



April 9, 2012

**TO:** CMHDA Governing Board and All Directors

**FROM:** Molly Brassil, Associate Director, Public Policy

**SUBJECT:** Implementation of the Patient Protection and Affordable Care Act and Other Health Reform Activities – Updates & Recent Highlights

**NOTE:** *An electronic copy of this memorandum is posted to the CMHDA website at <http://www.cmhda.org/go/aboutcmhda/alldirectors/handouts.aspx>. To access the various links included in the document, please see the electronic version.*

## MEMORANDUM

On March 23, 2010, President Obama signed into law the comprehensive health reform legislation, the Patient Protection and Affordable Care Act (ACA). Please find below several recent updates and highlights related to ACA implementation activities as they pertain to California's public mental health system.

### California Health Benefit Exchange Activities

#### *CMHDA Joins Coalition Effort to Respond to California HBEX Solicitation for Comments Related to Qualified Health Plans, Benefit Design and Delivery System Reform*

The California Health Benefit Exchange (HBEX or "The Exchange") released to stakeholders last month a solicitation to provide responses to a lengthy list of questions related to qualified health plans, benefit design and delivery system reform. According to the solicitation, the stakeholder responses will assist the board in developing qualified health plan contracting and delivery system reform strategies. Comments/responses to the questions were due by April 1, 2012. CMHDA worked closely with other members of the California Coalition for Whole Health to develop a coordinated behavioral health response to this public comment request. CMHDA's 1115 Waiver Workgroup was able to meet by conference call on March 16 to review the questionnaire from a county

mental health lens to inform the Coalition's comments. The primary emphasis of the Coalition's comments is on the need for the Exchange to ensure that all qualified health plans comply with all applicable state and federal parity laws, including the Federal Mental Health Parity and Addiction Equity Act (MHPAEA). Additionally, the comments emphasize the importance of issues such as continuity of care, timely access, network adequacy, uniform formularies, payment for unlicensed staff and care management for our mental health and substance use disorder client populations. The Coalition reminds the Exchange that the current public specialty mental health and substance use disorder systems are not the default providers of care if plans fail to comply with parity and equity laws to cover appropriate and legally required services. To review the comments submitted by the California Coalition for Whole Health, [click here](#) (cover letter) and [here](#) (comments).

#### *Milliman Report to California HBEX on Cost Estimates of the Benchmark Plans*

Earlier this year the Exchange asked Milliman, Inc. to compare relative costs of covered services between the California benchmark plans (*see federal regulations and guidance section for more details on the federal regulatory approach to identifying benchmark plans*). According to the Milliman analysis, the range in estimated plan costs (between the most generous and leanest, with respect to covered services) due to the chosen essential health benefit benchmark is only about 2.36%. However, in reviewing the report, it has come to CMHDA's attention that Milliman's application of mental health parity is not in line with our understanding of the federal parity law. CMHDA has brought this concern to the attention of our federal partners for further review and follow-up, as well as key staff members in the Legislature. Given the recent amendments to the legislation to define essential health benefits in California law (*discussed in next section*), the potential misapplication of parity in the Milliman analysis may no longer be as relevant. However, given the obvious ongoing confusion in this area, CMHDA is working with our coalition partners to develop proactive advocacy and education strategies to ensure appropriate application of federal and state parity and equity laws in ACA implementation. To review Milliman's report on the cost estimates of the ten benchmark plans, dated 2/21/12, [click here](#). To review Milliman's summary of services covered by the Essential Health Benefit benchmark plans, dated 2/13/12, [click here](#). The evidence of coverage used by Milliman for analysis is also available for public review on the HBEX website. To review that and other background materials, [click here](#).

