Better Mental Health Care, Lower-Cost Drugs, and Extenders Act
Section-by-Section Summary

Title 1—Expanding Mental Health Care Workforce and Services Under Medicare and Medicaid

Sec. 101. Expanding Eligibility for Incentives Under the Medicare Health Professional Shortage Area Bonus Program to Practitioners Furnishing Mental Health and Substance Use Disorder Services.

Medicare makes incentive payments to physicians for Part B professional services delivered to Medicare beneficiaries within a Health Resources and Services Administration (HRSA)-designated health professional shortage area (HPSA). This 10% bonus payment is only available to physicians.

This provision would extend eligibility for HPSA bonuses to certain mental health and substance use disorder services furnished in mental health HPSAs by non-physician health care professionals, including: (1) physician assistants, nurse practitioners, or clinical nurse specialists; (2) clinical social workers; (3) clinical psychologists; (4) marriage and family therapists; and (5) mental health counselors. This provision would also increase bonus payments from 10% to 15% for mental health and substance use disorder services furnished in mental health HPSAs by eligible providers. These provisions would apply to services furnished on or after January 1, 2026.

CBO estimates this provision would increase Medicare spending by $282 million over 10 years.

Sec. 102. Improved Access to Mental Health Services under the Medicare Program.

Medicare covers certain behavioral health services, which include mental health and substance use disorder services, furnished by licensed or certified clinical social workers (CSWs) for the diagnosis and treatment of mental health illness. Medicare does not currently cover health behavior assessment and intervention services provided by CSWs. Current law also includes CSW services in the skilled nursing facility (SNF) prospective payment system (PPS) per-diem bundled payment. Consequently, Medicare eligible SNF patients do not receive furnished services from a CSW billing independently under Medicare Part B.

This provision would, beginning January 1, 2026, modify the definition of CSW services covered under Medicare Part B to include services for health behavior assessment and intervention, identified by specific current and successor Healthcare Common Procedure Coding System (HCPCS) codes, furnished in an outpatient setting. This provision would also exclude CSW services from the Medicare Part A SNF PPS per-diem payment, allowing CSWs to bill Medicare Part B for qualified services furnished to SNF eligible patients. In order to prevent provider double-billing, the provision requires CMS apply a payment adjustment to the SNF PPS that accounts for the furnished CSW services removed from the per-diem payment bundle.

CBO estimates this provision would increase Medicare spending by $110 million over 10 years.

Sec. 103. Clarifying Coverage of Occupational Therapy under the Medicare Program.

Within one year of enactment, this provision would require the Department of Health and Human Services (HHS) Secretary to provide education and outreach to stakeholders about the availability of substance use disorder or mental health disorder services furnished by occupational therapists to Medicare beneficiaries.

CBO estimates this provision would have no impact on Medicare spending.

Sec. 104. Medicare Incentives for Behavioral Health Integration with Primary Care.

Beginning in 2026, this provision would increase the payment amount under the Medicare physician fee schedule (MPFS) for certain behavioral health integration services (identified in the legislation by specific service codes), and then phase down that increase in 2027 and 2028. For 2026, the payment for the codes would be 175% of the MPFS amount; for 2027, the payment would be 150%; and for 2028, it would be 125%. The increase and phase-down in payments under this provision would not be included in the MPFS's budget neutrality calculations.

CBO estimates that this provision would increase Medicare spending by $58 million over 10 years.

Sec. 105. Establishment of Medicare Incident to Modifier for Mental Health Services Furnished through Telehealth.

Directs the HHS Secretary to require tele-mental health service claims to include a code or modifier within two years of enactment of this Act.

CBO estimates this provision would have no impact on Medicare spending.

Sec. 106. Guidance on Furnishing Behavioral Health Services via Telehealth to Individuals with Limited English Proficiency under Medicare Program.

Directs the HHS Secretary to provide and or update best practices for providers to furnish behavioral health care services through telehealth for beneficiaries with limited English proficiency.

CBO estimates this provision would have no impact on Medicare spending.

Sec. 107. Ensuring Timely Communication Regarding Telehealth and Interstate Licensure Requirements.

Requires CMS to regularly update information on licensure requirements for furnishing telehealth services under Medicare and Medicaid. This includes regular updates on guidance to clarify interstate licensure compacts.

