I

111TH CONGRESS
1ST SESSION

H. R. 2369

To improve mental and substance use health care.

IN THE HOUSE OF REPRESENTATIVES

MAY 12, 2009

Mr. KENNEDY (for himself and Mrs. BONO MACK) 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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS; FINDINGS.

(a) SHORT TITLE.—This Act may be cited as the ''Improving the Quality of Mental and Substance Use Health Care Act of 2009''.

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

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

(1) In its study, ''Improving the Quality of Health Care for Mental and Substance-Use Conditions'', the Institute of Medicine found that each year, more than 33,000,000 Americans use health care services for their mental problems and illnesses, and for conditions resulting from their use of alcohol, inappropriate use of prescription medications, or, less often, illegal drugs. In the United States, mental and substance use illnesses (which often occur together) are the leading cause of death and disability for women, the highest for men ages 15 to 44, and the second highest for all men.

(2) Effective treatments for these medical illnesses exist, but multiple barriers prevent many from receiving them. The consequences of these barriers are serious for these individuals and their families, for their employers and the workforce, for the Nation's economy, and for the Nation's education, welfare, and justice systems. The Institute of Medicine further found that a comprehensive approach is

needed to remedy this issue that addresses the distinguishing characteristics of mental and substance use health care in the United States.

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

(A) individual patient preferences, needs, and values prevail in the face of residual stigma, discrimination, and coercion into treatment;

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

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

(D) emerging information technology related to health care benefits people with mental or substance use problems and illnesses;

(E) the health care workforce has the education, training, and capacity to deliver high-quality care for mental and substance use conditions; and

(F) government programs, employers, and other group purchasers of health care for mental and substance use conditions use their dol-

lars in ways that support the delivery of high-quality care.

(4) To implement this strategy, the Institute of Medicine noted that action is needed from many health care leaders, including the Congress.

SEC. 2. EVIDENCE-BASED MENTAL AND SUBSTANCE USE HEALTH CARE.

(a) COMMISSION FOR EVIDENCE-BASED MENTAL AND SUBSTANCE USE HEALTH CARE.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services (in this Act referred to as the ''Secretary'') shall establish a Commission for Evidence-Based Mental and Substance Use Health Care (in this section referred to as the ''Commission'') to strengthen, coordinate, and consolidate the synthesis and dissemination of evidence on effective mental and substance use treatments and services.

(2) DUTIES.—For the purposes described in paragraph (1), the Commission shall, on an ongoing basis—

(A) identify, describe, and categorize the available evidence-based preventive, diagnostic, and therapeutic interventions (including screening, diagnostic, and symptom-monitoring tools),

including interventions for various age and ethnic groups;

(B) recommend procedure and payment codes and definitions for such evidence-based interventions and tools for their use in administrative datasets under part C of title XI of the Social Security Act and recommend standards for health data collection relating to such interventions;

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

(i) the development of new evidence-based preventive, diagnostic, and therapeutic interventions;

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

(iii) how best to translate new evidence-based findings into practice in community-based clinical settings;

(D) recommend to the Director of the National Institute of Mental Health, the Director of the National Institute on Drug Abuse, the Director of the National Institute on Alcohol Abuse and Alcoholism, and other Federal offi-

cials methods to coordinate the conduct or support of research described in subparagraph (C);

(E) collect, synthesize, and disseminate information on research concerning evidence-based strategies for promoting the use of evidence-based preventive, diagnostic, and therapeutic interventions;

(F) provide guidance on effective mental and substance use interventions to Federal agencies that provide or support such interventions, including the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Department of Defense, the Department of Veterans Affairs, the Indian Health Service, and the Bureau of Prisons; and

(G) periodically assess the progress of agencies described in subparagraph (F) in implementing such interventions.

(3) CONSULTATION.—In carrying out this section, the Commission shall—

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

(B) ensure that interested parties have opportunities to provide input before the Commission makes recommendations or decisions.

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

(A) researchers;

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

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

(D) health care payers.

(5) TERMS.—

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

(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members of the Commission first appointed, ¼ shall each be appointed for terms of 1, 2, and 3 years and the remainder shall be appointed for a term of 4 years.

