TITLE —MENTAL HEALTH PARITY

SEC. __01. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This title may be cited as the Mental Health Parity Improvements Act.

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

TITLE —MENTAL HEALTH PARITY

Sec. __01. Short title; table of contents.

Subtitle A—Medicare Provisions

Sec. __11. Guidance on furnishing of partial hospitalization services and other outpatient services to Medicare beneficiaries with a diagnosis of substance use disorder.


Sec. __21. Requiring MA plans to maintain accurate and updated provider directories.

Sec. __22. GAO study and report comparing coverage of mental health and substance use disorder benefits and non-mental health and substance use disorder benefits.

Subtitle C—Medicaid Provisions

Sec. __31. Requiring accurate, updated, and searchable provider directories.

Sec. __32. GAO report on disparities in Medicaid payment rates for mental health and substance use disorder benefits.
Subtitle A—Medicare Provisions

SEC. 11. GUIDANCE ON FURNISHING OF PARTIAL HOSPITALIZATION SERVICES AND OTHER OUTPATIENT SERVICES TO MEDICARE BENEFICIARIES WITH A DIAGNOSIS OF SUBSTANCE USE DISORDER.

Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall issue guidance to providers of partial hospitalization services (as defined in section 1861(ff)(1) of the Social Security Act (42 U.S.C. 1395x(ff)(1))) and providers of outpatient services described in paragraph (3)—

(1) detailing the extent to which partial hospitalization services may be furnished to an individual with a diagnosis of substance use disorder;

(2) providing additional detail on any requirement that an individual with such a diagnosis must also have a diagnosis of a mental health disorder in order to be furnished partial hospitalization services; and

(3) providing information on other outpatient services covered under the Medicare program that could be utilized by an individual with a diagnosis of substance use disorder who requires significant care each week to manage their substance use disorder.
Subtitle B—Medicare Advantage
Provisions

SEC. 21. REQUIRING MA PLANS TO MAINTAIN ACCURATE
AND UPDATED PROVIDER DIRECTORIES.

(a) In General.—Section 1852(c) of the Social Se-
curity Act (42 U.S.C. 1395w–22(c)) is amended by adding
at the end the following new paragraph:

“(3) Provider directory information re-
quirements.—

“(A) In General.—For plan year [2025]
and subsequent plan years, each MA organiza-
tion offering a network-based MA plan (as de-
finite in subparagraph (F)) shall, with respect
to such plan—

“(i) establish the verification process
described in subparagraph (B);

“(ii) provide information as described
in subparagraph (C);

“(iii) establish the database described
in subparagraph (D); and

“(iv) include in any print directory de-
scribed in subparagraph (E) the notifica-
tion described in such subparagraph.

“(B) Verification process.—
“(i) IN GENERAL.—The verification process described in this subparagraph is, with respect to an MA organization offering a network-based MA plan, a process—

“(I) under which the organization verifies and, if applicable, updates the provider directory information of each provider included in the database of the plan described in subparagraph (D);

“(II) that provides, if the organization is unable to verify such information with respect to a provider, for the inclusion along with the information in the database with respect to such provider of a notification indicating that the information may not be up to date;

“(III) that provides for the removal of a provider from such database within 2 business days if the organization determines that the provider is no longer a participating provider.
“(ii) DESIGNATION OF DATABASE.—

The Secretary may designate a database which may be used at the option of MA organizations for purposes of verifying and updating provider directory information under clause (i)(I).

“(C) PROVISION OF INFORMATION.—

“(i) TOLL-FREE TELEPHONE NUMBER.—An MA organization shall maintain a toll-free telephone number for inquiries regarding whether a provider is a participating provider under a network-based MA plan offered by such organization. Each MA organization shall respond to any such inquiry in a timely manner, in no case later than 1 business day after the inquiry is received.