#### *Exchange Board Focus on Communication, Outreach and Enrollment Activities and HBEX Role in Selecting and Contracting with Qualified Health Plans*

The Exchange board continues to meet monthly to plan for implementation of California's Health Benefit Exchange in 2014. The meeting agenda for March primarily

focused on the Exchange's communications, outreach and enrollment activities. Presentations by invited technical experts included estimates of potential enrollment in the Exchange or other subsidized coverage according to modeling done by U.C. Berkeley/UCLA as part of their "California Simulation of Insurance Markets" (CaSIM) project. The estimates provided are based on two scenarios: 1) a "base" scenario in which propensities for individuals to take up coverage are based on the best available data from the health economics literature, and; 2) an "enhanced" scenario in which a number of factors are taken into account, such as simplification of eligibility determination, strong outreach and education, "no-wrong door," cultural sensitivity and language appropriate outreach and enrollment, and maximum use of pre-enrollment strategies. According to the modeling, the percentage of the non-elderly population with insurance in California in 2019 is estimated to be 89% under the base scenario and 92% under the enhanced scenario. Without ACA implementation, coverage is estimated at 84%. To review meeting materials from the March meeting, including an overview of the estimates provided through the CaSIM project, [click here](#).

The HBEX has also spent considerable time this year discussing the Exchange's role in selecting and contracting with qualified health plans. Presentations by invited technical experts at February's HBEX meeting included an overview of the California market, the existing regulatory structure (Department of Managed Health Care and Department of Insurance) and major purchasing strategies. Consumer groups raised, in public comment, significant concern with network adequacy and the need for strong protections to allow consumers to access out-of-network care under specified circumstances. To review meeting materials from the February meeting, including a helpful timeline of how plans have evolved and merged over the last 25 years in California, [click here](#).

### California Legislature Role in Establishing Essential Health Benefits

Substantive amendments were recently made to identical bills in the state Assembly and Senate (AB 1453 – Monning and SB 951 – Hernandez) related to the essential health benefits package to be made available by qualified health plans offered through the California Exchange. As discussed in more detail in the federal regulations and guidance section of this memorandum, the U.S. Department of Health and Human Services (HHS) released a bulletin in December describing the approach the federal government intends to take in future rulemaking to define the essential health benefits under the ACA, which utilizes a reference plan based on employer-sponsored coverage in the marketplace today, supplemented as necessary to ensure that plans cover the ten statutory categories of essential health benefits. Essentially, states have the flexibility to select an existing health plan to set the "benchmark" for the items and services included in the essential health benefit package. If the benchmark does not initially cover one of the ten categories, the benchmark must be supplemented. States

may choose a benchmark from among the following health insurance plans: 1) the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market; 2) any of the largest three state employee health benefit plans by enrollment; 3) any of the largest three federal plan options by enrollment; or 4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.

The proposed legislation would, in fact, adopt a uniform minimum essential benefits requirement in state-regulated health care coverage *regardless* of whether the policy or contract is offered to individuals or small employers inside or outside of the California Exchange. Per the legislation, any individual or small group health care service plan contract or health insurance policy that is issued, amended or renewed on or after January 1, 2014 shall at a minimum include coverage for essential health benefits (exceptions apply). The proposed legislation offers the following definition of essential health benefits: benefits and services covered by the Kaiser Small Group HMO plan contract as of December 31, 2011; habilitative services under the same terms and conditions as rehabilitative services; pediatric oral health care, as defined; and any other benefits already established as requirements under the relative chapters of state law. Of particular note to the mental health field is language in the legislation to specifically include coverage of "nonsevere mental illness services," as covered by the Kaiser Small Group HMO plan contract. Per an initial review of the Evidence of Coverage for the identified HMO product, it appears coverage should include services and benefits for a broad range of mental health conditions, utilizing the mental disorder definition as supplied by the DSM-IV-TR. CMHDA is working closely with our partners to conduct a more thorough analysis of the proposal to better understand the implications for mental health coverage. Both bills will be heard in policy committees this month. To review the proposed legislation, as amended, [click here](#) and [here](#). To review the Evidence of Coverage for the identified benchmark product, [click here](#).

### Federal Regulations and Guidance

There has been a notable windfall over the last several weeks of final rules filed with the Office of the Federal Register. As typical with the federal rulemaking process, a number of provisions within each final rule have been issued on an "interim final basis," pending additional public comment. CMHDA will be reviewing the final rules more closely over the next weeks and will work with our national and state coalition partners to better understand the full implications of the rules on our county mental health system, and to determine if/how we might provide further comment on the interim final components of any of the rules.