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

(b) CMS ANNUAL REPORT.—The Administrator of the Centers for Medicare & Medicaid Services shall report annually to the Congress on the extent to which the Medicaid program under title XIX of the Social Security Act provides coverage of evidence-based interventions identified by the Commission, including—

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

(2) a justification for each evidence-based intervention that is not so covered; and

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

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

(d) PROMPT DEVELOPMENT AND IMPLEMENTATION OF CLAIMS PROCESSING AND DATA CODES.—The Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall establish, or enter into an agreement with, one or more entities for the purpose of developing, as soon as practicable after the date of the enactment of this Act, codes that should be applied to claims processing and health data collection activities as recommended by the Commission pursuant to subsection (a)(2)(B).

(e) DEFINITION.—In this section, the term ''intervention'' means a preventive, diagnostic, or therapeutic action with respect to a mental health or substance use disease process.

SEC. 3. IMPROVED COORDINATION OF CARE.

(a) INTERAGENCY COLLABORATIVE GROUP.—

(1) ESTABLISHMENT.—The Secretary shall convene an interagency collaborative group (in this section referred to as the ''interagency collaborative group'') to provide for the coordination at the clin-

ical and programmatic level of mental health and substance use services and primary care services, funded in whole or in part through the Department of Health and Human Services, the Department of Justice, the Department of Veterans Affairs, the Department of Defense, and the Department of Education, using one or more evidence-based coordination models, such as the following:

(A) Formal agreements between mental health, substance use, and primary care providers.

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

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

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

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

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

(B) coordinate with States and appropriate public stakeholders to foster interagency collaboration at the State and local level;

(C) make recommendations to the President and the Congress to break down barriers to coordination of existing Federal programs funding mental health and substance use services and to allow for more effective integration of such programs across agencies and programs;

(D) assess progress toward such coordination through development and monitoring of performance measures of coordination; and

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

(3) COMPOSITION.—The interagency collaborative group shall include the following members:

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

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

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

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

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

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

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

(b) COORDINATED DELIVERY OF CARE.—The Federal agencies participating in the interagency collaborative group shall modify internal policies and practices, to the extent practicable and consistent with legal authority, in order to implement one or more of the evidence-based coordination models referred to in subsection (a)(1).

(c) NO EFFECT ON HIPAA PRIVACY RULES.—Nothing in this section shall be construed to alter the application of rules promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

(d) GAO REPORT.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General of the United States shall conduct a study and submit a report to the Congress on the implementation of this section.

(e) CLARIFICATION OF MEDICAID REIMBURSEMENT OPTIONS.—The Secretary shall provide, by regulation, for a change in the rules under title XIX of the Social Security Act relating to reimbursement for primary care services and mental health and substance use services to the same patient on the same day so as to permit payment for the legitimate provisions of both types of services on the same day to a patient.

SEC. 4. INFORMATION TECHNOLOGY FOR MENTAL HEALTH AND SUBSTANCE USE HEALTH CARE PROVIDERS.

(a) DEVELOPMENT AND IMPLEMENTATION OF PLAN.—The Secretary, acting through the National Coordinator for Health Information Technology and the Administrator of the Substance Abuse and Mental Health Services Administration, shall develop and implement a plan for ensuring that activities of the Department of Health and Human Services to promote the use of information technology by health care providers include promotion of information technology that is accessible and pertinent to mental health and substance use health care providers and consumers.

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

(1) how the development of an electronic health information infrastructure, including the awarding of grants and contracts to promote the use of electronic health records (EHRs), personal health records (PHRs), regional health information organizations (RHIOs), and other forms of health information technology, and the establishment of data standards, will ensure that the needs of mental and substance use health care providers and consumers are met with particular emphasis on the privacy concerns of consumers;

(2) how financial incentives that are generally made available for the development of such infrastructure for health care providers can be provided to individual mental health and substance use clinicians and organizations (and particularly publicly-funded providers) for investments in information technology to enable them to participate on a full and equal basis in the emerging electronic health infrastructure;

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

lation data and health records, and billing and clinical decision-support systems; and

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

(c) CONSIDERATION.—In awarding any grant or contract for the development or implementation of any component of a national electronic health infrastructure, the Secretary shall consider the application of such component to mental health and substance use health care and providers of such care.

