TITLE __—IMPROVING INTEGRATION, COORDINATION, AND ACCESS TO CARE

SEC. __01. SHORT TITLE OF TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This title may be cited as the ''Mental Health Care Integration and Crisis Care Improvement Act''.

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

Subtitle A—Medicare Provisions

SEC. __11. GUIDANCE FOR EXPANDING VALUE-BASED ARRANGEMENTS AND ALTERNATIVE PAYMENT MODELS IN MEDICARE.

Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue guidance to group practices, physicians, and practitioners on best practices for integrating behavioral health care within the primary care setting for the treatment of mental health and substance use disorders, including but not limited to depression, anxiety, and opioid use disorder. Such guidance may include the following, as determined appropriate by the Secretary:

(1) Use of the Collaborative Care Model or the Primary Care Behavioral Health Model for behavioral health integration.

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

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

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

(5) Developing or maintaining referral relationships to other providers or community-based organizations.

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

SEC. _12. INTEGRATION OF BEHAVIORAL HEALTH CARE FOR TREATMENT OF MENTAL HEALTH AND SUBSTANCE USE DISORDERS IN THE PRIMARY CARE SETTING.

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

''(xxviii) Promoting ways to support the adoption of behavioral health integration, such as the psychiatric Collaborative Care Model, Primary Care Behavioral Health Model, or other evidence-based models, in the primary care setting for the treatment of mental health and substance use disorders that require regular follow-up, such as depression, anxiety, and opioid use disorder.''.

SEC. __13. CLARIFYING THE ELIGIBILITY FOR PARTICIPATION OF PEER SUPPORT SPECIALISTS IN THE FURNISHING OF BEHAVIORAL HEALTH INTEGRATION SERVICES UNDER THE MEDICARE PROGRAM.

Section 1848(i) of the Social Security Act (42 U.S.C. 1395w–4(i)) is amended by adding at the end the following new paragraph:

"(4) CLARIFYING ELIGIBILITY OF PEER SUPPORT SPECIALISTS TO PARTICIPATE IN FURNISHING BEHAVIORAL HEALTH INTEGRATION SERVICES.—

"(A) IN GENERAL.—Not later than one year after the date of the enactment of this paragraph, the Secretary shall clarify that peer support specialists (as defined in subparagraph (B)) may participate in the furnishing of behavioral health integration services (as described in subsection (b)(12)(B)).

"(B) PEER SUPPORT SPECIALIST DEFINED.—For purposes of subparagraph (A), the term 'peer support specialist' means an individual who is certified as qualified to furnish peer support services under a national certification process that meets State law requirements or a State requirement process that is consistent with the National Practice Guidelines

for Peer Supporters and inclusive of the Substance Abuse and Mental Health Services Administration Core Competencies for Peer Workers in Behavioral Health Settings as determined appropriate by the Secretary.

''(C) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.''.

SEC. _14. REPORT ON PROGRESS INTEGRATING BEHAVIORAL HEALTH INTO PRIMARY CARE.

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

(1) by striking ''CONGRESS.—Beginning in'' and inserting ''CONGRESS.—

''(1) IN GENERAL.—Subject to paragraph (2), beginning in''; and

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

''(2) REPORT ON PROGRESS INTEGRATING BEHAVIORAL HEALTH INTO PRIMARY CARE.—In the case of the first report submitted under paragraph (1) on or after the date that is 1 year after the date of the enactment of this paragraph, such report shall include an analysis of the progress made by prac-

tices towards integrating behavioral health into primary care, based on such progress under relevant demonstration programs under titles XVIII and XIX. As part of such analysis, the Secretary shall—

"(A) conduct and take into consideration surveys of—

"(i) a range of providers, including providers currently participating in such demonstration programs, providers who have previously participated in such demonstration programs and who are no longer participating (regardless of reason), and providers who serve underserved communities and vulnerable populations (regardless of whether they have ever participated in such demonstration programs), on appropriate outcome and integration measures, including effectiveness of clinical assessment, screening, and therapeutic tools (inclusive of digital therapeutics) as well as clinical support tools; and

"(ii) patients on patient outcomes and experience;

"(B) establish a plan to develop additional outcome and integration measures , and clinical

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

''(C) consider workforce needs and any potential barriers to implementation of such demonstration programs.''.

