

The Road to Recovery 2011

Health Reform: What It Means for People With Substance Use and Mental Disorders

Discussion Guide

The show will be filmed in a panel format, with free discussion between the show host and other panelists. This discussion guide is not to be considered as a script. Rather, the information and resources provided in this discussion guide are meant to assist panelists in show preparation. The questions identified in each panel section will be asked by the show host. Panelists will respond to questions asked by the host and will also comment and add to information presented by other panelists in a discussion format. Panelists will bring to the show their own keen anecdotal experiences as well as references from scientific studies from the field.

Show Description: With the passage of the Patient Protection and Affordable Care Act, commonly known as health reform, important and far-reaching changes are underway in our Nation's health system. The Affordable Care Act gives Americans more freedom and control over their health care, as well as new benefits that ensure they will receive the care they need at a more reasonable cost. In addition, changes will include the adoption of electronic health records, allowing the comprehensive management and secure exchange of health information among insurers, primary care practitioners, general practitioners, pharmacists, and those in specialty fields such as pediatrics, cardiology, oncology, orthopedics, and treatment and recovery in behavioral health. There are many questions about what health reform changes will take effect and when the changes will be implemented. This show will provide information to help answer these questions and suggest other means for consumers to stay informed and determine what health reform will mean to them.

Panel 1: Overview of Health Reform Impacts on the Behavioral Health System

Key Questions:

- 1. What are the major ways that the Affordable Care Act (ACA) affects the behavioral health system?**
- 2. What is the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and how is this law fundamentally connected to the ACA? How many people in group health insurance plans are affected by MHPAEA?**
- 3. What is the timeline for implementation of the ACA? What provisions are in effect now and what key changes will go into effect later?**

4. **What are the costs of behavioral health care in the Nation today? What percentage does this represent of overall health care costs? Have costs for behavioral health care been growing in recent years?**
5. **Where does funding for behavioral health services come from? Has funding for behavioral health services kept pace with demand for services in recent years?**
6. **What role is SAMHSA playing in implementing health reform? What are the goals of the SAMHSA strategic initiative on health reform?**

Major Ways the ACA Affects the Behavioral Health System

Source: Substance Abuse and Mental Health Services Administration (2011). Leading change: A plan for SAMHSA's roles and actions, 2011–2014. HHS Publication No. (SMA) 11-4629, <http://store.samhsa.gov/product/SMA11-4629> (accessed May 10, 2011).

- In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, together referred to as the Affordable Care Act (ACA). The ACA makes health insurance coverage more affordable for individuals, families, and the owners of small businesses. The ACA is one aspect of a broader movement toward a reformed behavioral health system. For the behavioral health field, “health reform” includes MHPAEA; Olmstead and early periodic screening, diagnosis, and treatment (EPSDT) issues; integration with the broader health system; and increased use of health information technology (HIT).

Source: Substance Abuse and Mental Health Services Administration (April 21, 2010). Mental health and substance abuse provisions in the Patient Protection and Accountability Act [announcement].

Also, Substance Abuse and Mental Health Services Administration (December 20, 2010). Draft description of a good and modern addictions and mental health service system, http://www.samhsa.gov/healthReform/docs/good_and_modern_12_20_2010_508.pdf (accessed May 10, 2011).

- The ACA expands access to health care (including behavioral health care) to approximately 32 million Americans through expansion of eligibility for Medicaid, changes to Medicare, the creation of private health insurance exchanges, new requirements for existing private insurance plans, and requirements for new private insurance plans.
- The ACA expands availability of types of behavioral health services for persons with substance use and mental disorders by placing requirements on insurance plans related to substance use and MH treatment, prescription drugs, rehabilitative services, habilitative services, and prevention and wellness services. (These services must be available in benefit packages by Fiscal Year [FY] 2014.)
- The ACA emphasizes and supports prevention and wellness in the Nation's health care system, including prevention related to substance use and mental disorders.
- The ACA provides for major changes in the delivery system for health care services, including changes that directly affect the behavioral health system. Key change areas

include integration and coordination of primary and behavioral health care, support of health homes, school-based health centers, home and community-based service options for persons with substance use or mental disorders, workforce development initiatives, and improvements in HIT.

MHPAEA and its Relationship to the ACA

Source: Fact Sheet: The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

- The MHPAEA requires group health plans and health insurance issuers to ensure that financial requirements (such as copays and deductibles) and treatment limitations (such as visit limits) that are applicable to substance use or mental disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Source: Substance Abuse and Mental Health Services Administration. (2011). *Recovery Month kit—fast facts about health care reform, substance use and mental disorders, treatment, and recovery, draft #8.*

- The passage of the MHPAEA provides parity, or the recognition by insurance services—both public and private—that substance use and mental disorders are treated in a way that is comparable to other physical health and medical conditions.
- All employer health insurance plans with more than 50 enrolled employees, must comply with the MHPAEA. This means that, if the employer chooses to include substance use and MH treatment in their plan, these services must be offered at parity with other medical and surgical benefits. For instance, the copayments and deductibles for a visit cannot be larger and there cannot be greater limits in behavioral health inpatient days than for medical and surgical inpatient days.

Source: Substance Abuse and Mental Health Services Administration. (2011). *Leading change: A plan for SAMHSA's roles and actions, 2011–2014.* HHS Publication No. (SMA) 11-4629, <http://store.samhsa.gov/product/SMA11-4629> (accessed May 10, 2011).

- The MHPAEA affects 140 million individuals participating in group health plans.

Source: Center for Mental Health Services. (August 6, 2010). *Mental Health Parity and Addiction Equity Act of 2008: The law and regulations [presentation]*. Rockville, MD: SAMHSA.

- Parity is defined as the absence of treatment limitations to include restrictions on the number of visits or days of coverage; other limits on the duration and scope of treatment; and financial requirements including deductibles, coinsurance, copayments, and other cost-sharing requirements, as well as annual and lifetime limits on the total amount of coverage.
- The ACA builds upon the MHPAEA by applying the parity requirement on plans to be offered by private insurance exchanges, to expanded Medicaid coverage, to the

Children's Health Insurance Program (CHIP), and to all plans that include behavioral health coverage.