CBO estimates this provision would have no impact on Medicare spending.

Sec. 108. Facilitating Accessibility for Behavioral Health Services Furnished through Telehealth.

Directs the HHS Secretary to provide regular updates to guidance to facilitate the accessibility of behavioral health services furnished through telehealth for the visually and hearing impaired.

CBO estimates this provision would have no impact on Medicare spending.

Sec. 109. Requiring Enhanced & Accurate Lists of (REAL) Health Providers Act.

This provision requires Medicare Advantage (MA) plans to maintain accurate provider directories on a public website beginning in plan year (PY) 2026. Directory information is required to be updated at least every 90 days; the HHS Secretary can allow plans to verify hospitals and other facilities' information less frequently, as long as that information is verified at least annually. MA plans would be required to note in the directory providers whose information could not be verified and to remove providers listed in a directory within 5 business days if the organization determines the provider is no longer participating in the network. Provider directories would be required to include information that the enrollee may need to access covered benefits from a contracted provider. If an enrollee received care from an out-of-network provider that was listed when the appointment was made as an in-network provider in the plan's directory, the MA organization would be required to cover that out-of-network care, as long as it was a covered item or service, and ensure that the enrollee was only responsible for in-network cost sharing.

Beginning in PY2026, MA contracts would be required to conduct and submit to the HHS Secretary annual reports of their provider directories' accuracy. Beginning in PY2027, the HHS Secretary would be required to post on the CMS website the provider directory accuracy scores, in a machine-readable format, and plans would be required to disclose the accuracy scores on its plan directory. The HHS Secretary would be required to implement provider directory accuracy reports through the rulemaking process and would permit the Secretary to waive these requirements for certain low enrollment MA plans. To implement the plan provider directory report, $1,000,000 is provided to CMS Program Management Account, out of the General Fund of the Treasury, to remain available until expended.

By not later than January 15, 2031, the Comptroller General of the United States would be required to submit a study of the implementation of: (1) the requirement that in-network cost sharing amounts apply to care furnished by an out-of-network provider if the provider choice

was based on incorrect directory information; (2) provider response rates to plan outreach methods; and (3) the requirement that MA organizations conduct and submit provider directory accuracy analyses (both overall and among providers specializing in mental health or substance disorder treatment).

The HHS Secretary would be required to hold a public stakeholder meeting on best practices for maintaining accurate provider directories, issue guidance to MA Organizations on best practices, and issue guidance to providers on when to update their information in the National Plan and Provider Enumeration System.

CBO estimates this provision would increase Medicare spending by $35 million over 10 years.

Sec. 110. Guidance to States on Strategies Under Medicaid and CHIP to Increase Mental Health and Substance Use Disorder Care Provider Capacity.

This provision requires the HHS Secretary to issue state guidance within 18 months of the enactment of the Act on strategies to increase the capacity of mental health and substance use disorder providers under Medicaid and CHIP, with a focus on improving mental health and substance use disorder provider capacity in rural and underserved areas.

CBO estimates this provision would have no impact on Medicaid spending.

Sec. 111. Guidance to States on Supporting Mental Health Services and Substance Use Disorder Care for Children and Youth.

Within one year after enactment of the Act, this provision requires the HHS Secretary, in consultation with the CMS Administrator, the Assistant Secretary for the Administration for Children and Families (ACF), the Assistant Secretary for Mental Health and Substance Use, and the Director of the Office of National Drug Control Policy to release state guidance regarding opportunities to improve the design, implementation, screening for and access to a continuum of culturally competent, developmentally appropriate, and trauma-informed Medicaid and CHIP mental health and substance use disorder services for at-risk children and youth, as well as other special populations such as youth in foster care and those with intellectual or developmental disabilities.

CBO estimates this provision would have no impact on Medicaid spending.

Sec. 112. Recurring Analysis and Publication of Medicaid Health Care Data Related to Mental Health Services.

This provision requires the HHS Secretary to publish, on a publicly available website, specified information on the prevalence of conditions and mental health treatment services provided to Medicaid enrollees, based on federally-required state submissions of Transformed Medicaid Statistical Information System (T-MSIS) data. The first publication of Medicaid mental health data would be required to be made available within 18 months of the Act's enactment, and biennially thereafter. The provision would also require CMS to permanently continue to issue

annual updates of the SUD Databook authorized in the SUPPORT for Patients and Communities Act (SUPPORT Act, P.L. 115-271).