SEC. _15. INCENTIVES FOR BEHAVIORAL HEALTH INTEGRATION.

(a) INCENTIVES.—

(1) IN GENERAL.—Section 1848(b) of the Social Security Act (42 U.S.C. 1395w–4(b)) is amended by adding at the end the following new paragraph:

''(12) INCENTIVES FOR BEHAVIORAL HEALTH INTEGRATION.—

''(A) IN GENERAL.—For services described in subparagraph (B) that are furnished during 2025, 2026, or 2027, instead of the payment amount that would otherwise be determined under this section for such year, the payment amount shall be equal to the applicable percent (as defined in subparagraph (C)) of such payment amount for such year.

"(B) SERVICES DESCRIBED.—The services described in this subparagraph are services identified, as of January 1, 2022, by HCPCS codes 99484, 99492, 99493, 99494, and G2214 (and any successor or similar codes as determined appropriate by the Secretary).

"(C) APPLICABLE PERCENT.—In this paragraph, the term 'applicable percent' means, with respect to a service described in subparagraph (A), the following:

"(i) For services furnished during 2025 , 175 percent.

"(ii) For services furnished during 2026, 150 percent.

"(iii) For services furnished during 2027, 125 percent.".

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

(A) in subclause (IV), by striking "and" at the end;

(B) in subclause (V), by striking the period at the end and inserting "; and" and

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

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

(b) QUALITY MEASUREMENT.—

(1) IN GENERAL.—Section 1833(z) of the Social Security Act (42 U.S.C. 1395l(z)) is amended—

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

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

"(4) QUALITY MEASUREMENT RELATING TO BEHAVIORAL HEALTH INTEGRATION.—

"(A) IN GENERAL.—The Secretary shall establish quality measurement reporting requirements for applicable physicians and practitioners (as defined in subparagraph (B)) with respect to the extent to which clinician practices are integrating behavioral health services and primary care services, in accordance with the succeeding provisions of this paragraph.

"(B) APPLICABLE PHYSICIANS AND PRACTITIONERS.—For purposes of this paragraph, the term 'applicable physician or practitioner'

means, with respect to a year, a physician or a practitioner described in section 1842(b)(18)(C) who is participating in an eligible alternative payment entity for which the associated alternative payment model involves the delivery of primary care services to beneficiaries who may have the need for mental health or substance use disorder services, as determined by the Secretary.

''(C) QUALITY REPORTING BY SELECTED PHYSICIANS AND PRACTITIONERS.—With respect to each year beginning on or after the date that is one year after one or more measures are first specified under subparagraph (D), an applicable physician or practitioner shall submit to the Secretary data on quality measures specified under such subparagraph. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(D) QUALITY MEASURES.—

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

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

''(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(E) IMPLEMENTATION.—The Secretary may use quality measures developed pursuant to this paragraph in—

''(i) the shared savings program under section 1899; and

''(ii) the Primary Care First Model, the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model, and any other alternative payment model (as defined in paragraph (3)(C)) as determined appropriate by the Secretary.''.

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

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

(1) IN GENERAL.—Not later than January 1, 2024, the Secretary of Health and Human Services shall enter into contracts or agreements with appropriate entities to offer technical assistance to primary care practices that are seeking to adopt behavioral health integration models in such practices.

(2) BEHAVIORAL HEALTH INTEGRATION MODELS.—For purposes of paragraph (1), behavioral health integration models include the Collaborative Care Model (with services identified as of January 1, 2022, by HCPCS codes 99492, 99493, 99494, and G2214 (and any successor codes)), the Primary Care Behavioral Health model (with services identified as of January 1, 2022, by HCPCS code 99484 (and any successor code)), and other models identified by the Secretary.

(3) FUNDING.—In addition to amounts otherwise available, there is appropriated to the Secretary

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

SEC. __16. PAYMENT FOR MOBILE CRISIS RESPONSE INTERVENTION SERVICES UNDER PHYSICIAN FEE SCHEDULE.

