and equal basis in the emerging electronic health in-  
20 frastructure;

21           (3) how any continuing technical assistance and  
22 training for developing virtual networks may be  
23 made available to give individual and small group  
24 providers of mental health and substance use serv-  
25 ices standard access to software, clinical and popu-

1 lation data and health records, and billing and clin-  
2 ical decision-support systems; and

3 (4) how to create and support a continuing  
4 mechanism to engage mental health and substance  
5 use stakeholders in the public and private sectors in  
6 developing consensus-based recommendations for  
7 data elements, standards, and processes needed to  
8 address unique aspects of information management  
9 related to mental and substance use healthcare.

10 (c) CONSIDERATION.—In awarding any grant or con-  
11 tract for the development or implementation of any com-  
12 ponent of a national electronic health infrastructure, the  
13 Secretary shall consider the application of such component  
14 to mental health and substance use health care and pro-  
15 viders of such care.

16 (d) CONTINUED PRIVACY PROTECTIONS.—In devel-  
17 oping or promoting the national electronic health infra-  
18 structure, the Secretary shall ensure that privacy and con-  
19 fidentiality requirements traditionally applicable to mental  
20 health and substance use health care continue to be ap-  
21 plied.

22 (e) INCLUSION OF INFORMATION IN REPORTS.—In  
23 preparing any report to the Congress relating to the devel-  
24 opment or implementation of a national electronic health  
25 infrastructure or the promotion of the use of health infor-

1 mation technology, the Secretary shall include information  
2 on such development, implementation, or promotion in the  
3 field of mental health and substance use treatment.

4 **SEC. 5. COUNCIL ON THE MENTAL HEALTH AND SUB-**  
5 **STANCE USE HEALTH CARE WORKFORCE.**

6 (a) ESTABLISHMENT.—The Secretary shall establish  
7 a public-private advisory group called the Council on the  
8 Mental Health and Substance Use Health Care Workforce  
9 (in this section referred to as the “Council”).

10 (b) DUTIES.—

11 (1) DEVELOPMENT OF COMPREHENSIVE  
12 PLAN.—The Council shall develop and publish a  
13 comprehensive plan for purpose of strengthening the  
14 capacity of the workforce to deliver high-quality  
15 mental health and substance use health care.

16 (2) PLAN CONTENTS.—The plan developed  
17 under this subsection shall—

18 (A) identify the specific clinical com-  
19 petencies that all mental health and substance  
20 use professionals should possess to be certified  
21 or licensed and the competencies, including a  
22 component of patient centered care, that should  
23 be maintained over time;

24 (B) propose national standards for the  
25 credentialing and licensure of mental health and

1 substance use health care providers based on  
2 core competencies that should be included in  
3 curricula and education programs across all the  
4 mental health and substance use disciplines and  
5 make recommendations regarding accreditation  
6 standards for mental health and substance use  
7 health care programs;

8 (C) propose programs for funding from  
9 Federal, State, and local governments and the  
10 private sector to address and resolve long-  
11 standing workforce issues such as diversity, cul-  
12 tural relevance, faculty development, training  
13 effectiveness, continuing shortages of well-  
14 trained clinicians needed to work with children  
15 and the elderly and in high-need areas, and pro-  
16 grams for training competent clinical super-  
17 visors and administrators; and

18 (D) provide for continuing assessment of  
19 mental health and substance use workforce  
20 trends, issues, and financing policies.

21 (3) EVALUATION; REPORTING.—On a biannual  
22 basis, the Council shall—

23 (A) conduct an evaluation of the extent to  
24 which the purpose specified in paragraph (1)  
25 has been met; and

1 (B) submit a report to the Congress on the  
2 results of such evaluation, including a descrip-  
3 tion of the status of the mental health and sub-  
4 stance use health care workforce.

5 (4) ASSISTANCE.—The Council shall collaborate  
6 with private sector coalitions to facilitate and imple-  
7 ment its recommendations.

8 (c) MEMBERSHIP.—

9 (1) NUMBER; APPOINTMENT; CHAIR.—The  
10 Council shall be composed of not less than 21 and  
11 not more than 25 individuals appointed by the Sec-  
12 retary. The Council shall elect a chair from among  
13 its members.

