

# **SAMHSA’s Center for Financing Reform & Innovations (CFRI)**

## **Financing Focus: December 16, 2014**

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***The Center for Financing Reform and Innovations (CFRI) provides information, analysis, products, and technical assistance to address changes in the organization and financing of behavioral health care, and to guide Federal officials, States, Territories, Tribes, communities, and private payers on the most effective and efficient use of available resources to meet the prevention, treatment, and recovery support needs of the American public.***

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## National News

- **Open enrollment starts for Health Insurance Marketplaces.** On November 15, the **U.S. Department of Health and Human Services (HHS)** launched the 2015 **open enrollment period**, during which individuals may purchase **Health Insurance Marketplace** coverage through **Healthcare.gov** or state-based marketplaces. According to HHS, the open enrollment period will run through February 15, 2015; however, coverage must be purchased by December 15 to be effective on January 1, 2015. In addition, individuals may renew or change their existing subsidies and coverage, but consumers will be auto-renewed in their current plans if they do not make selections prior to December 15. HHS published a [report](#) detailing consumers' marketplace plan options, while the *New York Times* created a [Frequently Asked Questions](#) document about the open enrollment period ([HHS, 11/14](#); [New York Times, 11/11](#); [Kaiser Family Foundation 11/6](#); [HHS, 12/4](#)).
- **U.S. health care spending grew at lowest rate since 1960.** On December 3, the **Centers for Medicare & Medicaid Services (CMS)** released its official estimates for total U.S. health care spending in 2013, the [National Health Expenditures Accounts](#) report. According to the report, **U.S. health care spending** grew by 3.6 percent to \$2.9 trillion in 2013, the lowest rate of growth CMS has reported since it began tracking health care spending in 1960. The report found that Medicaid spending grew by 6.1 percent to \$449.4 billion, with the larger growth rate driven in part by higher provider reimbursement rates, expanded benefits, and the **Medicaid expansion** ([CMS, 12/3](#); [Kaiser Health News, 12/3](#)).
- **CMS proposes 2016 Health Insurance Marketplace enrollment and payment standards.** On November 26, **CMS** [proposed](#) a rule to implement new **Health Insurance Marketplace** consumer and insurer standards, beginning in the 2016 open enrollment period. Under the rule, the open enrollment period for each plan year would run from October 1 to December 15 instead of November 15 to February 15, and the auto-renewal system would be modified to protect consumers from price increases. The rule would also clarify and adjust premium stabilization programs for insurers, implement new transparency and meaningful access standards, streamline the prescription drug formulary standard exception process, and align **Small Business Health Options Program (SHOP)** regulations with existing market practices ([CMS, 11/21](#); [Bloomberg, 11/22](#)).
- **CMS proposes additional flexibility for accountable care organizations.** **CMS** issued a [proposed rule](#) to create new options for **accountable care organizations (ACOs)** participating in the **ACA's Medicare Shared Savings** program. Currently, ACOs in the program use a one-sided risk model for three years, during which time they retain a portion of any savings they achieve but are not responsible for their losses. After three years, ACOs transition to a two-sided risk model, which requires them to cover a portion of any losses they incur. Under the proposed rule, ACOs would be allowed to delay that transition for an additional three years; however, ACOs that do so would retain a smaller portion of their savings. The rule would also create a second two-sided model, based on the **Pioneer ACO model**, in which providers may retain a larger portion of their savings if they accept responsibility for a larger portion their losses. In

addition to the risk changes, the rule would also streamline the data sharing process for beneficiary claims ([CMS, 12/1](#); [Kaiser Health News, 12/1](#)).

- **CMS awards \$3.9 million for American Indian and Alaska Native enrollment and outreach.** To enhance **Medicaid** and **Children’s Health Insurance Program** (CHIP) enrollment and outreach efforts aimed toward eligible American Indian and Alaska Native children, **CMS** awarded \$3.9 million to tribes and tribal organizations in AK, AZ, CA, MS, MT, NM, and OK. Authorized under the **Children’s Health Insurance Program Reauthorization Act of 2009**, the awards will fund activities that engage schools and tribal agencies in outreach efforts, with several awardees focusing on enrolling eligible teens ([CMS, 11/12](#)).