“(ii) SUBMISSION OF PROVIDER DIRECTORY TO SECRETARY.—An MA organization shall submit to the Secretary the provider directory for each network-based MA plan offered by the organization. The Secretary shall make each provider directory submitted under the preceding sentence available on the internet website of
the Centers for Medicare & Medicaid Services.

“(D) DATABASE.—The database described in this paragraph is, with respect to a network-based MA plan offered by an MA organization, a database on the public website of such plan that contains provider directory information.

“(E) NOTIFICATION.—The notification described in this paragraph is, with respect to a print directory containing provider directory information, a notification that the provider directory information contained in such print directory was accurate as of the date of publication of such directory and that an individual enrolled in the network-based MA plan should consult the database described in subparagraph (D) with respect to such plan or contact such plan to obtain the most current provider directory information with respect to such plan.

“(F) DEFINITIONS.—For purposes of this paragraph:

“(i) NETWORK-BASED MA PLAN.—The term ‘network-based MA plan’ means an MA plan that has a network of providers that have agreed to a contractually speci-
fied reimbursement for covered benefits with the MA organization offering the plan.

“(ii) Provider directory information.—The term ‘provider directory information’ includes, with respect to a network-based MA plan, the name, address, specialty, telephone number, contact information (including digital contact information to the extent such information is available), availability (including whether the provider is accepting new patients), and cultural and linguistic capabilities (including the languages spoken by the provider or by a skilled medical interpreter who provides interpretation services at the provider’s office or facility) of each provider with which such plan has an agreement for furnishing items and services covered under such plan, and other information as determined by the Secretary.

“(G) Provider engagement and communication.—[To be supplied.]”.

(b) Enforcement.—Section 1857(g) of the Social Security Act (42 U.S.C. 1395w–27(g)) is amended—
(1) in paragraph (1)—

(A) in subparagraph (K), by striking “or” after the semicolon;

(B) by redesignating subparagraph (L) as subparagraph (M);

(C) by inserting after subparagraph (K), the following new subparagraph:

“(L) except as provided in paragraph (5), fails to comply with provider directory information requirements under section 1852(c)(3); or”; and

(D) in subparagraph (M), as redesignated by subparagraph (B), by striking “through (K)” and inserting “through (L)”;

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

“(5) SAFE HARBOR FOR USE OF DESIGNATED DATABASE.—In the case of an MA organization for which the Secretary makes a determination under paragraph (1)(L) with respect to a failure to comply with the verification process described in section 1852(c)(3)(B)(i), such organization shall not be subject to remedies under this subsection if such organization used information provided in the database designated by the Secretary under section
1852(c)(3)(B)(ii) for purposes of such verification process and such use resulted in such failure.”.

SEC. 22. GAO STUDY AND REPORT COMPARING COVERAGE OF MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS AND NON-MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

(a) Study.—

(1) In general.—The Comptroller General of the United States (in this section referred to as the “Comptroller General”) shall conduct a study that compares the mental health and substance use disorder benefits under Medicare Advantage plans (including specialized MA plans for special needs individuals, as defined in section 1859(b)(6) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)) under part C of title XVIII of such Act with—

(A) the non-mental health and substance use disorder benefits under the Medicare Advantage program; and

(B) the mental health and substance use disorder benefits under the original fee-for-service program under parts A and B of such title XVIII.
(2) **Analysis.**—To the extent data is available, the study under paragraph (1) shall include an analysis of—

(A) gross and relative out-of-pocket expenses for in-network care;

(B) the utilization of prior authorization and other utilization management tools;

(C) utilization rates of mental health and substance use disorder benefits among individuals with a mental health or substance use disorder condition;

(D) the extent to which differences in the provision of mental health and substance use disorder benefits and the provision of non-mental health and substance use disorder benefits in the Medicare Advantage program are reflective of policies in Medicare fee-for-service;

(E) the frequency at which providers of mental health and substance use disorder services decline to contract with Medicare Advantage plans compared to providers of non-mental health and substance use disorder services; and

(F) other items determined appropriate by the Comptroller General.
(3) PLAN AND SERVICE SPECIFIC.—To the extent practicable, the study under paragraph (1) shall examine differences by type of Medicare Advantage plan and type of service.