14 (2) PUBLIC SECTOR MEMBERS.—The Council  
15 shall include the following officials (or their des-  
16 ignees):

17 (A) The Assistant Secretary for Health in  
18 the Department of Health and Human Services.

19 (B) The Administrator of the Centers for  
20 Medicare & Medicaid Services.

21 (C) The Administrator of the Substance  
22 Abuse and Mental Health Services Administra-  
23 tion.

24 (D) The Secretary of Veterans Affairs.

1           (3) PRIVATE SECTOR MEMBERS.—The Council  
2 shall include representatives from the substance use  
3 and mental health services and consumer commu-  
4 nities who are not employees of the Federal Govern-  
5 ment. Such representatives shall be appointed by the  
6 Secretary without regard to the Federal civil service  
7 laws and shall include the following:

8           (A) One individual selected from full-time  
9 students enrolled in mental health training pro-  
10 grams.

11           (B) One individual selected from full-time  
12 students enrolled in substance use health care  
13 training programs.

14           (C) One individual selected from mental  
15 health consumers.

16           (D) One individual selected from substance  
17 use health care consumers.

18           (E) One individual selected from faculty  
19 members at mental health training facilities.

20           (F) One individual selected from faculty  
21 members at substance use health care training  
22 facilities.

23           (G) Five individuals selected from among  
24 leading professional associations in the various  
25 fields charged with carrying out mental health

1 and substance use services, including psychi-  
2 atry, addiction medicine, psychology, social  
3 work, psychiatric nursing, counseling, marriage  
4 and family therapy, pastoral counseling, psycho-  
5 social rehabilitation, and substance use treat-  
6 ment counselors.

7 (H) Five individuals selected from among  
8 leading professional licensing and credentialing  
9 entities in the various fields charged with car-  
10 rying out mental health and substance use serv-  
11 ices including psychiatry, addiction medicine,  
12 psychology, social work, psychiatric nursing,  
13 counseling, marriage and family therapy, pas-  
14 toral counseling, psychosocial rehabilitation,  
15 and substance use treatment counseling.

16 (4) SELECTION.—In selecting the members of  
17 the Council under paragraph (3), the Secretary shall  
18 ensure—

19 (A) the inclusion of both urban and rural  
20 members;

21 (B) a range of members from a variety of  
22 practice settings and including expertise in pre-  
23 vention and treatment across the lifespan;

1           (C) adequate representation of racial, eth-  
2           nic, religious, and economic diversity in its  
3           membership; and

4           (D) the members appointed under sub-  
5           paragraphs (G) and (H) of paragraph (3) are  
6           equitably distributed between those specializing  
7           in mental health services and those specializing  
8           in substance use services.

9           (5) TERMS.—

10           (A) IN GENERAL.—Each member of the  
11           Council under paragraph (3) shall be appointed  
12           for a term of 4 years, except that except as pro-  
13           vided in subparagraphs (B) and (C).

14           (B) TERMS OF INITIAL APPOINTEES.—As  
15           designated by the Secretary at the time of ap-  
16           pointment, of the members of the Council first  
17           appointed under paragraph (3),  $\frac{1}{4}$  shall each  
18           be appointed for terms of 1, 2, and 3 years and  
19           the remainder shall be appointed for a term of  
20           4 years.

21           (C) VACANCIES.—Any member appointed  
22           under paragraph (3) to fill a vacancy occurring  
23           before the expiration of the term for which the  
24           member's predecessor was appointed shall be  
25           appointed only for the remainder of that term.

1           A member may serve after the expiration of  
2           that member’s term until a successor has taken  
3           office.

4           (d) MEETINGS.—The Council shall conduct at least  
5   3 meetings each year.

6           (e) STAFF AND SUPPORT.—The Secretary shall pro-  
7   vide, without the requirement for reimbursement, staff  
8   and other administrative support necessary for the oper-  
9   ation of the Council.

10 **SEC. 6. FUNDING OF RESEARCH THROUGH NATIONAL CEN-**  
11 **TERS OF EXCELLENCE.**

12          (a) GRANTS.—The Director of the National Insti-  
13   tutes of Health (in this section referred to as the “Direc-  
14   tor of NIH”), acting through the Directors of the National  
15   Institute of Mental Health, the National Institute of Drug  
16   Abuse, and the National Institute on Alcohol Abuse and  
17   Alcoholism, and in consultation with the Administrator of  
18   the Substance Abuse and Mental Health Services Admin-  
19   istration, shall make grants to entities to fund a network  
20   of national centers of excellence in mental health and sub-  
21   stance use health care.