## State News

- **AK, MT, and WY governors propose Medicaid expansions, UT unveils premium assistance plan.** On November 17, **Montana Governor Steve Bullock** (D) released his [FY 2016-17 state budget proposal](#), which would accept federal funds to **expand Medicaid** to include individuals with incomes up to 138 percent of the federal poverty level (FPL). Additionally, on November 26, the **Wyoming Department of Health** (WDH) released its [plan for expanding Medicaid](#). Supported by **Wyoming Governor Matt Mead** (R), the plan would implement copayments for all individuals receiving expanded coverage and create monthly premiums of \$25 to \$50 for individuals with incomes between 101 and 138 percent of the FPL. Montana and Wyoming’s plans both require state legislative approval, and Wyoming’s plan would also require approval from HHS. **Utah Governor Gary Herbert** (R) unveiled the **Healthy Utah plan** to provide private premium assistance for the expansion population using Medicaid expansion funds. The **Utah Legislature** will meet in January to vote on the plan, which requires legislative approval. According to Governor Herbert, HHS has informally approved the plan, but official documentation has not been submitted. Finally, **Alaska Governor Bill Walker** (I) also announced his intention to expand Medicaid—either with legislative approval or through executive action ([Office of Montana Governor Bullock, 11/17](#); [Great Falls Tribune, 11/17](#); [WDH, 11/26](#); [Casper Star Tribune, 11/26](#); [Alaska Dispatch News, 12/1](#); [Alaska Public Media, 11/20](#); [Salt Lake Tribune, 12/4](#)).
- **Arizona submits Medicaid expansion waiver amendment to implement cost-sharing requirements.** As required under a bill ([HB2010](#)) signed by **Arizona Governor Jan Brewer** (R) in June 2013, the **Arizona Health Care Cost Containment System** (AHCCCS) submitted a **Medicaid Section 1115 Research and Demonstration** waiver [amendment request](#) to implement cost-sharing provisions for Medicaid expansion enrollees with incomes between 100 and 138 percent of the FPL. Under the amendment, affected individuals would pay premiums of up to two percent of their household income and a \$200 copayment for non-emergency use of hospital emergency rooms (Politico).
- **Hawaii transitioning Compact of Free Association residents to ACA coverage.** After the **U.S. Supreme Court** denied further appeals in an ongoing lawsuit, the **Hawaii Department of Human Services** (HDHS) published an [emergency rule](#) to transition low-income, non-pregnant, adult, non-citizens residing in Hawaii under the **Compact of Free Association** (COFA) from Medicaid-like state-funded coverage to **Health Insurance Marketplace** coverage. The state

originally announced this transition in 2010; however, COFA residents [challenged](#) the state’s authority to determine the level of public health coverage available to non-citizens who were ineligible for federal Medicaid funding. Under the ACA, low-income lawfully present non-citizens who are ineligible for Medicaid due to their immigration status are eligible for marketplace subsidies. HDHS created a “[Background Memo](#)” explaining the history of health coverage for COFA residents from the passage of the 1996 federal **Personal Responsibility and Work Opportunity Act** to present day ([DHS, 11/3](#); [DHS, 11/6](#); [Hawaii Star Advertiser, 11/3](#); [AP via The Republic, 11/18](#)).