### *Final Rule on Medicaid and the Children's Health Insurance Program*

March 16, 2012, HHS released its eligibility and enrollment final rule – *Medicaid Program: Eligibility Changes under the Affordable Care Act of 2010* – to assist States in implementing the ACA Medicaid coverage expansion. Specifically, the final rule implements several provisions of the ACA related to Medicaid eligibility, enrollment and coordination with the Affordable Insurance Exchanges, the Children's Health Insurance Program (CHIP), and other insurance affordability programs. While the final rule maintains much of the framework laid out in the proposed rule (as released for public comment on August 17, 2011), it also includes a number of additional improvements recommended by states, consumers, consumer organizations, and the healthcare provider community. According to CMS, the final rule provides additional protections for consumers, as well as additional flexibilities and options for states. More specifically, the final rule makes Medicaid available to individuals between ages 19 and 64 with incomes up to 133 percent of the federal poverty level, eliminates obsolete eligibility categories and collapses other categories into four primary groups (children, pregnant women, parents, and the new adult group), modernizes eligibility verification rules to rely primarily on electronic data sources, codifies the streamlining of income-based rules and systems for processing Medicaid and CHIP applications and renewals for most individuals, and ensures coordination across Medicaid, CHIP, and the Exchanges. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) analysis, families will be able to enroll in the appropriate coverage program through a single, streamlined, online application and states will have the benefit of reduced administrative costs. Several provisions of the final rule have been issued on an "interim final basis" pending further analysis and public comment. SAMHSA has noted a few interim final provisions that may be of particular interest to the behavioral health community. Among those are provisions related to safeguarding applicant and beneficiary information, timeliness and performance standards for Medicaid, coordinated eligibility and enrollment among insurance affordability programs, and coordinated eligibility and enrollment among CHIP and other insurance affordability. To review the final rule in its entirety, [click here](#). To review the final rule regulatory impact analysis, [click here](#). Finally, for a section by section summary of the final rule, [click here](#).

### *Final Rule on Standards Related to Reinsurance, Risk Corridors and Risk Adjustment*

On March 16, 2012, the HHS released the final rule on standards related to reinsurance, risk corridors and risk adjustment. The ACA creates three programs to eliminate incentives for health insurance plans to avoid insuring people with pre-existing conditions or those who are in poor health, and to reduce uncertainty that could increase premiums when Affordable Insurance Exchanges begin. The three programs

are risk adjustment, reinsurance, and risk corridors. According to HHS, these programs will help ensure that insurance plans compete on the basis of quality and service and not on attracting the healthiest individuals. To review the final rule, [click here](#). To review the regulatory impact analysis, [click here](#).

#### *Advance Notice of Proposed Rulemaking on Preventive Services Policy*

On March 16, 2012, HHS released an Advanced Notice of Proposed Rulemaking (ANPR) outlining draft proposals to implement the policy announced by President Barack Obama and HHS Secretary Kathleen Sebelius on Feb. 10, 2012. This policy will provide women with access to recommended preventive services including contraceptives without cost sharing, while ensuring that non-profit religious organizations are not forced to pay for, provide, or facilitate the provision of any contraceptive service they object to on religious grounds. Of particular note to the mental health community, included among those additional women's preventive services that HHS declares be covered without cost sharing requirements is screening and counseling for interpersonal and domestic violence. To review the ANPR, [click here](#). The ANPR calls for a 90-day public comment period. New private health plans must cover the guidelines on women's preventive services with no cost sharing in plan years starting on or after August 1, 2012.

#### *Final Rule on Student Health Plans*

March 16, 2012 HHS released a final rule governing student health plans. Essentially, the final rule extends to enrollees of student plans all of the protections provided to enrollees in individual market plans, with several adjustments in light of the unique nature of these plans. Under the final rule, students will gain the same consumer protections other people with individual market insurance have, like a prohibition on lifetime limits and coverage of preventive services without cost sharing. For more information on the student health plan final rule, [click here](#).