ACA Provisions Implementation Timeline

Source: HealthCare.gov, <http://www.healthcare.gov>

- Provisions that went into effect in 2010 include:
 - Providing access to insurance for those with pre-existing conditions;
 - Eliminating lifetime limits on insurance coverage and regulating limits on annual coverage;
 - Prohibiting rescinding coverage (e.g., for those with serious and costly health conditions);
 - Providing free preventive care (no cost-sharing) for certain services;
 - Extending coverage for young adults (i.e., children on their parents' plans up to age 26);
 - Holding insurance companies accountable for unreasonable rate hikes; and
 - Providing relief for seniors who hit the Medicare prescription drug coverage "donut hole."

- Provisions that go into effect in the 2011-2013 timeframe include:
 - Providing free preventive care for seniors;
 - Requiring insurers to spend at least 80 percent of premiums on health care;
 - Increasing access to home and community-based services;
 - Increasing funding for community health centers;
 - Encouraging integrated health care systems;
 - Understanding and fighting health disparities; and
 - Improving preventive health coverage.

- Provisions that go into effect in 2014 or later include:
 - Establishing health insurance exchanges;
 - Increasing access to Medicaid;
 - Promoting individual responsibility by mandating health coverage; and
 - Eliminating annual limits on insurance coverage.

Costs of Behavioral Health Services

Source: Substance Abuse and Mental Health Services Administration. (February 4, 2011). SAMHSA-sponsored study examining behavioral health spending between 1986 and 2005. SAMHSA's Weekly Financing News Pulse: National Edition, <http://www.samhsa.gov> (accessed May 10, 2011).

- The study found that U.S. behavioral health spending totaled \$135 billion in 2005, accounting for 7.3 percent of the \$1.85 trillion spent on health care. In addition, for

2005, the study determined that behavioral health spending represented 4.8 percent of private insurers' expenditures and 11.5 percent of Medicaid expenditures.

- Between 1986 and 2006, the study found that annual cost growth averaged 7.9 percent for all health spending while averaging 4.8 percent for substance abuse (SA) treatment and 6.9 percent for MH treatment. The authors also determined that the spending growth rate for psychiatric drugs declined to 5.6 percent between 2004 and 2005, down from 27.3 percent between 1999 and 2000.
- The study found that spending on drugs to treat substance dependence has grown from \$10 million in 1992 to \$141 million in 2005, accounting for 0.6 percent of SA treatment spending in 2005 (SAMHSA via Newswise, 2/3; SAMHSA, 2/3).

Funding for Behavioral Health Care

Source: Substance Abuse and Mental Health Services Administration. (2011). Leading change: A plan for SAMHSA's roles and actions, 2011–2014. HHS Publication No. (SMA) 11-4629, <http://store.samhsa.gov/product/SMA11-4629> (accessed May 10, 2011).

- As of 2005, Medicaid paid for 28 percent of all spending on MH services and 21 percent of SA treatment in the United States.
- As of 2005, Medicare paid for 8 percent of all spending on MH services and 7 percent of SA treatment services in the United States.
- Medicaid is a primary source of support for MH services at the State level—44 percent of MH funding managed by State Mental Health Authorities comes from Medicaid.
- In 2006, nearly 7.5 million individuals were dually eligible for both Medicare and Medicaid at a cost of approximately \$200 billion. Fifty-two percent of these people have a psychiatric illness.
- States spend as much as 75 percent of their Medicaid MH funds for children on residential treatment and inpatient hospital services.
- Many individuals with substance use and mental disorders will no longer pay significant out-of-pocket expenses for medication due to the closing of the “doughnut hole” in Medicare Part D.

Source: Substance Abuse and Mental Health Services Administration. (2010). National expenditures for mental health, services and substance abuse treatment, 1986–2005. DHHS Publication No. (SMA) 10-4612. Rockville, MD: Center for Mental Health Services and Center for Substance Abuse Treatment.

Total MHSAs Treatment Spending

- MH and SA treatment spending from all public and private sources totaled \$135 billion in 2005.
- MH and SA treatment spending declined as a share of all health spending, from 9.3 percent in 1986 to 7.3 percent in 2005.
- MH and SA treatment spending lagged behind growth in all-health spending between 1986 and 2005 (7.9 percent average annual all-health spending growth rate vs. 6.9 percent for MH spending and 4.8 percent for SA spending).

MH Spending

- MH spending accounted for 6.1 percent of all-health spending in 2005.
- MH treatment spending depended more on public payers than spending for all-health care in 2005; public payers accounted for 58 percent of MH spending but just 46 percent of all-health spending.
- Medicaid was the largest public payer for MH treatment in 2005, accounting for 28 percent of all MH spending; other State and local government sources made up 18 percent, Medicare made up 8 percent, and other Federal spending made up 5 percent of all MH spending.
- Private insurance was the largest private payer for MH treatment, with a 27 percent share of all MH spending. Out-of-pocket spending accounted for 12 percent, and other private sources made up 3 percent.
- Prescription drugs and hospital treatment each accounted for 27 percent of MH spending in 2005; in 1986, only 7 percent of MH spending went to prescription drugs.
- MH drug spending grew by an average of 24 percent a year between 1997 and 2001. After 2001, growth slowed dramatically, to an average rate of 10 percent a year between 2001 and 2005.
- The share of MH spending dedicated to specialty psychiatric and chemical dependency hospitals fell sharply between 1986 and 2005, from 26 percent in 1986 to 12 percent in 2005.
- Specialty MH centers received 13 percent of MH treatment spending in 2005.

SA Treatment Spending

- SA spending accounted for only 1.2 percent of all-health spending in 2005.
- Public payers were responsible for nearly 80 percent of SA treatment spending in 2005.
- State and local payers (excluding the State share of Medicaid) accounted for the largest share of SA treatment spending in 2005 (36 percent). Medicaid (21 percent of SA spending), other Federal (16 percent), and Medicare (7 percent) were the remaining public payers.
- Private insurance paid for 12 percent of SA treatment spending in 2005, down from 27 percent in 1986. Between 1986 and 2005, the share of SA spending increased for Medicaid (from 12 percent to 21 percent), for other State and local governments (from 31 percent to 36 percent), and for other Federal Government (from 10 percent to 16 percent), while Medicare spending changed little (from 8 percent to 7 percent).

- The SA share of all-health spending was 0.4 percent for private insurance, 1.5 percent for Medicaid, and 7.3 percent for other State and local in 2005.
- Specialty MH and SA centers received the largest portion (52 percent) of SA treatment spending in 2005.