- **Idaho launches Health Insurance Marketplace.** In advance of the 2015 open enrollment period, Idaho launched its state-based **Health Insurance Marketplace**, [Your Health Idaho](#). According to *Kaiser Health News*, Idaho is the only state to move from a federally facilitated marketplace during the 2014 open enrollment period to a state-based marketplace for 2015. Funded through a 1.5 percent premium fee on all marketplace plans, the marketplace features 198 health and dental plans—52 more than the federally facilitated marketplace offered last year. The Kaiser Family Foundation created a [list](#) of state marketplaces by type ([Kaiser Health News, 11/12](#)).
- **Kansas suspends voluntary admissions at inpatient psychiatric hospital.** Citing “ongoing and critical census challenges,” the **Kansas Department for Aging and Disability Services** (KDADS) [suspended](#) voluntary admissions to **Osawatomie State Hospital**, one of the state’s two inpatient psychiatric hospitals. The hospital will also deny involuntary admission for individuals with a sole diagnosis of a substance use disorder, organic mental health disorder such as trauma or dementia, or anti-social personality syndrome. According to the Kansas Health Institute, overcrowding has affected hospital services to the point that **CMS** threatened to end the hospital’s Medicare certification if it did not implement a corrective action plan. According to KDADS, the suspension will remain in place until the 206-bed hospital reduces its census to 185 patients ([Kansas Health Institute, 12/3](#)).
- **Maine: Court affirms ACA requirements, state must retain contested coverage.** On November 17, the **U.S. Court of Appeals for the First Circuit** [affirmed](#) the ACA’s Medicaid “**maintenance of effort**” (MOE) requirements, rejecting the **Maine Department of Health and Human Services’** (MDHHS) argument that Maine’s Medicaid eligibility was overly generous and harmful to the state budget. Prior to the case, MDHHS sought to end Medicaid eligibility for individuals age 19 or 20; however, under the ACA, states were prohibited from changing most adult eligibility requirements until January 2014 and may not alter child eligibility requirements until January 1, 2019. According to the court, although Maine law usually considers 19- and 20-year-olds to be adults, they were considered children for purposes of Medicaid coverage at the time that the MOE eligibility “freeze” took effect ([Bangor Daily News, 11/17](#)).
- **Massachusetts awards \$1.5 million to expand acute substance use services.** Following recommendations from the **Massachusetts Opioid Task Force**, the **Massachusetts Department of Public Health** (MDPH) awarded \$900,000 to create a 32-bed Acute Treatment Services (ATS) program and a 32-bed Clinical Stabilization Services (CSS) program in Franklin County. According to MDPH, the ATS program will provide 24-hour inpatient, medically monitored detoxification

services, while the CSS program will provide short-term 24-hour care, including stabilization and assessment. MDPH also awarded \$600,000 to police and fire departments in 23 communities with high incidences of fatal opioid overdoses. Under those awards, police and firefighters will receive opioid overdose response training and naloxone supplies ([MDPH, 11/21a](#); [MDPH, 11/21b](#)).