Section 1848(b) of the Social Security Act (42 U.S.C. 1395w–4(b)), as amended by section __05, is amended by adding at the end the following new paragraph:

''(13) MOBILE CRISIS RESPONSE TEAM SERVICES.—

''(A) IN GENERAL.—Beginning January 1, 2025, the Secretary shall, subject to the succeeding provisions of this paragraph, make a single global payment (as determined by the Secretary under subparagraph (C)) under this section for mobile crisis response team services (as defined in subparagraph (B)) furnished by a physician (as defined in section 1861(r)(1)), physician assistant or nurse practitioner (as defined in section 1861(aa)(5)(A)), clinical nurse specialist (as defined in section 1861(aa)(5)(B)), clinical social worker (as de-

fined in section 1861(hh)(1)), or clinical psychologist (as defined by the Secretary for purposes of section 1861(ii)).

"(B) DEFINITION OF MOBILE CRISIS RESPONSE TEAM SERVICES.—In this paragraph, the term 'mobile crisis response team services' means physicians' services that are furnished outside of a hospital, other facility setting, or physician office to an individual experiencing a mental health or substance use disorder crisis to—

"(i) provide screening and assessment for the individual's mental health or substance use disorder crisis;

"(ii) support the de-escalation of the individual's mental health or substance use disorder crisis;

"(iii) facilitate or support subsequent referral to health, social, and other services, as determined appropriate by the Secretary; or

"(iv) otherwise address the individual's pressing behavioral health needs, as determined appropriate by the Secretary.

"(C) DETERMINATION OF SINGLE GLOBAL PAYMENT.—

"(i) IN GENERAL.—The Secretary shall determine an appropriate global payment for mobile crisis response team services under the fee schedule under this section to account for the work, practice expenses, and malpractice expenses involved in furnishing physicians' services that would typically be furnished to an individual experiencing a mental health or substance use disorder crisis to accomplish the objectives described in clauses (i) through (iv) of subparagraph (B) (as identified by the Secretary).

"(ii) RELATIVE VALUES.—In determining work, practice expenses, and malpractice expenses under clause (i), the Secretary shall account for differences in work, practice expenses, and malpractice expenses between furnishing physicians' services identified in clause (i) in a physician office and the work, practice expenses, and malpractice expenses involved in furnishing such services at the site at which

at individual is experiencing a mental or substance use disorder crisis, including potential practice expenses associated with transportation to such site.

"(iii) ENSURING NO DUPLICATE PAYMENT.—The Secretary shall ensure that if a physician or practitioner receives payment for mobile crisis response team services under this paragraph, additional payment is not made under this section for physicians' services identified in clause (i) that are furnished to the same individual by the same physician or practitioner on the same day on which such mobile crisis response team services are furnished.

"(D) REQUIREMENTS FOR PHYSICIANS AND PRACTITIONERS RECEIVING PAYMENT.—In order to receive payment for mobile crisis response team services, a physician or practitioner who submits a claim for payment for such services must document, in a form and manner determined appropriate by the Secretary, that the physician or practitioner furnishing such services and any auxiliary personnel (as defined in section 410.26(a)(1) of

title 42, Code of Federal Regulations, or any successor regulation) furnishing such services under the supervision of the physician or practitioner—

"(i) are trained in trauma-informed care, de-escalation strategies, and harm reduction;

"(ii) are capable of coordinating with emergency response systems, crisis intervention hotlines, and hospitals furnishing crisis stabilization services (as defined in section 1833(t)(23)); and

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

"(E) ADDITIONAL CLARIFICATION.—The Secretary shall allow for auxiliary personnel (as defined in section 410.26(a)(1) of title 42, Code of Federal Regulations, or any successor regulation), including peer support specialists (as defined in subsection (i)(4)(B)), to furnish mobile crisis response team services under the supervision of a physician or practitioner billing for such services under this section.".

SEC. __17. PAYMENT FOR CRISIS STABILIZATION SERVICES UNDER PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) IN GENERAL.—Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) is amended—

(1) in paragraph (1)(B)—

(A) in clause (iv), by striking ''and'' at the end;

(B) in clause (v), by striking the period at the end and inserting ''; and''; and

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

''(vi) includes crisis stabilization services (as defined in paragraph (23)) furnished on or after January 1, 2025.''; and

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

''(23) CRISIS STABILIZATION SERVICES.—

''(A) CRISIS STABILIZATION SERVICES DEFINED.—In this subsection, the term 'crisis stabilization services' means applicable items and services (as defined in subparagraph (B)) that are furnished to an eligible individual who is experiencing a mental health or substance use dis-

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

"(B) APPLICABLE ITEMS AND SERVICES DEFINED.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the term 'applicable items and services' means items and services described in clause (ii) that are—

"(I) covered under this part; and

"(II)(aa) reasonable and necessary for the diagnosis and active treatment of the individual's mental health or substance use disorder condition; or

"(bb) reasonably expected to support the de-escalation of the individual's mental health or substance use disorder crisis.

