

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

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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

- **President Obama proposes FY2017 budget with new behavioral health funding.** On February 9, **President Obama** released a \$4.15 trillion [budget proposal](#) to fund the federal government in FY2017. To further address national behavioral health issues, President Obama proposed \$1.5 billion in new mandatory funding over two years, spanning several federal agencies. Of that funding, \$1 billion would go to substance use treatment and recovery services to address **opioid misuse and abuse** and \$500 million would expand access to mental health services, including the **Certified Community Behavioral Health Clinic** demonstration, early intervention programs addressing serious mental illness, suicide prevention programs, and behavioral health programs for Native Americans. Under the proposed **U.S. Department of Health and Human Services (HHS)** [budget](#), the **Substance Abuse and Mental Health Services Administration (SAMHSA)** would receive \$4.3 billion in total funding, an increase of \$590 million from the FY2016 enacted budget. Of the new funding, SAMHSA would allocate \$469 million to substance use treatment and recovery services, \$115 million to mental health treatment and support services, and \$6 million to health surveillance programs. Additionally, the budget would maintain two key funding increases enacted in FY2016, \$50 million for the **Mental Health Block Grant** and \$38.2 million for the **Substance Abuse Prevention and Treatment Block Grant**. The **White House Office of Management and Budget** provides an [overview](#) of the overall budget proposal, and **HHS** provides a department-specific [fact sheet](#), which includes SAMHSA funding ([New York Times, 2/9](#); [Washington Post, 2/9](#)).
- **U.S. Preventive Services Task Force recommends depression screenings for all adults.** On January 26, the **U.S. Preventive Services Task Force (USPSTF)** announced a “B Grade” [recommendation](#) for all general physicians to screen adult patients for depression. The USPSTF also recommends that general physicians refer patients to specialized treatment services or prescribe antidepressant medication, as appropriate. Previously, the USPSTF recommended such screenings only under specific circumstances. The **Affordable Care Act (ACA)** requires non-grandfathered private health plans to provide in-network coverage of all USPSTF recommendations with an A or B grade without imposing cost-sharing requirements. Additionally, under the ACA, the **Centers for Medicare & Medicaid Services (CMS)** must increase the **Federal Medical Assistance Percentage (FMAP)** for state Medicaid coverage of USPSTF recommendations with A or B grades. **Healthcare.gov** provides [information](#) on the other preventive services most health plans must cover ([Los Angeles Times, 1/26](#); [Behavioral Healthcare, 1/28](#); [Health Affairs 12/28/10](#)).
- **Open enrollment ends for Affordable Care Act Marketplace coverage for 2016.** On February 1, **HHS** ended the 2016 open enrollment period, during which individuals were able to purchase **Affordable Care Act Marketplace** coverage through **Healthcare.gov** or state-based marketplaces. Under the **ACA’s individual mandate**, most remaining

uninsured individuals will incur a fine of \$695 or 2.5 percent of their annual income, whichever is greater. Meanwhile, on January 19, CMS [eliminated](#) six **special enrollment periods** that allow individuals experiencing qualifying life events to purchase **Affordable Care Act Marketplace** coverage outside of the open enrollment period. According to CMS, these six periods and the previously eliminated tax season enrollment period were no longer needed or were providing “unintended loopholes.” CMS also updated its guidance regarding how to qualify for special enrollment periods and announced plans to further assess the legitimacy of enrollments made during those periods ([New York Times, 1/29](#); [Washington Post, 1/31](#); [Fierce Health Payer, 1/20](#)).