Source: Substance Abuse and Mental Health Services Administration (February 18, 2011). Reference in SAMHSA's Weekly Financing News Pulse: National Edition, <http://www.samhsa.gov> (accessed May 10, 2011).

- On February 16, 2011, the National Association of State Mental Health Program Directors (NASMHPD) offered a Congressional briefing examining State MH funding. The briefing noted that States have cut MH agency budgets by \$2.2 billion between FY 2009 and FY 2011. In addition, NASMHPD notes that 60 percent of States reported higher demand for community-based MH services over the same period. Finally, NASMHPD found that five States have closed a total of six State psychiatric hospitals since 2010 (State Net via PR Web, 2/15; NASMHPD).

SAMHSA's Role in Implementing Health Reform

Source: Substance Abuse and Mental Health Services Administration. (2011). Leading change: A plan for SAMHSA's roles and actions, 2011–2014. HHS Publication No. (SMA) 11-4629. <http://store.samhsa.gov/product/SMA11-4629> (accessed May 10, 2011).

- SAMHSA has a prominent role in several key ACA provisions, including a requirement for States and Territories to consult with SAMHSA in developing medical homes for individuals with mental and substance use disorders. If funds are appropriated by Congress, SAMHSA will also be responsible for developing Centers of Excellence for depression and postpartum depression.
- In addition, SAMHSA is taking a lead role in shaping policies on home- and community-based services for individuals with substance use and mental disorders. Parity between MH and addiction services and medical and health services is a SAMHSA priority. SAMHSA will work to ensure that behavioral health services covered by the ACA and MHPAEA are at parity and that these services are managed no differently than medical and other health benefits offered by Medicaid and private insurance.
- The ACA will have an effect on SAMHSA's Block Grants and the alignment of public and private sectors. The new opportunities under the law will significantly expand mental and substance use treatment and recovery support services under Medicaid and insurance products offered to working-class families. Some changes are already in effect, while others are not yet implemented, including a major expansion in Medicaid enrollment in 2014.
- Because of this anticipated increase in funding for treatment and services, SAMHSA Block Grants will soon be able to purchase other needed services that support individuals and families in moving toward their recovery and resiliency goals. Many of these services may not be covered by Medicaid or private insurance; therefore, Block

Grant services will likely be necessary to complete the benefit package for people with insurance coverage and to deliver the full range of services to others who still do not have or who move in and out of coverage.

SAMHSA's Goals of Health Reform Strategic Initiative

Source: Substance Abuse and Mental Health Services Administration. (2011). Leading change: A plan for SAMHSA's roles and actions, 2011–2014. HHS Publication No. (SMA) 11-4629. <http://store.samhsa.gov/product/SMA11-4629> (accessed May 10, 2011).

- Goal 5.1: Ensure behavioral health is included in all aspects of health reform.
- Goal 5.2: Support Federal, State, Territorial, and Tribal efforts to develop and implement new provisions under Medicaid and Medicare.
- Goal 5.3: Finalize and implement the parity provisions in MHPAEA and the ACA.
- Goal 5.4: Develop changes in SAMHSA Block Grants to support recovery and resilience and increase accountability.
- Goal 5.5: Foster the integration of primary and behavioral health care.

Panel 2: Expanding Access to Behavioral Health Care

Key Questions:

- 1. How many individuals in this country are still uninsured?**
- 2. Why is it important to reduce the number of uninsured persons in this country with respect to treatment for substance use and mental disorders?**
- 3. How does the ACA increase access to behavioral health services by expanding eligibility to Medicaid?**
- 4. How does the ACA increase access to behavioral health services by creating health insurance exchanges?**
- 5. How do regulations and requirements in the ACA for existing and new private health insurance plans expand access to behavioral health services?**

Number of Individuals in the United States Who Are Uninsured

Source: U.S. Census Bureau. Table 8: People Without Health Insurance Coverage by Selected Characteristics: 2008 and 2009. *Current Population Survey, 2009 and 2010 Annual Social and Economic Supplements*,

<http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2009/tab8.pdf> (accessed May 10, 2011).

U.S. Census Bureau. Figure 8: Coverage by Type of Health Insurance: 2008 and 2009. *Current Population Survey, 2009 and 2010 Annual Social and Economic Supplements*, <http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2009/fig08.pdf> (accessed May 10, 2011).

- According to the 2009 U.S. Census, 50.67 million people are uninsured.

Breakdown of the Type of Health Coverage

Table 8.
People Without Health Insurance Coverage by Selected Characteristics: 2008 and 2009

(Numbers in thousands, confidence intervals [C.I.] in thousands or percentage points as appropriate. People as of March of the following year. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see www.census.gov/apcd/techdoc/cps/cpsmar10.pdf)

