2010

- March 23, 2010 legislation enacted P.L. 111-148
- States expand Medicaid to low-income childless adults through the State Plan
- Young adults can remain on parents' insurance up to age 26
- Discounted prescription drug coverage in Medicare
- Eliminated lifetime limits
- Prohibits pre-existing condition exclusions for children
- Workforce investments
- Prevention and Public Health Fund established
- Funding to Substance Abuse and Mental Health Services Administration (SAMHSA) for wellness promotion/chronic disease prevention

2011

MEDICARE and MEDICAID

- Medicaid health home option for beneficiaries with multiple chronic conditions
- States must consult with SAMHSA on addressing mental health and substance abuse needs of enrollees
- States receive 90 percent federal funding for 2 years for eligible health home services
- Optional Medicaid benefit to provide community-based services and supports to certain people with disabilities
- Provides qualifying States with enhanced Federal match for Home-and Community-Based Services (HCBS)

PREVENTION AND WELLNESS

- Eliminate cost-sharing for certain Medicare-covered preventive services
- Includes Screening, Brief Intervention and Referral to Treatment for alcohol misuse
- Includes mental health screenings
- Provide Medicare beneficiaries access to comprehensive health risk assessment without cost-sharing
- National Prevention, Health Promotion and Public Health Council to develop strategies to improve nation's health, with mandated participation of the director of the Office of National Drug Control Policy
- Continued funding through the Prevention and Public Health Fund
- Incentives for Prevention of Chronic Diseases in Medicaid for states to provide incentives for Medicaid beneficiaries that participate in health promotion programs and/or adopt healthy behaviors
- Provides grants for up to five years for small businesses to establish workplace wellness program

QUALITY IMPROVEMENT

- Establishes National Quality Strategy to improve delivery of health care services, health outcomes, and public health
- Creates the Community-Based Collaborative Care Network Program to facilitate coordination and integration of care for low-income uninsured and underinsured

2014 – 2018 FULL IMPLEMENTATION

- Health Insurance Exchanges
- Medicaid expansion
- Insurance reforms and other consumer protections

The National Council on Alcoholism and Drug Dependence-New Jersey (NCADD-NJ) works with and on behalf of individuals, families, and communities affected by alcoholism and drug dependence. The organization's role is to advocate and educate the best and most cost effective approach to treatment, recovery and prevention. NCADD-NJ is one of only eight sites across the country selected by Open Society Foundations to generate state and local understanding of the issues of addiction treatment. With knowledge and action, positive change does happen. This is the third in a series of brochures on health care reform related to addiction treatment.

To learn more about the elements of health care reform covered in this brochure, see resource links at NCADDNJ.org.

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OPEN SOCIETY FOUNDATIONS

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NCADD-NJ HEALTH CARE REFORM SERIES

KEY ELEMENTS OF HEALTH REFORM

NCADD NEW JERSEY

ADDICTION IS A DISEASE. LET'S TREAT IT THAT WAY.

KEY ELEMENTS OF HEALTH CARE REFORM

The Patient Protection and Affordable Care Act (PPACA) introduces to health care an approach that will change how treatment is delivered, who receives it, and how it is paid for. The reform aims to improve care as it reduces medical costs. At the heart of the law is the innovative approach that care must encompass the whole person. The broad aim of the health care overhaul is captured in a 1948 quote from the World Health Organization (WHO), which defined health as "a state of complete physical, mental and social well-being."

Overview

The PPACA is a huge achievement and an equally huge and complex law. The following only covers some of its important goals and features. The PPACA was signed into law on March 23, 2010. Important features of the law include that it prohibits insurers from denying coverage to people with pre-existing conditions, prevents them from charging higher premiums based on health status, and from imposing annual or lifetime caps on insurance coverage. To improve health and save health care dollars, the PPACA includes funding for preventative medicine and early intervention. Some of the law's provisions went into effect at the time of its enactment, while others are taking effect over the next several years. Many of the most significant provisions take effect in 2014, with full implementation of the law expected by 2019 (see chart on back flap).

Among the most important elements of the reform is that it expands health coverage, with insurance being provided by Medicaid, Health Insurance Exchanges, and Employer Health Insurance. The PPACA has expanded the reach of health care by extending Medicaid eligibility to all Americans up to 133 percent of the federal poverty level.

