U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

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of the
SAMHSA National Advisory Council (NAC)

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PROCEEDINGS

Agenda Item: Call the 56th SAMHSA NAC Meeting to Order

MS. GERETTA WOOD: Operator, if you could open the line, and we'll begin.

OPERATOR: Okay. One moment, please. And you'll just hear a brief moment of silence while I start the recording. Please stand by.

Welcome, and thank you for standing by. At this time, all participants are in a listen-only mode. After the presentation, we will be having a time for public comment. At that time, to ask a question or make a comment, you may press *1 on your touchtone phone and record your name when prompted.

Today's conference is being recorded. If you have any objections, please disconnect at this time.

I would now like to turn the call over to Ms. Geretta Wood. Go ahead. You may begin.

Agenda Item: Welcome and Opening Remarks

MS. PAMELA S. HYDE: [on telephone] Hi, thank you, Operator. Is your name Sharon?

OPERATOR: Yes, thank you.

MS. PAMELA S. HYDE: Thanks, Sharon. Appreciate your help.

OPERATOR: You're welcome.

MS. PAMELA S. HYDE: So hello, everybody. Sorry for the technological difficulties. I want to make sure I know who all is on the line. I understand -- well, let's go around. Josh, are you there?

MS. GERETTA WOOD: Yes, Josh is here.

MS. PAMELA S. HYDE: Okay. So we got Geretta and Josh. Is --

MS. GERETTA WOOD: Holly is here.

MS. PAMELA S. HYDE: -- Holly there?

MS. GERETTA WOOD: Holly is here.

MS. PAMELA S. HYDE: Okay. And is Betsy there?

MS. ELIZABETH A. PATTULLO: [on telephone] Yes, I am, Pam.

MS. PAMELA S. HYDE: Betsy, hi. How about Larry?

DR. LAURENT S. LEHMANN: [on telephone] I'm here. Hi, everybody.

MS. PAMELA S. HYDE: Hi. Chris?

MR. CHRISTOPHER R. WILKINS: [on telephone] I'm here. Hi, everybody.

MS. PAMELA S. HYDE: Great. And Lorrie?

DR. LORRIE RICKMAN JONES: [on telephone] Hey, everybody.

MS. PAMELA S. HYDE: And Pete?

DR. PETER J. DELANY: Yep.

MS. PAMELA S. HYDE: Okay. So that's the names I got. Is Henry on?

MS. GERETTA WOOD: He's not going to be calling -- able to call in.

MS. PAMELA S. HYDE: Okay. How about Ric? Is he there?

MS. GERETTA WOOD: I have not heard from him this morning. He did complete the paperwork. So I was hoping he would join.

MS. PAMELA S. HYDE: Okay. So he may be having some trouble, too. How about Junius?

MS. GERETTA WOOD: Yeah.

DR. JUNIUS GONZALES: [on telephone] Hello?

MS. PAMELA S. HYDE: Hi, great. How about Megan?

MS. GERETTA WOOD: Megan is going to join just a little bit later.

MS. PAMELA S. HYDE: Okay. How about Charlie, Charles?

MS. GERETTA WOOD: Charles is on.

MS. PAMELA S. HYDE: Okay. How about Cassandra?

MS. CASSANDRA PRICE: [on telephone] How's that?

MS. PAMELA S. HYDE: Hey, good to hear your voice. How about Dee?

[No response.]

MS. PAMELA S. HYDE: Okay. How about Ben?

MS. GERETTA WOOD: Ben won't be joining.

MS. PAMELA S. HYDE: Okay, and how about Marleen?

[No response.]

MS. PAMELA S. HYDE: All right. So at least I'm trying to see, Geretta, if we have a quorum. Can you count for us?

MS. GERETTA WOOD: Once she gets logged in, we will have a quorum. Once Marleen gets logged in.

MS. PAMELA S. HYDE: Oh, she's still working on it?

MS. GERETTA WOOD: Yes.

MS. PAMELA S. HYDE: All right. Well, thank you, everybody. And if anybody hears somebody else click in, let me know, and we'll see what we can do about getting -- being aware that they're on.

So I really appreciate your joining this way. I don't know how many of you were able to participate yesterday. I know that, obviously, Chris was there because he was on our panel. So I don't want to repeat a lot of stuff from yesterday, and I don't know also how many of other SAMHSA staff are available.

So do we have -- let me just check that while we're waiting for a couple people. Do we have anybody from CMHS on the line?

[No response.]

MS. PAMELA S. HYDE: How about from CSAT?

[No response.]

MS. PAMELA S. HYDE: Okay. Anybody from prevention, CSAP?

[No response.]

MS. PAMELA S. HYDE: Okay. So we've only got CBHSQ in terms of the centers available. Kana, are you on the line?

MS. KANA ENOMOTO: I'm here.

MS. PAMELA S. HYDE: Kana may be having the same problems calling in as well. So --

MS. GERETTA WOOD: Kana is in the room with us. Her microphone is having some difficulties.

MS. PAMELA S. HYDE: Oh, okay.

MS. GERETTA WOOD: And I just wanted to inform you that Marleen Wong has joined.

MS. PAMELA S. HYDE: Okay. Great. Marleen, hi.

DR. MARLEEN WONG: [on telephone] Hi. Good morning, everybody. Or good afternoon.

MS. PAMELA S. HYDE: Morning for you, huh?

DR. MARLEEN WONG: Yeah.

MS. PAMELA S. HYDE: All right. Well, again, I appreciate all of you being here, and I appreciate you working through the technology problems with us. We are -- we continue to try to see what we can do about having conversations and having some of these meetings without having to travel you all to D.C.

I can tell you right now that we are going to have you all back in person on April 7th, 8th, and 9th, I believe it is. Is that right, Geretta?

MS. GERETTA WOOD: That would be 8, 9, and 10.

MS. PAMELA S. HYDE: 8, 9, and 10. All right. So if you'll put that on your calendars, for those of you who will be continuing with us. I know there's a person or two maybe cycling off. But April 8th through the 10th is when we'll have our next meeting in D.C. at the SAMHSA building. So put that on your calendars, and we'll get you more information later.

I also just want to take an opportunity -- I did this yesterday, and I don't know if you were all on, but I want to take an opportunity to thank Geretta for her work over the last years. She is retiring in September, and we're going to miss her work. But we -- she's already working hard to transition this role to Holly Berilla, who is on the phone. So watch for Holly's name or an email from her.

Holly, you want to say hello?

LT. HOLLY BERILLA: Yes, hello. I'm really excited to be serving in this role, and you will be hearing from me shortly. I'll be sending some "save the dates" out.

Thank you.

MS. PAMELA S. HYDE: Great. So we at SAMHSA will have time to wish Geretta godspeed a little bit later, but we wanted you to know that we are shifting over in the leadership on the staff role about this. We're pleased that Holly is able to transition with Geretta still there. So that's very helpful. And thanks to the OPPI staff for helping to get that done.

I also wanted to just let you know that we are very interested in your feedback. You know, I often use all of you as advisers about these meetings. So be interested in your feedback about yesterday, if you were able to be on the phone. We had the whole meeting was about -- with the joint councils was about military families and veterans, and we had -- Larry, we had Wendy from VA with us, and that was great. She really added a lot to the conversation.

DR. LAURENT S. LEHMANN: Thank you very much. She is terrific.

MS. PAMELA S. HYDE: Yeah, she is. And she's fairly new to working with us, but we really have appreciated her help and her partnership. So thanks, and thank you for being here today.

So anybody have any quick feedback from yesterday? Did you get to hear the conversation yesterday?

MS. ELIZABETH A. PATTULLO: Pam, this is Betsy Pattullo. And I sent Chris a note. I thought it was very interesting conversation. You know, I felt like I learned a lot. I always feel like I don't understand how big the United States is until you hear about Samoa.

MS. PAMELA S. HYDE: Yeah.

MS. ELIZABETH A. PATTULLO: But also some of the challenges in providing services from the provider point of view, but also sort of every perspective. I thought it was a really interesting discussion and very helpful to me.

MS. PAMELA S. HYDE: Great.

DR. LORRIE RICKMAN JONES: I agree. This is Lorrie, Pam. I agree. It was also great hearing Kathryn still very much involved in this work. But it was very enlightening, learned from different perspectives about providing these services to this population.

So well done. Very nicely done.

MS. PAMELA S. HYDE: Oh, good. Good. Anybody else have a reaction from yesterday?

[No response.]

MS. PAMELA S. HYDE: Okay. Well, I'm glad that some of you got to hear it. I usually ask you all by the time we're done, and so I'll probably circle back around before we're done today about just if you have thoughts about April. We are going through our 2016 budget process. So by then we may want to talk about that a little bit.

There are other things moving and shaking at SAMHSA around -- a couple things we mentioned yesterday, demonstration program around community mental health services and some opioid overdose prevention and addiction prevention issues, some work we continue to do on military families effort. You'll hear today about some of our healthcare and health systems integration work. And I know you all had a conversation about that last April when I was not able to be with you that final day.

But we'll have a little bit more conversation about that today, as well as some other things going on in the health reform and health financing area. There is lots of work going on in our data area, and then you all often have really interesting ideas about things that you think it would be worth a good conversation to have your advice.

And I always just want to remind you that we are very interested in the advice you give us, and it really does impact our thinking. I'm one of those people who really like advisory committees. Not everybody does, but I love them. And I love the time to sit back and reflect. I love your perspectives.

And while you may or may not see a particular action from a particular conversation, just know that every one of these conversations is really valuable to us as we try to both lead the Nation, lead the public health efforts in the Nation to advance behavioral health in the Nation and also, frankly, as we sit at the tables that we get an opportunity to sit at on behalf of the Nation's behavioral health activities.

So please know that your time is precious, and we really appreciate that you give us some of it and you give us your best thinking. And we appreciate that a ton. So thank you in advance, and be thinking as we talk today about what things you think would be appropriate and that you might have things to offer in April when we get together.

We also have our strategic initiatives for the next 4 years coming out soon. I hope you saw those in public and out for public comment, and you all obviously provided us with great input, especially the young people, what they did in April and what they told us was really helpful. And we've asked some of them if they would give us a reflection on how we responded to that and if it was adequate.

So that will be being finalized this month, this month being September, actually. We're not quite there yet, but it'll be finalized before October 1st with all the public input. We got tons of public input, mostly positive. But some good pieces of suggestion and advice from the public about that, what we call now Leading Change 2.0.

We're also about to finish up an accomplishments report. So that accomplishments report will also be available in the fall. So by we hope somewhere around October 1st, thereabouts, which will talk a little bit about what we've done in the last 4 years from our Leading Change eight strategic initiatives over the last 4 years. So watch for that as well.

Again, anytime you see anything like that, we really hope that you'll give us your feedback about what you think about it. Don't wait until our meetings to do that. You can send that input to now Holly Berilla, B-e-r-i-l-l-a. Of if you want to reach out directly to us, you can do that as well. Any of the center directors or myself or Kana, but it's helpful to us if you "cc" Holly or at least let her know that you're doing that so we can kind of keep track of all that.

So let me, with that, just say we've got a couple things on the agenda today that we're really excited about. We hope that Marilyn Tavenner doesn't have quite as much trouble with the technology as the rest of us have and that she's able to join us at 1:30 p.m. She is, of course, the Administrator of the Centers for Medicare and Medicaid Services.

This is the group that not only runs those two major programs, but also has been guiding the Affordable Care Act implementation and also running some major new initiatives around payment structures that really are moving health reform and healthcare, the delivery of healthcare across the entire Nation.

We have a tendency to think of the Affordable Care Act as enrollment. And while those are important, and it's critical and lots going on about that, there's a lot more going on about the implementation of the Affordable Care Act that is in

many ways under Marilyn's leadership and direction. So prevention efforts, which the Surgeon General also is involved in, and ARC and others, as well as ourselves, and then some innovation activities. The Affordable Care Act actually put a fair amount of dollars into innovation work that's in Marilyn's shop and then just the enrollment leadership as well.

So she's going to be on at 1:30 p.m. and will talk to us for about 15 minutes or so about where we stand with all that, and you all will have an opportunity to ask her questions. I can tell you that she's been a very supportive partner on things like suicide prevention. When we first got some of the screening measures in to some of the early regs, and she and her staff, Cindy Mann at Medicaid and Jon Blum at Medicare, who has now left us, but Sean Cavanaugh behind him, they've all been extremely great partners with SAMHSA.

And sometimes what you ask us to do is to help you understand how we relate to other Federal agencies. So this is really, obviously, a critical one. So you may have conversations to have with her when she's on the phone with us.