"(ii) ITEMS AND SERVICES DESCRIBED.—The following items and services are described in this clause:

"(I) Observation services and supervised care for individuals in severe distress for up to 23 consecutive hours.

''(II) Screening for suicide risk, including comprehensive suicide risk assessments and planning when clinically indicated.

''(III) Screening for violence risk, including comprehensive violence risk assessments and planning when clinically indicated.

''(IV) Assessment of immediate physical health needs and delivery of care for physical health needs that are within the capability of the hospital.

''(V) Such other items and services as the Secretary determines appropriate.

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

''(i) the hospital accepts referrals, within the capability of the hospital, for crisis stabilization services;

''(ii) the hospital is capable of providing referrals for health, social, and

other services and supports, as needed, that are not provided as part of crisis stabilization services;

''(iii) the unit of the hospital that furnishes crisis stabilization services is staffed at all times (24 hours a day, 7 days a week, 365 days a year) with a multidisciplinary team, which may include providers such as a psychiatrist or psychiatric nurse practitioner (who may be available by telehealth for such staffing purposes), registered nurses, practitioners legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, and peer support specialists (as defined in subsection (i)(4)(B)); and

''(iv) the unit of the hospital that furnishes crisis stabilization services is capable—

''(I) of timely communication with emergency response systems, crisis intervention hotlines, and physicians and practitioners furnishing mo-

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

''(II) within the capacity of the hospital, of accepting referrals of individuals from such entities for crisis stabilization services.''.

(b) REPORT ON MEDICARE COVERAGE OF CRISIS STABILIZATION FACILITY SERVICES.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall submit to the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a report on policy issues for consideration in relation to providing Medicare coverage of crisis stabilization services (as defined in section 1833(t)(23) of the Social Security Act, as added by subsection (a)), when furnished by crisis stabilization facilities that are not eligible to enroll in the Medicare program as a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B))). Such report may include an assessment of the following:

(1) Considerations relating to licensure and accreditation of such facilities by States and accredita-

tion organizations to ensure care quality and program integrity.

(2) Considerations relating to the development of payment rates for such facilities, including collection of data on the costs that such facilities incur in furnishing crisis stabilization services.

(3) Considerations relating to any program integrity risks associated with crisis stabilization facilities and potential measures that could be implemented to mitigate those risks.

(4) Other considerations determined appropriate by the Secretary.

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.

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

(1) consider different models for how mental health or substance use disorder care is delivered and integrated within the primary care setting, including when providers operating in an integrated model are physically located in the same practice or building, when at least 1 provider in an integrated care model is available via telehealth, and when primary care or mental health or substance use disorder health providers seek education and consultation from other providers through electronic modalities; and

(2) evaluate—

(A) the use of different payment methodologies, such as bundled payments and value-based payment arrangements; and

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

(b) GUIDANCE.—Not later than 12 months after the Secretary of Health and Human Services completes the analysis required under subsection (a), the Secretary shall issue guidance to States on supporting integration of mental health or substance use disorder care within the primary care setting under Medicaid and CHIP. Such guid-

ance shall be informed by the analysis required under subsection (a) and, at minimum, shall do the following:

(1) Provide an overview of State options for adopting and expanding value-based payment arrangements and alternative payment models, including accountable care organizations and other shared savings programs, that integrate mental health or substance use disorder care within the primary care setting.

(2) Describe opportunities for States to use and align existing authorities and resources to finance integration of mental health or substance use disorder care within the primary care setting, including with respect to the use of electronic health records in mental health and substance use disorder care settings.

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

(4) Provide examples of specific strategies and models designed to support integration of mental health or substance use disorder care within the primary care setting for differing age groups, including

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

(5) Describe options for assessing the clinical outcomes of differing models and strategies for integration of mental health or substance use disorder care within the primary care setting.

(6) Describe best practices for supporting successful integration of mental health or substance use disorder care within the primary care setting for individuals eligible for assistance under Medicaid or CHIP.