22          (b) USE OF FUNDS.—As a condition on receipt of  
23   a grant under this section, an entity shall agree to use  
24   the grant to establish or support one or more centers of

1 excellence in mental health and substance use health care.

2 Each such center shall—

3           (1) integrate basic, clinical, or health services  
4           research with interventions in a range of usual set-  
5           tings of care delivery and involve a broad cross-sec-  
6           tion of mental health and substance use health care  
7           stakeholders; and

8           (2) develop innovative approaches to tie to-  
9           gether research and practice in order to develop a  
10          research agenda relevant to providers of mental  
11          health and substance use health care services in a  
12          range of usual settings of care.

13          (c) **AUTHORIZATION OF APPROPRIATIONS.**—To carry  
14          out this section, there are authorized to be appropriated  
15          \$10,000,000 for fiscal year 2008, \$15,000,000 for fiscal  
16          year 2009, \$20,000,000 for fiscal year 2010, \$25,000,000  
17          for fiscal year 2011, and such sums as may be necessary  
18          for each subsequent fiscal year.

19 **SEC. 7. PATIENT-CENTERED CARE.**

20          (a) **PROMOTION IN FEDERAL PROGRAMS.**—With re-  
21          spect to any program that provides for the Department  
22          of Health and Human Services, the Department of Jus-  
23          tice, the Department of Veterans Affairs, Department of  
24          Defense, or the Department of Education to pay for or

1 provide mental health and substance use care, each such  
2 Department shall provide for the following:

3 (1) Within the authority of the Department  
4 with respect to such program—

5 (A) include payment for, or provision of,  
6 peer support and illness self-management pro-  
7 grams that meet evidence-based standards for  
8 individuals with chronic mental illnesses or sub-  
9 stance use dependence; and

10 (B) provide for appropriate payment and  
11 coverage reforms, such as the application of co-  
12 payments, service exclusions, and benefit limits,  
13 so as to eliminate barriers to the effective, ap-  
14 propriate, and evidence-based provision of such  
15 care.

16 (2) Endeavor to make reliable comparative in-  
17 formation on the quality of such care provided by  
18 practitioners and organizations available to con-  
19 sumers and to encourage consumers to use this in-  
20 formation when making decisions about from whom  
21 to receive such care.

22 (3) Insofar as the Department does not have  
23 authority described in paragraph (1), make rec-  
24 ommendations to the Congress regarding changes in  
25 law to provide for such authority.

1 (b) SENSE OF CONGRESS FOR ALL PROGRAMS.—It  
2 is the sense of the Congress that clinicians and organiza-  
3 tions providing mental health and substance use treatment  
4 services should—

5 (1) incorporate, consistent with applicable State  
6 laws, informed, patient-centered decision-making and  
7 (for children) informed family decision-making  
8 throughout their practices, including active patient  
9 participation in the design and revision of the pa-  
10 tient treatment and recovery plans, psychiatric ad-  
11 vance directives, and provision of information on the  
12 availability and effectiveness of mental health and  
13 substance use treatment options;

14 (2) adopt recovery-oriented and illness self-  
15 management practices that support patient pref-  
16 erence for treatment (including medications), peer  
17 support, and other elements of the wellness recovery  
18 plan; and

19 (3) maintain effective, formal linkages with  
20 community resources to support patient illness self-  
21 management and recovery.

22 **SEC. 8. UNIFORM METHODOLOGIES FOR REIMBURSING BE-**  
23 **HAVIORAL HEALTH CLAIMS.**

24 (a) IN GENERAL.—The Secretary, through the work-  
25 ing group convened under subsection (b), shall develop

1 uniform methodologies across geographic areas and types  
2 of payers for the following with respect to medical assist-  
3 ance, related services, and administrative costs furnished  
4 to individuals with mental illnesses and substance use dis-  
5 orders in both community-based and residential settings:

6 (1) Qualifications for eligibility for payment.

7 (2) Financial auditing.

8 (3) Claims payment (including billing codes).