CBO estimates this provision would have no impact on Medicaid spending.

Sec. 113. Guidance to States on Supporting Mental Health Care or Substance Use Disorder Care Integration with Primary Care in Medicaid and CHIP.

This provision requires the HHS Secretary to conduct an analysis of Medicaid and CHIP clinical outcomes associated with various integrated care models and payment methodologies, within 18 months of the enactment of this Act. Within 12 months of completing this analysis, the HHS Secretary would be required to issue state guidance on supporting the integration of Medicaid and CHIP mental health care or substance use disorder care with primary care that meets specified requirements.

CBO estimates this provision would have no impact on Medicaid spending.

Sec. 114. Medicaid State Option Relating to Inmates with a Substance Use Pending Disposition of Charges.

This provision permits states to receive federal payment, for a period not to exceed 7 days, for medical assistance for individuals with a substance use disorder who are inmates of a public institution pending disposition of charges, who were assessed to confirm a substance use disorder diagnosis while incarcerated, and whose eligibility for medical assistance is suspended by the state during the period the individual is an inmate of such a public institution. The provision would be effective beginning January 1, 2026.

CBO estimates this provision would increase Medicaid spending by $800 million over 10 years.

Sec. 115. Defining Certified Community Behavioral Health Clinics (CCBHCs) Within the Medicaid Program.

This provision would add the definition of CCBHC services to the list of Medicaid optional service categories under traditional Medicaid. The definition includes the same services that CCBHCs are required to provide in the currently authorized demonstration program (e.g., crisis mental health services, targeted case management, psychiatric rehabilitation). A CCBHC would be defined in the Medicaid statute as an organization that furnishes CCBHC services, is legally authorized to furnish such services under State law, agrees to furnish data as required as a condition of certification, and has been certified by a State to meet the criteria issued by the HHS Secretary as of January 1, 2024, and any subsequent updates to those criteria, regardless of whether the state is participating in the Medicaid demonstration program. The effective date for this provision would be January 1, 2024.

CBO estimates this provision would have no impact on Medicaid spending.

Title 2—Reducing Prescription Drug Costs under Medicare and Medicaid

Section 201. Assuring Pharmacy Access and Choice for Medicare Beneficiaries.

This provision would codify regulatory requirements that Part D plan sponsors must contract with any willing pharmacy that meets their standard contract terms and conditions, as well as that such terms and conditions must be reasonable and relevant. The provision would direct the Secretary to undertake notice-and-comment rulemaking to promulgate standards for reasonable and relevant terms and conditions under this policy, to take effect beginning in 2028.

This provision would also create a new designation for "essential retail pharmacies," defined as pharmacies that are not affiliated with a pharmacy benefit manager (PBM) or plan sponsor and are located in a medically underserved area. Beginning in 2028, the policy would require that:

- A plan sponsor offering preferred pharmacy networks must contract with a minimum percentage of essential retail pharmacies for such preferred networks in their service area (80% of independent community pharmacies and 50% of all other essential retail pharmacies).
- Total reimbursement for essential retail pharmacies that are independent pharmacies could not be lower than a drug's average National Average Drug Acquisition Cost.

The provision would require, with respect to enforcement, that no later than January 1, 2028, the Secretary establish a process for pharmacies to submit allegations of violations of these provisions. The Secretary would have the authority to impose civil monetary penalties for such violations, as appropriate. Each contract between a Part D plan and a PBM would be required to include a written agreement stipulating that the PBM reimburse the sponsor for any civil monetary penalties related to violations of these provisions, insofar as such violations were related to responsibilities delegated to the PBM.

CBO estimates this provision would increase Medicare spending by $1.005 billion over 10 years.

Section 202. Ensuring Accurate Payments to Pharmacies Under Medicaid.

This provision would require participation by retail community pharmacies (RCPs) in the National Average Drug Acquisition Cost (NADAC) survey. The NADAC survey measures pharmacy acquisition costs and is often used in the Medicaid program to help inform reimbursement to pharmacies.