- **CMS issues rule reforming Medicaid prescription drug reimbursements and rebates.** On January 21, CMS finalized a [rule](#) implementing ACA reforms to Medicaid reimbursement and rebate systems for outpatient prescription drugs. Among other reforms, the rule requires prescription drug manufacturers to increase the **minimum rebate percentages** offered to state Medicaid programs and to ensure that prescription drug rebates are the same for patients enrolled in Medicaid managed care programs and traditional Medicaid. According to CMS, the new rule will save Medicaid approximately \$2.7 billion over five years through Federal and state savings ([CMS, 1/21](#)).
- **CMS announces 121 new Medicare ACOs, proposes revising ACO initiative.** On January 11, CMS announced that 121 additional health care organizations began participating in **Medicare Accountable Care Organization (ACO)** initiatives. According to CMS, 100 of the new ACOs are participating in the **Medicare Shared Savings Program** and 21 are participating in the **Next Generation ACO Model**, a new initiative that offers ACOs greater incentives and opportunities for care coordination in exchange for assuming more financial risk. CMS reports that the 353 ACOs had combined net program savings of \$411 million in 2014. In addition, on February 3, CMS proposed a [rule](#) that would modify Medicare Shared Savings Program benchmarks to assess ACO savings on the basis of regional spending growth trends rather than national trends ([HHS, 1/11](#); [Modern Healthcare, 1/28](#); [Becker’s Hospital Review, 1/28](#)).
- **SAMHSA offers up to \$58.7 million to serve homeless individuals.** On January 22, SAMHSA announced plans to award up to \$58.7 million in **Cooperative Agreements to Benefit Homeless Individuals (CABHI) program** grants. The CABHI program provides integrated behavioral health, supportive housing, peer support, and other services to homeless individuals who have substance use disorders, co-occurring mental and substance use disorders, serious mental illness, or serious emotional disturbance ([SAMHSA, 1/22](#)).

State News

- **Illinois: Chicago expands law enforcement behavioral health training.** On January 29, **Chicago Mayor Rahm Emanuel** (D) announced plans to reform and expand behavioral health training programs for law enforcement officers and other first responders. Among other reforms, the **Chicago Police Department** will expand the 40-

hour Crisis Intervention Team (CIT) program by 50 percent, require all supervisors and training officers to undergo CIT training, and develop an 8-hour mental health awareness training program for all officers. Additionally, Chicago will improve crisis intervention training for 911 operators and dispatchers and collaborate with behavioral health advocates to provide immediate access to services for individuals encountering first responders ([Office of Chicago Mayor Emanuel, 1/29](#); [NBC Chicago, 1/29](#)).

- **Illinois: Social service provider ends 30 programs, including behavioral health services.** On January 25, **Lutheran Social Services of Illinois**, the largest social service provider in Illinois, announced plans to shut down 30 programs and eliminate 750 clinical and administrative positions. Lutheran Social Services plans to close substance use treatment programs, mental health counseling programs, housing programs for formerly incarcerated individuals, a children’s center, and other programs. According to a spokesperson, the closures are occurring because Illinois did not provide over \$6 million in payments and the agency is concerned about the state’s future finances. The *Chicago Tribune* notes that the state has been operating without a budget for over seven months because of disagreements between the Governor and the State Legislature and only state programs affected by court orders or permanent laws have continued to receive funding. ([Chicago Tribune, 1/25](#)).
- **Kentucky begins transition from state-based Marketplace to Healthcare.gov.** **Kentucky Governor Matt Bevin** (R) officially informed **HHS** that the state will transition its **Affordable Care Act Marketplace** from its state-based Marketplace, **Kynect**, to **Healthcare.gov**. According to Governor Bevin, Kynect is “redundant,” and he expects to complete the transition by the end of 2016 ([Washington Post, 1/11](#); [Louisville Courier-Journal, 1/11](#)).
- **Louisiana expands Medicaid under the ACA.** On January 12, **Louisiana Governor John Bel Edwards** (D) issued an executive order ([JBE16-01](#)) **expanding Medicaid** as authorized under the ACA. Under a concurrent resolution ([HCR75](#)) approved by the **Louisiana Legislature** in June 2015, Louisiana hospitals will pay a fee to cover most of the state’s share of the expansion costs, including \$2.8 million in startup costs. The executive order directs the **Louisiana Department of Health and Hospitals** to implement the expansion by July 1, 2016 ([New York Times, 1/12](#); [New Orleans Times-Picayune, 1/12](#)).
- **Massachusetts launches joint opioid investigatory task force.** On January 20, **Massachusetts Attorney General Maura Healey** (D) unveiled the **Interagency Group on Illegal Prescribing**, which will include state analysts, officials from state and local law enforcement and public health organizations, and agents from the **U.S. Drug Enforcement Administration** and **U.S. Federal Bureau of Investigation**. The task force will identify and investigate physicians with histories of over-prescribing opioids or prescribing opioids to individuals from outside their service areas, as well pharmacists who routinely fill such prescriptions. The task force may file Federal or state criminal

