Financing and Delivery of Behavioral Health Services and the Patient Protection and Affordable Care Act

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Summary

Behavioral health disorders (including both mental disorders and substance use disorders) affect a large number of people and contribute costs to the health care system, even as indicated treatment is often not received by individuals in need. In the United States, an estimated 26% of non-institutionalized adults experience behavioral health disorders in a given year; over the course of a lifetime, the estimate rises to 46%. One study estimated spending on behavioral health care in 2005 to be $135 billion, of which $40 billion was paid by the federal government (including $10 billion by Medicare) and $44 billion by state governments. Both higher and lower cost estimates have been found in other studies. Among U.S. adults suffering from a behavioral health disorder severe enough to interfere with major life activities in 2009, 40% received no treatment; despite spending on behavioral health care, cost remains the most common barrier to treatment reported by adults with unmet need.

The federal government has a role in both the financing and delivery of behavioral health care services, as a payer, regulator, and provider, and as such, Congress may have an interest in behavioral health care broadly. This interest was reflected in the recently enacted health reform law (Patient Protection and Affordable Care Act [PPACA], P.L. 111-148, as amended). Although transforming the behavioral health care delivery system was not an explicit focus of the law, it includes sections that are expected to increase access to behavioral health services through changes to the financing and delivery of health care services.

This report provides an overview of sections in the health reform law that are expected to affect the financing and delivery of behavioral health care services. Access to health care services is determined by multiple factors, including (among other things) financing arrangements and covered benefits. PPACA may increase access to behavioral health services by increasing the availability and affordability of financing arrangements; the law also contains sections that will affect both the coverage of behavioral health services, as well as the conditions under which those services are covered. In addition, PPACA contains sections that are likely to affect the way in which health care services are delivered, specifically through changes to the workforce, the safety net, and new care delivery models.

The report concludes by presenting the relevant sections in a series of nine tables: (1) essential health benefits; (2) mental health parity; (3) private health insurance; (4) Medicare; (5) Medicaid; (6) safety net services; (7) workforce; (8) miscellaneous sections (e.g., sections on research, education, or community-based services, among others); and (9) relevant Indian Health Service (IHS) sections (in an appendix).

Contents

Tables

Appendixes

Contacts

Introduction

Behavioral health disorders[1] affect a large number of people and contribute costs to the health care system, even as indicated treatment is often not received by individuals in need. In the United States, an estimated 26% of non-institutionalized adults experience behavioral health disorders in a given year;[2] over the course of a lifetime, the estimate rises to 46%.[3] One study estimated spending on behavioral health care in 2005 to be $135 billion, of which $40 billion was paid by the federal government (including $10 billion by Medicare) and $44 billion by state governments.[4] Both higher and lower cost estimates have been found in other studies.[5] Among U.S. adults suffering from a behavioral health disorder severe enough to interfere with major life activities in 2009, 40% received no treatment.[6] Despite spending on behavioral health care, adults with unmet need report numerous barriers to access, including factors such as cost, lack of time, and not knowing where to go for treatment, among others.[7]

The federal government has a role in both the financing and the delivery of behavioral health care services, as a payer, regulator, and provider. It pays for behavioral health care services through the Medicare and Medicaid programs and, in its role as regulator, has required the establishment and coverage of a minimum set of benefits, including behavioral health care services, for many private health plans, as well as the Medicaid program. It supports the delivery of safety net services as a direct provider (e.g., Indian Health Service) and through the development and training of safety net health care providers (e.g., the National Health Service Corps). The federal government supports both clinical training for the behavioral health workforce as well as programs to alleviate provider shortages. Given the investment in these programs, among others, the financing and the delivery of behavioral health care services are likely to be of interest to Congress.

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[1] Substance use disorders (e.g., drug abuse or dependence) are often separated from other mental disorders (e.g., depression or schizophrenia); the term "behavioral health disorder" is used to capture both.

[2] Ronald C. Kessler et al., "Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry*, vol. 62 (2005), pp. 617-627.

[3] Ronald C. Kessler et al., "Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry*, vol. 62 (2005), pp. 593-602.

[4] Tami L. Mark et al., "Changes in U.S. Spending on Mental Health and Substance Abuse Treatment, 1986-2005, and Implications for Policy," *Health Affairs*, vol. 30, no. 2 (2011), pp. 284-292.

[5] Estimates of behavioral health care costs vary. Charles Roehrig et al., "National Health Spending By Medical Condition, 1996-2005," *Health Affairs*, vol. 28, no. 2 (2009), pp. w358-w367, estimated spending on behavioral health care in 2005 to be $142 billion, or 9% of total health care spending; costs are limited to those incurred among non-institutionalized civilians, nursing home residents, other institutionalized populations, and active-duty military. Anita Soni, *The Five Most Costly Conditions, 1996 and 2006: Estimates for the U.S. Civilian Noninstitutionalized Population*, Agency for Healthcare Research and Quality, Statistical Brief #248, July 2009, http://www.meps.ahrq.gov/mepsweb/data_files/publications/st248/stat248.pdf, used the Medical Expenditure Panel Survey (MEPS) to estimate spending on behavioral health care in 2006 to be $58 billion, or less than half the other estimates; however, the MEPS is known to underestimate costs, because it covers only the non-institutionalized population and underreports certain categories of spending (as noted in Mark et al., supra.).

[6] Bridget M. Kuehn, "Treatment is Lacking for Many U.S. Adults with Mental Illness or Substance Abuse," *Journal of the American Medical Association*, vol. 305, no. 1 (2011), p. 27.

[7] Rachel L. Garfield, *Mental Health Financing in the United States: A Primer*, The Henry J. Kaiser Family Foundation, The Kaiser Commission on Medicaid and the Uninsured, April 2011, p. 14, http://www.kff.org/medicaid/upload/8182.pdf.

Congressional interest in behavioral health care is reflected in the recently enacted health reform law (Patient Protection and Affordable Care Act [PPACA], P.L. 111-148, as amended). Although transforming the behavioral health care delivery system was not an explicit focus of the law, it includes sections that are expected to increase access to behavioral health services through changes to the financing and the delivery of health care services. Changes to financing affect both financing arrangements (e.g., public programs like Medicare and Medicaid, as well as private health insurance) and coverage of specific services (i.e., covered benefits) under those arrangements. Changes to the delivery system affect (among other things) the delivery of safety net services and the development of the health workforce. PPACA includes sections that are specific to behavioral health, as well as broad reforms to health care financing and delivery that will affect behavioral health.

This report provides an overview of sections in PPACA identified as having relevance to behavioral health.[8] It first discusses these sections broadly in the context of both financing and delivery of behavioral health care services. It then presents relevant sections from the law, and selected information about each section, in a series of eight tables (see **Tables 1** through **8**).

PPACA and Financing of Behavioral Health Care

Access to health care services is determined by multiple factors, including (among other things) financing arrangements and covered benefits. Addressing both components concomitantly may increase access to care more efficiently than addressing each component independently. For example, if existing financing arrangements are augmented or new arrangements are created, access will increase only to those services that are covered. Similarly, if benefits under existing financing arrangements are expanded (as through a coverage mandate) or the terms of those services are altered (as through mental health parity law[9]), these changes are relevant only for those individuals participating in the financing arrangement. This section briefly discusses sections in PPACA that address these dimensions of access to care and that are relevant to behavioral health.