This provision would also require the Secretary to survey drug prices at "applicable non-retail pharmacies" to determine NADAC-like benchmarks for such pharmacies, which would be separate and distinct from those used for retail community pharmacies. "Applicable non-retail pharmacies" would comprise state-licensed non-RCP pharmacies, including mail-order and specialty pharmacies.

The following pharmacies would not be considered applicable non-retail pharmacies: nursing homes, long-term care facilities, hospitals, clinics, charitable or not-for-profit, government, and low-dispensing pharmacies. States would be prohibited from using NADAC survey information from applicable non-retail pharmacies to set reimbursement rates for RCPs.

These provisions would be effective on the first day of the first quarter 18 months after this provision's enactment date.

CBO estimates this provision would decrease Medicaid spending by $2.046 billion over 10 years.

Section 203. Protecting Seniors from Excessive Cost-Sharing for Certain Medicines.

Beginning in 2028, this provision would require post-deductible enrollee coinsurance for certain covered Part D drugs ("discount-eligible drugs") to be based on net prices, inclusive of projected manufacturer rebates, rather than Part D negotiated prices (which generally exclude such rebates, subject to plan sponsor and PBM discretion) or other list-price derivatives. "Discount-eligible drugs" would be defined as Part D drugs that are on a plan's formulary, are subject to a coinsurance amount, and:

1. Are in the following categories and classes: anti-inflammatories that are inhaled corticosteroids; bronchodilators, anticholinergic agents; bronchodilators, sympathomimetic agents; respiratory tract agents; anticoagulants; or cardiovascular agents; and
2. For which aggregate manufacturer price concessions to Part D plan sponsors/PBMs, in the aggregate, are equal to or exceed 50% of aggregate Part D gross costs, based on the Secretary's analysis of DIR data.

Every year, CMS will produce a list of discount-eligible drugs to identify which products are subject to the net price rules under this provision. When a drug is identified as a discount-eligible drug, the rules shall apply regardless of an individual plan's level of rebates or discounts on the product.

The "net price" would be defined as the Part D negotiated price, net of all approximate price concessions not already reflected in the negotiated price for a plan year. "Approximate price concessions" would be defined as the amount of price concessions that Part D sponsors prospectively expected to receive from manufacturers for a plan year.

Additionally, beginning in 2028, Part D plans would be required to limit post-deductible enrollee cost-sharing for any covered Part D drug included in their formulary to the net price for such drug, inclusive of manufacturer rebates.

CBO estimates this provision would increase Medicare spending by $1.159 billion over 10 years.

Title 3—Medicaid Expiring Provisions

Sec. 301. Delaying Certain Disproportionate Share Hospital Payment Reductions under the Medicaid Program.

This provision further amends the Medicaid Disproportionate Share Hospital reductions by eliminating the reductions for FY 2024 and FY 2025. The reductions for FY 2026 and FY 2027 would be unchanged. The aggregate reduction amount from FY 2024 to FY 2027 would decrease from $32.0 billion under current law to $16.0 billion.

CBO estimates this provision would increase Medicaid spending by $3.7 billion over two years.

Sec. 302. Extension of State Option to Provide Medical Assistance for Certain Individuals who are Patients in Certain Institutions for Mental Diseases.

This provision makes the state option permanent to make Medicaid coverage available for no more than a 30-day period to eligible individuals who are patients in an eligible IMD. The section also amends the maintenance of effort (MOE) requirement to broaden the type of expenditures relevant to the MOE standard. In addition, the provision adds a requirement that states commence an assessment of the availability of treatment at each level of care for Medicaid enrollees.

CBO estimates this provision would increase Medicaid spending by $517 million over 10 years.

Title 4—Medicare Expiring Provisions and Provider Payment Changes

Sec. 401. Extension of Funding for Quality Measure Endorsement, Input, and Selection.

The Department of Health and Human Services (HHS) Secretary is required to contract with a consensus-based entity (CBE) to carry out specified duties related to health care performance measurement. The Consolidated Appropriations Act, 2021 (P.L. 116-260) recently extended mandatory funding for quality measure endorsement, input, and selection through September 30, 2023. The law appropriated $26 million for fiscal year (FY) 2021, $20 million for FY 2022, and $20 million for FY 2023.