Characteristic	2008					2009					Change in uninsured ¹	
	Total	Uninsured				Total	Uninsured				Number	Percent
		Number	90 percent C.I. ² (±)	Percent	90 percent C.I. ² (±)		Number	90 percent C.I. ² (±)	Percent	90 percent C.I. ² (±)		
Total	301,483	46,340	529	15.4	0.2	304,280	50,674	549	16.7	0.2	*4,335	*1.3
Family Status												
In families	248,301	35,248	472	14.2	0.2	249,384	38,228	489	15.3	0.2	*2,981	*1.1
Householder	78,874	10,535	170	13.4	0.2	78,867	11,586	178	14.7	0.2	*1,050	*1.3
Related children under 18	72,980	7,025	222	9.6	0.3	73,410	7,202	225	9.8	0.3	177	0.2
Related children under 6	24,884	2,142	124	8.6	0.5	25,104	2,275	127	9.1	0.5	134	0.5
In unrelated subfamilies	1,207	300	46	24.9	3.3	1,357	364	51	26.8	3.2	*64	1.9
Unrelated individuals	51,975	10,791	172	20.8	0.3	53,539	12,082	181	22.6	0.3	*1,290	*1.8
Race³ and Hispanic Origin												
White	240,852	34,890	470	14.5	0.2	242,403	38,399	490	15.8	0.2	*3,509	*1.4
White, not Hispanic	197,159	21,322	377	10.8	0.2	197,436	23,658	395	12.0	0.2	*2,336	*1.2
Black	38,076	7,284	257	19.1	0.6	38,624	8,102	269	21.0	0.7	*818	*1.8
Asian	13,315	2,344	147	17.6	1.1	14,011	2,409	149	17.2	1.0	65	-0.4
Hispanic (any race)	47,485	14,558	323	30.7	0.7	48,901	15,820	332	32.4	0.7	*1,263	*1.7
Age												
Under 65 years	263,695	45,693	526	17.3	0.2	265,667	49,998	546	18.8	0.2	*4,305	*1.5
Under 18 years	74,510	7,348	227	9.9	0.3	75,040	7,513	229	10.0	0.3	165	0.1
18 to 24 years	28,688	8,200	239	28.6	0.7	29,313	8,923	249	30.4	0.7	*723	*1.9
25 to 34 years	40,520	10,754	273	26.5	0.6	41,085	11,963	287	29.1	0.6	*1,209	*2.6
35 to 44 years	41,322	8,035	237	19.4	0.5	40,447	8,759	247	21.7	0.5	*723	*2.2
45 to 64 years	78,655	11,355	280	14.4	0.3	79,782	12,840	297	16.1	0.3	*1,485	*1.7
65 years and older	37,788	646	68	1.7	0.2	38,613	676	70	1.8	0.2	30	-
Nativity												
Native born	264,733	34,036	465	12.9	0.2	266,674	37,694	486	14.1	0.2	*3,658	*1.3
Foreign born	36,750	12,304	331	33.5	0.8	37,606	12,980	340	34.5	0.7	*677	*1.0
Naturalized citizen	15,475	2,792	161	18.0	0.9	16,024	3,044	168	19.0	0.9	*252	1.0
Not a citizen	21,274	9,511	293	44.7	1.0	21,581	9,936	299	46.0	1.0	*425	*1.3
Region												
Northeast	54,191	6,277	205	11.6	0.4	54,654	6,789	212	12.4	0.4	*512	*0.8
Midwest	65,672	7,588	223	11.6	0.3	66,096	8,770	237	13.3	0.4	*1,181	*1.7
South	110,845	20,154	357	18.2	0.3	112,312	22,105	370	19.7	0.3	*1,951	*1.5
West	70,775	12,321	284	17.4	0.4	71,218	13,011	290	18.3	0.4	*690	*0.9
Residence												
Inside metropolitan statistical areas	253,399	39,023	493	15.4	0.2	256,383	43,028	514	16.8	0.2	*4,006	*1.4
Inside principal cities	97,364	17,963	348	18.4	0.3	97,856	19,270	360	19.7	0.3	*1,307	*1.2
Outside principal cities	156,036	21,060	375	13.5	0.2	158,527	23,758	396	15.0	0.2	*2,699	*1.5
Outside metropolitan statistical areas ⁴	48,083	7,317	277	15.2	0.5	47,897	7,646	283	16.0	0.5	329	*0.7
Household Income												
Less than \$25,000	55,814	13,673	306	24.5	0.5	58,159	15,483	324	26.6	0.5	*1,811	*2.1
\$25,000 to \$49,999	69,621	14,908	319	21.4	0.4	71,340	15,278	322	21.4	0.4	369	-
\$50,000 to \$74,999	57,525	8,034	237	14.0	0.4	58,381	9,352	255	16.0	0.4	*1,318	*2.1
\$75,000 or more	118,523	9,725	260	8.2	0.2	116,400	10,561	270	9.1	0.2	*836	*0.9
Work Experience												
Total, 18 to 64 years old	189,185	38,345	505	20.3	0.3	190,627	42,485	524	22.3	0.3	*4,140	*2.0
All workers	148,463	27,772	444	18.7	0.3	145,184	29,263	454	20.2	0.3	*1,491	*1.4
Worked full-time, year-round	100,626	14,723	336	14.6	0.3	95,808	14,589	335	15.2	0.3	-134	*0.6
Less than full-time, year-round	47,837	13,049	318	27.3	0.6	49,376	14,674	335	29.7	0.6	*1,625	*2.4
Did not work	40,723	10,573	289	26.0	0.6	45,443	13,222	321	29.1	0.6	*2,649	*3.1

- Represents or rounds to zero.

* Statistically different from zero at the 90 percent confidence level.

¹ Details may not sum to totals because of rounding.

² A 90 percent confidence interval is a measure of an estimate's variability. The larger the confidence interval in relation to the size of the estimate, the less reliable the estimate. For more information, see "Standard Errors and Their Use" at www.census.gov/hhes/www/p60_238sa.pdf.

³ Federal surveys now give respondents the option of reporting more than one race. Therefore, two basic ways of defining a race group are possible. A group such as Asian may be defined as those who reported Asian and no other race (the race-alone or single-race concept) or as those who reported Asian regardless of whether they also reported another race (the race-alone-or-in-combination concept). This table shows data using the first approach (race alone). The use of the single-race population does not imply that it is the preferred method of presenting or analyzing data. The Census Bureau uses a variety of approaches. Information on people who reported more than one race, such as White and American Indian and Alaska Native or Asian and Black or African American, is available from Census 2000 through American FactFinder. About 2.6 percent of people reported more than one race in Census 2000. Data for American Indians and Alaska Natives, Native Hawaiians and Other Pacific Islanders, and those reporting two or more races are not shown separately.

⁴ The "Outside metropolitan statistical areas" category includes both micropolitan statistical areas and territory outside of metropolitan and micropolitan statistical areas. For more information, see "About Metropolitan and Micropolitan Statistical Areas" at www.census.gov/population/www/estimates/aboutmetro.html.

Source: U.S. Census Bureau, Current Population Survey, 2009 and 2010 Annual Social and Economic Supplements.

Source: *Health reform puts American families and small business owners in control of their own health care*, <http://www.whitehouse.gov> (accessed May 10, 2011).

- By 2016, 32 million Americans will be able to afford health care who do not have it today, and the ACA makes coverage more affordable for many others. Under the plan, 95 percent of Americans will be insured.
 - An additional 2 million Americans will be able to afford health care by 2014—for a total of 34 million—according to the updated CBO analysis, <http://cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf>, page 19.

Source: *States and the Affordable Care Act: More Funding, More Flexibility*, February 25, 2011, <http://www.healthcare.gov/center/reports/states02252011a.pdf> (accessed May 10, 2011).

- In 2008, for example, States spent \$17.2 billion on uncompensated care due to the large number of Americans without health insurance. Rising health care costs have also had a significant effect on State budgets.