#### *Final Rule on Affordable Health Insurance Exchanges*

On March 12, 2012, HHS published a final rule on Affordable Health Insurance Exchanges, which combines policies from two Notices of Proposed Rulemaking (NPRMs) published last summer. The final rule offers a framework to assist states in setting up Affordable Insurance Exchanges. The rules also include standards for the establishment and operation of an Exchange, health insurance plans that participate in an Exchange, determinations of an individual's eligibility to enroll in Exchange health plans and in insurance affordability programs, enrollment in health plans through Exchanges and employer eligibility for and participation in the Small Business Health Options Program (SHOP). According to HHS, the framework preserves and, in some cases, expands the significant flexibility in the proposed rules that enables

states to build an Exchange that works for their residents. For example (per the HHS summary), the final rule allows states to decide whether their Exchange should be operated by a non-profit organization or a public agency, how to select plans to participate, and whether to partner with HHS for some key functions. According to HHS, the final rule also offers significant additional flexibility regarding the eligibility determination process. Several provisions in the final rule, which are being issued as interim final, are open to further public comment. This includes the new flexibility for the eligibility process. Of particular note to the mental health community, the final rule also includes important changes from the previous version of the rule related to the provision that Qualified Health Plans must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. The final rule specifically highlights mental health and substance abuse providers to encourage Qualified Health Plan issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities. To review the final rule, [click here](#). To review the regulatory impact analysis, [click here](#).

#### *CMS Bulletin on Actuarial Value and Cost-Sharing Reductions*

On February 24, 2012, CMS released guidance, in the form of a bulletin, to provide information and solicit comments on the regulatory approach that they plan to propose to define actuarial value for qualified health plans and other non-grandfathered coverage in the individual and small group markets under the ACA, as well as to implement cost-sharing reductions of the ACA. Specifically, the ACA directs issuers to reduce cost-sharing on essential health benefits for individuals with household incomes below 400 percent of the federal poverty level who are enrolled in a qualified health plan in the individual market through an Affordable Insurance Exchange. These cost-sharing reductions are designed to have the effect of achieving certain actuarial values and therefore follow the same definitions and calculation of actuarial value. The concept of actuarial value plays a large role in the implementation of the ACA, as it is a key piece of information that consumers will use to navigate their coverage choices in the individual and small group markets. While actuarial value is a concept long used by health insurance plans and actuaries, it is generally unfamiliar to consumers, regulators and policymakers. According to the bulletin, actuarial value is expected to be used by consumers to compare qualified health plans and non-grandfathered individual and small group market plans with different cost-sharing designs and as a method for consumers to understand relative plan value. To review the bulletin, [click here](#). To review a helpful primer on actuarial value developed by the Consumers Union, [click here](#).

## *HHS Guidance on Essential Health Benefits*

On December 16, 2011, HHS released a bulletin describing the approach it intends to take in future rulemaking to define the essential health benefits under the Affordable Care Act. To review the bulletin, [click here](#). The intended regulatory approach utilizes a reference plan based on employer-sponsored coverage in the marketplace today, supplemented as necessary to ensure that plans cover the ten statutory categories of essential health benefits. Essentially, states would have the flexibility to select an existing health plan to set the “benchmark” for the items and services included in the essential health benefit package. If the benchmark does not initially cover one of the ten categories, the benchmark must be supplemented. States could choose a benchmark from among the following health insurance plans: 1) the largest plan by enrollment in any of the three largest small group insurance products in the state’s small group market; 2) any of the largest three state employee health benefit plans by enrollment; 3) any of the largest three federal plan options by enrollment; or 4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state. To review the illustrative list of the largest three small group products by state, [click here](#). Consistent with Congressional intent, the bulletin proposes that parity applies in the context of the essential health benefits. Subsequent to the release of the December bulletin, CMS has developed and posted a Frequently Asked Questions (FAQ) on the Essential Health Benefit Bulletin (dated 2-17-12) to provide additional guidance on HHS’s intended approach in defining essential health benefits. To review the FAQ, [click here](#). CMHDA, alongside a number of our behavioral health partners, submitted recommendations to the California HBEX in January to inform California’s comments to HHS Secretary Sebelius on the bulletin. To review CMHDA’s comments submitted to the HBEX as part of the California Coalition for Whole Health, [click here](#). To review California’s comments to Secretary Sebelius, [click here](#). CMHDA was also able to join national efforts around this issue, including signing onto the comments developed by the Coalition for Whole Health. To review the national Coalition for Whole Health comments to the Centers for Medicare and Medicaid Services (CMS), [click here](#). To review the Coalition’s consensus recommendations on the Essential Health Benefits, [click here](#).