And then, following that, we're going to have Chris Carroll, who's our new -- he's not new to SAMHSA, but he's new in the role of our health financing lead and the senior adviser on that and head of our strategic initiative on healthcare and health systems integration. He's going to tell you a little bit about what we're doing in this area and things we're working on and particularly how the concept of integration is evolving for us, and what role we think we will play in that.

And he'll talk to you a little bit about parity and where we are with that and some other things. And then there will definitely be a good hour, we hope, for us to have a conversation about that and get your advice about what's going on out there in the field and how we can be helpful to all of you and how you can be helpful to us and giving us your best thinking.

So that's kind of what we have planned for the day. Our goal was to have this be a little shorter. Everybody told us that if we were going to do these meetings virtually that we needed to not ask people to sit on the phone or in a webinar for a whole day, that that was just more than people could bear. So we've tried to have this be a reasonable length of time.

We are not going to take a formal break. So we assume that you all will take care of your own creature comforts in the way you need to do that. And we will just get through the agenda here today. At somewhere around 3:30 p.m., we're going to open it up for public comment. And to the extent that you can, I really ask you to stay because part of your role is to hear from the public, as we do. And then, you know, to provide us any input or feedback about what you hear there as well.

So, with that, I don't know if, Marilyn, are you on the phone yet?

MS. MARILYN TAVENNER: I just joined. So perfect timing. I was able to hear you talking about Cindy and Jon. That's the piece where I joined.

MS. PAMELA S. HYDE: Okay. Well, perfect. So, Marilyn, this is our National Advisory Council. If I can do a real quick rundown on who's on the phone, just so you know. We have Betsy Pattullo, who is chairman and founder of Beacon Health Strategies. She's one of our advisers.

We have Cassandra Price, who is the director of -- she's actually what we call the single State agency for substance abuse in Georgia.

We have Lorrie Rickman Jones, who is in the Office of the Governor of the State of Illinois.

We have Marleen Wong, who is an associate dean and clinical professor at the School of Social Work at the University of Southern California.

And we have Chris Wilkins, who is from Pittsford, New York. He is the president and chief executive officer of Loyola Recovery Foundation.

Has any of our other advisers joined us?

DR. ERIC B. BRODERICK: [on telephone] Pam, this is Ric. I'm on.

MS. PAMELA S. HYDE: Hey, Ric. So Ric is retired, Health Commissioned Corps, and was the Deputy Director here at SAMHSA some years ago. He's from Pagosa Springs, Colorado. He was in the Indian Health Service for many years before that.

So anyone else join us?

MS. JUANA MAJEL-DIXON: [on telephone] Juana Majel-Dixon from California.

MS. PAMELA S. HYDE: All right. Okay. So that's it, Marilyn. So I've told them that we were going to hear from you for about 15 minutes on what CMS is doing around the Affordable Care Act or anything else you want to tell us, some of the payment structures that are changing and how healthcare is changing under this administration and your leadership.

And then we thought we might have 10 or 15 minutes for folks to ask you questions.

Agenda Item: Healthcare Implementation – A

Perspective from the Centers for Medicare and Medicaid Services (CMS)

MS. MARILYN TAVENNER: All right. That sounds great, Pam.

And I will -- Pam and I have had the opportunity to work closely together over the last several years, and I cannot believe that I'm actually approaching my fifth anniversary here at CMS. But I think I can -- we've had so many changes with the Affordable Care Act, and I think the improvements have been widespread, but I'm going to try to put them into three buckets to start off with. And I'll try to talk about how mental health is connected in each of those buckets.

But if I don't do a good job, I'm sure you all can ask me the right questions, and I'll certainly try to answer your questions. And if I can't, then I'll take them down and get them back to Pam so we can get you information as quickly as possible.

But I would say, you know, I actually came to CMS in February of 2010, about 3 weeks prior to the passage of the Affordable Care Act, and the Affordable Care Act has certainly been everyone's tool and strategic plan. But probably nowhere is that more apparent than in CMS because of the payment changes, as well as access and a few other areas. But I'm going to group it into three areas.

The first one would be access. The second one would be quality. And then the third would be about cost, cost reduction or cost reform, depending on how you want to take a look at it.

So let me start with access because I certainly think that's probably one of the things we're most proud of, and I know it's one of the things the President is most proud of because it's kind of been a, you know, three-pronged approach, if you will. First of all, there is the issue of, obviously, the marketplace or exchange. And what we were able to accomplish after a very rocky start, we were able to end up with a little over 8 million folks in the exchange.

And certainly, we've had people come on and go off since that time, and we'll probably be releasing more solid numbers in the next few weeks. But it's been a tremendous opportunity to get to work with a lot of people nationwide. I certainly think mental health and other services benefited from this move toward access. We certainly tried as we were developing what we were calling the qualified health plans to make sure that we had mental health and mental parity covered in those, as well as other key services.

But it's been basically a nationwide push, and it's been amazing to me to see how much the uninsured have dropped just in one year's time. Now there's a great deal more work to do, and we will start up again in November, mid November. And of course, we want to retain the 8 million we have, as well as

grow another somewhere between 5 and 7 million depending on how much we lose by attrition.

But the CBO target for year two is around 13 million. And while that may not be our target yet, it's a public target. So we tend to talk about our work in relationship to that target.

The second part has been the Medicaid expansion. We have -- you may have seen a little Associated Press article this morning saying that we were close to a deal, if you will, with Pennsylvania, which is true. We are close to concluding that agreement. And when we do, that will be the 28th State to expand Medicaid.

And we certainly feel like we want everyone in. But when you start to have 28 and we have like 3 more we're in discussion with, you feel like the tide is turning. And I think probably some of the biggest beneficiaries from my days in Virginia has been how to -- are those individuals with mental illness who can actually now qualify, receive Medicaid services and get much needed help.

But that Medicaid expansion has also been a good success story in terms of the drop in the uninsured, and then there's the Medicare program, which continues to grow quite rapidly. We probably bring in about 300,000 new Medicare beneficiaries each month. And obviously, a lot of that is related to my generation or the baby boomers who are certainly coming into the Medicare rolls at a rapid rate.

Which leads to the third issue of cost and delivery system reform. But I would say access, while there is a lot of work left to do for sure, and it will be a several year process, it's been a really good first year. We are now looking at insurance rates and plans for year two in the market. And thus far, they are looking really, really strong. So we're pleased.

So that's a little bit about access. There is another whole section of access I could talk to as well, one of which is very important to you all, and that has to do with primary care and mental health providers. And the President has proposed in his 2015 budget I think a little over $6 billion to try to get at this issue of primary care, mental health, and other what I'll call high-level practitioners, how do we change that whole system of our reliance on physicians alone and have more complete support system, which again gets to the issue of quality and delivery system reform.

So a lot of work in that area. Then I'd say the second area which, thanks to Patrick Conway, who's our chief medical officer but also heads up the innovation program and our quality program, we have spent the last 3 years trying to rationalize a complicated quality program, much of which was unintentional, but sometimes difficult to navigate, nonetheless. Somewhat for hospitals, but

definitely for practitioners.

And that we had a lot of quality programs that were mandated by Congress that came on at different times and had been set up in different systems. So we're trying to rationalize the systems and move them to a single quality point of view, if you will, working with our sister agencies, working with mental health, obviously, and SAMHSA. Also working with the private sector so that if you are a practitioner or a hospital, you understand what the quality measures are, regardless of whether it's a Medicaid, a Medicare, a marketplace, or a private insurer or employer-sponsored insurance program.

So we've been working in that area, again not complete. We are still trying to get meaningful use in some other things where they need to be, which also brings up the issue of are we going to be able to expand meaningful use beyond the acute care hospital setting? And we're having discussions in that area as well.

In addition, we've tried to change the quality measures from looking so much at process and trying to look at outcome, which brings me to the third area, which is how we're going to manage payment and delivery system reform in this new environment. And having the quality measures and the quality platform is really critical for us to move from a process or individual payment to a payment for an episode of care or a payment for a population and tie it to quality and outcome measures.

That work is going on throughout the agency. Certainly, the Innovation Center carries a big part of that, but it's also going on throughout the Medicare world and the Medicaid world as we look at innovation projects, as we look at payment reforms, and as we try to focus a little more on not just the hospital and doctor setting, but how do we look at entire communities?

So that is probably what I'd say are the things that I try to emphasize to folks when I'm talking to them. There are a thousand other little projects, all equally important. But if I try to keep it on those three themes and tie everything back to those three, I think it's a little easier to understand.

So I love this work. It's fascinating work, and I could probably talk forever, but in the interest of time, I'll try to quit talking and let anyone ask any questions that may have some questions.

MS. PAMELA S. HYDE: Thanks so much, Marilyn. And I didn't tell you earlier and I should, these are public meetings. So there could be a number of people listening from all over the country, and then some of our other advisory committee members may be listening as well.

So while the actual people I introduced to you are fairly small number, and those are the ones who will be speaking or asking questions, there's a number of

SAMHSA staff and a number of the public and members of our other advisory committees all listening, Marilyn. So thank you a ton for being here.

And this is a rare opportunity, folks, to ask -- to have a dialogue with Marilyn. So who has a question they'd like to ask.

DR. ERIC B. BRODERICK: Pam, this is Ric.

MS. PAMELA S. HYDE: Yes. Go.

DR. ERIC B. BRODERICK: Marilyn, I'm curious as to what you're seeing happen with cost, healthcare cost generally and CMS cost specifically, as enrollment numbers go up?

MS. MARILYN TAVENNER: Right. A great question. So let me take Medicare first, the CMS side of the house. We recently had a Medicare Trustees report in, gosh, I'm trying to think, I guess it was in July, where we basically talked about the extension of the Medicare Trust Fund. A big part of that is driven by the fact that Medicare cost per capita, and I can talk about it both ways. Medicare costs in general are probably the lowest year-over-year trend that we've seen probably in about 40 years, and this has been the third or fourth year that that's been the case.

And I think in the initial years, some of the thought process was the economy, and the economy is certainly a factor. I think as year two and three and four came into view, I think we now believe it's a combination of [audio disturbance] done in the Affordable Care Act. So we're seeing very low cost trends overall in Medicare, but I would say because of the numbers I just gave you about the number of new entries into the Medicare program, we will always have to keep our eyes open on cost and what the best quality, most efficient way we can provide services.

And obviously, that's a pretty big initiative inside the Medicare population. So we do the work there through the Innovation Center, but also through general Medicare policy and payment policy.

On the marketplace side, currently what we have, at least in most States, are proposed rates. So final rates won't be in until probably sometime in September for many States. But I think we're seeing a cost trend on both the marketplace side and on the employer side that says costs are going up in single digits. There's always exceptions to that. There are some negatives, and there are some that go up 10 percent.

So the cost trend there has actually flattened a little bit, too. For the individual who's having to pay a 6 or 7 percent increase in premium, that's probably always a difficult argument to make. But there were a lot of predictions that as we

started to expand coverage that we'd see the private market soar in pricing and cost, and we're not seeing that.

If you look at it by segment, on the inpatient side, the hospital side, it's either flat or even a little bit negative on cost trends. Outpatient is certainly still positive cost trend, and we're seeing more and more work being done in the outpatient setting, which, again, I don't think is that surprising. But it's an area of focus. And in fact Part B expenditures in Medicare are quickly approaching Part A in terms of overall expense.

So I'd say cost trends are good, but they're still increasing year over year, and we've had, you know, 20-year history of some pretty expensive cost increases. So we'll have to continue to do work in that area, and that's part of the reason for the accountable care organizations, some of the bundle programs we're doing and other work with physician groups or our delivery system groups.

MS. ELIZABETH A. PATTULLO: Pam, this is Betsy Pattullo.

MS. PAMELA S. HYDE: Yeah, Betsy, go.

MS. ELIZABETH A. PATTULLO: Marilyn, just to you and Pam, I just want to say thank you for all of your work on the implementation of the Affordable Care Act. It is incredible to me. And when I think about the gift to my grandkids that you have created here with the success that has been enjoyed so far, and we're at the very beginning of this. I think it's just remarkable.

But I wonder, could you speak a little bit about some of the dual-eligible programs that are rolling out around the country and sort of how you view those?

MS. MARILYN TAVENNER: I certainly am happy to do that. You know, we have, and I can't remember how many States we have now, and I should know that. So I'm embarrassed. But it's in the double digits. So let's say we have 13 or 14 States that have explored some type of dual-eligible program. What we have seen initially was a managed care model, which is fine. But we wanted some diversity beyond the managed care model, and we're seeing more of that.