Financing Arrangements

PPACA may increase access to behavioral health services by increasing the availability and affordability of financing arrangements. As of 2006, nonelderly adults with evidence of mental illness had higher rates of uninsurance (37% versus 27%), higher rates of public coverage through Medicaid and/or Medicare (24% versus 6%), and lower rates of coverage by private health insurance (39% versus 66%), when compared to nonelderly adults with no evidence of mental illness.[10] PPACA is expected to increase the number of people with behavioral health disorders

[8] For a discussion of the search strategy CRS employed to identify these provisions, see **Appendix B**, "Search Strategy."

[9] Federal mental health parity law requires certain plans, when they choose to cover mental health and substance use disorder services, to do so at parity with medical and surgical services. For more information, see CRS Report R41768, *Mental Health Parity and Mandated Coverage of Mental Health and Substance Use Disorder Services After PPACA*, by (name redacted).

[10] Rachel L. Garfield, *Mental Health Financing in the United States: A Primer*, The Henry J. Kaiser Family Foundation, The Kaiser Commission on Medicaid and the Uninsured, April 2011, p. 14, http://www.kff.org/medicaid/upload/8182.pdf.

who have health coverage, through (1) expansion of Medicaid eligibility, (2) market reforms for private health insurance, and (3) creation of health insurance exchanges.

Medicaid Expansion. PPACA creates a new Medicaid eligibility category for specified individuals with incomes up to 133% of federal poverty level.[11] This expansion is particularly relevant for behavioral health, as Medicaid is the largest source of financing for behavioral health services and targets populations that are less likely to have other financing arrangements and more likely to need behavioral health services.[12] Researchers estimate that after the implementation of PPACA, the number of users of behavioral health services in the Medicaid program will increase by approximately 2.3 million.[13]

Private Health Insurance Market Reforms. PPACA contains many sections requiring reforms to the private health insurance market; these reforms are expected to increase access to the private market generally by removing many existing coverage eligibility requirements.[14] The numerous reforms include, among others, guaranteed issue and renewal of policies; a prohibition on discrimination based on preexisting conditions or health status; a prohibition on rescissions; and limits on the factors that may be considered when pricing plans (community rating). Considered together, these reforms will allow some individuals with behavioral health disorders to purchase private insurance that previously would have been either unavailable to or unaffordable for them (due, for example, to the designation of a behavioral health disorder as a preexisting condition).

Health Insurance Exchanges. PPACA requires and supports states' creation by 2014 of "American Health Benefit Exchanges." State-based exchanges are marketplaces where individuals and employers may purchase comprehensive private health insurance plans.[15] Exchanges may decrease the cost of coverage for certain individuals through risk-pooling, thereby making private health insurance more affordable. Additional responsibilities of the exchanges include certifying plans and identifying individuals eligible for Medicaid, CHIP, and premium and cost-sharing credits.[16] Some individuals with behavioral health disorders who are currently uninsured may be able to purchase insurance through the exchanges.

[11] These individuals include nonelderly, non-pregnant individuals who are not entitled to or enrolled in Medicare Part A or enrolled in Medicare Part B, and who are otherwise ineligible for Medicaid. For more information about PPACA and Medicaid generally, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline*, by (name redacted) et al.

[12] Rachel L. Garfield, *Mental Health Financing in the United States: A Primer*, The Henry J. Kaiser Family Foundation, The Kaiser Commission on Medicaid and the Uninsured, April 2011, p. 14, http://www.kff.org/medicaid/upload/8182.pdf.

[13] Rachel L. Garfield et al., "The Impact of National Health Care Reform on Adults With Severe Mental Disorders," *American Journal of Psychiatry*, vol. 168, no. 5 (2011), pp. 486-494.

[14] For more information on private health insurance market reforms, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by (name redacted) and (name redacted) (archived).

[15] In order to be offered through an exchange, plans must meet certain criteria and be certified as Qualified Health Plans (QHPs). For more information on exchanges, see CRS Report R41269, *PPACA Requirements for Offering Health Insurance Inside Versus Outside an Exchange*, by (name redacted).

[16] For more information about PPACA and private health insurance, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by (name redacted) and (name redacted) (archived).

Covered Benefits

As noted previously, the effect of expanding financing arrangements on access to care is dependent, in part, on the benefits covered under those arrangements. Coverage of benefits may be considered both as a question of whether a particular service is covered at all, and as a question of the conditions under which the service is covered. PPACA contains sections that will affect both the coverage of behavioral health services, as well as the conditions under which those services are covered. Specifically, PPACA addresses coverage of behavioral health care services through (1) essential health benefits and (2) mental health parity.

Essential Health Benefits. PPACA creates a partial coverage mandate for mental health and substance use disorder services. As mentioned above, PPACA enables the establishment of exchanges. Plans offered in the exchanges, the Qualified Health Plans (QHPs), must meet a number of requirements, one of which is the offering of a minimum set of benefits (the Essential Health Benefits [EHB]). These benefits are statutorily defined to include mental health and substance use disorder services. PPACA does not require all plans to offer the EHB. It specifically requires four types of plans to offer the EHB: (1) new plans offered through the individual market, (2) new plans offered through the small group market, (3) QHPs offered inside and outside the exchanges, and (4) certain Medicaid plans, specifically, the benchmark and benchmark equivalent plans.[17]

Mental Health Parity. PPACA affects the terms under which behavioral health services are offered by expanding the applicability of federal mental health parity law.[18] The goal of federal parity law is to make coverage terms for mental health and substance use disorder services, when those services are offered, no more restrictive than those terms for medical and surgical services. PPACA builds on existing federal parity law by expanding the requirement for compliance with the law to three types of plans: (1) QHPs offered through the exchanges, (2) plans offered through the individual market, and (3) Medicaid benchmark and benchmark-equivalent plans (that are *not* managed care plans).

PPACA and Delivery of Behavioral Health Care

Access to care is not merely a matter of financing; it also depends on the health care service delivery system. PPACA contains sections that are likely to affect the way in which health care services are delivered.[19] Two major aspects of the health care service delivery system addressed by PPACA are the safety net and the health care workforce. In addition, a number of sections establish models of patient-centered care that aim to improve health outcomes, increase coordination of care, and integrate behavioral health care services into mainstream clinical

[17] Medicaid may be offered either in the form of traditional state plan benefits or by enrolling state-specified groups in benchmark or benchmark-equivalent coverage. For more information about Medicaid, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline*, by (name redacted) et al.

[18] For more information on expansion of the mental health parity law under PPACA, see CRS Report R41249, *Mental Health Parity and the Patient Protection and Affordable Care Act of 2010*, by (name redacted).

[19] Many of the programs established by PPACA that would make changes to the delivery of services are funded through discretionary funding and therefore their status depends on the appropriation of authorized funding.

settings. This section briefly discusses sections in PPACA that address these dimensions of the health care service delivery system and that are relevant to behavioral health.