### Dual Eligibles Care Coordination Demonstration

The Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) was established within CMS pursuant to Section 2602 of the Affordable Care Act. California is one of 15 states awarded a federal contract from the Coordinated Health Care Office to develop new models of coordinated care for people eligible for both Medicare and Medicaid (Medi-Cal), also known as dual eligibles. Currently, only a small portion of California’s dual eligibles are enrolled in organized care systems. The Dual Eligibles Coordinated Care Demonstration will involve models through which one entity

is coordinating care for the total needs of a person – medical and social. That includes behavioral health, social supports, medical care, and long-term care. This design could take a number of different forms. According to the state, it does not necessarily imply that demonstration sites control home- and community-based services; however there is an expectation that all services are coordinated and the care experience is seamless for the beneficiary. CMHDA's 1115 Waiver Workgroup has been actively involved over the last several months in monitoring the development of the demonstration and providing guidance to the state to inform the state's proposal to CMS. Per the feedback of CMHDA's workgroup, the final Request for Solutions (RFS) posted by the state in late January included an additional appendix with more information regarding coordinating and integrating mental health and substance use services. CMHDA recognizes that the success of this demonstration largely rests on the ability of the plans to ensure appropriate coordination of high quality care. For more information on the Duals Demonstration, [click here](#). To review a comprehensive overview of the demonstration that was developed by Harbage Consulting (dated October 2011), [click here](#).

*DHCS and DSS Release for Public Comment Draft Proposal for State Demonstration to Integrate Care for Dual Eligible Individuals – Initial Four Counties to Include Los Angeles, Orange, San Diego, and San Mateo*

DHCS and Department of Social Services (DSS) released on April 4 a draft proposal for California's Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Beneficiaries. This draft proposal is being published for a 30-day public comment period, prior to submission to CMS. According to the proposal, the four counties where the demonstration will be implemented under current state law are: Los Angeles, Orange, San Diego and San Mateo. However, if the Administration's Coordinated Care Initiative trailer bill is adopted this year (*see additional discussion on this proposal below*), California proposes to implement the demonstration in six additional counties: Alameda, Contra Costa, Riverside, Sacramento, San Bernardino and Santa Clara. To review the draft proposal published for public comments, [click here](#). To review applications from all 22 applicant plans, including those from the four selected counties, [click here](#). According to DHCS, the state hopes to submit a final proposal to CMS by early May. Once the final proposal is submitted, there will be another public comment opportunity before CMS takes action on the proposal. CMHDA will be reviewing the proposal more closely with our 1115 Waiver Workgroup to inform our comments to the state.

*State Creates New Workgroup Structure to Support Development & Implementation of the Demonstration – CMHDA to Co-Lead the Behavioral Health Workgroup*

To complement the existing stakeholder process around the Duals Demonstration, DHCS and DSS announced last month a new workgroup structure to support the

development and implementation of the Demonstration. According to DHCS/DSS, the goal is for the workgroups to develop policy recommendations in a team setting to ensure the needed policies and processes are in place for a 2013 launch, understanding that final decisions will be made by the Secretary of the California Health and Human Services Agency. The seven identified workgroups are: *Beneficiary Notification, Appeals, and Protections*; *Provider Outreach and Engagement*; *Integrated Care Systems*; *Long-Term Services and Supports Integration and Network Adequacy*; *Mental Health and Substance Use Services Integration*; *Fiscal Rate-Setting*; and *Data Quality Management*. To review a more detailed overview of the goals of the seven proposed workgroups and the schedule of upcoming meetings, [click here](#). CMHDA was recently approached by DHCS and Harbage with a request for CMHDA to “co-lead” the Mental Health and Substance Use Services Integration Workgroup, which we have agreed to do. CMHDA is additionally working to ensure strong county mental health representation on the workgroups and is pleased to have had members from at least three counties volunteer to participate. If you or someone on your staff is interested in participating in one of the proposed workgroups, please advise CMHDA staff as soon as possible.