We're seeing some work done in the fee-for-service or more in what I'll call the traditional Medicare and Medicaid relationship. So that's good because we really want to demo different types of programs and see how they do, both from a quality standpoint and a cost standpoint. It's early on. I don't think we'll probably have any data until, you know, '15 or so.

But what we have seen is, first of all, probably the sharing of data between the Medicare and the Medicaid programs. And even before the demos began, that's been a big plus because it's created a conversation about who are these individuals? What are their needs? I think most of us know or have family who

sit in a dual population world, and I don't think there's been any question that their care has been fragmented.

So how do we use data to try to figure out what resources they need and how to deliver those resources in a coordinated way, which has been the goal, whether it's done in a fee-for-service environment or a managed care environment. We now have folks who are enrolling and actually delivering care under this model, which really didn't happen until 2014. So we really -- early indications are we've had our challenges, as we expected. I think we've seen a lot of difficult diagnoses to work with.

We've had to work with plans to help -- on the managed care side help plans understand. Physician participation has been really good. But it's still too early to determine how it's going, but at least early on, the approach to coordinated care and the satisfaction thus far has been okay. But we are closely monitoring this environment because it is so new and because it is such a vulnerable population.

MS. PAMELA S. HYDE: All right.

DR. LORRIE RICKMAN JONES: Pam, this is Lorrie. I have a question, if that would be okay?

MS. PAMELA S. HYDE: Certainly. Go.

DR. LORRIE RICKMAN JONES: Hi, Marilyn. Thank you for your presentation, and I'd like to echo what Betsy said, thank both of you for your incredible work in this area. I've been in the field for over 30 years, and it's probably the most exciting time in my career to be a part of this rollout.

My question is about the quality, and your statement that you want to move toward a single quality construct or point of view, bringing together both the public and private sectors to the same page in terms of how we look at quality. And I was wondering if you could talk a little bit about your approach to that?

What kind of incentives are there to bring the private sector to the table, and what kind of guidance can you give to States on making that happen at a local level?

MS. MARILYN TAVENNER: A great question. I'd say, first, the work that we've tried to do internal to HHS across all the different agencies, of which SAMHSA was a part of that, was to try to create National Quality Strategy as a framework for the areas where we were going to concentrate and the approach we would try to take. That is a pretty big document, and Pam will tell you that from that document, we tried to weed it down to the top five or six objectives so that at least across Government, whether it was a Medicaid provider, Medicare, or

whether we were working with different agencies and their public programs, we at least were thinking about this in the same way.

Because obviously SAMHSA, CDC, HRSA, there's a lot of care delivered in a lot of different settings that we were trying to talk to and have agreement on how to approach. So that is the first way.

The second way is we have a great deal of private insurers who do Government work. I think you all are aware, for better or for worse, and there's lots of opinions about this, Medicaid has now, at least on the acute care side, moved to very much a managed care program. I think fee-for-service is still there, particularly in chronic care and long-term care, obviously. But a lot of acute care is now being delivered through a managed care environment.

So that gave us a natural way to sit down with States and with their managed care programs and try to offer some demonstration projects in this area, which we've done over the last several years. And also to offer, we recently put out a second, if you will, request for information and grant opportunity to States to try to look at how do we have all payers come together and sit at the table and talk about what works? Whether it's the State government or whether it's a private issuer or whether it's Medicaid or whether you're working with, you know, health clinics, et cetera, how do we get everyone at the table to talk about this and look at it in the same way, which I think creates -- there's always going to be a little variety in populations and approaches [audio disturbance] general core.

The work that we've done in meaningful use, and our work with the ONC has been to have core objectives that apply to everyone and then have some optional menu items. The last, of course, is payment, and now, you know, we have started to work initially with hospitals, but now it's moved to other areas, quality, specific quality measures and payment together.

So, again, this will be several years in evolution. It's not overnight. But I think there's just been a practical way to sit down and make this work through demos, through payment strategy, and just honest conversation.

DR. LORRIE RICKMAN JONES: Thank you.

MS. PAMELA S. HYDE: Anyone else?

DR. MARLEEN WONG: Yeah, hi. This is Marleen Wong. Thanks so much for this opportunity to speak with you.

I just had some questions about when sort of the payment structures, the models of payment structures might be put into place for medical homes and the variety, as you said, the sort of range of ways in which people can access healthcare. It seems that that uncertainty, at least at the ground level, is it sort of prevents

people from making the changes that they might want to make, particularly practitioners on the ground.

MS. MARILYN TAVENNER: So I think that's very true, and that's one of the things we struggle with every day. Obviously, we're doing that some in the Innovation Center through just some basic requirements in the Affordable Care Act. We are in the process of evaluating some of the medical home models. The process would be if we find the results are strong, then obviously it has to be scored by our actuary within CMS. There's an independent actuary.

There, we can make recommendations to the Secretary. You could make recommendations to Congress. In some cases, Congress is already interested in these. Medical homes is obviously one. There are several key sponsors on the Hill who are constantly at us with the "Can you hurry up already," you know?

We just want to do it methodically and do it right. But there is a sense of urgency because people, particularly practitioners in communities, even health systems have trouble understanding which world they're supposed to live in. So it's a fair question. I don't have a magic date. But I'll say it's very much on our mind and the mind of --

DR. MARLEEN WONG: You know, I just wanted to comment that I'm -- I head up the internships, all of the internships for the University of Southern California. And we have 3,600 students now. So we have over 5,000 contracts and MOUs across the country, many of which are, you know, various kinds of health providers.

But it's interesting to see the students who, on the one hand, are learning about the ACA and the hopes and the intent of the ACA, and yet the great discrepancy between what they hope will come into place for communities, for patients, you know, for just general care, and the reality of practice, which is, you know, it is in fits and starts. And I think that's a difficult part of this current generation of, you know, developing professionals.

MS. MARILYN TAVENNER: I think you're exactly right. And when I talk, a few lectures, not as many as I should throughout the year, it is one of the more difficult questions to answer. So I hear you loud and clear.

DR. MARLEEN WONG: Thanks.

MS. PAMELA S. HYDE: So, Cassandra, Chris, do you have comments or thoughts?

MR. CHRISTOPHER R. WILKINS: It's Chris Wilkins, Pam. Thank you. And thank you, Marilyn, just to echo the thanks everyone else gave you.

I just want to add that I've been particularly grateful for the initiative and the thoughtfulness and the innovation efforts. Can you talk a little bit about where that stands and what the future of that might be?

MS. MARILYN TAVENNER: Another great question. You know, I think the first couple of years from the innovation side, I think we were migrating more to I'd say the work that has been outlined either by individuals in the industry or by Congress, and the ACOs is a big part of that and the shared saving models and pioneers. And then certainly is true with the work that we have started around bundled payments.

One of the things we're trying to do now and we have put out some proposals, but there will be more proposals throughout the year, is ACOs and those models are great. Bundles are great. But how do we actually -- they tend to be more hospital centric or system centric. How do we help physicians, individual or group? And how do we help post acute care providers have some capital and interest in looking at their delivery system model?

Because, obviously, you can't address the entire system through a physician practice or through a hospital practice, but if you start to look across the spectrum. So some of the work you'll see us do this year, and we've sent out some requests for information, has been in post acute care and in physicians, and I'd say that's next on the list.

Then at the same time, we've had two offerings where we talked across whether it was mental health or substance abuse or specialized populations, having individuals bring their proposals to us with certain, you know, elements included, stimulate some creativity in this area, too, and look at populations that we might not think about. So I think we'll continue some of that, but I think you'll see us branch out probably more into the community and into community issues or chronic issues, physician-oriented issues, a little less emphasis on delivery systems.

MR. CHRISTOPHER R. WILKINS: That's terrific. Thank you.

MS. PAMELA S. HYDE: So we don't have too much more time with Marilyn. So does anyone else got a question for her?

MS. CASSANDRA PRICE: I think -- I think everybody's questions really covered the broad spectrum of topics and all the wonderful information she shared. This is Cassandra. So ditto and ditto and ditto.

MS. PAMELA S. HYDE: All right, thanks.

Marilyn, I might ask you just to end up with, if I'm not putting you on the spot and I don't mean to be, but I know we've talked a lot with Cindy about the work that

Medicaid is doing in the parity area, if you had any comments about that? I know there is some stuff in the works.

And then if there's anything in the works about that in Medicare, and then maybe you could just wrap up with telling us how you see the enrollment process rolling out this fall?

MS. MARILYN TAVENNER: Sure. So I would say, and Cindy is definitely the mental parity expert as it relates to Medicaid, but it is a personal passion of hers. And she has been, whether through State Medicaid director letters or proposed rules, trying to push this out front and center, also in any benefit package that we are considering either for Medicaid waivers or Medicaid expansion, as well as the core program.

I would say in Medicare more of the same. What we've tried to do in the Medicare is look at and Medicare has a very traditional and some would say somewhat dated approach to mental health services. So we've tried to, if you will, modernize some of the work, particularly outside of inpatient setting, in outpatient and outpatient services. But there is no question we have a lot more work to do.

And then in the marketplace, obviously, there are certain core requirements meant to drive mental health parity. So we're trying to make sure they are included in any of the qualified health programs that we receive.

The way I would say that we will handle rollout this year and open enrollment is starting -- and we actually have a more complicated message this year, if that were possible. I thought last year was pretty complicated. But what we have this year is we have returning individuals, and then we have new individuals.

So what we will try to do, history has taught us from Medicaid experience and otherwise, to the extent that people can auto-enroll or not have to take any action, and I think that's true for employer-sponsored insurance, too, because I fall into that model every year. Sometimes I just auto-renew versus trying to go through and pick out new plans, which is not always in my best interest.

So what we're trying to do is balance those returning and offer an auto-renewal process, but also balance that with, you know, you need to pay attention to your plan, to your changes in your life or your family circumstances, and obviously, you need to pay attention to rates and quality. So that will be message one.

And then message two is, well, you need to go find additional folks. And the theory being that in year one, probably people who needed it most are who heard about us, probably came to the door first. So how do we make sure we target markets and go, if you will, deeper and broader with the message to identify folks that didn't enroll in year one. So first step is hanging on to those we

have. Second step is growing.

And we will definitely be working with navigators again, with the sisters and with all of the wonderful community advocacy programs that we identified with last year. I think part of the reason that we were successful is the great community partnerships we had. So that won't change, and hopefully, we'll be able to tell from our data where to go and where to emphasize more.

So I can't believe it's almost time again, but we'll start talking about this probably next month, but definitely mid October on.

MS. PAMELA S. HYDE: So, Marilyn, thank you so much for your time. I know it's precious, and this group, as you can see, is fairly sophisticated. So they're asking all the right questions. So I really appreciate your time being here with us. Thanks.

MS. MARILYN TAVENNER: No problem. Thank you all, and thank you for everything you're doing.

FEMALE SPEAKER: Thank you, Marilyn.

MALE SPEAKER: Thanks, Marilyn.

MS. PAMELA S. HYDE: All right. It's always a --

FEMALE SPEAKER: That was great, Pam.

MS. PAMELA S. HYDE: Yeah, it's always -- I think you've gotten a flavor, those of you who've been around for a while with us now, a flavor of all the interagency work that we do with as we said earlier, with VA, with DoD, with Education we've had here. We've had HRSA here. We've had now CMS here.

If there are other groups that you think we ought to bring and let you see kind of how we're interacting with them, you can think about that and let us know.

Agenda Item: Consideration of Minutes from the April 2014 SAMHSA NAC Meeting

MS. PAMELA S. HYDE: Before I move to Chris, I want to go back while we have a quorum and get the minutes. Geretta, do you want to tell us, they got sent out ahead of time, I guess?

MS. GERETTA WOOD: They did get out ahead of time, and they were certified in accordance with the Federal Advisory Committees Act, FACA regulations.

Members were given the opportunity to review and comment on the draft minutes. They received a copy of the certified minutes.

If you have any changes or additions, they will be incorporated. If not, can we have a motion to approve the minutes?

MS. ELIZABETH A. PATTULLO: So moved.

DR. LORRIE RICKMAN JONES: This is Lorrie Jones. Second.

MS. PAMELA S. HYDE: Who was the first one? Who moved it?

MS. ELIZABETH A. PATTULLO: Betsy Pattullo.

MS. PAMELA S. HYDE: Oh, thanks, Betsy. And Lorrie seconded. Okay. All in favor, or anybody opposed? Let's put it that way. Anyone opposed?

[No response.]

