

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

## **Financing Focus: June 15, 2015**

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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

- **CMS' proposed Medicaid managed care regulations would alter the IMD exclusion.** For the first time since 2003, the **Centers for Medicare & Medicaid Services (CMS)** proposed a [rule](#) that would update managed care regulations for **Medicaid** and the **Children's Health Insurance Program (CHIP)**. Published May 26, the proposed rule would end the prohibition on using federal Medicaid funding for adult behavioral health care in **"institutions of mental disease"** (IMDs). IMDs are inpatient facilities with more than 16 beds in which at least 51 percent of the patients receive care for serious behavioral health conditions. If finalized, the rule would allow Medicaid managed care plans to fund adult behavioral health treatment in IMDs for up to 15 days. In the rule, CMS cites psychiatric boarding in emergency rooms, access concerns, and the declining number of inpatient facilities as the primary reasons for the change. The proposed rule would also require states to establish quality ratings for Medicaid and CHIP managed care plans, annually certify that those plans meet new federal network adequacy standards, and improve enrollee engagement and administrative experiences. Additionally, the rule would give states additional flexibility to implement managed care reform waivers and best practices for long-term services and supports. Finally, the rule would set a nationwide **medical loss ratio (MLR)** standard of 85 percent for Medicaid and CHIP managed care plan. However, unlike the MLR standard for private insurers, the rule would not require plans to provide rebates if they spend less than 85 percent of funds on medical care; instead, states may adjust capitation rates for plans that do not meet the MLR standard ([CMS, 5/26](#); [Kaiser Health News, 5/26](#); [Bloomberg Business, 5/26](#); [Open Minds, 6/6](#); [Politico Pulse, 6/9](#))
- **CMS grants Medicare Accountable Care Organizations additional flexibility.** On June 4, CMS finalized a [rule](#) updating regulations for **Accountable Care Organizations (ACOs)** that participate in the ACA's **Medicare Shared Savings Program**. Among other changes, the rule allows ACOs currently using a one-sided risk model to delay their transition to a two-sided risk model for an additional three years. Under the program, ACOs may use a one-sided risk model, during which time they retain a portion of any savings they achieve but are not responsible for their losses. However, all ACOs must eventually transition to a two-sided risk model, which requires them to cover a portion of any losses they incur. The rule also creates a third model, based on the two-sided **Pioneer ACO** model, in which providers may retain a larger portion of their savings if they accept responsibility for a larger portion of their losses. Additionally, the rule streamlines the data sharing process between ACOs and CMS and updates CMS' policies around resetting ACOs' performance benchmarks ([CMS, 6/4](#); [Fierce Healthcare, 6/4](#)).
- **SAMHSA offers up to \$24.6 million for certified community behavioral health clinics.** On May 20, SAMHSA announced plans to award up to \$24.6 million in **Planning Grants for Certified Community Behavioral Health Clinics**. The purpose of the program is to support state efforts to certify community behavioral health clinics and

establish prospective payment systems for Medicaid reimbursable services provided by those clinics. SAMHSA expects to award up to 25 planning grants ([SAMHSA, 5/20](#)).

- **CMS releases hospital- and physician-level Medicare reimbursement data.** On June 1, CMS released [datasets](#) detailing Medicare utilization and reimbursement data for hospital inpatient services, hospital outpatient services, and physician-level services. Representing \$62 billion in FY2013 hospital reimbursements and \$90 billion in FY2013 physician reimbursements, this is the third annual release of hospital-level data and the second annual release of physician-level data. According to *USA Today*, the datasets show that Medicare reimbursements for psychiatric services increased 9.3 percent from FY2012 to FY2013, to \$853 million ([CMS, 6/1](#); [New York Times, 6/2](#); [USA Today, 6/2](#)).