Safety Net

Safety net facilities, such as community health centers (CHCs), are an important source of care for individuals with behavioral health disorders; as of 2003, more clinical visits at CHCs were attributed to behavioral health disorders than to any other condition.[20] PPACA contains sections that directly appropriate funding for the construction and operation of safety net facilities, including CHCs and other types of health centers. PPACA funding is expected to contribute significantly to increased capacity in the safety net; for example, between 2009 and 2015, health center caseloads are expected to increase from 19 million to between 34 million (assuming mandatory funding levels) and 44 million (assuming appropriation of authorized funding levels).[21]

Workforce

PPACA includes sections that are expected to affect the health care workforce providing behavioral health care services through the development of the safety net workforce, incentives to increase the supply of primary care physicians, and efforts to alleviate mental health provider shortages.[22] Between 1998 and 2003, the average number of behavioral health patients per CHC nearly tripled (from 302 to 899); at the same time, the average number of behavioral health providers per CHC remained level, and the average number of primary care providers per CHC increased.[23] Researchers have speculated that primary care providers may be delivering most of the behavioral health care services in CHCs.[24] PPACA incentivizes the development of the safety net workforce through increased National Health Service Corps (NHSC) funding; targeted loan repayment programs; and incentives to teaching health centers to establish or expand residency training programs, among other things. Additionally, PPACA includes funding for training in primary care and for education of primary care providers specifically about behavioral health services, among other workforce sections.

As of July 2011, 95 million Americans lived in 3,770 areas designated as mental health professional shortage areas by the Health Resources and Services Administration (HRSA); HRSA estimates that an additional 6,221 practitioners would be required to meet the need for mental

[20] Benjamin G. Druss et al., "Trends in Mental Health and Substance Abuse Services at the Nation's Community Health Centers: 1998-2003," *American Journal of Public Health*, vol. 96 (2006), pp. 1779-1784.

[21] Leighton Ku et al., *Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform*, Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Research Brief No. 19, June 30, 2010, pp. 5-7. In this research, the term "health centers" refers to federally qualified health centers (FQHCs), authorized under Section 330 of the Public Health Service Act, and FQHC look-alikes, which meet all requirements but do not receive grants under Section 330.

[22] For more information on workforce provisions of PPACA, see CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in PPACA: Summary and Timeline*, coordinated by (name redacted) and (name re dacted).

[23] Benjamin G. Druss et al., "Trends in Mental Health and Substance Abuse Services at the Nation's Community Health Centers: 1998-2003," *American Journal of Public Health*, vol. 96 (2006), pp. 1779-1784.

[24] Ibid.

health providers in these shortage areas.[25] In addition to the efforts noted above to expand the safety net workforce, and specifically primary care physicians, PPACA creates a program targeting training funds for specific types of mental health professionals who will be treating high-need or vulnerable populations.

New Models of Care Delivery

PPACA includes a number of sections that aim to incentivize changes to the delivery of health care services, and that are likely to affect the delivery of behavioral health services. Specifically, PPACA sections support models of care that are patient-centered with an emphasis on improved care coordination; the integrated delivery of behavioral health care services with other health care services; and an increased emphasis on primary and preventive care. The law creates the option for states to establish "health homes" for individuals with chronic conditions, including behavioral health disorders, in the Medicaid program.[26] New grant programs will support educating primary care physicians about behavioral health care services and the co-location of primary and specialty care in community-based mental health settings.

Presentation of Relevant PPACA Sections

Sections in PPACA identified as being relevant to behavioral health care have been divided into nine tables. The first five tables address topics described under "PPACA and Financing of Behavioral Health Care": (1) essential health benefits;[27] (2) mental health parity;[28] (3) private health insurance; (4) Medicare; and (5) Medicaid. The remaining tables address topics described under "PPACA and Delivery of Behavioral Health Care": (6) safety net services; (7) workforce; and (8) miscellaneous sections (e.g., sections on research, education or community-based services, among others).[29] Relevant Indian Health Service (IHS) sections are in **Appendix A**.[30]

In each table, sections are presented by relevant issue area; for example, the private health insurance sections are divided into those relating to (1) private market reforms and (2) the health

[25] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations*, http://bhpr.hrsa.gov/shortage/index.html.

[26] PPACA Section 2703(a) defines "health home" as "a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services."

[27] PPACA Sec. 1302(b) established the Essential Health Benefits, a group of services and items to be determined through rulemaking, that must be covered by plans as a condition of being certified as a Qualified Health Plan (QHP). Only QHPs may be offered through the Health Insurance exchanges (established by Sec. 1311 of PPACA), marketplaces where both individuals and employers may purchase health coverage.

[28] Federal parity law requires that certain health insurers, when they choose to offer mental health and substance use disorder services, must do so at parity with medical and surgical services with respect to four coverage terms: (1) financial requirements; (2) treatment limitations; (3) annual and lifetime aggregate limits; and (4) in- and out-of-network benefits.

[29] Details of the search strategy used to identify the provisions populating these tables can be found in **Appendix B** of this report.

[30] For more information on Indian health care under PPACA, see CRS Report R41152, *Indian Health Care: Impact of the Patient Protection and Affordable Care Act (PPACA)*, by (name redacted).

insurance exchanges.[31] Each table then presents a description of the section, its section number, and whether it is a new or existing authority. Finally, each table indicates whether the section is specific to behavioral health (noted with "S"), or is general in nature (noted with "G"), but affects behavioral health care providers or their patients. Sections may appear in multiple tables, where relevant, as the tables are not mutually exclusive.[32]

[31] The table presenting the provisions relating to IHS (found in **Appendix A**) is not presented according to issue areas, as are the eight tables presented in the main part of this report.

[32] The status of some sections of PPACA mentioned in the tables may be found in other CRS reports. See CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (PPACA)*, by (name redacted), and CRS Report R41390, *Discretionary Funding in the Patient Protection and Affordable Care Act (PPACA)*, coordinated by (name redacted).

Table 1. Essential Health Benefits Sections Affecting Persons with Behavioral Health Disorders: Patient Protection and Affordable Care Act of 2010 (P.L. 111-148, as amended)

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
Definition of Essential Health Benefits	**Essential Health Benefits Requirements**. Authorizes HHS Secretary to define the essential health benefits within certain parameters. Specifies certain categories, such as mental health and substance use disorder services, including behavioral health treatment. Effective date(s): January 1, 2014.	1302	New authority	G
Required Coverage of Essential Health Benefits	**Coverage of Essential Health Benefits, Nongroup and Small Market.** Requires plans offered through the small and nongroup market to cover the essential health benefits defined at Sec. 1302(a). Essential health benefits include mental health services. Effective date(s): January 1, 2014.	1201(4)	New PHSA Sec. 2707(a)	G
	Coverage of Essential Health Benefits, Qualified Health Plans. Requires qualified health plans to offer the essential health benefits described in 1302(a), which includes mental health services. Effective date(s): January 1, 2014.	1301(a)(1)(B)	New authority	G
	Medicaid Benchmark Benefits Must Consist Of At Least Minimum Essential Coverage. Requires Medicaid benchmark and benchmark equivalent plans to cover at least the essential health benefits defined at Sec. 1302(b). Effective date(s): January 1, 2014.	2001(c)(2)	Amends SSA Sec. 1937(b)	G

Source: Congressional Research Service analysis of PPACA (as amended).