MS. PAMELA S. HYDE: All right. Hearing none, then we will have the minutes show as approved as you have in front of you.

Agenda Item: Healthcare and Parity Implementation

MS. PAMELA S. HYDE: All right. So the next part of our program is to kind of follow up on the conversation with Marilyn is to now take you into some of the work that SAMHSA is doing around health reform. And I certainly didn't want to use up Marilyn's time to jump in and talk to you about, for example, she mentioned the National Quality Strategy.

We're doing a National Behavior Health Quality Framework that is a part of that effort, and Pete, who was on the call -- I assume still is -- is leading and has been leading on that. We have done a lot of work with enrollment stuff, and Chris is going to talk to you a little bit about that. Obviously, we've done a significant amount of work with the parity efforts that HHS and Treasury and Labor have done, and he'll talk with you some about that.

We've also done quite a bit of work with the Innovation Center on everything from health homes to primary behavioral healthcare integration, and we're now taking that integration construct beyond just primary care. And we'll talk more about that in a little bit.

So we're kind of moving from what Marilyn talked about into what SAMHSA is doing, and we're going to have Chris walk us through some of those things, and

then we're going to try really hard to have at least an hour, 50 minutes to an hour of just conversation and interaction about it so that we can get your best advice about what we need to be paying attention to.

So, Chris, we're pretty much on time, maybe 5 minutes after. So if you can try to keep your comments to a half an hour or less, that would be great.

MR. CHRISTOPHER D. CARROLL: I'd be happy to. Thank you, Pam.

First, just to open, I'd like to thank you and Kana and Mary Fleming and, frankly, the rest of the executive leadership team in supporting and encouraging me in taking this on. It's been very helpful in a really wide and broad and deep area of focus. And exciting to take this on.

I have been involved in these efforts for a while now, both from content to management support of the effort, and I'm heartened to see the SAMHSA support being brought in through a structure and focused assembly of the FIT team, which is a cross intercomposition of financing specialists hired specifically to help us with these efforts.

There is one in each center, and they are beginning to drive our agenda, I guess, down into the center. So it's nice to see that be operationalized with an opportunity to sustain these efforts. And of course, I'd be remiss if I didn't mention the legacy of accomplishment that John O'Brien and -- both John O'Brien and Suzanne Fields brought to this role. So I have some big shoes to fill here.

So now I will hurry, I promise. Today, I think what I would like to discuss are three areas of focus. I think buckets are the popular thing in Government now. So I'll use the bucket terminology as well.

First, I think we should discuss briefly the movement from the healthcare reform SI to the healthcare and systems integration SI. I would like to speak a little bit to the status of the health systems integration as a SAMHSA concept, and then the meat and potatoes, I guess, will be the accomplishments and ongoing activity in both the health reform and the healthcare and health systems integration SI as we move toward it, specifically around enrollment and parity.

So the health reform SI was -- it was in the original Leading Change, and it was important for us to direct SAMHSA resources and effort into supporting the Affordable Care Act. And we did just that, and again, I'll discuss some of those accomplishments as we move forward.

As we move towards implementation of the Affordable Care Act, healthcare and health systems -- healthcare financing and healthcare systems integration becomes more important as we look at how the systems are changing, how the

structures are changing, how the payment methodologies are changing. And how the focus of our healthcare system moves from purchasing quantity of services to quality of services.

So as we look at Leading Change 2.0, it's important that we put our efforts on what are the emerging models? What are the innovation system development efforts? And what are the quality-based approaches being used to construct and deliver services? And what's being focused on by HHS?

So this presentation and moving forward kind of straddles both worlds of that since we are still -- we're still in the health reform SI, and we're looking forward to moving towards Leading Change 2.0. A part of -- a part of this is the integration discussion, and I was present and appreciated your lengthy discussions about integration the last time you were here in person. Our vision for behavioral health integration, and I think that you may have a briefing paper. I asked that that be sent out. So I hope that you have it, but we'll address it briefly.

It was a SAMHSA briefing for Secretary Burwell on July 22nd, and what this does, it starts to lay out SAMHSA's vision for behavioral health integration. I just kind of wanted to mention, as I reread it, thinking about your perspective, there were a couple of things that I thought were important to highlight in that memo.

So the term "behavioral health" in this context of the memo means the promotion of mental health resilience, well-being, the treatment of mental and substance use disorders, and the support of those who experience and/or are in recovery from these conditions along with their families and communities.

Integration, as SAMHSA envisions it, extends beyond health and behavioral healthcare systems and recognizes that to treat an individual's health and behavioral health needs requires addressing their social needs, such as housing, employment, and transportation. The goals of this strategic initiative are better health for individuals and communities, better outcomes for accessing healthcare delivery systems, and better value for the health promotion and healthcare dollar.

There are a couple of bullet points on the last page of which SAMHSA commits to, and remember, this is what we're committing to the Secretary at this point. To foster integration between behavioral healthcare and public healthcare system to include Government, private, nonprofit, and faith-based entities providing health, behavioral health, and social services. Collaborate on developing a comprehensive strategy to effectively finance behavioral health services and other social services that contribute to the overall health of the individual and communities.

The last line is particularly important, I thought, is SAMHSA is a small agency with a big mission, and we will continue to need HHS's support as it -- as it trans -- well, as we transform to the SAMHSA of the future. So I would add, you know,

the NAC in there, too. We're going to need your support as we move forward.

So, with that, it's going to be important for us to get your thoughts as we move to the open part of the discussion later. So I would like to move into the health reform SI, of which we have some major accomplishments that I would like to talk about.

First is improving the business of providing behavioral health, and this really focuses on the BH Business project that SAMHSA runs that you may have heard about previously. This project provides the opportunity for community-based behavioral health -- sorry, my microphone keeps cutting out for some reason. Behavioral health providers to develop structured business operation design plans and expert-facilitated peer learning networks.

They focus on business strategy in the area of health reform, third-party contract negotiation, billing and compliance, eligibility and enrollment, and HIT procurement. So far, the effort has produced 19 nationwide learning networks and has trained nearly 800 behavioral health provider networks.

Eligibility and enrollment, we'll talk about that in depth as well. The expanded eligibility for Medicaid and new health insurance marketplaces have really changed the landscape of our service system and the behavioral health needs of more individuals being addressed. We have implemented a 3-year phased eligibility enrollment strategy, including systems marketing, research, and extensive HHS and external partner/stakeholder engagement opportunities.

Part of what I mentioned yesterday is that SAMHSA is developing a best practices toolkit on LGBT populations, communities. These communities have very high prevalence rates of behavioral health needs. On August 26th, there was a Gallup poll that came out. We've had this underway for a couple of months now, but there was some validation yesterday as a Gallup poll was released about LGBT populations and how they are more likely than non-LGBT to be uninsured.

So it's timely, with enrollment coming on. So that's something that we're interested in pushing quickly.

Additionally, the growth in the number of insured requires us to think differently about the programs that we run, specifically the block grants. So in our 2014-2015 application, we encouraged the block grant programs to focus their plans on four areas, which were to fund priority treatment and supports for individuals without insurance for whom coverage is terminated for short periods of time, to fund those priority treatments and support services not covered by Medicare or Medicaid or private insurance, to fund primary prevention -- universal, selective, and indicated prevention activities and services for persons not identified as needing treatment, and to collect performance and outcome data to support

these efforts.

Currently, we're preparing our 2016-2017 block grant application, which encourages States to recognize the need for improved coordination and integration of care, physical and behavioral health, with other healthcare in primary specialty, emergency, and rehabilitative care settings. So pulling as many levers as we think -- as we think we can.

Also important to the SI work is our collaboration on ACA implementation. With Pam's support, SAMHSA has been seen as a central partner in ACA implementation, and we've provided a consultative role and an expert behavioral health policy advice mechanism for our Federal partners. Specifically, with CMS, we've done a number of things. We have partnered with CMS on designing new delivery models, such as Section 2073 health homes program. And to date, SAMHSA has engaged in over 45 consultations with more than 25 States to promote coordinated, integrated care for persons with behavioral health conditions.

We have worked on providing educational and informational materials in partnership with CMS and CDC and HRSA and NIH regarding health coverage and evidence-based practices. So we did do several informational bulletins, including community alternative, psychiatric residential treatment, coverage in service design opportunities for individuals with mental and substance use disorders, trauma-focused screening, prevention and early identification of mental health and substance use conditions, and we did a MAT, Medicaid-assisted treatment bulletin, as well.

Additionally, there's kind of some offline things that we continue to work with CMS on to help them improve their approach to health systems redesign and financing. So we provided some significant technical assistance and behavioral health consultation in the development of the Center for Medicare and Medicaid Innovation -- that's the CMMI -- for the review of their funding opportunity announcement and review of their grant applications in both the Healthcare Innovations Award program and the health -- and the State Innovation Model program.

And in addition to that, we've developed a number of public learning tools and collaborated with our partners on webinars and different educational publications, as well as conference presentations. And individual consultation, I think, has been critical for us as well.

So kind of moving, here's the straddle part, as we continue to think about moving from health reform into healthcare and health systems integration, we continue to have ongoing work and collaboration with our Federal partners. So just recently, SAMHSA and CMS provided assistance to the National Institute of Corrections on a webinar on eligibility and enrollment and how does it actually

work. The webinar was targeted to audiences that included criminal justice professionals, correctional health professionals, and community-based providers.

Also we continue to push out information which is publicly available information for decision-makers in the public. Some of these include some issues brief on managed care strategies for behavioral health, the 2013 profiles of State mental health and substance abuse agencies, spending estimates for substance abuse and mental health, financing of medication-assisted therapy, and an exploration of Medicaid managed care and fee-for-service data.

Also as it relates to innovative financing and the purchasing of quality, SAMHSA, in collaboration with CMS and ASPE, continues to provide overall leadership in establishing a demonstration program, which we've been referring to as Section 223. I'm not really sure how much information you all have on that, but we can get that out if we need to. That was called the Protecting Access to Medicare Act of 2014, and that is for States to certify community behavioral health clinics in an effort to increase the quality and access of community-based mental healthcare.

So this is -- this is more than a demonstration program. I think it is -- it begins to construct a new -- and interact with the healthcare system in a new way.

Another brand-new effort that we have been partnering with or collaborating with CMS on is an initiative to improve health and reduce costs for Medicaid beneficiaries with substance use disorder, and this is called the Medicaid Innovation Accelerator Program, the IAP. I think there was a "Dear State" Medicaid letter that was not -- just recently released. And this is just an extension of service delivery and payment system reform already under the Affordable Care Act.

Our partners at CMS understand that substance use disorders and the vital recovery supports that come with it will be important for us to address, and this is an initial focus of the IAP, and we will continue to work with CMS as this initiative develops. I should also mention that we continue to do significant internal work, that we've done extensive staff training on Medicaid expansion, marketplaces, eligibility, and enrollment to bring us up to where I think we really need to be.

Pam mentioned earlier that Leading Change 2.0, in which healthcare systems and healthcare and health systems integration is placed, was out for public comment. I hope you all had the opportunity to comment on that. We do have some of the public comments, and we're working our way through that. And this really -- this document really begins the transition from our health reform work to the system redesign and integration efforts.

The two issues that I wanted to go in a little more in-depth, and I'll hurry through these -- I see that time is pressing here -- is the enrollment work and our parity

work. So we are currently building off the significant enrollment work that we did for the initial enrollment 2014 period. That includes toolkits, webinars, technical assistance, education, and outreach using social media and blog posts.

We have assisted CMS, our partners, with content development, such as 10 Ways products. All of these are publicly available as well. We did do enrollment toolkits. I'm fairly sure that you've heard about these, but we did toolkits on general population, community-based prevention, consumer, family, peer, and recovery organizations, housing and homelessness service organizations, mental health and substance use providers, and criminal justice.

We continue to do training and technical assistance and partner with organizations and our Federal partners to get more training and TA out there on culturally and linguistically appropriate outreach and enrollment practices. Our continued work is focused on supporting outreach and enrollment to African Americans, Latinos, Asian Americans, Pacific Islanders, and urban Indians. This is -- this is an important area for us to identify under-enrolled populations and continue to move forward.

One of the things besides the LGBT toolkit that we're excited about and one of the things that we've just developed is an opportunity to partner with CMS on the Coverage to Care initiative. And we see this as an area that we can really begin to start to emphasize behavioral health. The Coverage to Care initiative is out of CMS, and it's an initiative to help people with new healthcare coverage understand their benefits and connect to primary care and the preventive services that are right for them so they can live a long and healthy life. So just keeping coverage once you get it.