Number of Uninsured With Substance Use and Mental Disorders

Source: Substance Abuse and Mental Health Services Administration. (2011). Leading change: A plan for SAMHSA's roles and actions, 2011–2014. HHS Publication No. (SMA) 11-4629, <http://store.samhsa.gov/product/SMA11-4629> (accessed May 10, 2011).

- In 2014, 32 million more Americans will be covered by health insurance because of changes under the ACA. Between 20 and 30 percent of these people (6–10 million) will have a substance use or mental disorder.
- The ACA will increase the number of people who are insured. Currently, individuals with a mental disorder are twice as likely to be uninsured than those without a mental disorder.
- Among the currently uninsured aged 22 to 64 with family income of less than 150 percent of the Federal Poverty Level (FPL), 32.4 percent had illicit drug or alcohol dependence/abuse or mental illness.
- Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) populations, as well as racial and ethnic populations, are disproportionately represented in the ranks of the uninsured. In 2008, 22 percent of gay and lesbian individuals reported having no health insurance. In 2009, 34 percent of Hispanics, 28 percent of American Indians and Alaska Natives, 23 percent of African Americans, and 18 percent of Asian Americans, compared with 14 percent of White Americans, were uninsured.

Source: Substance Abuse and Mental Health Services Administration (September/October 2010). Health Reform: What You Need To Know: What the Affordable Care Act Offers. *SAMHSA News*, 18(5).

- “Right now, estimates show that one-fifth to one-third of the uninsured are people with mental and substance use disorders,” said SAMHSA Administrator Pamela S. Hyde, J.D.

“Of the estimated 32 million people we anticipate gaining coverage, about 6 to 10 million will have untreated mental illnesses or addictions we can actually help.”

- “There exists widespread lack of health insurance among many of the people who need it the most,” said John O’Brien, M.A., Senior Advisor for Health Financing at SAMHSA. “Thirty-nine percent of the individuals who are now served by State mental health authorities have no insurance now,” he pointed out. “And 61 percent of individuals served by State substance abuse authorities have no insurance.”

Expansion of Medicaid Eligibility

Source: Substance Abuse and Mental Health Services Administration. (2011). *Recovery Month kit—Fast facts about health care reform, substance use and mental disorders, treatment, and recovery*, draft #8.

- Medicaid, a health program for low-income individuals and families, will expand its eligibility to 133 percent of the FPL, and all newly eligible parents and adults without children will receive basic benefits, which include essential substance use and MH services at parity.

Source: Substance Abuse and Mental Health Services Administration. (August 6, 2010). Affordable Care Act [presentation].

- Effective January 1, 2014, the ACA will expand eligibility for Medicaid to individuals under age 65 who earn less than 133 percent of the FPL (approximately \$14,000 for an individual and \$29,000 for a family of four) based on modified adjusted gross income.
- Expansion of Medicaid is expected to result in 16 million new enrollees (40 percent of them under 30 years old).

Health Insurance Exchanges

Source: Substance Abuse and Mental Health Services Administration. (2011). *Recovery Month kit—Fast facts about health care reform, substance use and mental disorders, treatment, and recovery*, draft #8.

- Coverage changes under both Medicaid and State health exchanges will be implemented by 2014, expanding coverage to millions who are currently uninsured.
- Employer health insurance premiums will be subsidized for those with limited income defined under the law through State exchanges.
- Through the State exchanges, individuals and small businesses can purchase affordable health plans with basic benefits, which include essential substance use and MH services at parity.

ACA Requirements and Regulations Supporting Expanded Access

Source: HealthCare.gov, <http://www.healthcare.gov>

- A Pre-Existing Condition Insurance Plan established by the ACA provides new coverage options to individuals who have been uninsured for at least 6 months because of a pre-existing condition. States have the option of running this new program in their State. If a State chooses not to do so, a plan will be established by the Department of Health and Human Services (HHS) in that State. This program serves as a bridge to 2014, when all discrimination against pre-existing conditions will be prohibited.
- Beginning in 2014, the law implements strong reforms that prohibit insurance companies from refusing to sell coverage or renew policies because of an individual's pre-existing conditions. Also, in the individual and small group market, this law eliminates the ability of insurance companies to charge higher rates due to gender or health status.

Source: Substance Abuse and Mental Health Services Administration. (January 21, 2011). SAMHSA's Weekly Financing News Pulse: National Edition.

- On January 18, HHS officials released a study estimating the number of Americans with pre-existing health conditions that could preclude them from obtaining health care in the absence of the national health care reform law. Using 2008 data, the study projects that between 50 million and 129 million nonelderly Americans have pre-existing conditions, including mental illnesses, as defined under the law's high-risk insurance pools and the underwriting standards of seven major insurers.
- In addition, the study estimates that up to 20 percent of nonelderly individuals with pre-existing conditions are uninsured. HHS officials say that the study highlights the importance of the national health reform law's consumer protections, which, starting in 2014, bar insurers from discriminating against individuals with pre-existing conditions (The Washington Post, 1/18; Kaiser Health News, 1/18).
- Other insurance reforms and consumer protections that have the effect of increasing or preserving access to health care include:
 - Eliminating lifetime limits on insurance coverage and regulating limits on annual coverage;
 - Prohibiting rescinding coverage (e.g., for those with serious and costly health conditions);
 - Extending coverage for young adults (i.e., children on their parents' plans up to age 26); and
 - Eliminating annual limits on insurance coverage.

Panel 3: Prevention and Wellness in the ACA

Key Questions:

1. How does the ACA shift health care in this country more toward prevention and wellness?
2. How do the prevention and wellness provisions of the ACA connect to behavioral health care?
3. What is the National Prevention Council? How does the national prevention strategy being developed by the Council relate to behavioral health?
4. What is the Prevention and Public Health fund?
5. What are “evidence-based preventive health services” that the ACA requires to be provided with no cost-sharing? What behavioral health areas are included in this?
6. What are Community Transformation Grants? How will they support prevention and wellness with respect to behavioral health?
7. What other provisions of the ACA are directly related to prevention and early intervention for substance use and mental disorders?

Shifting of the Nation’s Health Care System Toward Prevention and Wellness

Source: Substance Abuse and Mental Health Services Administration (September/October 2010). Health reform: What you need to know: What the Affordable Care Act offers. *SAMHSA News*, 18(5).