This provision would provide CMS $20 million to carry out quality measure endorsement, input, and selection activities through September 30, 2024.

CBO estimates this provision would increase Medicare spending by $20 million over the next fiscal year.

Sec. 402. Extension of Funding Outreach and Assistance for Low-Income Programs.

Beginning in FY 2009, Section 119 of the Medicare Improvements for Patients and Providers Act (MIPPA) provided mandatory funding for outreach and assistance to low-income Medicare beneficiaries through State Health Insurance Assistance Programs (SHIPs), Area Agencies on

Aging (AAAs), and Aging and Disability Resource Centers (ADRCs). MIPPA also provided mandatory funding to an entity to help inform older Americans about benefits available under Federal and State Programs.

The provision would extend authority for these programs through September 30, 2024. For FY 2024, it would provide the same funding levels as FY 2023, for a total of $50 million annually to be transferred from the Medicare HI and SMI Trust Funds in the following amounts: SHIPs, $15 million; AAAs, $15 million; ADRCs, $5 million; and grant funding to coordinate efforts to inform older Americans about benefits available under Federal and State programs, $15 million.

CBO estimates this provision would increase Medicare spending by $50 million over the next fiscal year.

Sec. 403. Extension of the Work Geographic Index Floor Under the Medicare Program.

The provision would extend the floor value of 1.0 for the physician work geographic index used in the calculation of payments under the Medicare physician fee schedule through December 31, 2024.

CBO estimates this provision would increase Medicare spending by $542 million over 10 years.

Sec. 404. Extension of Medicare Advanced Payment Model (APM) Payment Incentives.

This provision would provide for a 1.75% APM Incentive Payment for Qualifying APM Participants (QPs) for payment year 2026 (based on performance year 2024) and would extend the QP payment and patient thresholds in place with respect to payment year 2025 through payment year 2026 (based on performance year 2024).

CBO estimates this provision would increase Medicare spending by $680 million over 10 years.

Sec. 405. Payment Rates for Durable Medical Equipment Under the Medicare Program.

This provision would extend by one year (through December 31, 2024) the 25/75 blend payment for durable medical equipment that applies to areas other than rural or noncontiguous areas.

CBO estimates this provision would increase Medicare spending by $177 million over 10 years.

Sec. 406. Extending the Independence at Home Medical Practice Demonstration Program under the Medicare Program.

The provision would extend the Independence at Home demonstration program through December 31, 2025.

CBO estimates this provision would increase Medicare spending by $19 million over 10 years.

Sec. 407. Increase in Support for Physicians and Other Professionals in Adjusting to Medicare Payment Changes.

This provision would replace the statutory increase of 1.25% for Medicare physician fee schedule services furnished in 2024 with 2.50% for that year.

CBO estimates this provision would increase Medicare spending by $670 million over 10 years.

Sec. 408. Revised Phase-In of Medicare Clinical Laboratory Test Payment Changes.

This provision would continue to limit payment reductions of up to 15% in the Medicare Clinical Laboratory Fee Schedule until January 1, 2025 by delaying the reporting and collecting of private insurance payments for clinical laboratory services through December 31, 2024 and by extending the zero-percent cap on payment reductions through 2024.

CBO estimates this provision would decrease Medicare spending by $589 million over 10 years.

Sec. 409. Extension of Adjustment to Calculation of Hospice Cap Amount under Medicare.

This provision would extend, for one additional year at the back end of the ten-year budget window, the change to the annual updates to the hospice aggregate cap first made in the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, (P.L. 113-185). Specifically, this provision would apply the hospice payment update percentage, rather than the medical expenditure component of the Consumer Price Index for Urban Consumers (CPI–U), to the hospice aggregate cap through FY 2033.

CBO estimates this provision would decrease Medicare spending by $927 million over 10 years.

Title 5—Offsets

Sec. 501. Medicaid Improvement Fund.

This provision decreases funding available to the Medicaid Improvement Fund for FY 2028 and thereafter from $6,357,117,810 to $561,000,000.

Sec. 502. Medicare Improvement Fund.

This provision would change the total amount available in the Medicare Improvement Fund for services furnished “during and after fiscal year 2022, $180 million” to “during and after fiscal year 2022, $936,000,000.”