Also part of what we did was take stock of all the enrollment efforts that we've undertaken. So we have developed a compendium of enrollment efforts, which I think is a good picture of the populations of focus that we worked on and the types of information that we've provided. Did we provide a toolkit, a webinar, outreach, educational information, and technical assistance, blogs, social media, or other, and where those resources are actually located. That really helped me kind of understand the depth and breadth of what we were dealing with and -- and also identified significant gaps for us as where do we need to focus additional enrollment efforts.

The last time that you were here, I think in person, you asked for some specific, maybe State-by-State data on enrollment. You heard from Administrator Tavenner about the 8 million people that have enrolled, that we do have some specific data. I have some highlights here from it, but we also have some issue briefs that we can share with you if you'd like.

So in the insurance marketplace, there is over 8 million new enrollees. Fifty-four percent of these are male, and 46 percent are female. Thirty-four percent are

under the age 35, and 28 percent are between 18 and 34. As far as race and ethnicity, about 63 percent are white, 16 percent African American, 10 percent Latino, 8 percent Asian, 0.3 percent American Indian and Alaska Native, and 0.1 percent Native Hawaiian and Pacific Islander. So that also, I think, reinforces or informs our enrollment strategy.

Medicaid and CHIP enrollment, that's another interesting area. We heard Pennsylvania's intent to expand Medicaid. But it appears as though Medicaid expansion through ACA is over -- the number enrolled is over 66 million people at this point, and of the States that have expanded Medicaid, 6.7 million of the 12.8 that were eligible have enrolled in Medicaid or CHIP, and it's 52 percent of the eligible -- eligible people.

And lastly, August 26th, Secretary Burwell announced an addition to her executive leadership team, that there's a news release which details this in depth, but Kevin Counihan will join the Centers for Medicaid and Medicare Services as the marketplace chief executive, the CEO. He comes from Connecticut. He's got more than 30 years' experience in insurance.

Within Connecticut, he cut the insurance -- the uninsured rate in half in their enrollment period. So he brings some gravitas with him. He will focus on being accountable and responsible for the Federal marketplace. He will manage relationships, and he will run CCIIO, which is the Consumer Information and Insurance Oversight Office.

And quickly, we'll do MHPAEA. Before I do that, I did want to acknowledge a staff member that has been supportive of this effort, not supportive, has been the broad shoulders of this effort, and that's David Shillcutt, who's here with us. And if we have any technical questions, I'm going to look to David because he really understands this stuff.

But David is leaving us to take another position in CMS. So it's a big loss for us, but I'm proud of David, and he's done a fine job in taking this on.

So just quickly an overview of MHPAEA. MHPAEA requires that the financial requirements and treatment limitations imposed on coverage for mental and substance use disorders be no more restrictive than the financial requirements and treatment limitations for medical/surg, med/surg benefits. It's important to remember, and this is often a sticking point, that MHPAEA does not require plans to offer coverage for mental and substance use disorder. Nor does it require plans to offer coverage for specific treatment or services for mental health -- mental and substance use conditions.

It does, however, require coverage for a plan. It requires a plan to offer coverage that must be provided in parity with its coverage for med/surg benefits. Enforcement efforts, responsibility for enforcement is shared among the three

Federal departments and the States. For individual and small group plans in most States, the State insurance commissioner enforces MHPAEA.

States are in a variety of stages of planning for their enforcement strategies, but most are currently adopting a complaint-driven process. And a few States that don't have authority to enforce MHPAEA under their State law, CMS's CCIIO, again the Center for Consumer Information and Insurance Oversight is enforcing it. CCIIO assesses plans' compliance with MHPAEA as part of its review process.

CCIIO also has enforcement authority for most employer-sponsored plans in the public sector. For most employer-sponsored plans in the private sector, the U.S. Department of Labor and the IRS have enforcement authority. So that is HHS, Department of Labor, IRS is the tri-agency responsibility, specifically CCIIO, of which we have a very good working relationship.

But given the complexities of the rules for parity, the Federal Government is currently concentrating its effort on providing technical assistance to plans and insurers to help them understand the requirements of the law and what it means for their beneficiaries or their benefits. SAMHSA continues to support this effort.

We have heard from our partners that we do have a role through our regional administrators who have just met with the tri-agency group. We are closer to the ground on a number of issues. We're closer to the population that we serve. We're closer to knowing the issues. So we continue to be supportive of our Federal partners.

Medicaid, we did briefly discuss Medicaid managed care plans, and the alternative benefit plans and CHIP programs are all subject to MHPAEA. Guidance on the application of MHPAEA to Medicaid was released in a State Medicaid directors letter in 2013. And additional details and a proposed rule we are expecting somewhere around 2015. We hope that's sooner. There's a lot of concern in the States around the application of Medicaid and CHIP with MHPAEA.

So as we move forward in our health reform and health system, health systems financing role, it's important that we recognize the better information that we can get to consumers and providers, the better the communications are about the enforcement and strategy of MHPAEA application. I think we see that as our role. There are opportunities for us to clear up a number of things around nonquantitative treatment limitations and provider adequacy and a number of things like that.

But we're committed to this is the law of the land now, and we're committed to working with our partners to ensure that MHPAEA is implemented across systems in a beneficial way for the people that we serve. So, with that, I'll stop,

and that's almost the right time. So --

MS. PAMELA S. HYDE: Thanks, Chris. You did a good job of that.

So I appreciate it. You can tell by Chris's presentation that there's a lot going on, and he's really taken the lead in making sure that not only he, but our whole organization is focused on some of these issues. So I really want to just open it up now. You've heard -- you may have questions for Chris. If you do, that's great.

I would also just like to open it up for some comments about how you all, as advisory council members, think we're doing. Can you tell either from his presentation or from what you see out there the impacts of the work that we're doing around health reform, healthcare, health systems integration, and do you have questions? Do you have recommendations? Do you have thoughts for us?

Just let's have a conversation for a few minutes about that. So who wants to start?

DR. LORRIE RICKMAN JONES: Hey, Pam. This is Lorrie. I'll start.

MS. PAMELA S. HYDE: Okay.

DR. LORRIE RICKMAN JONES: First of all, it's amazing, absolutely amazing just listening to all the work you're doing. Oh, my God.

MS. PAMELA S. HYDE: Yeah, it makes you tired, doesn't it?

DR. LORRIE RICKMAN JONES: Yeah, it does. But you know, from -- from where I'm sitting, it seems to be all the right stuff. So I can't tell you how pleased I am about all the different efforts that you have going on and all the different balls in the air that you're managing to keep up in the air. So it's really amazing that you're doing all this work.

But I do think that -- I think, you know, from my vantage point, you're hitting all the right areas. I had to think a little more and see if there's any particular gap that I could recognize, but I am, you know, really pleased to hear that the strategic initiative has its commitment to the goals that not only focus on health and behavioral health, but the social determinants. Because you know those of us who've been in the field for years know how important that is. So that, of course, was music to my ears.

So I probably need to digest this a little more and think about where the gaps are, but my initial impression is, you know, kudos. Kudos. Absolute kudos to you and your team.

MS. PAMELA S. HYDE: Great. Thank you. That's good feedback. You think we're hitting the right things. So that's helpful.

Others' comments?

DR. MARLEEN WONG: Hi, Pam. This is Marleen.

MS. PAMELA S. HYDE: Yeah.

DR. MARLEEN WONG: Just a question about -- I want to echo what Lorrie said. I mean, the amount of work that's going into this has been tremendous, and I'm looking at what's going on at the ground when we place students in healthcare settings, including hospitals. And I think what I'm not seeing is or that I see rarely is that reform is a partnership at so many different levels.

And I don't know that agencies or institutions necessarily are engaged with all the stakeholders if, indeed, we're really focusing on expanding healthcare into the community, where the community plays, you know, an important role in their own health. And SAMHSA is always great at issuing practical guidelines, you know, to achieve the next level of service. And what I've heard from the last two speakers is the tremendous amount of work that's going on at the policy level. I mean getting things in place and program implementation at a very high level.

And I wonder whether or not there could be guidelines, like practical guidelines for healthcare agencies, what they can do to prepare for reform. Like, ways in which they can start thinking about transition activities themselves. Whether it's examining their current budgets to, you know, implement prevention and resilience activities or incorporate more community members and train them for healthcare education and support. I just don't know -- and of course, you know, in terms of the next generation of professionals, to incorporate supervised interns to provide early intervention activities, particularly when we think about the integration of behavioral health with primary health.

But I just don't know whether it would be helpful or whether it, in fact, has already happened that there are guidelines for this interim period, like before all of the, you know, finance models, funding models have been established, what are some of the things that, as I said, agencies and institutions on the ground can do to kind of prepare for that, to do their own homework?

MS. PAMELA S. HYDE: So, Chris, do you have a response to that? I had a thought, but let me see if you have something.

MR. CHRISTOPHER D. CARROLL: Go ahead, please.

MS. PAMELA S. HYDE: My reaction, Marleen, was both a reaction and then a question back, which is -- and I'm not sure if I'm totally getting your comment, but

one thing that SAMHSA has done, at least in the last 4 years since the Affordable Care Act passed in 2010, is to really we have focused on that high-level policy stuff because there have been a lot of major decisions being made and information being pushed out, et cetera, that we're just trying to impact. And I think we've done a pretty good job at that.

But now what I hear you saying is that, okay, we've kind of done good work there. Now what about getting on down? And some of the BH Biz business stuff that Chris talked about is certainly a way that we've tried to do that for providers, and we have incorporated some of the Affordable Care Act type requirements into some of our grant RFA proposal in language and such.

But I hear you saying that there's a need for, for example, saying to schools or community coalitions or some other group, here is how you need to think about this differently given the Affordable Care Act or given the changes in health reform because of the Affordable Care Act? Is that -- is that what I'm hearing?

DR. MARLEEN WONG: Yeah, and here are some of the activities that might contribute to that, to preparing for it.

MS. PAMELA S. HYDE: So what -- what kind of things do you think they need to hear? Do they need to hear issues about what healthcare payment structures are changing, or do you think they need to hear more about the National Quality Strategy and what they can do to be working with that? Or what do you think they need to hear?

DR. MARLEEN WONG: I guess how I'm thinking more about programmatically how those -- those policy changes might affect the delivery of service, and are there any things that they can do in advance of that to, you know, train community members now, for instance, to be incorporated into this, into the changes that are yet to come?

MS. PAMELA S. HYDE: Okay. So that's a really helpful comment. I certainly need to cogitate about that just a little bit. So if you have -- if you think of more examples or more specifics about what you think we could do that would be helpful to what kinds of organizations, that would really be helpful, Marleen.

DR. MARLEEN WONG: Okay. I'll think about it a bit more. I don't think it's moving forward in my mind, but I was just thinking about it on the ground how it doesn't -- I don't see -- I don't see agencies and practitioners really preparing for this change.

MS. PAMELA S. HYDE: Well it's a good point because, if you recall, I don't think it was in April, but I think it was a year ago. Or Betsy, when did you come on? Because it was, I think, the first meeting you were at.

MS. ELIZABETH A. PATTULLO: Yeah, I came on a year ago. I came on in April of '13.

MS. PAMELA S. HYDE: Oh, in April. So about a year and a half ago.

MS. ELIZABETH A. PATTULLO: Yeah.

MS. PAMELA S. HYDE: Yeah. So it was somewhere around there that we started having some conversations with our advisers about some of this, and I think some of the early indications were -- I mean, you guys are all humongous -- you all meaning not just the 10 or so of you, but the whole 70 of them are some of the most sophisticated and some of the most informed folks out there. And I think what we found was that people were just struggling to even wrap their heads around how to think about it differently.

And I can see the movement. Just for whatever it's worth, I can see the movement in all of you in the kinds of questions you ask, in the kind of places you are in your own thinking. So, clearly, the whole field has shifted quickly in a couple of years.

But I think we also find, and Cassandra, you may have a response to this, some of the States, single State agencies and some of the mental health authorities are still sort of shaking their heads and going, "Well, I'm not sure what to do about this." And in other cases, States are telling them they can't think about it.

But I do think -- I think you're on to something there, Marleen. I'm just trying to get a little more -- my head wrapped around a little more detail about how would we be able to be most helpful there.

MR. CHRISTOPHER D. CARROLL: Pam, as we think about Leading Change 2.0 and as I look to my left to the workforce development SI, who's waving at me angrily right now, this may be one of those things in which we need to collaborate better about what we're learning as far as financing of services and how that will impact the workforce. So that may be an opportunity for us as well.