Holistic Care Integration

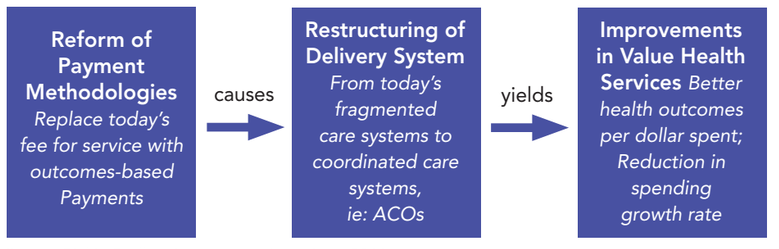
For the World Health Organization's definition of health to become a reality depends a great deal on how holistically the PPACA integrates care. The reform's move toward care integration breaks from the medical silos in which physicians and other health professionals have traditionally had their practices. These silos have kept providers in their own realms instead of having them work together to consider the entire spectrum of issues facing a patient and how those issues might be interrelated. The silos have been especially counterproductive by keeping physical and behavioral health care separate.

NCADD HEALTH CARE SERIES

The consequence of the narrow scope of care has been a system that is always expensive and often ineffective. The PPACA has the ambitious goal of producing better patient outcomes at lower costs. While these two goals may seem mutually exclusive, in fact they are complementary. Within the PPACA are a number of provisions that support an integrated approach to care, which will improve the quality of care and at the same time reduce the expense. This is particularly true with chronic illnesses.

The Accountable Care Organization

Within the infrastructure of the PPACA is the Accountable Care Organization (ACO), an entity explicitly designed to bring about reform's dual goals of improving care and reducing health care costs. ACOs, which will be set up regionally, comprise a network of doctors and hospitals, primary care and behavioral care, and specialty services to treat the patient across the entire care continuum. To promote care integration, ACOs foster an environment of cooperation and coordination among this network of care providers. It ensures medical treatment that is efficient and, vitally, measures the outcomes of that treatment. This treatment setting is meant to interrupt diseases early on, thereby lowering the number of full-blown cases and emergency room visits. Furthermore, the ACO is responsible for aligning procedures, protocols, and philosophy of care across different types of care.



Source Rivkin Radler, Attorneys at Law, June 2011

A distinguishing feature of the ACO is that it puts the focus squarely on the needs of the patient, rather than the provider. The ACO provides incentives for good care outcomes and cost savings, rejecting the existing model that pays for the provision of medical services whether or not they benefit the patient. In addition to efficient care, the ACO makes available transparent, real-time medical data. Overall, the ACO assigns shared responsibility for high quality care and positive outcomes, with some of the resulting savings being returned to the medical practice.

FOCUS ON RECOVERY SUPPORT

The Medical Home

Medical Homes, also known as Health Homes, are the embodiment of holistic treatment. They complement ACOs in that they are person-centered and emphasize strengthening and empowering primary care to coordinate treatment across the full continuum of care. Medical Homes should be especially beneficial to individuals with multiple chronic conditions. The primary care physician is at the center of the medical home model and refers patients to treatment and services throughout the home's interdisciplinary network. This team may comprise specialty care, acute care, behavioral health services, long-term community-based care, and supports. To promote communication among providers, each patient's medical history will be contained in an Electronic Medical Record that can be readily shared among all involved with his or her care.

Some of the care provided through a medical home is not commonly found in a primary care setting, such as patient and family education for chronic diseases, home-based services, telephonic communication, group care, and culturally and linguistically appropriate care. Health information technology, chronic disease registries, and electronic health records are used across the patients' life-span and across all domains of the health care system and the patient's community.

Health Insurance Exchanges

For those not covered by employer health plans, Medicare or Medicaid, choosing a plan will be done through Health Insurance Exchanges. These exchanges, which will be in place in all states by January 2014, facilitate the purchase of health insurance for individuals, families and small businesses. An array of plans, coverage and costs will be accessible through a web portal. The exchanges, which have been likened to Travelocity for health care, will make the marketplace navigable and will facilitate choice according to need and cost. The exchanges also serve to pool risk and thereby lower premiums.

The components of the PPACA outlined above will have a significant impact on the treatment of addiction. This impact on addiction care will be the subject of the next and last document in this series; in particular, the issues of who will be covered by Medicaid and what treatment services will be reimbursed will be of major consequence.