- **New York City launches \$130 million overhaul of criminal justice behavioral health services.** Based on recommendations from the **New York City Mayor’s Task Force on Behavioral Health and the Criminal Justice System’s [2014 Action Plan](#)**, **New York City Mayor Bill de Blasio** (D) announced a four-year, \$130 million overhaul of the city’s criminal justice system, aimed at expanding and improving behavioral health services. According to Mayor de Blasio, the overhaul is designed to address the rising percentage of incarcerated individuals with behavioral health conditions. Among the initiatives, the city will develop new police officer training programs to increase awareness of behavioral health conditions, establish “clinical drop-off centers” to provide treatment and referral services for individuals brought into custody for minor crimes that do not require arraignment, increase the number of slots in the city’s pretrial supervised release program from 1,100 to 3,400, expand access to behavioral health services for incarcerated individuals, and develop in-jail discharge planning teams to refer discharged individuals to resources in the community. The overhaul is funded by \$40 million in asset forfeiture funds from the **Office of the District Attorney of Manhattan** and \$90 million from the New York City general fund ([Office of New York City Mayor de Blasio, 12/2](#); [New York Times, 12/1](#)).
- **Ohio awards \$10 million to expand substance use recovery housing.** The **Ohio Department of Mental Health and Addiction Services** (ODMHAS) awarded \$10 million in additional funding to organizations providing recovery housing for individuals in recovery from substance use disorders. According to ODMHAS, the funding will support 657 additional beds and is composed of \$5 million in operating funds set aside from the [FY2013-14 Mid-Biennium Review](#) and \$5 million appropriated from the [FY2015-16 Capital Budget](#) ([ODMHAS, 11/7](#)).
- **Oregon clarifies mental health parity law.** On November 14, the **Oregon Department of Consumer and Business Services** (ODCBS) issued [two bulletins](#) clarifying the insurance coverage requirements under the [Oregon Mental Health Parity Statute of 2005](#). The bulletins clarified that, retroactive to August 8, 2014, private health insurers may not use categorical exclusions that result in broad denials of mental health or autism treatment services. According to ODCBS, the clarifications were necessary because of the publication of the [final rule](#) implementing the federal [Mental Health Parity and Addiction Equity Act of 2008](#) (MHPAEA), the release of the **Diagnostic and Statistical Manual of Mental Disorders 5<sup>th</sup> Edition** (DSM-5), and several recent state court cases ordering insurers to cover **applied behavioral analysis** therapy for clients with autism. **SAMHSA** offers [information resources](#) about MHPAEA and its implementation ([ODCBS, 11/14](#); [Oregon Public Broadcasting, 11/14](#)).
- **Pennsylvania launches premium assistance program, Governor-elect supports Medicaid expansion.** On December 1, the **Pennsylvania Department of Public Welfare** (PDPW) launched the **Healthy Pennsylvania** program, which provides private **premium assistance** with **Medicaid expansion** funds. [Approved](#) by **HHS**, the program covers individuals

with incomes up to 138 percent of the FPL. The program will also require enrollees with incomes between 100 and 138 percent of the FPL to pay a monthly premium of up to two percent of their household income, beginning in January 2016. Additionally, the program restructures the state's existing Medicaid program into "Low Risk" and "High Risk" programs, with different coverage based on enrollees' pre-existing conditions. **Governor-elect Tom Wolf** (D) opposes the program and hopes to replace it with a traditional Medicaid expansion after he takes office on January 20, 2015 ([Pittsburgh Post-Gazette, 12/1](#)).

- **Texas allocates \$1 million in matching-funds for veterans' mental health services.** To expand mental health services for veterans, **Texas Governor Rick Perry** (R) announced the creation of the **Texas Veterans Initiative** pilot program. Under the program, the **Texas Health and Human Services Commission** will award up to \$1 million to organizations that obtain local or private matching funds to provide mental health services to veterans. According to Texas officials, the program will address gaps in **U.S. Department of Veterans Affairs** services while supporting and evaluating new programs. The **Texas Legislature** will vote on a bill ([SB55](#)) during the 2015 legislative session that would allocate an additional \$20 million to the program ([Office of Texas Governor Perry, 11/10](#); [Texas Tribune, 12/2](#)).
- **West Virginia to launch behavioral health call center.** On November 10, **West Virginia Governor Earl Ray Tomblin** (D) announced plans to launch the **Behavioral Health Referral & Outreach Call Center**, the state's first 24-hour behavioral health call center. According to Governor Tomblin, the call center will provide behavioral health education and treatment referrals, using a live database of available services. The center will provide navigation and referral support to individuals in need of behavioral health services and follow-up with callers and providers to ensure "timely access, quality assistance, and successful outcomes." The **West Virginia Department of Health and Human Resources** is preparing to solicit bids to administer the call center ([Office of West Virginia Governor Tomblin, 11/10](#); [Charleston Gazette, 11/10](#)).
- **Wisconsin Assembly creates Mental Health Reform Standing Committee.** On December 2, **Wisconsin Assembly Speaker Robin Vos** (R) announced the creation of a **Mental Health Reform Standing Committee** for the 2015 legislative session. According to Speaker Vos, the committee will examine ways to expand the mental health reforms approved during the 2014 legislative session and implement recommendations from the **Speaker's Task Force on Mental Health**. Among other initiatives, the Committee will consider developing legislation to encourage mental health professionals to relocate to underserved communities, support mental health and physical health care integration, and allow counties to create additional mental health courts ([Capital Times, 12/3](#); [Milwaukee Public Radio, 12/2](#)).