## State News

- **IN, MN and NV pass telemedicine parity laws affecting behavioral health.** In May, the Governors of [Indiana](#), [Minnesota](#), and [Nevada](#) signed bills requiring insurers to cover telemedicine services at the same rates as equivalent in-person services and without additional restrictions. All three state laws include telemedicine parity requirements for behavioral health, and Indiana's law specifically references substance abuse evaluation and treatment. Meanwhile, Nevada's law requires the **Nevada Commissioner of Insurance** to consider telehealth availability when assessing an insurer's network adequacy. Additionally, Indiana's law directs the **Indiana Family and Social Services Administration** (IFSSA) to establish a **mental health first aid training** program, focusing on behavioral health issues in children and young adults ([Fierce Health IT, 5/29](#); [American Telemedicine Association, 5/27](#)).
- **California caps specialty prescription drug costs for Marketplace plans.** On May 22, California's **Affordable Care Act Marketplace** announced plans to become the first state to implement monthly caps on Marketplace enrollees' out-of-pocket costs for specialty prescription drugs, including certain behavioral health medications. Effective January 1, 2016, the monthly caps will range from \$150 to \$500, depending on plan design. Enrollees' out-of-pocket costs for specialty drugs were previously capped at \$6,250 annually ([Los Angeles Times, 5/22](#); [Covered California, 5/21](#)).
- **Connecticut expands access to naloxone.** On June 4, the **Connecticut Legislature** unanimously approved a bill ([HB6856](#)) to address opioid abuse through numerous related measures. The bill will require prescribers to use Connecticut's **prescription drug monitoring program** (PDMP), checking the database before prescribing more than a six-day supply of any narcotic and reporting all such prescriptions that they issue. The bill also will authorize pharmacists to prescribe and dispense naloxone to individuals at risk for an opioid overdose. Additionally, under the bill, providers' continuing medical education must include a course on pain management and the use of opioids. **Connecticut Governor Dannel Malloy** (D) announced plans to sign the bill ([Office of Connecticut Governor Malloy, 6/3](#); [Hartford Courant, 5/29](#)).

- Florida to reform and expand behavioral health services at Dade Correctional Institution.** Following recent events, the **Florida Department of Corrections (FDC)** reached a [settlement](#) with **Disability Rights of Florida (DRF)** to reform and expand behavioral health services at **Dade Correctional Institution (DCI)**. Under the settlement, FDC agreed to provide behavioral health and crisis intervention training to all DCI staff, hire additional personnel to oversee services provided to inmates with behavioral health needs, upgrade DCI's surveillance system, and allow DRF-appointed psychiatrists and security experts to monitor the settlement's implementation. The settlement does not resolve an ongoing **U.S. Department of Justice (DOJ)** criminal inquiry into staff operations at DCI ([Miami Herald, 5/27](#); [DRF, 5/28](#)).
- Kansas approves Medicaid prior authorization requirements for behavioral health drugs.** On May 19, **Kansas Governor Sam Brownback (R)** signed a bill ([HB2149](#)) authorizing the **Kansas Department of Health and Environment (KDHE)** to implement **prior authorization** requirements for brand-name **behavioral health drugs** under Medicaid. Under the bill, Medicaid covers only generic drugs unless the prescribing physician completes the prior authorization process for a brand-name drug. Enrollees may receive a three-day emergency supply of a brand-name drug while awaiting prior authorization. The bill also authorizes KDHE's **Drug Utilization Review Program Board** to review and alter the state's **Medicaid Preferred Drug List** to further limit access to brand-name behavioral health drugs ([Kansas Health Institute, 5/8](#); [Wichita Eagle, 5/8](#)).
- Kansas creates behavioral health system review committee.** On May 21, the **Kansas Adult Continuum of Care Committee** held its first meeting to review the state's behavioral health system of care. Created by the **Kansas Department for Aging and Disability Services (KDADS)**, the committee is tasked with identifying areas in need of improvement and issuing recommendations. According to KDADS, the committee will build on the Governor's Mental Health Task Force's [final report](#) released in April 2014 ([KDADS, 5/12](#); [Kansas Health Institute, 5/14](#)).
- Louisiana approves financing tool for potential Medicaid expansion.** On June 2, the **Louisiana Legislature** approved a concurrent resolution ([HCR75](#)) that would finance the state's share of a potential **Medicaid expansion**. Under the resolution, the **Louisiana Hospital Association (LHA)** will cover most state costs if Louisiana does expand its Medicaid program. According to the Associated Press (AP), **Louisiana Governor Bobby Jindal (R)** opposes the move, but the governor lacks the authority to veto concurrent resolutions. With Louisiana's gubernatorial election set to occur on October 24, 2015, the concurrent resolution would enable the next governor to more easily expand Medicaid ([AP via New Orleans Times-Picayune, 6/2](#); [The Advocate, 6/2](#)).
- Maine: Largest substance abuse treatment center ending operations.** Citing "decreasing insurance coverage and declining Medicaid reimbursement rates," **Mercy Hospital** in Westbrook announced plans to close **Mercy Recovery Center** on August 30.