(c) INTEGRATION OF MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE WITHIN THE PRIMARY CARE SETTING.—For purposes of subsections (a) and (b), integration of mental health and substance use disorder care within the primary care setting may include (and shall not be limited to, including when furnished via telehealth, when appropriate)—

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

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

methods through a multidisciplinary collaborative behavioral health team approach co-managed with primary care, to include same-day access to family-focused mental health treatment services;

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

(4) implementing or maintaining enhanced care coordination or targeted case management which includes regular interactions between and within care teams;

(5) providing mental health and substance use disorder screening and follow-up assessments, interventions, or services within the same practice or facility as a primary care or physical service setting;

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

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

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

SEC. _22. GUIDANCE AND TECHNICAL ASSISTANCE FOR STATES TO SUPPORT ACCESS TO COMMUNITY SOCIAL SUPPORTS AND SERVICES.

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

(1) A description of common components and key considerations for agreements between Medicaid managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and community-based organizations with respect to providing beneficiaries such connections.

(2) Considerations for complying with applicable requirements and restrictions under the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), including the privacy, security, and breach notification regulations promulgated under section 264(c) of such Act, and part 2 of title 42, Code of Federal Regulations.

(3) Information on financing and allowable reimbursement, rate setting, and funding parameters for the coordination with and provision of non-medical services under Medicaid and CHIP.

(4) Measurement of health outcomes of beneficiaries using allowable data sharing agreements between States, Medicaid managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and community-based organizations.

(5) Strategies to incorporate non-clinical professionals and paraprofessionals, such as trained peer support specialists, in care teams and care coordination efforts.

(6) Strategies to develop and encourage States to use value-based payment financing mechanisms to improve health outcomes and encourage collaborations between Medicaid managed care organizations,

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

(7) Strategies for States to help Medicaid managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans identify social needs of beneficiaries, which may include food services, housing support services, employment supports, and transportation support, and to connect beneficiaries to social supports provided by community-based organizations.

(b) TECHNICAL ASSISTANCE.—The Secretary of Health and Human Services shall provide technical assistance to States to support activities related to the guidance provided under subsection (a). Such support may include direct one-on-one technical assistance, peer-to-peer learning, affinity group facilitation, cross-industry convenings, webinars, and other supports that advance collaborations between Medicaid managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and community-based organizations.

(c) DEFINITIONS.—In this section:

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

cluding a payment model specified by the Secretary under section 1115A(c) of the Social Security Act (42 U.S.C. 1316a(c)) for implementation on a nationwide basis), or through a Medicaid managed care organization, prepaid inpatient health plan, or prepaid ambulatory health plan.

(2) COMMUNITY-BASED ORGANIZATION.—The term ''community-based organization'' means an organization, including a governmental organization, such as a county or local organization, a local or regional nonprofit organization, a nongovernmental organization, or a tribal organization, that provides individuals with non-medical services and other social supports that may include food services, housing services, employment supports, and transportation support.

SEC. __23. SUPPORTING ACCESS TO A CONTINUUM OF CRISIS RESPONSE SERVICES UNDER MEDICAID AND CHIP.

(a) GUIDANCE.—Not later than 18 months after the date of enactment of this Act, the Secretary, in coordination with the Administrator of the Centers for Medicare & Medicaid Services and the Assistant Secretary for Mental Health and Substance Use, shall issue guidance to

States regarding Medicaid and CHIP that includes the following:

(1) Establishes, in consultation with health care providers and stakeholders with expertise in mental health and substance use disorder crisis response services, recommendations for an effective continuum of crisis response services that—

(A) includes crisis call centers and 988 crisis services hotlines, mobile crisis teams, crisis response services delivered in home, community, residential facility, and hospital settings, and coordination with follow-on mental health and substance use disorder services, such as intensive outpatient and partial hospitalization programs, as well as connections to social services and supports;

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

(C) promotes culturally competent, trauma-informed care, and crisis de-escalation.

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

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

(3) Addresses how States under Medicaid and CHIP may support the ongoing implementation of crisis call centers and 988 crisis services hotlines and how Medicaid administrative funding, including enhanced matching, and the Medicaid Information Technology Architecture 3.0 framework, may be used to establish or enhance regional or statewide crisis call centers, including 988 crisis services hotlines, that coordinate in real time.

(4) Identifies how States under Medicaid and CHIP may support access to crisis response services that are responsive to the needs of children, youth, and families, including through CHIP health services initiatives, behavioral disorder-specific crisis response, trained peer support services, and establishing or enhancing crisis call centers that are youth-focused.