MS. PAMELA S. HYDE: Well, there's no question that workforce -- he's referring to Anne Herron. I assume Anne must be in the room there. Anne Herron is leading our workforce strategic initiative that we've proposed to work on for the next 4 years. So, Anne, you may have a comment, too.

But I heard Marleen saying it was more than just the healthcare workforce, that it was really community groups and schools and others to think about how this is changing their thinking and their world.

MR. CHRISTOPHER D. CARROLL: And I think that's consistent with our vision of integration as well. So --

MS. PAMELA S. HYDE: Yeah, it is. Absolutely. Anne, do you want to jump in here at all?

DR. ANNE HERRON: I think this is an opportunity really for us to do this. I like this. I like this a lot.

DR. LORRIE RICKMAN JONES: But I wonder, you know, we talk about workforce, but doesn't this -- this is Lorrie. Doesn't this in some way speak to what we need to do about public education? Do you know is this a communication strategy issue?

MS. PAMELA S. HYDE: It very well may be. And again, part of the scratching my head when Marleen first said this is, you know, we are at a point in history where -- the Federal Government or the administration is at a point where they are really kind of controlling the message pretty carefully. And I don't -- not so much for political reasons, although clearly politics are involved in everything we do, but more because, as you heard Marilyn talk about, the message is complicated.

So they ask us not to put things out that are not sort of focused on that clear and narrow message they're trying to get out to the American public about how to get enrolled or about how to use the marketplaces or what it means to them. And I think Chris mentioned that one of the things they learned, we learned in this process is that a lot of people who've never been insured before don't even know how insurance works.

So they don't know what a deductible is or what a co-pay is or, you know, that kind of stuff. So they don't know what an EOB is. So some of that has been kind of constrained by the administration wanting us all to stay on message about what the American public is -- needs to hear as the Affordable Care Act continues to roll out. And that's also somewhat true in the parity area as well.

So I think they're just now starting to loosen up a little bit on the parity messaging and some of the other stuff that isn't so focused completely on the enrollment effort. So this is why I'm sort of trying to get my head wrapped around about now what could we help with some of these community organizations and others? And Mary and Chris, maybe we need to take that into our integration conversation as we think about that larger world?

Because even workforce for us is beyond the healthcare delivery workforce. It's also about preventionists and about that kind of thing.

MR. CHRISTOPHER R. WILKINS: Hey, Pam. This is Chris Wilkins. I think that's a really good -- I think that's a really good focus for this reason. It's, you know, in a constricted messaging, what sometimes comes out the other side of

that is among certain constituencies and SAMHSA as a stakeholder group, people get the perception that there's nothing going on at SAMHSA, when nothing could be further from the truth.

And how you take a lot of complex information and speak to the consumer groups and the health systems and the traditional SAMHSA providers in mental health and substance use disorders and then the other stakeholders becomes critical because it helps alleviate some of the anxiety that they're feeling. Helps them reach some understanding and helps them behave more credibly and responsibly in trying to get their jobs done.

But it's a really, really interesting thing. The constricted message, in my opinion, ends up producing exactly the opposite of what the administration would want, which is movement, understanding, consensus, creativity, and all that other stuff. So I think we pay a price for that. I think SAMHSA pays a direct price for that in some quarters. I think that price is related to people's anxiety and their, you know, reactionary feelings about the environment.

But still in all I think if we really tore that question of how you communicate the good stuff that's happening in a way that builds consensus and gets people going in the direction that the administration would want them to go, that'd be a good discussion.

MS. PAMELA S. HYDE: Yeah, it is interesting, and I think you're making a really good point, Chris. I have to tell you I've worked for politicians all my life, and I've never yet seen one when they were implementing a major policy shift like this that didn't want to control the message. So it's not like something we have a choice about. It's just what they're going to do.

So the question I think Marleen is raising and you're raising is how -- what's the best way for us to try to help people understand what's happening in an environment in which the messaging is constricted on some level? But I think we've managed to figure out ways a little bit on the parity arena, where we can't always be the ones out front about it, but we have been able to have conversations with and do some behind-the-scenes review of materials and stuff for some folks. Just to make sure that it's accurate and things of that nature.

When we are not so much the ones who are able to talk about it, but help others be prepared to talk about it. So that may be a way we can take a look at this issue as well.

MS. ELIZABETH A. PATTULLO: Pam, this is Betsy Pattullo. Just kind of a vague spot that I've got is that we have a lot of conversations going on now around the country with different kinds of provider organizations and community organizations coming together, wanting to know how they could play a part. And it might be in a home health kind of situation or an accountable care

organization, or it might be sort of more in general than in particular knowing that the world is changing and not knowing exactly how it's going to play out, but wanting to be part of that change.

So an example is, you know, we've got some of the adolescent residential school services providers coming to us and saying, "How can we be helpful?" We know you still will get kids jammed up in hospital settings, and we'd really like to think about the services that would fill in some gaps that exist.

And I just wonder if there isn't almost like a convening role or a fostering role without necessarily a big agenda, but just sort of getting disparate groups together. Because I think part of what I'm seeing is, you know, the anxiety goes down as different players in the system -- and Chris alluded to this a little bit in his talk yesterday. You know, the network guys with the local clinic with the individual practitioner. You know, you get them in the room and they begin to see each other as elements of a service delivery system, even if we don't know what the rates are going to be or exactly what the quality indicators are going to be, or you know, there are a lot of questions that are unanswered.

But I think there is a spirit of people wanting to come together now, that SAMHSA could be helpful in nurturing in some way.

MS. PAMELA S. HYDE: Yes. Well, these are all really helpful comments because the concept of messaging has come up more than once in our conversations. And certainly within SAMHSA, we are -- in fact, we have a meeting scheduled coming up about it. We've been really struggling with how to best position SAMHSA, and partly it's for the organization, but partly it's for the message we have to give out.

For example, after the Robin Williams suicide, death by suicide, we were able actually to get quite a bit of good, positive media coverage around the issue of suicide, but not so much in a context of what role SAMHSA plays in that or what role the behavioral health system can play in that. It was more just about the public health issue or the lifeline, our disaster distress -- I mean, not disaster, the suicide prevention lifeline.

And so, we're sort of thinking a lot about that. So these are -- this comment and this set of conversations comes at a good time for us to just sort of struggle through that. In fact, we might put it on our agenda with you for next April is just how to think about that a little differently. So this is really helpful.

Anybody else have more to add to this?

DR. LAURENT S. LEHMANN: Yeah, this is Larry Lehmann. I'm sorry. Let the other person go first.

DR. MARLEEN WONG: Okay, hi. This is Marleen again, Pam.

MS. PAMELA S. HYDE: Yes.

DR. MARLEEN WONG: You know, if we use that example of the Robin Williams suicide, that is sort of an event that permits people to reflect. But the ACA is a vision that is being realized slowly, and it's going to be a very long transition period, and so there are people, I think, that are thinking about next steps. But there are those that are just waiting because they don't know.

And I think it was well stated before about there are just people wanting to be a part of it. Is there a way to initiate those discussions with guidelines, you know, saying we don't know what the ultimate -- we know what the goal is. We just don't know how it's going to play out.

It's sort of like what goes on with military with people who return from the war. And we know that reunion is the goal, but it's a long transition. And so, whether -- there's lots and lots of steps in between the return home and the actual then the reunion and the actual readjustment to civilian life. And that was just the point I was trying to make is are there transition guidelines between now and when it finally all plays out and we have some clearer idea of what it's going to look like on the ground for providers and consumers and community partners now?

MS. PAMELA S. HYDE: Okay. Well, this is really good, and there was another person who wanted to jump in on this?

DR. LAURENT S. LEHMANN: Yeah, this is Larry Lehmann. And your mentioning military is a nice intro to this. The SAMHSA activity that I've been most closely involved with recently has been the issue of the policy academies and the implementation academies, a lot of which is coming up in September. And essentially, what these have done has been created networks in the States for dealing with a specific issue of helping returning veterans and their families and their wives and children get better integrated into the community, health, life, work, jobs rather globally supporting them.

And so, you've got there a network of -- of community and State providers working towards a particular goal, and there's a technical assistance center, et cetera. An opportunity perhaps with this group to ask them the question, you know, hey, how are you guys preparing locally for ACA? What are some good ideas that you have?

And sort of see what some of the -- what comes up from that group or from any of the other partnership groups that -- that SAMHSA has worked at developing and sort of gathering some information from them and trying to glean out some good ideas, good plans from which we'll grow out good practices that then can

be fed back through SAMHSA's Web site and other kinds of communications approaches to try to promote these kinds of ideas and share some ideas with folks who may be scratching their heads and figuring out how am I going to do this, and they see something that may click well with their clinical and political environment.

MS. PAMELA S. HYDE: Okay. Does any of the staff there have -- any of our executive leaders have any reaction to any of this or anything to weigh in on here? Pete or Kana or anybody else?

MR. CHARLES R. OLSON: [on telephone] This is Charlie Olson. I have a couple of things I'd like to bring up.

MS. PAMELA S. HYDE: Okay. Go ahead.

MR. CHARLES R. OLSON: Sorry I'm just a little hard to understand. I'm getting over a head cold. But regarding the Robin Williams suicide, you know, suicide is one of those things I'm most passionate about. And I've got to witness a wide variety of emotions from, you know, being on social media. I got to witness every single person that I knew made a comment about it, and it was really -- it was really good to see that much publicity. I guess that's probably a bad way to say it.

But I was really glad to see that that many people cared, and it was a topic that people felt comfortable talking about or they felt was they needed to talk about. And I even saw the other side of it where people were so hopeless that they saw someone as Robin Williams to be extremely successful and well liked, and you know, that that was still the fate that they encountered. And I think a lot of people felt hopeless in their own depression that they are nowhere near the person, you know, that they compare themselves to Robin Williams to be. It didn't give them a lot of hope.

And I was just kind of curious if -- if SAMHSA had any -- any way to take advantage of that situation to -- or if there could be a way to take advantage of a similar situation that ever happens in the future. I just feel like this is one of those situations that comes up and in a while it's going to be history, as we all know how media works like that.

MS. PAMELA S. HYDE: It's a good question, a good point, Charles. Is Marla there? Marla on the line?

[No response.]

MS. PAMELA S. HYDE: Okay. I'm not going to be able to sort of lay out all of this. She would be much better at it. But we actually had a lot of involvement in media response to the event. Mostly what we did, though, I mean, it was media

response. It was social media response. It was CBS News. It was major story on the lifeline. We got lots of good coverage about suicide issues and about services or places that people could call, the National Suicide Prevention Line especially.

What we didn't -- weren't able to do or didn't do in this case was tie it to anything. So obviously taking advantage, if that's the right word to say for such a tragedy, but taking advantage of those kinds of situations is something that whether we like it or not, we do want to be ready to do. Because we know they're going to happen, and we know that it's a teachable moment in the Nation.

So that's part of what's driving us, Charles, to have this meeting I told you that we're scheduling internally to do a little more thinking about how could we do that more in a more organized way. Now if Marla were here, she would run down with you all of the media hits, all of the social media we did, all the Twitters and Tweets and stories and stuff. So we did a lot, but we think there are other opportunities that we could do.

And I think you're right. It opens up a possibility when otherwise people might not be open to talking about something that's difficult to talk about. So, yeah. So I think some of those conversations are things that maybe we need to bring back to you after we've done a little bit more thinking about it and get your reaction.

So, again, anybody else. We've gotten away from the Affordable Care Act and the health reform and health financing just a little bit, but any reaction to this messaging issue? Okay --

MS. KANA ENOMOTO: Hi, Pam. Can you hear me?

MS. PAMELA S. HYDE: Yes.

MS. KANA ENOMOTO: This is Kana. I did have a chance to talk with Marla about the suicide issue, and I think she agrees that we need to sort of be on our best game and be very prepared when any kind of event happens so that we can be not only responsive, but also proactive. I think she also cautions about how to respond in a high-profile event, such as Robin Williams, as we have also been cautious in other events, not to appear sort of opportunistic or to be sensationalizing something that's obviously a very tragic and personal event for Mr. Williams and his family.

So I guess there were some organizations who tried to "leverage" the death of Robin Williams to raise awareness for their suicide prevention activities, and they were sort of roundly criticized for that. So I think it's just -- it's a delicate balance of being sensitive, supportive, timely, and proactive.