(4) BOTH REQUIRED AND SUPPLEMENTAL BENEFITS.—For purposes of the study under paragraph (1), benefits under part C of title XVIII of the Social Security Act shall include both and differentiate between—

(A) benefits required to be furnished under Medicare Advantage plans; and

(B) supplemental benefits available under such plans.

(b) REPORT.—Not later than 30 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a).

Subtitle C—Medicaid Provisions

SEC. 31. REQUIRING ACCURATE, UPDATED, AND SEARCHABLE PROVIDER DIRECTORIES.

(a) APPLICATION TO MANAGED CARE.—Section 1932(a)(5) of the Social Security Act (42 U.S.C. 1396u–2(a)(5)) is amended—
[(1) in subparagraph (B)(i), by inserting “consistent with the requirements of subparagraph (E)” before the period at the end; and]

[(2) by adding at the end the following new subparagraph:]

”(E) PROVIDER DIRECTORIES.—"

“(i) IN GENERAL.—Each managed care organization, prepaid inpatient health plan (as defined by the Secretary), prepaid ambulatory health plan (as defined by the Secretary), and, when appropriate, primary care case management entity (as defined by the Secretary) with a contract with a State to enroll individuals who are eligible for medical assistance under the State plan under this title or under a waiver of such plan, shall publish (and update on at least a quarterly basis or more frequently as required by the Secretary) on a public website, a searchable directory of network providers, which shall include physicians, hospitals, pharmacies, providers of mental health services, providers of substance use disorder services, providers of long term services and supports, and such other pro-
providers as required by the Secretary, and that includes with respect to each such provider—]

[(I) the name of the provider;]

[(II) the specialty of the provider;]

[(III) the address at which the provider provides services;]

[(IV) the telephone number of the provider; and]

[(V) information regarding—]

[(aa) the provider’s cultural and linguistic capabilities, including the languages spoken by the provider or by a skilled medical interpreter who provides interpretation services at the provider’s office;]

[(bb) whether the provider is accepting as new patients individuals who receive medical assistance under this title;]

[(cc) whether the provider’s office or facility has accommodations for individuals
with physical disabilities, including offices, exam rooms, and equipment;]

[(“(dd) the Internet website of such provider, if applicable; and]

[(“(ee) whether the provider offers covered services via telehealth.]

[(“(ii) NETWORK PROVIDER DEFINED.—In this subparagraph, the term ‘network provider’ includes any provider, group of providers, or entity that has a network provider agreement with a managed care organization, a prepaid inpatient health plan (as defined by the Secretary), a prepaid ambulatory health plan (as defined by the Secretary), or a primary care case management entity (as defined by the Secretary) or a subcontractor of any such entity or plan, and receives payment under this title directly or indirectly to order, refer, or render covered services as a result of the State’s contract with the entity or plan. For purposes of this subparagraph, a
network provider shall not be considered to
be a subcontractor by virtue of the network
provider agreement.]

[(iii) Provider engagement and
communication.—To be supplied.]

[(b) Conforming amendments to State Plan
Requirements.—Section 1902(a) of the Social Security
Act (42 U.S.C. 1396a) is amended—]

[(1) by striking paragraph (83) and inserting
the following:]

[(83) provide that in the case of a State plan
(or waiver of the plan) that provides medical assist-
ance on a fee-for-service basis or through a primary
care case-management system described in section
1915(b)(1), the State shall publish (and update on
at least a quarterly basis or more frequently as re-
quired by the Secretary) on the public website of the
State agency administering the State plan, a search-
able directory of the providers described in sub-
section (mm) that includes with respect to each such
provider—]

[(A) the name of the provider;]

[(B) the specialty of the provider;]

[(C) the address at which the provider
provides services;]
"(D) the telephone number of the provider;

"(E) information regarding—]