(5) Identifies policies and practices to meet the need for crisis response services with respect to differing patient populations, including urban, rural, and frontier communities, differing age groups, cultural and linguistic minorities, individuals with co-

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

(6) Identifies policies and practices to promote evidence-based suicide risk screenings and assessments.

(7) Identifies strategies to facilitate timely provision of crisis response services, including how States can enable access to crisis response services without requiring a diagnosis, the use of presumptive eligibility at different stages of the continuum of crisis response services, the use of telehealth to deliver crisis response services, strategies to make crisis response services available 24/7 in medically underserved regions, and best practices used by States and health providers for maximizing capacity to deliver crisis response services, such as identifying and repurposing available beds, space, and staff for crisis response services.

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

(9) Describes best practices for establishing effective connections with follow-on mental health and substance use disorder services, as well as with social services and supports.

(10) Describes best practices for coordinating and financing a continuum of crisis response services through Medicaid managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and fee-for-service delivery systems, including when States carve-out from delivery through Medicaid managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, or fee-for-service systems, mental health or substance use disorder benefits or a subset of such services.

(11) Identifies strategies and best practices for measuring and monitoring utilization of, and outcomes related to, crisis response services.

(b) TECHNICAL ASSISTANCE CENTER.—

(1) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services, in coordination with the Administrator of the Centers for Medicare & Medicaid Services and the Assistant Secretary for Mental Health and Substance Use, shall

establish a technical assistance center to help States under Medicaid and CHIP design, implement, or enhance a continuum of crisis response services for children, youth, and adults. Such technical assistance shall, at least in part, provide support to States in—

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

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

(C) adopting the best practices and strategies identified in the guidance issued under subsection(a).

(2) COMPENDIUM OF BEST PRACTICES.—The Secretary of Health and Human Services shall develop and maintain a publicly available compendium of best practices for the successful operation under Medicaid and CHIP of a continuum of crisis response services. The Secretary shall update the information available through the compendium at least annually.

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

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

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

(A) Assess the need for crisis response services for children, youth, and adults in the State who are eligible for assistance under Medicaid or CHIP.

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

stance use disorder crisis response services under the State programs under Medicaid and CHIP that the State will seek to address to support improved access to a continuum of crisis response services under such programs.

(C) Identify how the State will leverage Federal authorities under the State programs under Medicaid and CHIP to finance mental health and substance use disorder crisis services, and coordinate such financing with other sources of Federal funds as appropriate, to implement and expand access to mental health and substance use disorder crisis response services under such programs.

(D) Consult with stakeholders in order to support access to culturally competent and trauma-informed care under the State programs under Medicaid and CHIP, and to identify and address the needs of underserved communities in the State.

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

(F) Identify strategies to measure and monitor crisis response services access, utilization, and outcomes.

(G) Such other activities as the Secretary may approve to support the design, implementation, or enhancement under Medicaid and CHIP of a continuum of crisis response services.

(3) CRISIS PLAN.—Not later than 18 months after the date on which a State is awarded a grant under this subsection, the State shall submit to the Secretary a plan for implementing or enhancing under Medicaid and CHIP a continuum of crisis response services. Such plan shall describe, at a minimum, the results of the required activities carried out under paragraph (2), including the results of the needs assessment described in subparagraph (A) of such paragraph, how the State will ensure that the plan is implemented, and how the State will measure over time the State's progress in carrying out the plan.

[(d) PLANNING GRANT AND TECHNICAL ASSISTANCE FUNDING.—**]**

SEC. __24. MAKING PERMANENT STATE OPTION TO PROVIDE QUALIFYING COMMUNITY-BASED MOBILE CRISIS INTERVENTION SERVICES.

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

(1) in subsection (a), by striking ''during the 5-year period'';

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

(3) in subsection (d)(2)—

(A) in subparagraph (A), by striking ''for the fiscal year preceding the first fiscal quarter occurring during the period described in subsection (a)'' and inserting ''for the fiscal year preceding the first fiscal quarter in which the State provides medical assistance for qualifying community-based mobile crisis intervention services under this section''; and

(B) in subparagraph (B), by striking ''occurring during the period described in subsection (a)'' and inserting ''occurring during a fiscal quarter''.