MS. PAMELA S. HYDE: Yeah, those are good points, and I think the way I look at it is that we have to, as SAMHSA, because we are, for lack of a better term, the Nation's voice on behavioral health. So we have to leverage it such that people are aware of SAMHSA. They are aware of our resources. They are aware of our expertise. And they immediately call us. So we're not out there having to sell the issue or sell ourselves in that delicate time, but rather, we have done the groundwork to make sure that people know to come to us --

MS. KANA ENOMOTO: Yes.

MS. PAMELA S. HYDE: -- when these kinds of opportunities for conversation and for information arise. And that's the trick. So the comments that people are making here are raising very good issues, and it's not simple, and it's something that we're going to have to spend a little more time on.

But I really do think this is something we need to bring back to you, as our advisers, as we kind of work on this a little bit because it's something we take very seriously, and yet it's not a straightforward kind of thing.

So let me get back to the health financing stuff that Chris was raising. Are there other things that he said or that you have in your minds about health reform and where it's going and where you wish it were going? And health reform is kind of an interesting word these days. It's really the entire healthcare delivery system and even the prevention approach or the approach to prevention, you heard Marilyn talk about that, is really fundamentally undergoing significant change in America.

So are there other things that you think SAMHSA should have on its plate or be thinking about differently as we go through this process?

Cassandra, you run a State entity, the SSA for Georgia. Do you have a thought from where you sit?

MS. CASSANDRA PRICE: Well, you know, we sit in a unique position with some other States that are not expanding Medicaid, and we're not actively engaged in a lot of the conversations around parity implementation. Just not as engaged as other States, and so I think that becomes something that SAMHSA does have to consider and how they can support the States that are not necessarily in the same place and what that kind of support could look like, just kind of trying to keep balance but not stopping the forward training and movement towards the goals you're trying to achieve, if that makes any sense?

I don't know if that's helpful.

MS. PAMELA S. HYDE: It does. You know, we have had several States tell us that the fact that their political leadership has asked them not to participate in

Affordable Care Act related activities or not to react and to programmatic opportunities that might be tied to that is a challenge.

We actually were at the National Association of State Mental Health Program Directors a couple weeks ago, and a couple of -- couple of critical States, which wouldn't surprise you who they were, said exactly that. And my response was, as I scratched my head a little bit was, well, this administration actually doesn't want to make it comfortable necessarily for States who are not getting onboard with some of what the administration sees as the right way to get coverage for people.

So, having said that, Cassandra, I mean, I totally get where you're coming from because I've been in States or I've worked for, excuse me, for politicians who -- or for administrations who were not interested in going the way the opportunities were making themselves available. So you have to walk that fine line.

So we're trying to figure out how best to do that and how best to be supportive, at the same time recognizing that this administrative is trying to push States to expand Medicaid. It's just what they're trying to do, and you heard Marilyn talk about that with we're now up to 28 States or so that have done so. And the hope is that after the election or in a few more months that more States will come along and do that.

Some of the other of you have that experience in the States that you live in or the interactions you have in your service delivery systems about this sort of push-pull between those who want to take advantage of what the Affordable Care Act offers and those who are politically not there and don't want to? Is that something that plays out for any of the rest of you?

Lorrie, it's got to play out for you.

DR. LORRIE RICKMAN JONES: In what way, Pam? I'm sorry. Well, obviously, we're onboard.

MS. PAMELA S. HYDE: Yeah.

[Laughter.]

DR. LORRIE RICKMAN JONES: We're fully onboard.

MS. PAMELA S. HYDE: You don't have folks in your State, though, that are still pushing to -- to be less onboard?

DR. LORRIE RICKMAN JONES: Unless -- I must be honest, if -- if there are people out there, I'm not in touch with them. So most of the people, and of course, we're heading to an election. So all of that might change, but --

depending on the outcome of the gubernatorial election. But you know, people -- we're pretty much embracing the change.

And of course, Illinois has gone for, you know, the CMMI money and 1115 waiver and a lot that's going on that's in support of or direct result of healthcare reform and ACA. So that's not, you know, as much of an issue for us.

MS. PAMELA S. HYDE: Okay. So did Junius join us ever? I thought we thought he might. Is he there? Is he on the line? I was going to ask him his opinion about this since he's from Texas, and that's clearly a State that has political leadership much like Georgia that doesn't want to do that expansion. And so, I know there are differences of opinions in that State among stakeholder groups.

LT. HOLLY BERILLA: Pam, this is Holly. I'm sorry. He has not joined.

MS. PAMELA S. HYDE: Okay. All right. So are there other comments about health reform or about parity or about the broader construct of integration that Chris put out there that we're trying to think about?

DR. LORRIE RICKMAN JONES: Pam, I have a couple comments. This is Lorrie again. One is that I found it interesting with regard to parity that the way that they're looking at enforcement is around complaint systems. And I'm wondering, and I don't know if you have the answer to this, is there -- is that seen as like a Phase 1 approach? And so, it would move to a more rigorous monitoring approach down the line? Or is that where we think we're going to leave it?

That's, I guess, a question.

MS. PAMELA S. HYDE: Chris, or if David is there, do you guys want to react to that?

MR. DAVID SHILLCUTT: Hi. This is David Shillcutt. Yes, to some extent, I think it is a Phase 1 issue. As Chris mentioned, there is still a lot of confusion about exactly how parity will apply to certain plans and certain issues. And so, there's a lot of need for technical assistance at this point.

Another issue is the different States are in different places in terms of the willingness to invest in this issue, given the variety of challenges they're facing as their systems are transforming. And third of all, depending on the type of plan, it's an authorities issue. So the CCIIO has the authority to do the form final reviews, but the Department of Labor does not have the authority right now to do sort of comprehensive review with regards to parity.

And at the State level, there is generally it depends on some State laws and

what the State is interested in doing.

MS. PAMELA S. HYDE: The other thing that might be helpful to say here just to remind you, and I'm sure, Lorrie, you know this. But oversight of insurance, this has been traditionally a State responsibility.

DR. LORRIE RICKMAN JONES: Yes, yes.

MS. PAMELA S. HYDE: So the Federal Government has been very cautious about jumping into an area where States are pretty much interested in and continue to have a legitimate role in doing it their way. So each individual State might do this more or less aggressively, depending on their own perspective on implementing Federal laws.

I know there are a few States, and I don't know, David, if you can reel them off. But there is, I don't know, five or six States that have just sort of adamantly either refused or who have said they don't have the authority to implement Federal parity laws, in which case the Federal Government has a somewhat different role in those situations.

So can you say any more about that, David?

MR. CHRISTOPHER D. CARROLL: Pam, according to our Federal partners, Texas, Alabama, Oklahoma, Wyoming, and Missouri have elected not to comply with the ACA or MHPAEA.

MS. PAMELA S. HYDE: Not to enforce compliance?

MR. CHRISTOPHER D. CARROLL: Correct.

DR. LORRIE RICKMAN JONES: Well, I know that, you know, Illinois is grappling with how to do it, and I guess information about how others -- the decisions that other States are making about that obviously would be useful to share with the field. It's something that's important.

We fought very hard, very hard for a number of years, those of us who've been in the system for a long time, to see this happen. So, you know, information sharing about the States' approaches to this might be useful.

MS. PAMELA S. HYDE: Chris, that might be an opening for us to go the National Association of Insurance Commissioners. We have interacted with them a couple of times over the last couple of years, but they have different leadership now. And Chris and I were just talking about reaching out to them, and it's an association, in a different way.

So it might be worth doing that, Chris, just to say what some ways to do TA or

even just information sharing from State to State about how they're doing this. It might be worth it.

MR. CHRISTOPHER D. CARROLL: That's a good idea.

MS. PAMELA S. HYDE: Okay. Anything else on anybody's minds about health reform or health financing or healthcare, health systems integration, anything of that nature?

Ric, how are you seeing this out in Colorado? You're not in the public system at this point, I don't guess. But what do your friends say about it?

[No response.]

MS. PAMELA S. HYDE: Ric? Did we lose Ric? All right. Well, we must have.

Okay. Well, we're getting close to 3:30 p.m. I want to make sure we spend just a minute or two talking about topics that you think the joint advisers should be taking up. Oh, actually, before I go into this, let me just thank Chris for all the work he did in preparing for today and all the information that he and David have shared with you and put forward.

Were we able to get PowerPoints or papers or anything, Chris? The webinar and telephone has not been great technology for me. So was there stuff people could see?

MR. CHRISTOPHER D. CARROLL: They had the Secretary Burwell briefing document, and that's -- I think that's the extent of what they received. I'll work with Geretta and Holly to make sure that what I referenced is given and distributed.

MS. PAMELA S. HYDE: Okay. So if anybody has any further conversation or questions about that, again it would be great if you'd go through Holly, but you also are welcome to reach out to Chris. And his email address is Christopher.Carroll -- with two Rs and two Ls -- @samhsa.hhs.gov.

So thanks, Chris and David.

So let me go to the issue of topics. So what's your thinking about you've given us an idea today about what would be worth talking a little bit more about with you and sort of trying to get out of your heads? We -- for the other conversations that you've heard us have in other ways, I'd be interested in both your comments about topics as well as your comments about format.

So we have worked with a variety of formats, more panels, some presentations, but more discussion. Some small group stuff, some other stuff. So tell us what

works the best when we have those big joint meetings, and then when we have these small meetings, what -- smaller NAC meetings, what works the best for you process wise and just format wise? And then what are the topics that you think you would be prepared to give us more advice about or you think really we should have some more conversation about?

MS. ELIZABETH A. PATTULLO: Pam, this is Betsy Pattullo. And I'd just say in the large meeting of the various advisory councils, I think the combination of some presentations and then some breakout sessions, from my point of view have been very helpful. Partly, you know, it's really interesting to talk to members of the different groups, you know, from around the country, very different perspectives. And I've found those to be pretty stimulating conversations.

I think in terms of topics, one of the things I'm really interested in are concrete experiences around successful examples of integration in primary care and behavioral health sites or systems. Because, you know, I continue to be struck by in how far away we are in many places from one another, and yet how there are still kind of shining examples of organizations and individuals that have come together and really done some very creative, effective projects or just have a way of working with each other that have worked really well.

And I was thinking about Chris's piece for the Secretary and just sort of describing some of the kind of goals that SAMHSA has. I think to bring those down to sort of a pragmatic level, and maybe that gets at some of what Marleen was saying is, you know, what can people be doing to actually prepare for the brave new world that we're coming to? And I think we do have examples around the country of people who are being pretty successful at bringing kind of a whole perspective to people's challenges in covering the physical side as well as the behavioral side pretty effectively.

MS. PAMELA S. HYDE: Okay.

DR. LORRIE RICKMAN JONES: Pam, this is Lorrie. I would agree with Betsy, both in terms of the format. I think that that's a really useful format, the combination of the two. I think it's really useful.

And I agree with her on the topic. I might also add something related to workforce. I mean, one of the things, as we know, that ACA is doing is putting pressure on the behavioral health workforce, both in terms of numbers and so the extent to which we have to look at workforce issues and the relationship between the workforce demands and IT solutions is also something like the telepsychiatry and things like that and telemedicine and how we kind of bridge some of the workforce gaps using technology.

So I think the whole, you know, especially a rural area, it's very challenging to

figure out with this increased demand, how to deal with that. And so, what are some of the promising strategies that have worked and to how States kind of rolled this out? What is their thinking about it?

MS. PAMELA S. HYDE: Okay.

MR. CHRISTOPHER R. WILKINS: Pam, it's Chris Wilkins. This is maybe something for a couple of meetings or further down the road, although, I don't know, I feel some urgency about it. I'm very taken by the work being done in behavioral economics right now. In other words, those actions outside a mental health or a substance use or other mental hygiene condition.

And it's, you know, that whole science of how people gather short-term, medium-term, and long-term incentives that shape their lives and their existential reality and then the behaviors they engage in once they've gathered those incentives or in gathering those incentives to act in a certain way.

I saw a couple of months ago a product in the Kaiser system that's being tested that is a 6-minute personality inventory moved against a big database that then determining -- that then determines specific messaging to the patient in order to predict that they will receive the message in the most engaging way. That whole field is really right in our wheelhouse.

And even though it doesn't relate to diagnosis and treatment or prevention of condition, it is going to impact the work being done in mainstream healthcare. I suggest to you it already is impacting it in a big way. And then it's going to -- it's going to challenge us to think about if you control that side of the equation, what happens to how we serve people on the treatment and prevention sides of the equation?

So I'm thinking a lot about that and hope we can discuss it at some point.

MS. PAMELA S. HYDE: That's a great point. Actually, just this morning, I heard Richard Frank, who is our Assistant Secretary for Behavioral Health -- I mean for Planning and Evaluation. What I started to say is he has a lot of background in behavioral health. He's an economist, health economist, as is Chris, by the way. But he was just talking about this this morning, actually, at another meeting I was at.

