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117TH CONGRESS
1ST SESSION

H. R. 5218

To amend the Public Health Service Act to increase uptake of the Collaborative Care Model.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 10, 2021

Mrs. FLETCHER (for herself and Ms. HERRERA BEUTLER) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend the Public Health Service Act to increase uptake of the Collaborative Care Model.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Collaborate in an Orderly and Cohesive Manner Act''.

SEC. 2. INCREASING UPTAKE OF THE COLLABORATIVE CARE MODEL.

(a) IN GENERAL.—Subpart XII of part D of title III of the Public Health Service Act (42 U.S.C. 256i et seq.) is amended—

(1) in the subpart heading, by striking ''**Community-based Collaborative-Care Network Program**'' and inserting ''**Collaborative Care**''; and

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

''SEC. 340J. INCENTIVIZING PRIMARY CARE UPTAKE OF THE COLLABORATIVE CARE MODEL.

''(a) GRANTS.—The Secretary shall make grants to primary health care physicians and primary health care practices to meet the initial costs of establishing and delivering behavioral health integration services through the collaborative care model or a combined approach of the collaborative care model and primary care behavioral health integration models.

''(b) USE OF GRANTS.—A primary health care physician or primary health care practice that receives a grant under this section shall use funds received through the grant—

''(1) to hire staff;

''(2) to identify and formalize contractual relationships with other health care providers, including providers who will function as psychiatric consultants and behavioral health care managers in pro-

viding behavioral health integration services through the collaborative care model;

''(3) to purchase or upgrade software and other resources needed to appropriately provide behavioral health integration services through the collaborative care model, including resources needed to establish a patient registry and implement measurement-based care; and

''(4) for other such purposes that the Secretary may determine to be necessary.

''(c) PRIORITY.—In making grants under this section, the Secretary shall give priority to primary health care physicians and primary health care practices—

''(1) providing services to any medically underserved population; and

''(2) are located in areas with a prevalence of mental illnesses or substance use disorders that are higher than the national average.

''(d) CONSIDERATION.—If, in reviewing applications for grants under this section, the Secretary determines that more than one primary health care physician or a primary health care practice submitting such an application meets the criteria to be given priority under subsection (c), the Secretary shall give a preference to the primary health care physician or primary health care prac-

tice (that meets such criteria) that has the least existing capacity and resources to use grant funds as described in subsection (b).

''(e) INCENTIVE PAYMENTS.—

''(1) IN GENERAL.—The Secretary shall provide to primary health care physicians and primary health care practices receiving a grant under this section that meet the criteria specified in paragraph (3), additional payments.

''(2) METHODOLOGY AND TIMING.—The amount and timing of payments made under this subsection shall be determined using a methodology and disbursement schedule established by the Secretary.

''(3) CRITERIA.—Criteria described in this paragraph are such criteria as the Secretary may specify, in consultation with stakeholders, including physicians in the primary care community and in the field of mental health and substance use disorder treatment. Such criteria shall include whether—

''(A) a primary health care physician or primary health care practice participates in an alternative payment model that bills for the collaborative care model using the appropriate

common procedural terminology billing codes; and

''(B) a primary health care physician or primary health care practice uses of validated quality measures, including, but not limited to, those related to depression screening, patient follow up, and symptom remission.

''(4) CALCULATION.—A payment received under this subsection shall not be factored into any determination with respect to meeting cost reduction targets for purposes of a model implemented pursuant to section 1115A of the Social Security Act.

''(f) ACCOUNTABILITY.—The recipient of a grant under this section shall submit to the Secretary, in such time and manner as the Secretary may specify, a report that measures each recipient's progress toward—

''(1) implementing and appropriately providing behavioral health integration services through the collaborative care model;

''(2) improving access to behavioral health integration services provided through the collaborative care model among medically underserved populations;

''(3) improving health outcomes for individuals who receive behavioral health integration services provided through the collaborative care model; and

''(4) other such purposes that the Secretary may determine to be necessary.

''(g) CLARIFICATION.—

''(1) REIMBURSEMENT.—Nothing in this section shall be construed as preventing a primary health care physician or primary health care practice that receives a grant under this section from receiving direct reimbursement for rendering behavioral health integration services through the collaborative care model.

''(2) OTHER PROGRAMS.—Participation in, or application for, any other grant or demonstration program administered by the Secretary by a primary health care physician or primary health care practice shall not affect the eligibility of such physician or practice to receive a grant under this section.

''(h) DEFINITIONS.—For the purposes of this section:

''(1) COLLABORATIVE CARE MODEL.—The term 'collaborative care model' means the evidence-based, integrated behavioral health service delivery method described in 81 Federal Register 80230, which includes a formal collaborative arrangement among a

primary care team consisting of a primary care provider, a care manager, and a psychiatric consultant, and includes the following elements:

"(A) Care directed by the primary care team.

"(B) Structured care management.

"(C) Regular assessments of clinical status using developmentally appropriate, validated tools.

"(D) Modification of treatment as appropriate.

"(2) MEDICALLY UNDERSERVED POPULATION.—The term 'medically underserved population' means the population of an urban or rural area designated by the Secretary as an area with a shortage of mental health or substance use disorder services or a population group designated by the Secretary as having a shortage of such services.

"(3) PRIMARY HEALTH CARE PHYSICIAN.—The term 'primary health care physician' means a physician that—

"(A) provides health services related to family medicine, internal medicine, pediatrics, obstetrics, gynecology, or geriatrics;

''(B) is a doctor of medicine or osteopathy that is licensed to practice medicine by the State in which such physician primarily practices.