(d) CONTINUED PRIVACY PROTECTIONS.—In developing or promoting the national electronic health infrastructure, the Secretary shall ensure that privacy and confidentiality requirements traditionally applicable to mental health and substance use health care continue to be applied.

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

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

SEC. 5. COUNCIL ON THE MENTAL HEALTH AND SUBSTANCE USE HEALTH CARE WORKFORCE.

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

(b) DUTIES.—

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

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

(A) identify the specific clinical competencies that all mental health and substance use professionals should possess to be certified or licensed and the competencies, including a component of patient centered care, that should be maintained over time;

(B) identify the specific mental health and substance use education that should be required

of health care professionals and integrated into the medical education and training of all health care professionals;

(C) propose national standards for the credentialing and licensure of mental health and substance use health care providers based on core competencies that should be included in curricula and education programs across all the mental health and substance use disciplines and make recommendations regarding accreditation standards for mental health and substance use health care programs;

(D) propose programs for funding from Federal, State, and local governments and the private sector to address and resolve long-standing workforce issues such as diversity, cultural relevance, faculty development, training effectiveness, continuing shortages of well-trained clinicians needed to work with children and the elderly and in high-need areas, and programs for training competent clinical supervisors and administrators; and

(E) provide for continuing assessment of mental health and substance use workforce trends, issues, and financing policies.

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

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

(B) submit a report to the Congress on the results of such evaluation, including a description of the status of the mental health and substance use health care workforce.

(4) ASSISTANCE.—The Council shall collaborate with private sector coalitions to facilitate and implement its recommendations.

(c) MEMBERSHIP.—

(1) NUMBER; APPOINTMENT; CHAIR.—The Council shall be composed of not less than 21 and not more than 25 individuals appointed by the Secretary. The Council shall elect a chair from among its members.

(2) PUBLIC SECTOR MEMBERS.—The Council shall include the following officials (or their designees):

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

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

(C) The Administrator of the Substance Abuse and Mental Health Services Administration.

(D) The Secretary of Veterans Affairs.

(3) PRIVATE SECTOR MEMBERS.—The Council shall include representatives from the substance use and mental health services and consumer communities who are not employees of the Federal Government. Such representatives shall be appointed by the Secretary without regard to the Federal civil service laws and shall include the following:

(A) One individual selected from full-time students enrolled in mental health training programs.

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

(C) One individual selected from mental health consumers.

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

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

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

(G) Five individuals selected from among leading professional associations in the various fields charged with carrying out mental health and substance use services, including psychiatry, addiction medicine, psychology, social work, psychiatric nursing, counseling, marriage and family therapy, pastoral counseling, psychosocial rehabilitation, and substance use treatment counselors.

(H) Five individuals selected from among leading professional licensing and credentialing entities in the various fields charged with carrying out mental health and substance use services including psychiatry, addiction medicine, psychology, social work, psychiatric nursing, counseling, marriage and family therapy, pastoral counseling, psychosocial rehabilitation, and substance use treatment counseling.

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

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

(B) a range of members from a variety of practice settings and including expertise in prevention and treatment across the lifespan;

(C) adequate representation of racial, ethnic, religious, and economic diversity in its membership; and

(D) the members appointed under subparagraphs (G) and (H) of paragraph (3) are equitably distributed between those specializing in mental health services and those specializing in substance use services.

(5) TERMS.—

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

(B) TERMS OF INITIAL APPOINTEES.—As designated by the Secretary at the time of appointment, of the members of the Council first appointed under paragraph (3), ¼ shall each be appointed for terms of 1, 2, and 3 years and the remainder shall be appointed for a term of 4 years.

(C) VACANCIES.—Any member appointed under paragraph (3) to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office.

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

(e) STAFF AND SUPPORT.—The Secretary shall provide, without the requirement for reimbursement, staff and other administrative support necessary for the operation of the Council.