9 (b) CONVENING OF WORKING GROUP.—The Sec-  
10 retary shall carry out subsection (a) by convening a work-  
11 ing group is composed of the Directors and Administrators  
12 of all relevant agencies, including the Centers for Medicare  
13 & Medicaid Services, the Office of Management and Budg-  
14 et, the Health Resources and Services Administration, the  
15 Substance Abuse and Mental Health Services Administra-  
16 tion, the office of the Inspector General of the Department  
17 of Health and Human Services, acting jointly with State  
18 Medicaid directors and other State, local, and private  
19 healthcare payers.

20 (c) REQUIREMENTS.—The methodology developed  
21 under subsection (a)—

22 (1) shall not result in new medical necessity cri-  
23 teria, and shall not prohibit or restrict payment for  
24 medical assistance, related services, and administra-  
25 tive activities under title XIX of the Social Security

1 Act that are provided or conducted in accordance  
2 with options under such title regarding targeted case  
3 management, rehabilitative services, or clinical serv-  
4 ices; and

5 (2) with respect to administrative costs, shall be  
6 based on—

7 (A) standards related to time studies and  
8 populations estimates; and

9 (B) a national standard for determining  
10 payment of such costs.

11 (d) **RULE OF CONSTRUCTION.**—Nothing in this sec-  
12 tion shall be construed as requiring, as a condition of pay-  
13 ment under the Medicaid program under title XIX of the  
14 Social Security Act, that an intervention must be an evi-  
15 dence-based practice.

16 **SEC. 9. STUDY ON USE OF PUBLIC MENTAL HEALTH AND**  
17 **ADDICTION SERVICES BY INDIVIDUALS WITH**  
18 **PRIVATE HEALTH COVERAGE.**

19 (a) **IN GENERAL.**—The Comptroller General of the  
20 United States shall conduct a study on the use of publicly  
21 supported mental health and addiction services by individ-  
22 uals who have any level of private health insurance cov-  
23 erage.

1 (b) REPORT.—The Comptroller General shall submit  
2 to the Congress a report on the study under subsection

3 (a). The report shall include a description of—

4 (1) the number of individuals described in sub-  
5 section (a);

6 (2) the types of private health insurance cov-  
7 erage involved; and

8 (3) the public programs providing the mental  
9 health and addiction services involved and the cost  
10 of such services provided.

11 **SEC. 10. HIGH-QUALITY MENTAL HEALTH AND SUBSTANCE**  
12 **USE HEALTH CARE MEDICAID DEMONSTRA-**  
13 **TION PROJECT.**

14 (a) IN GENERAL.—The Secretary shall establish a 5-  
15 year demonstration project (in this section referred to as  
16 the “project”) designed to demonstrate the impact of cre-  
17 ating delivery and financing structures that deliver high-  
18 quality, integrated mental health and substance use health  
19 care. Such project shall be based upon the report of the  
20 Institute of Medicine (of November 2005) relating to Im-  
21 proving the Quality of Health Care for Mental and Sub-  
22 stance-Use Conditions: Quality Chasm Series, and shall  
23 include demonstrating at least the following:

1           (1) Coordinated delivery of mental health, sub-  
2           stance use, and primary health care, utilizing a co-  
3           location or integrated delivery model.

4           (2) Use of evidence-based practices, to as great  
5           an extent as possible.

6           (3) Provision of patient-centered care that em-  
7           phasizes recovery-oriented practices and informed  
8           patients and, where appropriate, family decision-  
9           making.

10          (4) A commitment to utilizing health informa-  
11          tion technology to improve the quality and efficiency  
12          of care.

13          (b) REQUIRED REPORTING ON QUALITY.—The Sec-  
14          retary shall provide that each health care provider partici-  
15          pating in the project shall submit data on quality meas-  
16          ures determined by the Secretary.

17          (c) WAIVER OF REQUIREMENTS.—

18           (1) IN GENERAL.—Subject to paragraph (2),  
19           the Secretary is authorized to waive such require-  
20           ments of title XIX of the Social Security Act, such  
21           as statewideness, a limitation on the scope of serv-  
22           ices included in medical assistance, and the coverage  
23           of additional administrative expenses, as may be  
24           necessary for the implementation of the project.

1           (2) LIMITATION ON FUNDING.—The Secretary  
2           shall design the project in such a manner so that the  
3           net additional Federal expenditures under title XIX  
4           of the Social Security Act resulting from the project  
5           does not exceed \$50,000,000.