According to a spokesperson, the Center has referred individuals receiving inpatient treatment or group therapy to other substance abuse programs. However, as the largest substance abuse treatment center in Maine, Mercy has yet to find replacement programs for its nearly 250 Suboxone clients ([Maine Public Broadcasting Network, 5/27](#)).

- **Massachusetts awards \$2.9 million for substance abuse prevention.** To expand substance abuse prevention services, the **Massachusetts Department of Health and Human Services (MDHHS)** and the **Massachusetts Department of Public Health (MDPH)** jointly awarded \$2.9 million in **Substance Abuse Prevention Collaborative (SAPC)** grant funding. Newly created by MDPH, the SAPC program seeks to build communities' substance abuse prevention capacity, with a focus on opioids and supporting strategies recommended by the state's Opioid Addiction Working Group. According to MDHHS, 127 communities received SAPC funding ([MDHHS, 5/18](#); [MassLive, 5/18](#)).
- **Minnesota approves \$13 million for children's inpatient mental health services.** On May 22, **Minnesota Governor Mark Dayton (D)** signed the state's FY2016-17 omnibus health and human services budget bill ([SF1458](#)), which included \$13 million in new funding to expand inpatient mental health services for children. Under the bill, the **Minnesota Department of Human Services (MDHS)** will establish 150 new child psychiatric beds over the next three years, including a network of inpatient treatment centers for "children with highly aggressive or self-injurious behaviors." According to a MDHS spokesperson, the Department expects 50 new beds to be available by July 2017 and the remaining beds to be available by July 2018 ([Minnesota Star Tribune, 5/29](#)).
- **Missouri reaches \$4.5 million autism coverage settlement with Aetna.** To resolve allegations that the companies violated Missouri's 2010 **autism coverage mandate (HB1311)**, on May 19, **Missouri Governor Jay Nixon (D)** announced a settlement with **Aetna Life Insurance Company** and **Aetna Health Insurance Company**. According to Governor Nixon, Aetna wrongfully told enrollees that the company was not required to provide autism coverage and, in some cases, failed to provide that coverage. Under the settlement, Aetna agreed to pay a \$4.5 million fine and submit to a corrective action plan. Aetna also admitted wrongdoing and plans to issue retroactive payments for wrongfully denied claims, adding nine percent interest. The **Missouri Department of Insurance (MDI)** will monitor the settlement for three years and may suspend Aetna's Missouri operations if its companies violate the settlement. Aetna previously admitted to violating the autism coverage mandate in 2012, agreeing to a \$1.5 million fine and a compliance audit; however, Aetna did not conduct the audit ([MDI, 5/19](#); [Fierce Health Payer, 5/20](#)).
- **Montana allocates \$10 million to expand behavioral health services.** In May, **Montana Governor Steve Bullock (D)** signed a series of bills ([HB2](#), [HB33](#), and [HB34](#)) that include provisions to increase funding for behavioral health services. The bills allocate \$6 million in new funding to support community-based behavioral health programs and \$4 million in additional funding for staff and services at state inpatient

psychiatric facilities. The Montana Legislature rejected a separate bill to establish additional inpatient psychiatric beds. Governor Bullock also signed a bill ([HB517](#)) revising the state's involuntary commitment and guardianship laws for individuals with mental illness or developmental disorders ([The Missoulian, 5/23](#)).

- **Ohio to reinstate Medicaid coverage for 153,743 individuals.** On May 11, the **Ohio Department of Medicaid** (ODM) and the **Legal Aid Society of Columbus** (LASC) settled allegations that ODM improperly terminated Medicaid coverage for 153,743 enrollees between January and March 2015. According to LASC, federal regulations require ODM to attempt “**passive enrollment**” processes to check enrollees’ continued Medicaid eligibility prior to mailing “**active enrollment**” applications. However, LASC alleged that ODM mailed active enrollment applications without attempting passive enrollment and terminated coverage for enrollees who did not respond. Under the settlement, ODM will reinstate Medicaid coverage for all affected individuals by August 1 and check their eligibility with passive enrollment. Additionally, ODM will streamline the active enrollment process by creating a centralized telephone renewal option, providing prepaid return envelopes with application packets, and providing renewal documents in Spanish and Somali ([Columbus Dispatch, 5/12](#); [AP via WKBN27, 5/12](#)).
- **Washington implements judicial review for involuntary commitment.** On May 14, **Washington Governor Jay Inslee** (D) signed a bill ([SB5269](#)) requiring state superior court judges to review involuntary commitment petitions from family members. Under the bill, family members may submit a petition in situations where a mental health professional declines to order an involuntary commitment requested by the family. If a petition is submitted, a determination must be made within five judicial days ([AP via KGMI, 5/14](#)).