SEC. 6. FUNDING OF RESEARCH THROUGH NATIONAL CENTERS OF EXCELLENCE.

(a) GRANTS.—The Director of the National Institutes of Health (in this section referred to as the ''Director of NIH''), acting through the Directors of the National Institute of Mental Health, the National Institute of Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism, and in consultation with the Administrator of the Substance Abuse and Mental Health Services Administration, shall make grants to entities to fund a network

of national centers of excellence in mental health and substance use health care.

(b) USE OF FUNDS.—As a condition on receipt of a grant under this section, an entity shall agree to use the grant to establish or support one or more centers of excellence in mental health and substance use health care. Each such center shall—

(1) integrate basic, clinical, or health services research with interventions in a range of usual settings of care delivery and involve a broad cross-section of mental health and substance use health care stakeholders; and

(2) develop innovative approaches to tie together research and practice in order to develop a research agenda relevant to providers of mental health and substance use health care services in a range of usual settings of care.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $10,000,000 for fiscal year 2011, $15,000,000 for fiscal year 2012, $20,000,000 for fiscal year 2013, $25,000,000 for fiscal year 2014, and such sums as may be necessary for each subsequent fiscal year.

SEC. 7. PATIENT-CENTERED CARE.

(a) PROMOTION IN FEDERAL PROGRAMS.—With respect to any program that provides for the Department of Health and Human Services, the Department of Justice, the Department of Veterans Affairs, Department of Defense, or the Department of Education to pay for or provide mental health and substance use care, each such Department shall provide for the following:

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

(A) include payment for, or provision of, peer support and illness self-management programs that meet evidence-based standards for individuals with chronic mental illnesses or substance use dependence; and

(B) provide for appropriate payment and coverage reforms, such as the application of copayments, service exclusions, and benefit limits, so as to eliminate barriers to the effective, appropriate, and evidence-based provision of such care.

(2) Endeavor to make reliable comparative information on the quality of such care provided by practitioners and organizations available to consumers and to encourage consumers to use this in-

formation when making decisions about from whom to receive such care.

(3) Insofar as the Department does not have authority described in paragraph (1), make recommendations to the Congress regarding changes in law to provide for such authority.

(b) SENSE OF CONGRESS FOR ALL PROGRAMS.—It is the sense of the Congress that clinicians and organizations providing mental health and substance use treatment services should—

(1) incorporate, consistent with applicable State laws, informed, patient-centered decisionmaking and (for children) informed family decisionmaking throughout their practices, including active patient participation in the design and revision of the patient treatment and recovery plans, psychiatric advance directives, and provision of information on the availability and effectiveness of mental health and substance use treatment options;

(2) adopt recovery-oriented and illness self-management practices that support patient preference for treatment (including medications), peer support, and other elements of the wellness recovery plan; and

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

SEC. 8. UNIFORM METHODOLOGIES FOR REIMBURSING BEHAVIORAL HEALTH CLAIMS.

(a) IN GENERAL.—The Secretary, through the working group convened under subsection (b), shall develop uniform methodologies across geographic areas and types of payers for the following with respect to medical assistance, related services, and administrative costs furnished to individuals with mental illnesses and substance use disorders in both community-based and residential settings:

(1) Qualifications for eligibility for payment.

(2) Financial auditing.

(3) Claims payment (including billing codes).

(b) CONVENING OF WORKING GROUP.—The Secretary shall carry out subsection (a) by convening a working group is composed of the Directors and Administrators of all relevant agencies, including the Centers for Medicare & Medicaid Services, the Office of Management and Budget, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the office of the Inspector General of the Department of Health and Human Services, acting jointly with State

Medicaid directors and other State, local, and private healthcare payers.

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

(1) shall not result in new medical necessity criteria, and shall not prohibit or restrict payment for medical assistance, related services, and administrative activities under title XIX of the Social Security Act that are provided or conducted in accordance with options under such title regarding targeted case management, rehabilitative services, or clinical services; and

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

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

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

(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as requiring, as a condition of payment under the Medicaid program under title XIX of the Social Security Act, that an intervention must be an evidence-based practice.