Table 2. Mental Health Parity Sections in the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148, as amended)

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
Parity and QHPs	**Applicability of Mental Health Parity to QHPs**. Applies the existing federal mental health parity requirements to qualified health plans (which may be offered both inside or outside of an exchange). Effective date(s): January 1, 2014.	1311(j)	PHSA Sec. 2726	S
Parity in the Individual Market	**Applicability of Mental Health Parity in the Nongroup Market**. Applies existing mental health parity requirements to plans offered through the nongroup market. Effective date(s): Effective upon enactment (i.e., March 23, 2010).	1563	Amends PHSA Sec. 2726	S
Parity and Medicaid Benchmark and Benchmark Equivalent Plans	**Applicability of Mental Health Parity to Medicaid Benchmark and Benchmark Equivalent Plans**. Applies certain of the federal mental health parity requirements to Medicaid benchmark and benchmark-equivalent plans, that are not managed care plans. Those plans that provide early and periodic screening, diagnostic, and treatment services are deemed to satisfy the parity requirement. Effective date(s): January 1, 2014.	2001(c)(3)	Amends SSA Sec. 1937(b)	S

Source: Congressional Research Service analysis of PPACA (as amended).

Table 3. Private Health Insurance Sections Affecting Persons with Behavioral Health Disorders: Patient Protection and Affordable Care Act of 2010 (P.L. 111-148, as amended)

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
Private Market Reforms	**Prohibition on Rescissions; Extension of Dependent Coverage**. Prohibits rescissions (PHSA Sec. 2712) and extends dependent coverage (PHSA Sec. 2714) for a group health plan, a grandfathered plan, and a health insurance issuer offering group or individual health insurance coverage. Generally prohibits rescissions. A plan that provides dependent coverage must extend that coverage to adult children up to 26 years of age. Effective date(s): Effective for plan years beginning at least six months after enactment (i.e., September 23, 2010),	1001	New PHSA Sec. 2712 and Sec. 2714	G
	Coverage of Preventive Health Services. Requires group health plans and health insurance issuers in the group and individual markets to cover specified preventive services without cost-sharing. Services include any service rated "A" or "B" by the United States Preventive Services Task Force, as well as immunizations. For infants, children, adolescents, and women, services include preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Regarding breast cancer screening, mammography, and prevention, the current recommendations of the United States Preventive Service Task Force shall be considered the most current other than those issued in or around November 2009. Effective date(s): The HHS Secretary establishes the lag time (no less than one year) between issuance of a guideline and the effective date.	1001	New PHSA Sec. 2713	G
	Temporary High-Risk Insurance Pool. Requires the HHS Secretary to establish a temporary high-risk pool program to provide health insurance coverage for eligible individuals who have a preexisting condition and have been uninsured for six months. The program permits premium rates to vary on the basis of age by a factor of up to four to one and places limits on out-of-pocket costs. Effective date(s): The high-risk pool program is to be established within 90 days of enactment (i.e., June 21, 2010); the program terminates on January 1, 2014.	1101	New authority	G
	Prohibition of Preexisting Condition Exclusions or Other Discrimination Based on Health Status. Prohibits group health plans (new and grandfathered) and issuers in the individual and group markets from excluding coverage for preexisting health conditions. Effective date(s): For those under age 19, this became effective six months after enactment (i.e., September 23, 2010). For all others, this becomes effective as of January 1, 2014.	1201(2)(A)	New PHSA Sec. 2704	G

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
	Guaranteed Availability of Coverage. Requires individual and group health insurance issuers to accept every employer and individual in the state that applies for coverage. Effective date(s): January 1, 2014.	1201(4)	New PHSA Sec. 2702	G
	Guaranteed Renewability of Coverage. Requires individual and group health insurance issuers to renew or continue in force coverage, at the option of the plan sponsor or the individual, as applicable. Effective date(s): January 1, 2014.	1201(4)	New PHSA Sec. 2703	G
	Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status. Prohibits group health plans and issuers in the individual and group markets from establishing rules for eligibility (including continued eligibility) based on health status-related factors, including both physical and mental illnesses. Effective date(s): January 1, 2014.	1201(4)	New PHSA Sec. 2705	G
	Coverage of Essential Health Benefits. Requires QHPs and issuers in the individual and small group markets to offer coverage that includes the essential health benefits defined at Sec. 1302(a). Effective date(s): January 1, 2014.	1201(4)	New PHSA Sec. 2707(a)	G
	Applicability of Mental Health Parity in the Nongroup Market. Applies existing mental health parity requirements to plans offered through the nongroup market. Effective date(s): Effective upon enactment (i.e., March 23, 2010).	1563	Amends PHSA Sec. 2726	S
Health Insurance Exchanges and Qualified Health Plans (QHPs)	**Qualified Health Plan**. Requires qualified health plans to offer the essential health benefits package described in 1302(a), which includes mental health services. Effective date(s): January 1, 2014.	1301(a)(1)(B)	New authority	G
	Essential Health Benefits Requirements. Authorizes HHS Secretary to define the essential health benefits within certain parameters. Specifies certain categories, such as mental health and substance use disorder services, including behavioral health treatment. Effective date(s): January 1, 2014.	1302	New authority	G
	Assistance to States to Establish American Health Benefit Exchanges. Requires each state to have an exchange to facilitate access to insurers' qualified health plans. HHS Secretary is required to award grants to states to plan and establish exchanges. The grants can be renewed to states making progress in establishing an exchange, implementing PPACA's private health insurance market reforms, and meeting other benchmarks. Effective date(s): Exchanges must be in place by January 1, 2014. Grants must be awarded within one year of enactment (i.e., March 23, 2011); no grant may be awarded after January 1, 2015 (by which time exchanges will have to be self-sustaining).	1311(a) and (b)	New authority	G

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
	QHPs and State Mandated Benefits. Authorizes states to require qualified health plans offered through an exchange in the state to cover additional state mandated benefits. However, states must assume the cost attributable to the coverage of such services. Effective date(s): January 1, 2014.	1311(d)	New authority	G
	Applicability of Mental Health Parity to QHPs. Applies the existing federal mental health parity requirements to qualified health plans for the state exchanges. Effective date(s): January 1, 2014.	1311(j)	PHSA Sec. 2726	S

Source: Congressional Research Service analysis of PPACA (as amended).