#### *Governor's Care Coordination Proposal*

The Governor's proposal would increase the number of sites in the duals demonstration in the first year (beginning January 1, 2013) from four to up to ten counties, and expand to additional counties in subsequent years. With certain exceptions, the proposal would authorize DHCS to require all dual eligible beneficiaries and Medi-Cal beneficiaries with a share of cost in Medi-Cal fee-for-service to be assigned as mandatory enrollees into new or existing Medi-Cal managed care plans. It is additionally the Administration's intent per this proposal that Medi-Cal managed care plans assume the responsibility for the provision of and payment for Long Term Services and Supports (LTSS), in addition to their current provision of medical services. This component is especially complex and has raised significant concern among consumer and other advocates. To review the Administration's fact sheet on the proposal, [click here](#).

Given some notable challenges with the recent implementation of the mandatory enrollment of Seniors and Persons with Disabilities into managed care as part of California's 1115 waiver implementation, advocates have raised significant concern regarding the potential unintended negative implications of the proposal for consumers. According to advocates, there have been numerous instances of individuals receiving erroneous denials for critical life-sustaining care, such as organ transplants, because of system design flaws. CMHDA members have also noted instances where the mandatory enrollment of individuals into managed care threatened to disrupt or discontinue coverage of critical psychiatric medications, much due to tremendous variance in pharmacy formularies between payers. The Legislative Analyst's Office

(LAO) has raised similar concerns in its testimony to the Legislature, and has recommended that the Administration proceed with the originally designed four-county demonstration, but *reject* the Governor's proposal to expand it statewide at this time. To review the analysis of the Governor's Care Coordination Proposal prepared by the LAO for the Assembly hearing on 3/7, [click here](#). To review the LAO's analysis of the recent history of adult day health care and the transition of seniors and persons with disabilities into managed care, [click here](#). Additionally, the LAO released last month a comprehensive report entitled *Integrating Care for Seniors and Persons with Disabilities* that provides significant background on and analysis of California's current service delivery system. To review this report, [click here](#). For the aforementioned reasons, CMHDA's Legislative Committee has recommended that CMHDA join the coalition efforts of the California State Association of Counties (CSAC) and a number of its other affiliates and other disability rights advocates, to oppose the expansion proposal, and instead encourage the state to ensure a meaningful evaluation of the originally designed four-county demonstration. CMHDA will continue to work closely with CSAC and the other affiliates to attempt to mitigate potential negative implications for counties.

#### Federal Court Activity

The Supreme Court heard arguments on the constitutionality of the healthcare reform law and other issues pertaining to it for three days starting March 26, 2012. The first day of the hearing pertained to the applicability of the Anti-Injunction Act to the ACA. The Anti-Injunction Act prohibits lawsuits on taxation bills from being heard until the tax is brought into effect. If the Court rules that the Anti-Injunction Act applies, it will terminate any legal action against the ACA until the ACA tax penalty takes effect on January 1, 2014. The Court appointed outside counsel to argue for the applicability of the Anti-Injunction Act. The second day of the hearing focused on the extent that the Commerce Clause of the U.S. Constitution delegates to the federal government the authority to regulate interstate commerce, and specifically whether the federal government can force someone who does not want to engage in interstate commerce to buy something. The specific issue asks if the refusal to participate in interstate commerce by an individual failing to purchase health insurance, generally known as the individual mandate, constitutes engaging in interstate commerce and is thus subject to federal regulation. There are legal precedents to which both sides can appeal. The final arguments on March 28 included the constitutionality of the federal government forcing states to participate in the ACA or be subject to punishment by withholding Medicaid dollars. Additionally, the issue of the missing severability clause that would have protected the balance of the ACA in the event that the Supreme Court declares another part of the ACA to be invalid was heard on the last day. Severability clauses are standard boilerplate for legislation. A severability clause was included in all but the final draft of the ACA that passed the U.S. Senate. The U.S. House of Representatives

considered the Senate version for action, and passed the Senate version without a severability clause. Analysts and attorneys do not expect a decision in the case until mid to late summer.

#### California Coalition for Whole Health

The California Coalition for Whole Health (CCWH) is a diverse group of behavioral health stakeholders concerned with influencing the implementation of the Patient Protection and Affordable Care Act (ACA) to appropriately address mental health and substance use disorder issues. CCWH took root in the national Coalition for Whole Health, a group of over a hundred organizations in the mental health and addictions fields from across the nation with shared interest in ensuring appropriate inclusion of behavioral health issues in ACA implementation activities. CMHDA has been an active member of the CCWH steering committee for the last several months. The coalition meets monthly by conference call.