charges, submit civil complaints, issue fines, or revoke licenses, as appropriate ([Boston Globe, 1/20](#)).

- **Massachusetts reforms substance use disorder civil commitment process for women.** On January 25, **Massachusetts Governor Charlie Baker** (R) signed a bill ([H3956](#)) prohibiting the state from referring women to a state correctional facility when they have been civilly committed for a substance use disorder. The bill requires that such civilly committed women be referred to a treatment program licensed by the **Massachusetts Department of Public Health** (MDPH) or an MDPH-approved secure facility. Under state law, individuals whose substance use renders them a threat to themselves or others may be civilly committed by a judge for up to 90 days. Previously, civilly committed men were referred to **Bridgewater State Hospital** and civilly committed women were referred to **Massachusetts Committing Institution (MCI)-Framingham**, a state correctional facility. The bill does not alter the referral process for men. According to Governor Baker and advocates, MCI-Framingham does not offer adequate treatment options for women and the bill will ensure adequate access to treatment ([Office of Massachusetts Governor Charlie Baker, 1/25](#); [Mass Live, 1/25](#)).
- **New Hampshire approves task force-developed bills addressing opioid misuse and abuse.** On January 21, **New Hampshire Governor Maggie Hassan** (D) signed two bills developed and recommended by the state's opioid task force to address **opioid misuse and abuse**. The first bill ([SB576](#)) requires insurers to streamline claims processing for substance use treatment and to eliminate prior authorization requirements for certain outpatient treatment services. The bill also requires prescribers to use the state's **Prescription Drug Monitoring Program** (PDMP) in most circumstances and allocates \$100,000 for PDMP technological upgrades. Finally, the bill increases penalties for the illegal sale and distribution of **fentanyl** to match New Hampshire's penalties for heroin. The second bill ([SB447](#)) establishes a commission to evaluate the effectiveness of programs that provide **Narcan**, an opioid overdose reversal medication, and develop recommendations related to its use ([Office of New Hampshire Governor Hassan, 1/21](#); [Concord Monitor, 1/20](#)).
- **New York announces \$2 million in new residential substance abuse treatment funding.** On January 19, **New York Governor Andrew Cuomo** (D) announced plans to provide \$2 million annually to establish and support 50 residential substance abuse treatment beds in the Southern Tier region of upstate New York. According to Governor Cuomo, the **New York State Office of Alcoholism and Substance Abuse Services** (OASAS) will grant the new funding to a single treatment provider to operate at one or two new locations. OASAS also will work with that provider to secure capital funding, if necessary ([Office of New York Governor Cuomo, 1/19](#)).
- **New York reaches agreement to extend naloxone rebate program.** On January 19, **New York Attorney General Eric Schneiderman** (D) announced an [agreement](#) with **Amphastar Pharmaceuticals** to extend a **naloxone rebate program** for state and local

agencies. Under the agreement, Amphastar will continue to offer a \$6 rebate for each dose of naloxone sold to all state, county, and local public entities as well as to all substance use disorder treatment programs that receive public funding. The program was established January 27, 2015, and the agreement extends it until January 27, 2017 ([Office of New York Attorney General Schneiderman, 1/19](#)).