Table 4. Medicare Sections Affecting Persons with Behavioral Health Disorders: Patient Protection and Affordable Care Act of 2010 (P.L. 111-148, as amended)

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
Closing the Part D "Donut Hole"	**Medicare Coverage Gap Discount Program**. Closes the "donut hole" in the Medicare prescription drug benefit. Reduces patient out-of-pocket burden for prescription medication; persons with mental illness may use pharmacotherapy. Effective date(s): Phased in over time to close the coverage gap by 2020. Provides a rebate of $250 for Medicare Part D enrollees who enter the coverage gap in 2010. Reduces beneficiary cost-sharing for brand-name and generic drugs from 100% in 2010 (rebate notwithstanding) to 25% by 2020. Incorporates a voluntary agreement with the Pharmaceutical Research and Manufacturers of America (PhRMA) to provide discounts of 50% for brand-name drugs used by Part D enrollees in the Part D coverage gap in 2011 and 2012.	3301	New SSA Sec. 1860D–43	G
Medicare and Preventive Services	**Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan**. Requires that Medicare Part B cover, without cost-sharing, "personalized prevention plan services," including a comprehensive health risk assessment. The health risk assessment may include "detection of any cognitive impairment." Effective date(s): January 1, 2011.	4103	Amends SSA Sec. 186	G
	Removal of Barriers to Preventive Services in Medicare. Requires that Medicare cover an initial preventive physical examination, personalized prevention plan services, and screening and preventive services. Screening and preventive services may include mental health services. There shall be no cost-sharing for services recommended with a grade of A or B by the United States Preventive Services Task Force. Effective date(s): January 1, 2011.	4104	Amends SSA Sec. 1861(ddd)	G
	Evidence-Based Coverage of Preventive Services in Medicare. Authorizes the Secretary of HHS to modify which preventive services are covered and reimbursed, within limits. Effective date(s): January 1, 2010.	4105	Amends SSA Sec. 1834	G
Payment Changes	**Extension of Physician Fee Schedule Mental Health Add-On**. Extends an add-on payment provision increasing payments for certain Medicare mental health services by five percent. Effective date(s): The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) increased the payments beginning on July 1, 2008 and ending on December 31, 2009. This provision extended the add-on through December 31, 2010.	3107	Amends MIPPA Sec. 138(a)(1)	S

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
	Revision of Certain Market Basket Updates and Incorporation of Productivity Improvements into Market Basket Updates That Do Not Already Incorporate Such Improvements. Requires (among other provisions) psychiatric hospitals and psychiatric units in hospitals to report quality measures, to be made available on the CMS website. Quality measures are to be endorsed by a consensus-based organization. Failure to report quality measures will result in reduction of two percentage points in any annual update to a standard federal rate. Effective date(s): Rate year 2014 and each subsequent rate year.	3401(f)	Amends SSA Sec. 1886	S

Source: Congressional Research Service analysis of PPACA (as amended).

Table 5. Medicaid Sections Affecting Persons with Behavioral Health Disorders: Patient Protection and Affordable Care Act of 2010 (P.L. 111-148, as amended)

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
Medicaid Eligibility Expansion	**Medicaid Expansion.** Creates a new mandatory Medicaid eligibility group for all nonelderly, nonpregnant individuals (e.g., childless adults, certain parents, certain people with disabilities) who are not entitled to or enrolled in Medicare Part A or enrolled in Medicare Part B, and are otherwise ineligible for Medicaid. For such individuals, the provision establishes 133% of FPL based on modified adjusted gross income (or MAGI as described below) as the new mandatory minimum Medicaid income eligibility level.	2001(a)(1)	Amends SSA Sec. 1902	G
Covered Benefits	**Medicaid Benchmark Benefits Must Consist Of At Least Minimum Essential Coverage**. Requires Medicaid benchmark and benchmark equivalent plans to cover at least the essential health benefits defined at Sec. 1302(b). Effective date(s): January 1, 2014.	2001(c)	Amends SSA Sec. 1937	G
	Applicability of Mental Health Parity to Medicaid Benchmark and Benchmark Equivalent Plans. Applies certain of the federal mental health parity requirements to Medicaid benchmark and benchmark-equivalent plans, that are not managed care plans. Those plans that provide early and periodic screening, diagnostic, and treatment services are deemed to satisfy the parity requirement. Effective date(s): January 1, 2014.	2001(c)(3)	Amends SSA Sec. 1937(b)	S
	Elimination of Exclusion of Coverage of Certain Drugs. Specifies non-excludable drugs: agents used for smoking cessation, barbiturates, and benzodiazepines. Effective date(s): January 1, 2014.	2502(a)(2) and 2502(b)	Amends SSA Sec. 1927(d)	G
	Improving Access to Preventive Services for Eligible Adults in Medicaid. Clarifies services to be included as diagnostic, screening, preventive, and rehabilitative services. Provides an increase of one percentage point in FMAP for states providing all preventive services without cost-sharing. Effective date(s): January 1, 2013.	4106	Amends SSA Sec. 1905(a)(13) and 1905(b)	G

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
	Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid. Adds counseling and pharmacotherapy to promote cessation of tobacco use by pregnant women as a mandatory benefit under Medicaid, with no cost-sharing. Such coverage includes prescription and nonprescription tobacco cessation agents approved by the FDA. Services will be limited to those recommended for pregnant women in Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline (and if applicable, as subsequently modified), as well as other related tobacco cessation services designated by the HHS Secretary. States will receive a one percentage point increase in their regular FMAP for these smoking cessation services for pregnant women if they elect to cover the new optional adult preventive care benefit. Effective date(s): Coverage begins October 1, 2010; FMAP increase begins January 1, 2013.	4107	Amends SSA Sec. 1905	G
Service Delivery	**Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes**. Allows qualifying states to receive an FMAP increase for reducing their share of Medicaid long-term care (LTC) spending on institutional care and increasing their share of Medicaid LTC spending on home and community-based services (HCBS). To receive payments, states will be required to meet certain target spending percentages. Effective date(s): The balancing incentive period begins October 1, 2011, and ends on September 30, 2015.	10202	New authority	G
	Medicaid Emergency Psychiatric Demonstration Program. Requires the HHS Secretary to establish a three-year demonstration project in which eligible states will reimburse certain institutions for mental disease (IMDs) for emergency medical treatment services provided to Medicaid beneficiaries aged 21 through 64 who are in need of medical assistance to stabilize an emergency psychiatric condition. Effective date(s): Funds are appropriated for FY2011 and shall remain available through December 31, 2015.	2707	New authority	S
	State Option to Provide Health Homes for Enrollees with Chronic Conditions. Allows states, through a state plan amendment, to provide health homes to eligible individuals with chronic conditions. Chronic conditions include mental health conditions and substance use disorders. A single serious and persistent mental illness is defined as qualifying. The designated provider may be a community mental health center, and the team of health care professionals may include behavioral health professionals. The state shall consult and coordinate with SAMHSA in addressing issues regarding the prevention and treatment of mental illness and substance abuse. Effective date(s): January 1, 2011.	2703(a)	New SSA Sec. 1945	G

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
Enrollment Simplification	**Enrollment Simplification and Coordination with State Health Insurance Exchanges**. Requires states, as a condition of federal financial assistance under Sec. 1903(a), to establish procedures for conducting outreach and enrolling vulnerable and underserved populations eligible for medical assistance, including individuals with mental health or substance-related disorders. Effective date(s): Calendar quarters beginning after January 1, 2014	2201	New SSA Sec. 1943	G

Source: Congressional Research Service analysis of PPACA (as amended).