## Financing Reports

- [“Access to care for the insured and remaining uninsured: A look at California during year one of ACA implementation”](#) Kaiser Family Foundation (KFF). Garfield, R. et al. May 28, 2015.
- **Barriers to treatment are causing underutilization of substance use disorder services.** [“Confronting an epidemic: The case for eliminating barriers to medication-assisted treatment of heroin and opioid addiction”](#) Legal Action Center. March 2015.
- [“Behavioral health parity and Medicaid”](#) KFF. Musumeci, M. June 2, 2015.
- **California will gain \$50 for every \$1 invested in suicide prevention.** [“Should California continue to invest in Applied Suicide Intervention Skills Training \(ASIST\)?”](#) RAND. Ashwood, J. et al. May 2015.
- [“Early insights from Ohio’s demonstration to integrate care and align financing for dual eligible beneficiaries”](#) KFF. O’Malley Watts, M. May 14, 2015.
- [“Early insights from One Care: Massachusetts’ demonstration to integrate care and align financing for dual eligible beneficiaries”](#) KFF. Barry, C. et al. May 12, 2015.

- **Individuals dually eligible for Medicare and Medicaid comprised 5 percent of Medicaid enrollees but accounted for 48 percent of Medicaid costs from 2009 through 2011.** [“Medicaid: A small share of enrollees consistently accounted for a large share of expenditures”](#) U.S. Government Accountability Office (GAO). May 2015.
- **Insurance companies presentation of behavioral health benefits affects plan enrollment decisions.** [“A tale of two states: Do consumers see mental health insurance parity when shopping on state exchanges?”](#) Berry, K. et al. *Psychiatric Services* 66(6): 565-567.
- **[“Health insurer responses to medical loss ratio regulation: Increased efficiency and value to consumers”](#)** Robert Wood Johnson Foundation (RWJF). Clemans-Cope, L. et al. May 2015 ([Fierce Health Payer, 5/14](#)).
- **HHS estimates 137 million individuals with private health insurance have access to free preventative services.** [“The Affordable Care Act is improving access to preventive services for millions of Americans”](#) HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE). May 14, 2015 ([HHS, 5/14](#)).
- **[“Making the case for funding and supporting comprehensive, evidence-based mental health services in Illinois”](#)** National Alliance on Mental Illness of Greater Chicago. May 2015 ([Chicago Tribune, 5/28](#)).
- **Massachusetts: Boston should expand inpatient substance abuse treatment capacity.** [“Addiction and recovery services in the city of Boston: A blueprint for building a better system of care”](#) Blue Cross Blue Shield of Massachusetts Foundation on behalf of Boston Office of Recovery Services. January 2015 ([WBUR, 5/20](#)).
- **[“Missed opportunities: The consequences of state decisions not to expand Medicaid”](#)** White House Council of Economic Advisors. July 2014 ([Baltimore Sun, 6/4](#)).
- **[“Public-private partnerships for providing behavioral health care to veterans and their families: What do we know, what do we need to learn, and what do we need to do?”](#)** RAND. Pedersen, E. et al. May 2015.
- **Report reviews implementation of alternative Medicaid expansions through Section 1115 waivers in AR, IA, IN, MI, NH, and PA.** [“Medicaid expansion, the private option, and personal responsibility requirements: The use of section 1115 waivers to implement Medicaid expansion under the ACA”](#) RWJF. Wishner, J. et al. May 2015.
- **Report: Standardize criteria for determining the medical necessity of behavioral health services under managed care.** [“Code blue: Many Kentucky hospitals struggling financially due to health system changes”](#) Kentucky Hospital Association. April 2015 ([Lexington Herald-Leader, 5/8](#)).
- **[“State-by-state effects of a ruling for the challengers in King v. Burwell”](#)** KFF. June 3, 2015 & **[“The combined effect of not expanding Medicaid and losing Marketplace assistance”](#)** RWJF. Buettgens, M. et al. May 2015 ([Fierce Health Payer, 5/15](#)).