## Financing Reports

- "[Access to care: Provider availability in Medicaid managed care](#)" HHS Office of the Inspector General. November 8, 2014 ([New York Times, 12/8](#)).
- "[Analyzing different enrollment outcomes in select states that used the federally facilitated Marketplace in 2014](#)" Urban Institute. Wishner, J. et al. November 13, 2014.

- **Behavioral health services are covered under 14 of 19 states' Medicaid managed long-term services and supports waivers.** [“Key themes in capitated Medicaid managed long-term services and supports waivers”](#) KFF. Musumeci, M. November 14, 2014.
- **Community behavioral health providers serving veterans require greater cultural competency.** [“Ready to serve: Community-based provider capacity to deliver culturally competent, quality mental health care to veterans and their families”](#) RAND. Tanielian, T. et al. December 2014 & [“Creating a culture of equity for veterans' mental health”](#) CommonHealth Action. October 2014.
- **“Early impacts of the Medicaid expansion for the homeless population”** KFF. DiPietro, B. et al. November 13, 2014.
- **Marketplace pricing: Cost of average benchmark silver-level marketplace plans decreased 0.2 percent in 49 major cities from 2014 to 2015.** [“An analysis of mark premiums in year 2 of the Affordable Care Act exchanges”](#) American Action Forum. Ryan, C. November 13, 2014.
- **Marketplace pricing: Cost of average lowest-cost silver-level federally facilitated marketplace plan premium increased four percent from 2014 to 2015.** [“Avalere analysis: 2015 exchange premium file”](#) Avalere Health. November 14, 2014.
- **“Marketplace renewals: State efforts to maximize enrollment into affordable health plan options”** RWJF. Corlette, S. et al. December 2014.
- **“Parity or disparity: The state of mental health in America 2015”** Mental Health America. December 2014 & [“Behavioral prescription drug and services coverage: A snapshot of exchange plans”](#) Mental Health America. November 2014 ([Washington Post, 12/4](#)).
- **“Private health insurance: Concentration of enrollees among individual, small group, and large group insurers from 2010 through 2013”** U.S. Government Accountability Office (GAO). December 1, 2014.
- **“Promoting physical and behavioral health integration: Considerations for aligning federal and state policy”** National Academy for State Policy. Stanek, M. November 2014.
- **“Risk stratification to inform care management for Medicare-Medicaid enrollees: State strategies”** Center for Health Care Strategies. Ensslin, B. & Barth, S. November 2014.
- **“Small business health insurance exchanges: Low initial enrollment likely due to multiple, evolving factors”** GAO. November 13, 2014 ([Washington Post, 11/13](#)).
- **States implementing Basic Health Plans likely to have reduced competition in Health Insurance Marketplaces.** [“The ACA's Basic Health Program option: Federal requirements and state trade-offs”](#) KFF. Dorn, S. & Tolbert, J. November 25, 2014.
- **State Medicaid expenditures increased by \$41.8 billion in FY2014.** [“State expenditure report: Examining fiscal 2012-2014 state spending”](#) National Association of State Budget Officers. November 2014 ([Washington Post, 11/20](#)).
- **Substance use cost New Hampshire's economy \$1.85 billion in FY2012.** [“The corrosive effects of alcohol and drug misuse on NH's workforce and economy”](#) Polecon Research on behalf of New Futures. November 2014 ([Concord Monitor, 11/17](#)).
- **“The ACA and recent Section 1115 Medicaid Demonstration waivers”** KFF. Rudowitz, R. et al. November 24, 2014.