Table 6. Safety Net Services Sections Affecting Persons with Behavioral Health Disorders: Patient Protection and Affordable Care Act of 2010 (P.L. 111-148, as amended)

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
School-Based Health Centers	**Grants for the Establishment of School-Based Health Centers**. Requires the Secretary to create a grant program for the establishment of school-based health centers. Funds may be used for facility construction, expansion, and equipment. SBHCs are not required to provide behavioral health services to be eligible for this funding, but some may provide these services. Effective date(s): Fiscal years 2010 through 2013.	4101(a)	New authority	G
	Grants for the Operation of School-Based Health Centers. Requires the Secretary to award grants to fund the management and operation of SBHCs that provide comprehensive physical and behavioral health services to children and adolescents, subject to parental consent. Effective date(s): Fiscal years 2010 through 2014.	4101(b)	New PHSA Sec. 399Z-1	G
Safety Net Workforce Development	**Health Care Workforce Loan Repayment Programs.** Requires the Secretary to implement a loan repayment program that pays up to $35,000 for each year of service (for a maximum of three years) to eligible individuals in exchange for a commitment to work in a pediatric medical specialty, in pediatric surgery, or in child and adolescent mental and behavioral health care in a medically underserved area. Effective date(s): Fiscal years 2010 through 2014 for pediatric medical specialists and pediatric surgical specialists; fiscal years 2010 through 2013 for child and adolescent mental and behavioral health professionals.	5203	New PHSA Sec. 775	G
	Funding for National Health Service Corps. Provides (1) scholarships to students training in a primary care discipline to cover tuition, fees, other educational costs, and a stipend; and (2) student loan repayments of up to $50,000 a year to primary care and mental health clinicians. Scholarships and loan repayments are in exchange for a commitment to work in federally designated Health Professional Shortage Areas (HPSAs). Effective date(s): Begins in federal fiscal year 2010.	5207	Permanently reauthorizes PHSA Title III, Part D, Subpart III	G
	Teaching Health Centers Training and Enhancement. Authorizes three-year grants of up to $500,000 to community-based ambulatory care centers, including community mental health centers, that establish or expand a primary care residency training program. Effective date(s): Begins in federal fiscal year 2010.	5508(a)	New PHSA Sec. 749A	G

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
	Payments to Qualified Teaching Health Centers. Requires the Secretary to make payments for direct and indirect graduate medical education costs to qualified teaching health centers, including community mental health centers, for the expansion of existing, or establishment of new approved medical residency training programs. Effective date(s): Federal fiscal years 2011 through 2015.	5508(c)	New PHSA Sec. 340H	G
	Mental and Behavioral Health Education and Training Grants. Authorizes grants for the recruitment and education of students in social work, interdisciplinary psychology training, and internships or other field placement programs related to child and adolescent mental health. Priority for social work grants given to schools of social work meeting certain criteria such as recruiting from and placing graduates into areas with a high-need and high-demand population. Priority for psychology grants given to institutions that focus on the needs of specified vulnerable groups. Priority for grants to train professional and paraprofessional child and adolescent mental health workers given to applicants that can, among other things, assess workforce needs and that have programs designed to increase the number of child and adolescent mental health workers serving high-priority populations. Effective date(s): Federal fiscal years 2010 through 2013.	5306	New PHSA Sec. 756	S
Health Centers	**Spending for Federally Qualified Health Centers (FQHCs)**. Provides grants to health centers serving federally designated medically underserved populations and furnishing comprehensive primary care services, referrals, and other services needed to facilitate access to such care, regardless of ability to pay. The mentally ill are disproportionately represented in the population served by health centers. Effective date(s): Begins in federal fiscal year 2010.	5601	Permanently reauthorizes PHSA Sec. 330	G
	Community Health Centers and the National Health Service Corps Fund. Establishes a Community Health Center Fund (CHCF) and appropriates a total of $11 billion over a five-year period to the fund, to be transferred by the Secretary to HHS accounts to increase funding, over the FY2008 level, for (1) community health center operations; and (2) National Health Service Corps (NHSC) operations, scholarships, and loan repayments. Effective date(s): Federal fiscal years 2011 through 2015.	10503(b)	New authority	G
	Community Health Centers and the National Health Service Corps Fund. Provides funding for construction and renovation of community health centers. Expands access to health centers; persons with mental illness are disproportionately represented in the population served by health centers. Effective date(s): Federal fiscal years 2011 through 2015.	10503(c)	New authority	G

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
	Community Mental Health Centers. Requires that a community mental health center demonstrate that it provides at least 40% of its services to individuals not eligible for Medicare, in order to receive payment under Medicare. Also restricts Medicare reimbursement for mental health services delivered in an individual's home or in an inpatient or residential setting. Effective date(s): Applies to items and services furnished on or after the first day of the first calendar quarter that begins at least 12 months after enactment (i.e., April 1, 2011).	HCERA 1301	Amends SSA Sec. 1861	S

Source: Congressional Research Service analysis of PPACA (as amended).

Table 7. Workforce Sections Affecting Persons with Behavioral Health Disorders: Patient Protection and Affordable Care Act of 2010 (P.L. 111-148, as amended)

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
National Health Service Corps	**Funding for National Health Service Corps**. Provides: (1) scholarships to students training in a primary care discipline to cover tuition, fees, other educational costs, and a stipend; and (2) student loan repayments of up to $50,000 a year to primary care and mental health clinicians. Scholarships and loan repayments are in exchange for a commitment to work in federally designated HPSAs. Effective date(s): Begins in federal fiscal year 2010.	5207	Permanently reauthorizes PHSA Title III, Part D, Subpart III	G
Title VII/VIII Existing Programs	**Training in Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantship.** (1) Authorizes five-year grants to support training programs in primary care. (2) Authorizes five-year grants for primary care capacity building. Funds are to be used to create academic units or programs that improve clinical teaching in the primary care fields, and (in a separate authorization) to integrate academic units to enhance interdisciplinary recruitment, training, and faculty development. Certain programs are prioritized for funding, including those that propose interprofessional integrated models of health care that incorporate transitions in health care settings and integrating physical and mental health. Effective date(s): Federal fiscal years 2010 through 2014.	5301	Amends and reauthorizes PHSA Sec. 747	G
	Area Health Education Centers. Requires the Secretary to award grants (with a matching requirement) of at least $250,000 to (1) plan, develop, and operate AHEC programs; and (2) to maintain and improve the effectiveness of existing AHEC programs. AHECs recruit, train, and prepare individuals from minority populations or from disadvantaged or rural backgrounds to work in medically underserved areas. Interdisciplinary training involving psychologists, along with other providers, is a required activity. Effective date(s): Federal fiscal years 2010 through 2014.	5403(a)	Amends and reauthorizes PHSA Sec. 751	G
	Health Care Workforce Loan Repayment Programs. Requires the Secretary to implement a loan repayment program that pays up to $35,000 for each year of service (for a maximum of three years) to eligible individuals in exchange for a commitment to work in a pediatric medical specialty, in pediatric surgery, or in child and adolescent mental and behavioral health care in a medically underserved area. Effective date(s): Fiscal years 2010 through 2014 for pediatric medical specialists and pediatric surgical specialists; fiscal years 2010 through 2013 for child and adolescent mental and behavioral health professionals.	5203	New PHSA Sec. 775	G