- **Vermont launches opioid addiction recovery pilot program.** In January, the **Vermont Agency of Human Services (VAHS)** launched a pilot program to provide extended release injectable **naltrexone** to individuals re-entering the community from the **Marble Valley Correctional Center** in Rutland. Approved for treating opioid dependence by the **U.S. Food and Drug Administration (FDA)** in 2010, naltrexone is an **opioid antagonist** administered to individuals who have completed detoxification. According to **Vermont Governor Peter Shumlin (D)**, the pilot program will expand to correctional centers throughout the state after VAHS evaluates its effectiveness. SAMHSA provided funding for the program through a \$3 million **Medication Assisted Treatment and Recovery** grant. Vermont is the first state to approve statewide use of naltrexone, which is available through local programs in 30 states ([CBS News, 1/19](#); [KEYC12, 1/19](#); [Office of Vermont Governor Shumlin, 12/1/15](#)).
- **West Virginia establishes substance abuse select committee.** On January 13, the **West Virginia House of Delegates** approved a resolution ([HR3](#)) establishing the **House Select Committee on Prevention and Treatment of Substance Abuse** to develop recommendations that address substance abuse in the state. The resolution notes that drug overdoses are the leading cause of injury in West Virginia, surpassing motor vehicle accidents, and that West Virginia has the highest rate of drug overdose fatalities in the United States ([West Virginia Public Broadcasting, 1/14](#)).

Financing Reports

- **[“Addressing and reducing health care costs in states: Global budgeting initiatives in Maryland, Massachusetts, and Vermont.”](#)** National Academy for State Health Policy (NASHP). Zemel, S., & Riley, T. January 12, 2016.
- **Alaska: Medicaid expansion estimated to increase net state funding by \$170 million annually.** **[“Assessment of Medicaid expansion and reform: Initial analysis.”](#)** The Menges Group on behalf of the Alaska Legislative Budget and Audit Committee. Evans, A., et al. January 15, 2016 ([Alaska Dispatch News, 1/25](#)).
- **[“Behavioral health barometer: United States, 2015.”](#)** SAMHSA. January 26, 2016 ([SAMHSA, 1/26](#)).
- **CMS proposal to create standardized Marketplace plan options could reduce out-of-pocket costs.** **[“Proposed exchange standardized benefit designs expand first-dollar coverage for services and drugs.”](#)** Avalere Health. Pearson, C., & Carpenter, E. January 14, 2016 ([Kaiser Health News, 1/22](#)).

- **Massachusetts and Ohio require mental health recovery centers under care coordination initiatives for individuals dually-eligible for Medicare and Medicaid.** [“Report on early implementation of demonstrations under the Financial Alignment Initiative.”](#) RTI International, University of Southern Maine, & the National Academy for State Health Policy (NASHP) on behalf of CMS. Chepatis, A., et al. October 15, 2015 (*Modern Healthcare*, 1/25).
- **“Medicaid expansion spending and enrollment in context: An early look at CMS claims data for 2014.”** Kaiser Family Foundation. Snyder, L., et al. January 11, 2016.
- **Medicaid health homes in 19 states and the District of Columbia include initiatives for individuals with serious mental illness.** [“An overview of emerging state health care purchasing trends”](#) Center for Health Care Strategies on behalf of the National Governors Association. McGinnis, T., & Houston, R. January 2016.
- **“Parity of mental health and substance use benefits with other benefits: Using your employer-sponsored health plan to cover services.”** SAMHSA. February 4, 2016.
- **“State Medicaid expansion and changes in hospital volume according to payer.”** *New England Journal of Medicine* 374(2): 196-198. Hempstead, K., & Cantor, J. January 14, 2016.
- **“The implications of a finding for the plaintiffs in *House v. Burwell*: \$47 billion more in Federal spending over 10 years and smaller Marketplaces.”** Urban Institute. Blumberg, L., & Buettgens, M. January 26, 2016.
- **“Using peers to support physical and mental health integration for adults with serious mental illness”** NASHP. Purington, K. January 2016.