''(4) PRIMARY HEALTH CARE PRACTICE.—The term 'primary health care practice' means a medical practice of primary health care physicians, including a practice within a larger health care system.

"SEC. 340K. ESTABLISHING TECHNICAL ASSISTANCE CENTERS FOR IMPLEMENTATION OF THE COLLABORATIVE CARE MODEL.

''(a) IN GENERAL.—The Secretary shall make grants to national and regional eligible organizations to establish, for purposes of providing technical assistance and training to health care providers and health care systems to facilitate and improve implementation of the collaborative care model—

''(1) a national center, to be known as the National Collaborative Care Model Training and Technical Assistance Center (referred to in this section as the 'National Center'); and

''(2) regional centers, to be known as Regional Collaborative Care Model Training and Technical Assistance Centers (referred to in this section as 'Regional Centers').

''(b) COORDINATION REQUIRED.—As a condition on receipt of a grant under this section to establish the National Center, the eligible organization receiving such grant shall agree to coordinate with one or more eligible organizations and the Regional Centers in providing technical assistance and training referred to in subsection (a).

''(c) TECHNICAL ASSISTANCE AND TRAINING.—The technical assistance and training referred to in subsection (a) shall include—

''(1) developing financial models and budgets for implementing and maintaining a collaborative care model, based on practice size;

''(2) developing staffing models for essential staff roles, including care managers and psychiatric consultants;

''(3) providing strategic advice to assist practices seeking to utilize other clinicians for additional psychotherapeutic interventions;

''(4) providing information technology expertise to assist with building the collaborative care model into electronic health records, including assistance with care manager tools, patient registry, ongoing patient monitoring, and patient records;

''(5) training support for all key staff and operational consultation to develop practice workflows;

''(6) establishing methods to ensure the sharing of best practices and operational knowledge among primary health care physicians and primary health care practices that provide behavioral health integration services through the collaborative care model;

''(7) providing guidance and instruction to primary health care physicians and primary health care practices on developing and maintaining relationships with community-based mental health and substance use disorder facilities for referral and treatment of patients whose clinical presentation or diagnosis is best suited for treatment at such facilities; and

''(8) other such activities as the Secretary necessary.

''(d) REGIONAL CENTER STRUCTURE.—

''(1) IN GENERAL.—The Secretary shall issue regulations establishing the structure of the Regional Centers and the nature of coordination among the Regional Centers and the National Center, including—

''(A) the number of Regional Centers, subject to adjustment as described in paragraph (2);

''(B) the geographic locations for such Regional Centers, subject to adjustment as described in paragraph (2);

''(C) the degree to which such National Center may direct the activities and practices of such Regional Centers; and

''(D) other such specifications that the Secretary may deem necessary.

''(2) ADJUSTMENTS.—The number and geographic location of the Regional Centers established under paragraph (1) may be adjusted from time to time as the Secretary determines necessary so long as, in making such adjustments—

''(A) seeks to establish as many Regional Centers as is possible and practicable while still maintaining optimal efficiency and effectiveness; and

''(B) ensures that the distribution of such geographic locations enables such Regional Centers to provide training and technical assistance in areas with medically underserved populations.

''(e) ACCOUNTABILITY.—The Secretary shall issue regulations establishing such criteria as the Secretary determines is necessary to evaluate the effectiveness of the

National Center and Regional Centers in providing technical assistance and training referred to in subsection (a), including for monitoring the activities of, collecting data from, and evaluating the performance of each recipient of a grant under this section.

''(f) DEFINITIONS.—In this section:

''(1) COLLABORATIVE CARE MODEL; MEDICALLY UNDERSERVED POPULATION; PRIMARY HEALTH CARE PHYSICIAN; PRIMARY HEALTH CARE PRACTICE.—The terms 'collaborative care model', 'primary health care physician', and 'primary health care practice' have the meaning given such terms in section 340J.

''(2) ELIGIBLE ORGANIZATION.—The term 'eligible organization' means a national or regional nonprofit organization that can provide technical assistance and training to health care providers and health care systems, and has special expertise and broad experience in behavioral health integration services, generally, and in the collaborative care model, specifically, with preference given to such organizations that are currently or that have previously provided training and technical assistance on providing behavioral health integration services through the collaborative care model.

"SEC. 340L. RESEARCH ON PROMISING BEHAVIORAL HEALTH INTEGRATION MODELS.

''The Secretary, in consultation with the Assistant Secretary for Planning and Evaluation, may direct administrators and directors of the Department of Health and Human Services, including the Director of the National Institutes of Health, the Administrator of the Health Resources and Services Administration, the Director of the Agency for Healthcare and Research Quality, and the Director of the Center for Medicare and Medicaid Innovation, as the Secretary determines appropriate, to expand efforts to evaluate current and emerging behavioral health integration models, such as the primary care behavioral health model, and improve the foundation for evidence-based practice, with a focus on population-based care.

"SEC. 340M. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated to carry out sections 340J, 340K, and 340L, $30,000,000 for each of fiscal years 2022 through 2026.''.

(b) TECHNICAL CORRECTION.—Effective as if included in the enactment of section 301(c) of the Disaster Tax Relief and Airport and Airway Extension Act of 2017 (Public Law 115–63), such section is amended, in the matter preceding paragraph (1), by striking ''Part D'' and inserting ''Part D of title III''.

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