So he might be somebody who could really help us understand what's going on in that world and think about that a little bit if people find that an interesting topic. I think it's probably safe to say that SAMHSA hasn't really jumped into that, but the question of whether we should or whether we have any role in it or such is probably a good question.

So do other people have a thought about that one? I mean, we've got four good

things here that people have suggested maybe we ought to spend a little time on. So if anybody has any reaction to that one, but I also want to just put on your plate, you know, some of the things we're working on, which I talked about yesterday. Everything from Native youth issues to our transition age youth issues to our science of changing social norms issues to our crisis system issues that we're working on, Native youth issues we're working on.

I mean, there's just a lot of things we're working on, and I'm curious about whether any of those are things you would like to advise us about as we continue to explore what our roles can be in those things?

DR. MARLEEN WONG: Hi, Pam. This is Marleen. I just had a comment about future meetings, even though I'm rotating off. And that is I wonder whether or not the advisory members would benefit from having a presentation from regional, the regional SAMHSA folks just to know more about what supports might be available at the regional levels.

Because we -- I mean, it's amazing to be able to hear at the national level. But I just know I don't have a full sense of how the regional structure fits in to all of it through either implementation or, you know, support to providers, et cetera.

MS. PAMELA S. HYDE: That's a great comment, too, Marleen, because I tell you our regional administrators are out there, to use a colloquialism, kicking butt. They are doing incredible work. The generalists, looking at the entire behavioral health system and its interface with other Federal partners and its interface with the health systems and prevention efforts and housing and jail and all kinds of efforts. It's the nature of their beast because there is only one of them in each of the regions, and they're a really high-quality group of 10 incredible people.

So your point is well taken. I don't think we've actually done any presentation for your guys and had you give us feedback about our regional administrators. Anne, who was in the room, I assume still is, is their direct supervisor or their guide/leader. So, Anne, we might take that under advisement as well.

Anybody else got any other reactions either about format or topics that you think we should do either for this group or for the larger group? And just if you might weigh in here for a minute. We tried to do this as only a 3-hour long meeting, as opposed to the 5- or 6- or 8-hour long meeting on the phone. Is that better? Is that about the right time?

MS. ELIZABETH A. PATTULLO: That's better. And two thoughts. One is Richard Frank is a great presenter, as well as that being an interesting area. But I'm also thinking, you know, the youth panel that we had in the spring, and just given, Pam, what you were running down in terms of the broader advisory groups, I wonder if we shouldn't continue to kind of build on the youth theme, both engaging participation.

Charlie has been a terrific member of the National Advisory Committee, but also trying to get some of sort of the next generation among us or out there to come in and sort of chime in on some of these subjects. I think that that's energizing, and I think it's helpful for the future.

MS. PAMELA S. HYDE: Right. Good idea. Charles, I assume you agree with that?

MR. CHARLES R. OLSON: Yes, I do, of course. You know, as long -- as well as everyone else, I think that SAMHSA does a great job, and sometimes I think we get a deer in the headlight look when you ask for suggestions because, you know, you guys are on top of everything.

But I think that everyone needs to, including SAMHSA, needs to move forward on the youth thing. I think that that's a new category that isn't being taken totally advantage by anyone just because it is so new. But I'd love to see SAMHSA lead that as well.

MS. PAMELA S. HYDE: Great. There is a little bit of work going on inside SAMHSA about the youth issues. So we might think about how to bring that forward, too.

Okay. Well, so we're almost at the hour of doing public comment, and again, I'd like to ask you to stay if you can until we see if there's anybody on from the public who wants to comment.

I do want to just tell you he's not in the room right at the moment because he went to get his first ethics training, but we have the new -- our new political appointee Tom Coderre, who I think some of you may know. He comes out of the recovery world. He's been in Rhode Island and the chief of staff for the Rhode Island Senate president and before that was actually a senator himself.

He is bringing with him to his new position at SAMHSA, he just started this week, a very strong commitment and history in working on recovery issues. So he's been with me most of the day, introducing -- being introduced to a jillion people, and he's now off getting some training he's required to get. But he was here for much of this conversation. So he's getting immersed in some of these issues that he may not be quite as familiar with.

He'll be working with us on a number of things having to do with our interagency work and our substance abuse work and then some of our work across agencies within behavioral health -- or within HHS. So next time you're in, you'll get a chance to meet him, I hope, and he's going to be a great addition for us.

I didn't tell you, and I will, as we move to transition to the public, next month is

our Recovery Month. We're doing a lot of things about that. We're rolling out our national data on substance abuse and mental health for 2013. The date for that is September 4th. It's I believe I want to say it's at 10:00 a.m. Is that the right time, anybody in the room there?

It's going to be live streamed. So watch for that. You may want to see that data. This is the 2013 data from our NSDUH survey, which has a lot of substance abuse data, but also some mental health data. We also have some partnering work we're doing with the National Institute of Mental Health to put more mental health data out or be able to do more surveillance work about that.

So the press conference is actually at 9:30 a.m., 9:30 a.m. to 11:30 a.m. east coast time at the Press Club here in D.C. And for those of you on the east coast, I know it's a little bit early, but if you're up and about and want to watch the live stream, that'd be great. You can watch that as well.

Agenda Item: Public Comment

MS. PAMELA S. HYDE: All right. So, Operator, let's move into the public comment period. Or Josh, whoever is going to get us access to the public who have indicated they want to comment. Do we have -- Geretta, do we have people who've indicated that they want to comment?

MS. GERETTA WOOD: Yes, we have one individual who indicated they wanted to make comments, and that was Mr. Sean Bennett.

MS. PAMELA S. HYDE: Okay. Sean, you commented yesterday. That was great. Can you just try to keep that as short and to the point as you can so if there are other people who want to speak, they have the opportunity as well. So go ahead.

Operator, could you please open --

MR. SEAN BENNETT: [on telephone] Yes. Can everyone hear me okay?

MS. PAMELA S. HYDE: Yes.

MR. SEAN BENNETT: Oh, very good. Yes. Glad to be here today.

I definitely had some very important issues that I feel merited the attention of the group, and you know, for me it's a matter of how do I -- how am I going to succeed in my goal here as I talk to this group?

My lead issue, as I expressed yesterday, has to do with protecting the right of

informed consent for mental patients in the context of psychiatric drugs and that this is a massive problem nationally, and it will continue to be so. In fact, it's probably going to get worse with people like Tim Murphy, who are advocating to expand State outpatient civil commitment law so that patients can be -- people can be forcibly drugged on very dangerous drugs, week or month or year on end, by virtue of State law.

And Murphy is trying to -- trying to have the Federal Government fund these State programs, and they are staggeringly unconstitutional. These laws are very unconstitutional, and they're a great threat to the public health.

And so, I'm here today talking to this organization, trying to see if there's anything that this group can do to try to stem this tide of forced, coerced, nonconsensual psychiatric drugging. And that's my goal is to present the issue. I encourage everyone to study the issue, try to get informed. I would encourage an investigation by both the advisory council as well as SAMHSA, formally investigate the question of nonconsensual drugging.

And of course, finally, it's a matter of reforming policy. It's very informing and reforming policy in the administration so that the Federal Government's proper role is to uphold the Constitution to protect people's rights, protect the public health. That's my goal, and that's what this agency's goal should be. And I feel that we are neglectful if we don't do anything about this issue.

I think it should be no longer the elephant in the room. I think it's just time for everyone to be able to talk about it and for action to be taken because this is about liberty. This is about democracy. This is about the Constitution. And it's really, I feel, an attack, attack on the fabric of society.

This is not just a matter of a policy, a policy disagreement. To me, where you have a situation where people's lives can be destroyed, where people can be killed through State laws and policies, this is like Pearl Harbor. This is like -- this is like Emmett Till. This August 28th commemorates the date Emmett Till was kidnapped from his relatives' home and murdered down in Mississippi, all to be greeted with the murderers would be paid a lot of money by a national magazine to tell their story a few months later.

You know, this is similar to that. You know, you have a vulnerable group of people who's long been bullied, who doesn't have the protection of the laws that lives can be snatched from them. Their property, their earning capability, their -- everything they have can be stolen from them, and they can't get the protection of the laws.

So, to me, this is more than about a political debate. This is about what it means to be an American and to understand that everyone who is an American should have the equal protection of the laws. And informed consent to psychiatric drugs

has got to be considered a fundamental right, and it should be respected.

And I think a point I made yesterday, I hope that it wasn't too confusing, was that we can't leave this to the U.S. Supreme Court to settle. Because the judiciary has proven themselves that they don't really care too much. I mean, the First Amendment to our Supreme Court is about political donations. You mean, the First Amendment is interpreted as that you can't have State laws that curtail people giving money to politicians. The First Amendment means we must allow people to give money to politicians.

But when you talk about has the Supreme Court ever said that the First Amendment protects people from forced brain damage, which psychiatric treatments, that the drugs today, these antipsychotic drugs today as well as treatments historically were forced brain damage, the U.S. Supreme Court has never, ever, ever recognized that the First Amendment is abridged by forced psychiatric treatment.

So then, you know, it's giving money to politicians that is violated by the First Amendment. So, clearly, we got to do more than wait for the U.S. Supreme Court to do something about what's going on here with the assisted outpatient treatment laws. And as an executive agency, Thomas Jefferson said it well when he said each department, the legislative, judicial, and executive has equal right to uphold, to enforce the Constitution, to interpret it.

And I think from the point of view of the agency, the biggest, the most fundamental law that the executive agency has got to enforce is the idea of the First Amendment and the 14th Amendment that is law that supersedes the State civil commitment forced drugging law. So where we are today, I'm hoping to encourage the group to actually do something about this issue.

I hope I haven't just, you know, babbled, and it just goes into a paper shuffler, and everyone goes on with their life and think everything is fine and dandy. I hope that I'm doing something today as a whistleblower to begin to, you know, reform bad policies and laws.

So thank you very much for listening to me today.

MS. PAMELA S. HYDE: Thanks, Sean. I appreciate it. And we do have as part of the record and for this group your statement that you gave us. So appreciate that a ton.

MR. SEAN BENNETT: Thank you.

MS. PAMELA S. HYDE: Operator or Josh or Geretta, is there anyone else asking for public comment?

OPERATOR: If you would like to make a public comment, please press *1 on your touchtone phone. Please unmute your phone and record your name when prompted. That is *1 if you would like to comment, *2 to withdraw your request.

One moment, please, and we'll see if we get any other callers in.

[Pause.]

MS. PAMELA S. HYDE: Okay. So, Operator --

OPERATOR: We do have one caller. One moment, please.

MS. PAMELA S. HYDE: All right. Great.

OPERATOR: We have Rosie Bachand. Go ahead. Your line is open.

MS. ROSIE BACHAND: [on telephone] Thank you. I'm speaking as the coordinator for the California-Nevada United Methodist Church, pardon me, addiction recovery coordinator.

And I would like to thank you publicly for -- I'm pretty far down on the food chain here, but I thank you very much for being able to participate in your proceedings. Technology not being what it could be, but at any rate, I would like to thank you and tell you how much I appreciate your input and your inclusion and the ideas that I've come up with after listening to you for 3 days.

MS. PAMELA S. HYDE: Great. Thanks, Rosie. I appreciate -- we are very interested in the SAFE community. We do a lot of work with them. So pleased that you're on the line today.

MS. ROSIE BACHAND: Well, thank you. And I've commented on your strategic initiatives as well, and so I've had other avenues to comment on your work. And I really appreciate what you're doing.

MS. PAMELA S. HYDE: Thanks. Appreciate it.

So, Operator, anyone else?

OPERATOR: I am showing no further callers at this time.

Agenda Item: Closing Remarks and Adjournment

MS. PAMELA S. HYDE: Okay. Well, that's the case then, I appreciate all of the National Advisory Council members being on and sticking with us for here for a

while. And we have -- I have seven or eight things here that you suggested as might be good things for the spring. I think it's very possible that we will do another call with you before April, either on the budget rollout or some other issues that are emerging that we're going to want your advice and knowledge about.

And so, stay tuned, and again, let me just one more time thank Geretta for her work over the last few years, and welcome to Holly Berilla, who will be working with all of us to manage this council process.

So thanks a lot, everybody. Thanks to the contractor staff who help us on this, and Operator, thank you as well.

And with that, I think we're adjourned.

[Whereupon, at 3:46 p.m., the meeting was adjourned.]