- Imagine a shift from “sick care” to true health care. That’s how HHS Secretary Kathleen Sebelius, M.P.A., describes the transformation that health reform is bringing to our health care system.
- An emphasis on prevention pervades the ACA. “Focusing on prevention rather than waiting until people get to the point where they have to be treated for some sort of acute illness just makes good sense,” said Secretary Sebelius. “We want to take down the barriers that are keeping folks from being as healthy as they can.”

National Prevention Council

Source: National Prevention and Health Promotion Strategy; Draft Vision, Goals, Strategic Directions, and Recommendations

<http://www.healthcare.gov/center/councils/nphpphc>

- The ACA established a National Prevention Council, led by the U.S. Surgeon General, to develop a national prevention and health promotion strategy that is to be reported annually to Congress and the President. Among the 10 preliminary strategic directions identified by the Council are two that pertain to behavioral health: (1) countering alcohol and substance misuse and (2) tobacco-free living. Both the Secretary of HHS and the Director of the Office of National Drug Control Policy are members of the Council.
- Specifically, the ACA requires that the strategy contain a list of national priorities on health promotion and disease prevention to address lifestyle behavior modification

(e.g., smoking cessation, proper nutrition, appropriate exercise, MH, behavioral health, substance use disorder, domestic violence screenings) and prevention measures for the five leading disease killers in the United States (i.e., heart disease, cancer, stroke, chronic lower respiratory disease, and unintentional injuries).

Prevention and Public Health Fund

Source: HealthCare.gov, <http://www.healthcare.gov>

- The ACA creates a new Prevention and Public Health Fund designed to expand and sustain the necessary infrastructure to prevent disease, detect it early, and manage conditions before they become severe. This new initiative will increase the national investment in prevention and public health, improve health, and enhance health care quality. Initial investment was \$500 million in FY 2010 and will increase to \$2 billion per year beginning in FY 2015.

Evidence-Based Preventive Health Services

Source: U.S. Preventive Services Task Force, <http://www.ahrq.gov/clinic/uspstfix.htm>

- The ACA requires coverage of evidence-based preventive health services at no-cost sharing that have received an “A” or “B” grade recommendation by the United States Preventive Services Task Force (USPSTF).
- Screening and brief intervention for alcohol misuse is a “B” preventive list recommendation. The USPSTF recommends screening and counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
- Tobacco cessation is an “A” preventive list recommendation. The USPSTF strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. The USPSTF also strongly recommends that clinicians screen all pregnant women for tobacco use and provide augmented pregnancy-tailored counseling to smokers.
- Coverage of the preventive health services requirement applies to Medicaid benchmark plans for the newly eligible population, Medicare, qualified health plans in the newly created State health insurance exchanges, and new individual and small group plans.

Source: Substance Abuse and Mental Health Services Administration. (2011). Recovery Month kit—Fast facts about health care reform, substance use and mental disorders, treatment, and recovery, draft #8.

- Starting in 2011, health plans must cover certain evidence-based prevention services with no copayments, including screening for depression and substance use disorders, brief intervention, and treatment referral.

Community Transformation Grants

Source: HealthCare.gov, <http://www.healthcare.gov>

- Community Transformation Grants, awarded by the HHS Centers for Disease Control and Prevention (CDC), are competitive grants to State and local governmental agencies and community-based organizations for evidence-based, community preventive activities to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming.

Other ACA Provisions Related to Substance Use and Mental Disorders Prevention

Source: HealthCare.gov, <http://www.healthcare.gov>

- Establishes a community-based prevention and wellness grant program for individuals aged 55 to 64 years of age (targeted actions in these grants may address substance use).
- Establishes grants for student-based health centers (which includes health assessments and referrals for any health issue, including substance use).
- Establishes a national public-private outreach and education campaign regarding prevention benefits (which could include substance use).
- Provides for pilot programs directed toward at-risk populations who use community health centers to reduce risk, including alcohol and tobacco cessation counseling.

Panel 4: Implementing the ACA—Improving Service Delivery in Behavioral Health Care

Key Questions:

- 1. Why is it important to integrate primary health care with behavioral health care? How does the ACA support doing this?**
- 2. What are “health homes” or “medical homes”? How is this innovative approach in health care helpful to persons with substance use and mental disorders?**
- 3. What are “school-based health centers”? What role will these centers play in promoting behavioral health for young people?**
- 4. How does the ACA address HIT?**
- 5. How will ACA improve the quality of health care? What are some of the key areas that will be indicators of an improved health care system?**
- 6. What workforce development initiatives are contained in the ACA? How will these initiatives help improve the workforce in the behavioral health care system?**
- 7. What key resources can people access to learn more about health reform as related to behavioral health care?**

Integration of Primary Health Care and Behavioral Health Care

Source: Substance Abuse and Mental Health Services Administration. (2011). Leading change: A plan for SAMHSA's roles and actions, 2011–2014. HHS Publication No. (SMA) 11-4629. <http://store.samhsa.gov/product/SMA11-4629> (accessed May 10, 2011).

- SAMHSA will promote the planning and development of integrated primary and behavioral health care for individuals with mental and substance use disorders. This bidirectional integration of primary and behavioral health care will better meet the needs of individuals with mental and/or substance use disorders who seek care in primary care settings to address their health needs. As a result, SAMHSA will focus on enhancing access to health and behavioral health services and effective referral arrangements for those living with mental and/or substance use disorders across all health care settings—whether specialty behavioral health or primary care providers.
- SAMHSA will build upon its Primary and Behavioral Health Care Integration (PBHCI) program to implement new opportunities under the ACA, MHPAEA, and other initiatives. SAMHSA will collaborate in planning the next generation of PBHCI with HHS agencies, the Center for Medicaid Services (CMS), Indian Health Bureau, Health Resource Service Administration (HRSA), and relevant Federal Offices of Minority Health created by the ACA. These efforts will include developing new or expanding current models that support integration of services for substance use and mental disorders with physical health in both directions (primary care in behavioral health care and behavioral health in primary care).

Medical Homes

Source: Substance Abuse and Mental Health Services Administration. (2011). Leading change: A plan for SAMHSA's roles and actions, 2011–2014. HHS Publication No. (SMA) 11-4629. <http://store.samhsa.gov/product/SMA11-4629> (accessed May 10, 2011).