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

(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study on the use of publicly supported mental health and addiction services by individuals who have any level of private health insurance coverage.

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

(1) the number of individuals described in subsection (a);

(2) the types of private health insurance coverage involved; and

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

SEC. 10. HIGH-QUALITY MENTAL HEALTH AND SUBSTANCE USE HEALTH CARE MEDICAID DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary shall establish a 5-year demonstration project (in this section referred to as the ''project'') designed to demonstrate the impact of creating delivery and financing structures that deliver high-quality, integrated mental health and substance use health

care. Such project shall be based upon the report of the Institute of Medicine (of November 2005) relating to Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series, and shall include demonstrating at least the following:

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

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

(3) Provision of patient-centered care that emphasizes recovery-oriented practices and informed patients and, where appropriate, family decision-making.

(4) A commitment to utilizing health information technology to improve the quality and efficiency of care.

(b) REQUIRED REPORTING ON QUALITY.—The Secretary shall provide that each health care provider participating in the project shall submit data on quality measures determined by the Secretary.

(c) WAIVER OF REQUIREMENTS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary is authorized to waive such requirements of title XIX of the Social Security Act, such

as statewideness, a limitation on the scope of services included in medical assistance, and the coverage of additional administrative expenses, as may be necessary for the implementation of the project.

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

(d) INDEPENDENT EVALUATION.—The Secretary shall provide for an independent evaluation of activities provided under the project, in comparison with a control group. Such evaluation shall include an assessment of health and social outcomes for beneficiary participants, such as employment status, receipt of welfare benefits, criminal justice contacts, and homelessness, as well as the resource utilization for medical services, mental and substance use health care, and social services. Such evaluation shall also include an assessment of the impact of activities provided under the project on workforce recruitment and retention.

(e) REPORTS TO CONGRESS.—

(1) INTERIM REPORT.—Not later than 2 years after the initiation of the project, the Secretary shall submit to the Congress an interim report on the

project. Such report shall include such recommendations as the Secretary determines appropriate.

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

SEC. 11. MEDICAID REQUIREMENT FOR STATE REPEAL OF LAWS DENYING HEALTH BENEFITS COVERAGE BASED ON INTOXICATION.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 5006 of division B of Public Law 111–5, is amended—

(1) in subsection (a)—

(A) by striking ''and'' at the end of paragraph (72);

(B) by striking the period at the end of paragraph (73) and inserting ''; and''; and

(C) by inserting after paragraph (73) the following new paragraph:

''(74) provide that the State has in effect a law that requires any insurance contract covering medical care losses in the group and individual market that is to be offered in the State to meet the requirements of subsection (gg)(1).''; and

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

''(gg) REQUIREMENTS FOR INSURANCE COVERING MEDICAL LOSSES IN THE GROUP AND INDIVIDUAL MARKET.—

''(1) RESTRICTIONS ON EXCLUSIONS AND LIMITATIONS RELATING TO INTOXICATION.—The requirements of this paragraph with respect to insurance contracts covering medical care losses in the group and individual market are as follows:

''(A) A prohibition against the exclusion or denial of covered services and benefits, in connection with the treatment of any patient whose medical condition, illness, or injury, involves confirmed or suspected intoxication as a result of alcohol or other substance.

''(B) A prohibition against discrimination against health care providers in the rate or level of payment for covered services in cases in

which intoxication is either suspected or confirmed.

''(C) An express obligation to provide and pay for covered services and treatments necessary to the treatment of any condition, illness, or injury without regard to whether intoxication is either suspected or confirmed.

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

''(2) INCLUSION OF ALL FORMS OF COVERAGE.—For purposes of subsection (a)(74) and paragraph (1), the term 'insurance contract covering medical care losses in the group and individual market' includes any class or type of insurance relating to medical care in the group or individual market, including plans covering public employees as well as private employees, regardless of whether coverage under the contract is expressed in terms of defined benefits or defined cash contributions toward the cost of medical losses.''.

(b) EFFECTIVE DATE.—

(1) Except as provided in paragraph (2), the amendments made by subsection (a) shall apply to calendar quarters beginning on or after January 1,

2010, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

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