"(i) the provider’s cultural and linguistic capabilities, including the languages spoken by the provider or by a skilled medical interpreter who provides interpretation services at the provider’s office;

"(ii) whether the provider is accepting as new patients individuals who receive medical assistance under this title;

"(iii) whether the provider’s office or facility has accommodations for individuals with physical disabilities, including offices, exam rooms, and equipment;

"(iv) the Internet website of such provider, if applicable; and

"(v) whether the provider offers covered services via telehealth; and

"(F) other relevant information as required by the Secretary;”; and

(2) by striking subsection (mm) and inserting the following:

"(mm) DIRECTORY PROVIDER DESCRIBED.—]
[(1) IN GENERAL.—A provider described in this subsection, at a minimum, includes physicians, hospitals, pharmacies, providers of mental health services, providers of substance use disorder services, providers of long term services and supports, and such other providers as required by the Secretary, and—]

[(A) in the case of a provider of a provider type for which the State agency, as a condition on receiving payment for items and services furnished by the provider to individuals eligible to receive medical assistance under the State plan (or a waiver of the plan), requires the enrollment of the provider with the State agency, includes a provider that—]

[(i) is enrolled with the agency as of the date on which the directory is published or updated (as applicable) under subsection (a)(83); and]

[(ii) received payment under the State plan in the 12-month period preceding such date; and]

[(B) in the case of a provider of a provider type for which the State agency does not require such enrollment, includes a provider]
that received payment under the State plan (or
a waiver of the plan) in the 12-month period
preceding the date on which the directory is
published or updated (as applicable) under sub-
section (a)(83).]

[“(2) STATE OPTION TO INCLUDE OTHER PAR-
TICIPATING PROVIDERS.—At State option, a pro-
vider described in this subsection may include any
provider who furnishes services and is participating
under the State plan under this title or under a
waiver of such plan.”.”]

[(c) GENERAL APPLICATION TO CHIP.—Section
2107(e)(1)(G) of the Social Security Act (42 U.S.C.
1397gg(e)(1)(G)) is amended by inserting “and subsection
(a)(83) of section 1902 (relating to searchable directories
of the providers described in subsection (mm) of such sec-
tion)” before the period.]

[(d) EFFECTIVE DATE.—]

[(1) IN GENERAL.—Except as provided in
paragraph (2), the amendments made by this section
shall take effect on the first day of the first calendar
quarter that begins on or after the date that is 2
years after the date of enactment of this Act.]

[(2) DELAY IF STATE LEGISLATION NEEDED.—
In the case of a State plan under title XIX or XXI
of the Social Security Act or waiver of such plan, which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan or waiver to meet the additional requirements imposed by the amendments made by this section, the State plan or waiver 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.

SEC. 32. GAO REPORT ON DISPARITIES IN MEDICAID PAYMENT RATES FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

(a) Study.—The Comptroller General of the United States (in this section referred to as the “Comptroller General”) shall select a sample of States in which to conduct a review of Medicaid payment rates including base and net payment rates (including supplemental pay-
mments), for mental health services and substance use disorder services under fee for service, managed care, and other payment arrangements or combinations thereof, to determine the extent to which there are disparities in the amount of such rates when compared to the Medicaid payment rates for other Medicaid-covered, non-behavioral health services in such States. As part of such review, the Comptroller General shall, to the extent data are available and comparable, examine what is known about—

(1) mental health and substance use disorder outpatient screening, assessment, diagnostic, treatment, rehabilitation, and habilitation services;

(2) States’ and stakeholders’ views on the extent to which any such disparities contribute to workforce shortages and barriers to the availability of behavioral health services under Medicaid; and

(3) payment rates for mental health and substance use disorder services compared to appropriate non-behavioral health services when paid by commercial insurers.

(b) Report.—Not later than 24 months after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a) that includes the evaluations required by such subsection, as well as recommendations for such
1 legislation and administrative action as the Comptroller
2 General determines appropriate.