- The ACA seeks to enhance the availability of primary care services, especially for low-income individuals with complex health needs. Many provisions seek to identify and coordinate primary care and specialty services for these individuals through medical homes. In use for many years, the term “medical home” means the specific designation of a health care professional, practice, or clinic to be accountable for identifying and coordinating a wide range of services for a particular individual or group.
- Specific provisions of the ACA will increase access to medical homes for individuals with serious mental illness and individuals with co-occurring addiction and other chronic health and MH conditions. Better coordination will help reign in unsustainable costs for families, government, and the private sector, making care more accessible, affordable, and effective.

Source: Substance Abuse and Mental Health Services Administration (September/October 2010). Health reform: What you need to know: What the Affordable Care Act offers. *SAMHSA News*, 18(5).

- “Some folks are concerned that when you’re talking about homes, you’re talking about residential programs. Not so,” Mr. O’Brien, HHS Senior Advisor for Health Financing, explained. Rather than being a physical place, health homes are a strategy for helping individuals with chronic conditions manage those conditions better. An eligible individual—for example, a person with diabetes and a mental illness—selects a provider or team of health care professionals to be his or her health home. That home then becomes accountable for all the individual’s care, including performing the following:
 - Manage and coordinate all of the services the person receives from multiple providers;
 - Promote good health;
 - Help with transitions from one kind of setting to another;
 - Provide support to both the individual and his or her family members; and
 - Offer referrals to community and social support services.

School-Based Health Centers

Source: (April 2011). School-based health centers improving access for youth: School settings a boon to student health. *The Nation's Health* 41(3), 1-20.

- There are more than 1,900 school-based health centers nationally, operating in 48 States and Territories. Such centers provide access to primary health care, MH services, immunizations, sexually transmitted disease testing, and a host of other services to about 2 million children and youth, regardless of ability to pay.
- The ACA includes two provisions for school-based health centers—language authorizing a Federal school-based health centers grant program and an emergency appropriation that would provide \$200 million for centers over 4 years. HRSA recently sought applications for construction and the purchase of equipment for school-based health centers using funding provided for in the ACA. The maximum grant award is \$500,000 per application.

ACA Improves the Quality of Health Care

Source: U.S. Department of Health and Human Services. (2011). *Report to Congress: National Strategy for Quality Improvement in Health Care*, <http://www.healthcare.gov/center/reports/nationalqualitystrategy032011.pdf> (accessed May 10, 2011).

- The National Quality Strategy will pursue three broad aims. These aims will be used to guide and assess local, State, and national efforts to improve the quality of health care. These three aims are:
 - Better Care: Improve the overall quality by making health care more patient-centered, reliable, accessible, and safe;
 - Healthy People/Healthy Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social,

- and environmental determinants of health in addition to delivering higher quality care; and
- Affordable Care: Reduce the cost of quality health care for individuals, families, employers, and government.

Key Areas That Indicate an Improved Health Care System

Source: U.S. Department of Health and Human Services. (2011). *Report to Congress: National Strategy for Quality Improvement in Health Care*, <http://www.healthcare.gov/center/reports/nationalqualitystrategy032011.pdf> (accessed May 10, 2011).

- National Quality Strategy has developed six priorities to advance the aims. They are:
 - Making care safer by reducing harm caused in the delivery of care.
 - Goal:
 - Eliminate preventable health care-acquired conditions.
 - Opportunities for success:
 - Eliminate hospital-acquired infections.
 - Reduce the number of serious adverse medication events.
 - Illustrative measures:
 - Standardized infection ratio for central line-associated blood stream infection as reported by CDC's National Healthcare Safety Network.
 - Incidence of serious adverse medication events.
 - Ensuring that each person and family is engaged as partners in his or her care.
 - Goal:
 - Create a delivery system that is less fragmented and more coordinated, where handoffs are clear and patients and clinicians have the information they need to optimize the patient-clinician partnership.
 - Opportunities for success:
 - Reduce preventable hospital admissions and readmissions.
 - Prevent and manage chronic illness and disability.
 - Ensure secure information exchange to facilitate efficient care delivery.
 - Illustrative measures:
 - All-cause readmissions within 30 days of discharge.
 - Percentage of providers who provide a summary record of care for transitions and referrals.
 - Promoting effective communication and coordination of care.
 - Goal:
 - Build a system that has the capacity to capture and act on patient-reported information, including preferences, desired outcomes, and experiences with health care.
 - Opportunities for success:
 - Integrate patient feedback on preferences, functional outcomes, and experiences of care into all-care settings and care delivery.

- Increase use of electronic health records (EHRs) that capture the voice of the patient by integrating patient-generated data in EHRs.
 - Routinely measure patient engagement and self-management, shared decisionmaking, and patient-reported outcomes.
 - Illustrative measures:
 - Percentage of patients who were asked for feedback.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
 - Goal:
 - Prevent and reduce the harm caused by cardiovascular disease.
 - Opportunities for success:
 - Increase blood pressure control in adults.
 - Reduce high cholesterol levels in adults.
 - Increase the use of aspirin to prevent cardiovascular disease.
 - Decrease smoking among adults and adolescents.
 - Illustrative measures:
 - Percentage of patients aged 18 years and older with ischemic vascular disease whose most recent blood pressure during the measurement year is <140/90 mm Hg.
 - Percentage of patients with ischemic vascular disease whose most recent low-density cholesterol is <100.
 - Percentage of patients with ischemic vascular disease who have documentation of use of aspirin or other antithrombotic during the 12-month measurement period.
 - Percentage of patients who received evidence-based smoking cessation services (e.g., medications).
- Working with communities to promote wide use of best practices to enable healthy living.
 - Goal:
 - Support every U.S. community as it pursues its local health priorities.
 - Opportunities for success:
 - Increase the provision of clinical preventive services for children and adults.
 - Increase the adoption of evidence-based interventions to improve health.
 - Illustrative measures:
 - Percentage of children and adults screened for depression and receiving a documented followup plan.
 - Percentage of adults screened for risky alcohol use and, if screening was positive, percentage of adults who received brief counseling.
 - Percentage of children and adults who use the oral health care system each year.
 - Proportion of U.S. population served by community water systems with optimally fluoridated water.

- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.
 - Goal:
 - Identify and apply measures that can serve as effective indicators of progress in reducing costs.
 - Opportunities for success:
 - Build cost and resource use measurement into payment reforms.
 - Establish common measures to assess the cost impacts of new programs and payment systems.
 - Reduce the amount of health care spending that goes to administrative burden.
 - Make costs and quality more transparent to consumers.
 - Illustrative measures:
 - To be developed.