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
Title III/VII/VIII New Programs	**Primary Care Extension Program**. Authorizes a grant program to fund local primary care extension agencies to support and educate primary care providers about preventive medicine, chronic disease management, and mental health services. Effective date(s): Federal fiscal years 2011 through 2014.	5405	New PHSA Sec. 399V-1	G
	Mental and Behavioral Health Education and Training Grants. Authorizes grants for the recruitment and education of students in social work, interdisciplinary psychology training, and internships or other field placement programs related to child and adolescent mental health. Priority for social work grants given to schools of social work meeting certain criteria such as recruiting from and placing graduates into areas with a high-need and high-demand population. Priority for psychology grants given to institutions that focus on the needs of specified vulnerable groups. Priority for grants to train professional and paraprofessional child and adolescent mental health workers given to applicants that can, among other things, assess workforce needs and that have programs designed to increase the number of child and adolescent mental health workers serving high-priority populations. Effective date(s): Federal fiscal years 2010 through 2013.	5306	New PHSA Sec. 756	S
	United States Public Health Sciences Track. Establishes a science track at academic sites selected by the Secretary to award degrees that emphasize team-based service, public health, epidemiology, and emergency preparedness and response, including no less than 100 behavioral and mental health professional students annually. Effective date(s): Begins in federal fiscal year 2010.	5315	New PHSA Title II, Part D – Secs. 271-274	G
Teaching Health Centers	**Teaching Health Centers Training and Enhancement**. Authorizes three-year grants of up to $500,000 to community-based ambulatory care centers, including community mental health centers, that establish or expand a primary care residency training program. Effective date(s): Begins in federal fiscal year 2010.	5508(a)	New PHSA Sec. 749A	G
	Payments to Qualified Teaching Health Centers. Requires the Secretary to make payments for direct and indirect graduate medical education costs to qualified teaching health centers, including community mental health centers, for the expansion of existing, or establishment of new approved medical residency training programs. Effective date(s): Federal fiscal years 2011 through 2015.	5508(c)	New PHSA Sec. 340H	G

Source: Congressional Research Service analysis of PPACA (as amended).

Table 8. Other Sections Affecting Persons with Behavioral Health Disorders: Patient Protection and Affordable Care Act of 2010 (P.L. 111-148, as amended)

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
Integrated and Community Based Services	**Grants for the Operation of School-Based Health Centers**. Requires the Secretary to award grants to fund the management and operation of SBHCs that provide comprehensive physical and behavioral health services to children and adolescents, subject to parental consent. Effective date(s): Fiscal years 2010 through 2014.	4101(b)	New PHSA Sec. 399Z-1	G
	Community Transformation Grants. Requires CDC to fund competitive grants for the implementation, evaluation, and dissemination of evidence-based community preventive health activities, including activities related to emotional health. Effective date(s): Fiscal years 2010 through 2014.	4201	New authority	G
	Co-locating Primary and Specialty Care in Community-Based Mental Health Settings. Requires the Secretary to fund demonstration projects for providing coordinated and integrated services to individuals with mental illness and co-occurring chronic diseases through the co-location of primary and specialty care services in community-based mental and behavioral health settings. Effective date(s): Federal fiscal years 2010 through 2014.	5604	New PHSA Sec. 520K	S
Research, Education and Coordination	**National Prevention, Health Promotion and Public Health Council Report**. Requires the council to submit an annual report to Congress describing prevention, health promotion, and public health goals and actions, and specifically includes mental health, behavioral health, and substance use disorders. Effective date(s): First report to be submitted not later than July 1, 2010, and annually thereafter through January 1, 2015,	4001(h)	New authority	G
	Centers of Excellence for Depression. Requires SAMHSA to award five-year grants (with a matching requirement) on a competitive basis to eligible entities to establish national centers of excellence for depression. One grantee is to be designated as the coordinating center and required to establish and maintain a national database. Effective date(s): Federal fiscal years 2011 through 2020.	10410	New PHSA Sec. 520B	S

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
	Support, Education, and Research for Postpartum Depression. Authorizes grants to establish, operate and coordinate effective and cost-efficient systems for the delivery of essential services to individuals with, or at risk of, postpartum depression and their families. Administered by the Health Resources and Services Administration, Public Health Service, Department of Health and Human Services. Effective date(s): Federal fiscal years 2010, 2011, 2012.	2952	New SSA Sec. 512	S

Source: Congressional Research Service analysis of PPACA (as amended).

Notes: REC = Research, Education, and Coordination; ICBS = Integrated and Community-Based Services.

Appendix A. Indian Health Service Sections Relevant to Behavioral Health in the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148, as amended)

Table A-1. Indian Health Service Sections Affecting Persons with Behavioral Health Disorders: Patient Protection and Affordable Care Act of 2010 (P.L. 111-148, as amended)

Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
Training and Community Education. Directs the Secretaries of HHS and Department of the Interior (DOI) to develop or implement, or assist Indian Tribes (ITs) and Tribal Organizations (TOs) to develop and implement, within each Service unit or tribal program, a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community. Such program shall include education about behavioral health issues to political leaders, tribal judges, law enforcement personnel, members of tribal health and education boards, health care providers including traditional practitioners, and other critical members of each tribal community. Effective date(s): Begins in federal fiscal year 2010.	10221	New IHCIA Sec. 710	S
Fetal Alcohol Spectrum Disorders Programs. Authorizes the development and implementation of a fetal alcohol spectrum disorders program for prevention of these disorders and to identify and treat pregnant women at high risk of birthing a child with fetal alcohol spectrum disorders and children born with alcohol related disorders. Effective date(s): Begins in federal fiscal year 2010.	10221	New IHCIA Sec. 712	G
Child Sexual Abuse Prevention and Treatment Programs. Authorizes treatment programs in every IHS Area for child victims of sexual abuse and their family members who are Indians or members of Indian households. Requires program funds to be used for developing community education, identifying and providing treatment to victims, and developing culturally-sensitive prevention models and diagnostic tools. Effective date(s): Begins in federal fiscal year 2010.	10221	New IHCIA Sec. 713	G

Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
Domestic and Sexual Violence Prevention and Treatment. Authorizes programs in each IHS Area to prevent and treat Indian victims of domestic violence or sexual violence and their family members. Requires program funds be used for prevention and community education programs, behavioral health services and medical treatment for victims (including examinations by sexual assault nurse examiners), rape kits, and development of prevention and intervention models (including traditional health care), Effective date(s): appropriate protocols, policies, procedures, standards of practice, and, if not available elsewhere, training curricula and training and certification requirements for services for victims of domestic violence and sexual abuse to be established within a year of enactment (i.e., March 23, 2011); progress report to be submitted within 18 months of enactment (i.e., September 23, 2011); additional report to be submitted within two years of enactment (i.e., March 23, 2012).	10221	New IHCIA Sec. 714	G
American Indians into Psychology Program. Directs the Secretary to make grants to colleges and universities for the purpose of developing and maintaining Indian psychology career recruitment programs as a means of encouraging Indians to enter the behavioral health field. Effective date(s): Begins in federal fiscal year 2010.	10221	New IHCIA Sec. 132	S
Behavioral Health Prevention and Treatment Services. Directs the Secretary, through the IHS, to develop a comprehensive behavioral health care program that emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs. Effective date(s): Within a year of enactment (i.e., March 23, 2011).	10221	New IHCIA Sec. 702	S
Memoranda of Agreement with the Department of the Interior. Requires HHS and DOI to develop and enter into memoranda of agreement, covering specified activities, including a comprehensive assessment and coordination of Indian mental health care needs and services, ensuring and protecting Indians' right of access to general mental health services, and an assessment by IHS of existing and needed resources. Effective date(s): Within a year of enactment (i.e., March 23, 2011).	10221	New IHCIA Sec. 703	S
Comprehensive Behavioral Health Prevention and Treatment Program. Requires the Secretary to provide through IHS a program of comprehensive behavioral health, prevention, treatment, and aftercare for Indian tribal members, including prevention, education, specified treatments, rehabilitation, training, and diagnostic services. Authorizes the provision of services through contracts with public and private behavioral health providers. Effective date(s): Begins in federal fiscal year 2010.	10221	New IHCIA Sec. 704	S
Mental Health Technician Program. Establishes within IHS a mental health technician program for Indians to provide high-standard paraprofessional training in mental health care, to supervise and evaluate the technicians, and to ensure that the program includes using and promoting traditional Indian health care and treatment. Effective date(s): Begins in federal fiscal year 2010.	10221	New IHCIA Sec. 705	S

Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
Licensing Requirement for Mental Health Care Workers. Requires that any person employed as a psychologist, social worker, or marriage and family therapist to provide mental health care services to Indians be licensed to provide the specified service. A trainee in psychology, social work, or marriage and family therapy may provide mental health care services if the trainee is directly supervised by someone licensed in the specified service, is enrolled in or has completed at least two years of course work in an accredited postsecondary education program for the specified service, and meets other requirements that the Secretary may establish. Effective date(s): Begins in federal fiscal year 2010.	10221	New IHCIA Sec. 706	S
Indian Women Treatment Programs. Grants to ITs, TOs, or UIOs to develop and implement a comprehensive program for prevention, intervention, treatment, and relapse prevention of alcohol and substance abuse, specifically addressing the cultural, historical, social, and childcare needs of Indian women. Effective date(s): Begins in federal fiscal year 2010.	10221	New IHCIA Sec. 707	S
Indian Youth Program. Authorizes a number of Indian youth behavioral health programs, including acute and intermediate behavioral health services, community-based services, multi-drug abuse prevention services. Also requires at least one youth regional treatment center or treatment network in each IHS area. Effective date(s): Begins in federal fiscal year 2010.	10221	New IHCIA Sec. 708	S
Inpatient and Community-Based Mental Health Facilities Design, Construction, and Staffing. Authorizes the establishment, in each IHS area, of not less than one inpatient mental health care facility, or equivalent, to serve Indians with behavioral health problems. Effective date(s): Within a year of enactment (i.e., March 23, 2011).	10221	New IHCIA Sec. 709	S
Behavioral Health Program. Authorizes the development and implementation of programs to deliver innovative community-based behavioral health services to Indians, and would authorize grants to ITs and TOs for such programs. Effective date(s): Begins in federal fiscal year 2010.	10221	New IHCIA Sec. 711	S
Behavioral Health Research. Authorizes contracts with or grants to ITs, TOs, UIOs, and appropriate institutions for research on the incidence and prevalence of behavioral health problems among Indians served by IHS, ITs, or TOs and in urban areas. Specified research priorities include the multifactorial causes of Indian youth suicide; the interrelationship of behavioral health problems with alcoholism, suicide, homicide, and family violence, especially on children; and the development of models of prevention techniques, especially with regard to children. Effective date(s): Begins in federal fiscal year 2010.	10221	New IHCIA Sec. 715	S
Indian Youth Telemental Health Demonstration Project. Authorizes the Secretary, acting through the service, to carry out a demonstration project to award grants for the provision of telemental health services to Indian youth who have expressed suicidal ideas; have attempted suicide; or have mental/behavioral health conditions that increase or could increase the risk of suicide. Effective date(s): Federal fiscal years 2010 through 2013.	10221	New IHCIA Sec. 723	S

Description/Purpose	PPACA Section	New/Existing Authority	General or Specific
Substance Abuse and Mental Health Services Administration Grants. Requires the Secretary of HHS to streamline the process by which ITs and TOs apply for grants from the Substance Abuse and Mental Health Services Administration (SAMHSA), including providing nonelectronic methods; and requires states applying for a SAMHSA grant based on statewide data to consider the Indian population within the state and make reasonable efforts to collaborate with ITs within the state in implementing SAMHSA grant programs. Effective date(s): Begins in federal fiscal year 2010.	10221	New IHCIA Sec. 724	S
Use of Predoctoral Psychology and Psychiatry Interns. Requires the Secretary of HHS to carry out activities to encourage ITs, TOs, and other mental health care providers to obtain the services of predoctoral psychology and psychiatry interns in order to increase the quantity of patients served by those providers; and for purposes of recruitment and retention. Effective date(s): Begins in federal fiscal year 2010.	10221	New IHCIA Sec. 725	S
Indian Youth Life Skills Development Demonstration Program. Authorizes SAMHSA to carry out a demonstration program to test the effectiveness of a culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent suicide. Effective date(s): Federal fiscal years 2010 through 2014.	10221	New IHCIA Sec. 726	S

Source: Congressional Research Service analysis of PPACA (as amended).

Appendix B. Search Strategy

This report provides information about sections in the Patient Protection and Affordable Care Act of 2010 (PPACA, P.L. 111-148) that relate directly or indirectly to behavioral health. In order to identify relevant sections, a search was performed of the consolidated Act[33] using the following terms: "behavioral," " mental," "psych," and "substance." In consultation with other CRS analysts, the resulting list of sections was revised by including additional sections that would have an impact on behavioral health care providers and their patients, and excluding sections that would not. Because there is neither a specific part of PPACA dedicated to behavioral health nor standard language applied to all relevant sections, CRS is unable to ensure that the listing it has provided is comprehensive.

[33] The search was performed on PPACA, as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152) (the "consolidated Act"). This may be found at http://statutes.legcoun.house.gov/PDF/ppacacon.PDF.

Appendix C. Acronym Listing

The following acronyms appear in this report:

- Area Health Education Center (AHEC)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Community Health Center Fund (CHCF)
- Department of Health and Human Services (HHS)
- Department of the Interior (DOI)
- Federal medical assistance percentage (FMAP)
- Food and Drug Administration (FDA)
- Health Care and Education Reconciliation Act of 2010 (HCERA)
- Health Professional Shortage Area (HPSA)
- Home and Community-Based Services (HCBS)
- Indian Health Care Improvement Act (IHCIA)
- Indian Health Service (IHS)
- Indian Tribe (IT)
- Institutions for Mental Disease (IMD)
- Long-Term Care (LTC)
- Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)
- National Health Service Corps (NHSC)
- Patient Protection and Affordable Care Act of 2010 (PPACA)
- Pharmaceutical Research and Manufacturers of America (PhRMA)
- Public Health Service Act (PHSA)
- School-Based Health Center (SBHC)
- Social Security Act (SSA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Tribal Organization (TO)
- Urban Indian Organization (UIO)

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