6           (d) INDEPENDENT EVALUATION.—The Secretary  
7           shall provide for an independent evaluation of activities  
8           provided under the project, in comparison with a control  
9           group. Such evaluation shall include an assessment of  
10          health and social outcomes for beneficiary participants,  
11          such as employment status, receipt of welfare benefits,  
12          criminal justice contacts, and homelessness, as well as the  
13          resource utilization for medical services, mental and sub-  
14          stance use health care, and social services. Such evaluation  
15          shall also include an assessment of the impact of activities  
16          provided under the project on workforce recruitment and  
17          retention.

18          (e) REPORTS TO CONGRESS.—

19               (1) INTERIM REPORT.—Not later than two  
20               years after the initiation of the project, the Sec-  
21               retary shall submit to the Congress an interim re-  
22               port on the project. Such report shall include such  
23               recommendations as the Secretary determines appro-  
24               priate.

1           (2) FINAL REPORT.—Not later than one year  
2 after the completion of the project, the Secretary  
3 shall submit to the Congress a final report on the  
4 project. The report shall include the results of the  
5 independent evaluation provided under subsection  
6 (d) as well as recommendations regarding redesign  
7 of the mental health and substance use benefit  
8 under the Medicaid program to maximize the quality  
9 and efficiency of such benefits.

10 **SEC. 11. MEDICAID REQUIREMENT FOR STATE REPEAL OF**  
11 **LAWS DENYING HEALTH BENEFITS COV-**  
12 **ERAGE BASED ON INTOXICATION.**

13           (a) IN GENERAL.—Section 1902 of the Social Secu-  
14 rity Act (42 U.S.C. 1396a) is amended—

15           (1) in subsection (a)—

16           (A) by striking “and” at the end of para-  
17 graph (69);

18           (B) by striking the period at the end of  
19 paragraph (70) and inserting “; and”; and

20           (C) by inserting after paragraph (70) the  
21 following new paragraph:

22           “(71) provide that the State has in effect a law  
23 that requires any insurance contract covering med-  
24 ical care losses in the group and individual market

1 that is to be offered in the State to meet the re-  
2 quirements of subsection (dd)(1).”; and

3 (2) by adding at the end the following new sub-  
4 section:

5 “(dd) REQUIREMENTS FOR INSURANCE COVERING  
6 MEDICAL LOSSES IN THE GROUP AND INDIVIDUAL MAR-  
7 KET.—

8 “(1) RESTRICTIONS ON EXCLUSIONS AND LIM-  
9 TATIONS RELATING TO INTOXICATION.—The re-  
10 quirements of this paragraph with respect to insur-  
11 ance contracts covering medical care losses in the  
12 group and individual market are as follows:

13 “(A) A prohibition against the exclusion or  
14 denial of covered services and benefits, in con-  
15 nection with the treatment of any patient whose  
16 medical condition, illness, or injury, involves  
17 confirmed or suspected intoxication as a result  
18 of alcohol or other substance.

19 “(B) A prohibition against discrimination  
20 against health care providers in the rate or level  
21 of payment for covered services in cases in  
22 which intoxication is either suspected or con-  
23 firmed.

24 “(C) An express obligation to provide and  
25 pay for covered services and treatments nec-

1           essary to the treatment of any condition, illness  
2           or injury without regard to whether intoxication  
3           is either suspected or confirmed.

4           “(D) An express obligation to cooperate  
5           with the state agency for medical assistance as  
6           provided under section 1902(a)(25).

7           “(2) INCLUSION OF ALL FORMS OF COV-  
8           ERAGE.—For purposes of subsection (a)(71) and  
9           paragraph (1), the term ‘insurance contract covering  
10          medical care losses in the group and individual mar-  
11          ket’ includes any class or type of insurance relating  
12          to medical care in the group or individual market,  
13          including plans covering public employees as well as  
14          private employees, regardless of whether coverage  
15          under the contract is expressed in terms of defined  
16          benefits or defined cash contributions toward the  
17          cost of medical losses.”.

18          (b) EFFECTIVE DATE.—

19               (1) Except as provided in paragraph (2), the  
20               amendments made by subsection (a) shall apply to  
21               calendar quarters beginning on or after January 1,  
22               2008, without regard to whether or not final regula-  
23               tions to carry out such amendments have been pro-  
24               mulgated by such date.

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

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