Source: <http://www.healthcare.gov/news/factsheets/valuebasedpurchasing04292011a.html>.

The factsheet talks about hospital value-based purchasing and how the ACA improves quality:

- The Hospital Value-Based Purchasing initiative is just one part of a wide-ranging effort by the Obama Administration to improve the quality of health care for all Americans using important new tools provided by the ACA. The National Quality Strategy will serve as a tool to better coordinate quality initiatives. The Partnership for Patients is bringing together hospitals, doctors, nurses, pharmacists, employers, unions, and State and Federal Government committed to keeping patients from getting injured or sicker in the health care system and improving transitions between care settings. CMS intends to invest up to \$1 billion to help drive these changes through the Partnership. In addition, proposed rules allowing Medicare to pay new Accountable Care Organizations (ACOs) to improve coordination of patient care are also expected to result in better care and lower costs.
- Through the ACA, Medicare will link hospital payments with improving patient care in other ways. Beginning in 2013, hospitals will receive a payment reduction if they have excess 30-day readmissions for patients with heart attacks, heart failure, and pneumonia. By 2015, most hospitals will face reductions in their Medicare payments if they do not meaningfully use information technology to deliver better, safer, more coordinated care. In addition, beginning in 2015, hospitals with high rates of certain hospital-acquired conditions will receive further payment reductions from Medicare.
- The ACA also created the Center for Medicare and Medicaid Innovation to explore new approaches to the way we pay for and deliver care to patients so that we have better results both in terms of the quality of care and the affordability of coverage. The Innovation Center will rigorously and rapidly assess the progress of its programs and work with caregivers, insurers, and employers to replicate successful innovations in communities across the country.

- CMS will also continue to be an active partner with other organizations that share our commitment to improving hospital quality, including the Hospital Quality Alliance and the National Priorities Partnership. CMS will continue to administer the Quality Improvement Organization (QIO) Program in a manner that focuses on improving the quality of hospital care.

Workforce Development Initiatives

Source: Substance Abuse and Mental Health Services Administration. (2011). Leading change: A plan for SAMHSA's roles and actions, 2011–2014. HHS Publication No. (SMA) 11-4629. <http://store.samhsa.gov/product/SMA11-4629> (accessed May 10, 2011).

- Increasing the pool of health care providers is a key component in reforming the behavioral health system. The ACA, MHPAEA, and other efforts contribute to a comprehensive strategy to achieve this goal by improving the resources and training pipeline. SAMHSA is working with partners and stakeholders to develop a new generation of providers, promote innovation of service delivery through primary care and behavioral health care integration, and increase quality and reduce health care costs.
- SAMHSA is collaborating with HRSA and CMS workforce projects that include promoting and awarding grants for behavioral health workforce development, increasing access to providers in underserved areas, and integrating behavioral health and primary care. Specifically, SAMHSA and HRSA are jointly funding a national resource center that will provide training and technical assistance to community behavioral health programs, community health centers, and other primary care organizations. The resource center will also help develop models of integrated care across behavioral health and primary care.

Source: HealthCare.gov, <http://www.healthcare.gov>

- The ACA established a National Health Care Workforce Commission that lists the MH and behavioral health workforce, including substance use disorder prevention and treatment providers, as a high priority. Workforce issues involve education and training capacity, projected demands, and integration with the health care delivery system.

HIT

Source: Substance Abuse and Mental Health Services Administration (January 7, 2011). SAMHSA's Weekly Financing News Pulse: National Edition.

- On December 23, CMS released a plan to update the agency's data systems as required under health reform. Using new methods to collect and analyze data on resource utilization, health outcomes, and costs, CMS officials say the plan will help improve service delivery and reduce costs by rewarding quality care (The Hill, 12/23).

Source: Lardiere, M. R. (2010). What is meaningful about “meaningful use” for behavioral health IT? *National Council Magazine*, 2. Washington, DC: National Council for Community Behavioral Healthcare.

- The ACA identifies improvements in HIT as critical to health reform. This includes the concept of “meaningful use” of HIT, defined as encompassing the following:
 - Information that can follow the patient; is timely, accessible, and complete; and enables patient-centered, integrated care across all settings.
 - Evidence-based decision support at point of care for practitioners of all disciplines to ensure consistent, high-quality care.
 - Access to decision support and tools for managing health by and for patients.
 - Availability of population-based data to advance medical knowledge and understand factors that influence health practice and status and drive improvements in care.
 - Transparency of quality information to incentivize quality rather than cost and profit.
 - The statutory definition of meaningful use includes the use of an EHR that is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination (in accordance with law and standards applicable to the exchange of information).
- Domains of “meaningful use”:
 - Improve quality, safety, and efficiency and reduce health disparities;
 - Engage patients and families;
 - Improve care coordination;
 - Improve population and public health; and
 - Ensure adequate privacy and security protections for personal health information.

Source: Lardiere, M. R. (2010). What is meaningful about “meaningful use” for behavioral health IT? *National Council Magazine*, 2. Washington, DC: National Council for Community Behavioral Healthcare.

- EHRs can and should do things that a paper record cannot. One of those things is to make suggestions to help clinicians provide better care. Providing contextually appropriate cues to clinicians about the patient in front of them is the goal. The ultimate arbiters of treatment are the patient and the provider. We need electronic records that (1) are interoperable, (2) engage patients and families in their health care; and (3) provide real-time, research-based information to providers and patients.

Key Resources

Federal Government Web site on Health Reform: HealthCare.gov

<http://www.healthcare.gov>

SAMHSA Strategic Initiative on Health Reform

<http://www.samhsa.gov>

Report to Congress: National Strategy for Quality Improvement in Health Care

<http://www.healthcare.gov/center/reports/nationalqualitystrategy032011.pdf>

National Council Magazine, Published by the National Council for Community Behavioral Healthcare, 2010, Issue 2, Health Care Reform

Health Reform Source Web site—Henry J. Kaiser Foundation

<http://healthreform.kff.org/>

A link check was run on all the external Web sites listed in the discussion guide to identify and fix any broken links as of 5/10/11. However, we acknowledge that Web site URLs change frequently and may require ongoing link checks for accuracy. Last Updated Date will reflect the last round of edits before the document is finalized for distribution.

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