SAMHSA's Center for Financing Reform & Innovations (CFRI)
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The Center for Financing Reform and Innovations 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.

Implementing the Affordable Care Act (ACA)

- **Insurers to pay an estimated $1.3 billion in medical loss ratio (MLR) rebates**. According to a **Kaiser Family Foundation** (KFF) analysis, consumers and businesses will receive an estimated $1.3 billion in health insurance rebates by August 2012 because of the **ACA's medical loss ratio** (MLR) rules. Under the ACA, insurers must pay set percentages of premium revenue towards health care costs and quality improvement or return the difference to consumers. Large group plans must spend 85 percent of premium revenue on health care while small group and individual plans must spend at least 80 percent. According to the April 26 report, KFF estimates that the rebates will total $541 million in the large group market, $426 million in the individual market, and $377 million in the small group market, with rebates going to 19 percent, 31 percent, and 28 percent of those markets, respectively. The analysis includes state-level rebate estimates (KFF, 4/26; Kaiser Health News, 4/26a). Additional information on the ACA MLR provisions is available from KFF here.
- **HHS rules increase options for Medicaid home and community-based services**. On April 26, the **U.S. Department of Health and Human Services** (HHS) announced rules designed to increase the availability of **home and community based services** (HCBS) through Medicaid. The Centers for Medicare & Medicaid Services (CMS) released final rules governing the ACA's **Medicaid 1915(k) Community First Choice Option**, which would expand person-centered HCBS for individuals requiring an institutional level of care. Under the option, participating states would be eligible to receive a 6 percent increase in their federal medical assistance percentage (FMAP). Additional details are available through CMS' Community First Choice Option factsheet. HHS is also seeking comment on proposed rules that describe a separate HCBS state plan option, originally authorized in 2005 but enhanced by the ACA. The proposed benefit would make it easier for state Medicaid programs to provide HCBS services (CMS, 4/26).
- **Community health centers receive $728 million from HHS**. On May 1, HHS awarded $728 million in ACA funds to expand and modernize 398 existing **community health centers** in 48 states. Coming from two separate programs, the funds are expected to expand capacity to serve an additional 860,000 individuals. HHS will allocate $629 million to 171 centers to address long-term expansion under the **Building Capacity Program** and $99.3 million to 227 centers to address pressing facility and equipment needs under the **Immediate Facility Improvement Program**. The ACA provides $9.5 billion to expand services at community health centers and $1.5 billion to support major construction and renovation projects (HHS, 5/1; Kaiser Health News, 5/1). Detailed information on awards from the Building Capacity Program is available here and funding information for the Immediate Facility Improvement Program is available here.

National News

- **VA to increase mental health workforce; OIG finds VHA lacks reliable method to assess timely access to mental health care**. On April 19, the **U.S. Department of Veterans Affairs** (VA) announced plans to increase its mental health staff, adding 1,600 clinicians and 300 support staff to its current staff of 20,590. A separate VA announcement clarified that the new positions will include marriage and family therapists (MFTs) and licensed professional mental health counselors (LPMHCs) (VA, 4/19; VA, 4/24; Kaiser Health News, 4/20). In related news, on

April 23, the **VA Office of the Inspector General** (OIG) released a report, finding that the **Veterans Health Administration** (VHA) does not have an accurate or reliable method of determining whether veterans receive timely access to mental health care. As a result, the report found that the VHA's statistics overstate the percentage of veterans obtaining mental health appointments within VHA's targeted timeframe (Kaiser Health News, 4/24a). The **Senate Committee on Veterans' Affairs** heard testimony on timely access to mental health care on April 25 (Washington Post, 4/25).

- **McKesson to pay $190 million to settle Medicaid fraud allegations**. On April 26, **McKesson Crop.** agreed to pay $190 million to settle the **U.S. Department of Justice's** (DOJ) allegations that the company reported inflated drug prices, artificially driving up Medicaid pharmaceutical payments. McKesson admitted no wrongdoing in the settlement; however, DOJ notes that the settlement does not address the state share of Medicaid costs and that McKesson may face additional legal claims from states (AP via Yahoo!, 4/26; Wall Street Journal, 4/26).

State News

- **California's prison plan would cut spending, comply with court orders on mental health care**. On April 23, the California Department of Corrections and Rehabilitation (CDCR) released the "The Future of California Corrections: A blueprint to save billions of dollars, end federal oversight and improve the prison system," laying out a plan to save $1.5 billion and "satisfy the federal courts that CDCR has achieved and maintained constitutional levels of medical, mental health and dental care." An April 19 report by the California Legislative Analyst's Office found that the quality of medical care in California prisons has increased since receivership began in 2006; however, receivership has also dramatically increased expenditures. The report offers recommendations to help CDCR provide ongoing, cost-effective, and constitutional care (DCR, 4/23; AP via San Jose Mercury News, 4/24; AP via San Francisco Chronicle, 4/19).
- **Connecticut issues draft proposal on dual eligible integrated care**. On April 24, the Connecticut Department of Social Services (DSS) released a draft proposal for the state demonstration to integrate care for dually eligible Medicaid and Medicare enrollees. DSS is soliciting public comment on the proposal, which stems from a 2011 CMS Medicare-Medicaid Coordination Office planning grant. According to DSS, the proposal will integrate long-term care, medical, and behavioral services; promote provider practice transformation; and create pathways for sharing health information through care coordination and electronic communication (DSS, 4/25; Connecticut Mirror, 4/27).
- **Florida settles with mental health plan over Medicaid MLR allegations**. On April 17, the Florida Agency for Health Care Administration (AHCA) and **Florida Health Partners Inc.** reached a settlement over allegations that the company failed to comply with medical loss ratio (MLR) requirements in 2006. AHCA originally sought $4 million from Partners, claiming that the insurer failed to adhere to the 80 percent MLR requirement when providing mental health care for Medicaid enrollees. Under the settlement, AHCA will not seek any funds from Partners. AHCA officials declined to comment on the settlement (News Service of Florida via Marco Island Sun Times, 4/30).

- **Guam proposes behavioral health fee schedule**. In April, the Guam Department of Mental Health & Substance Abuse released a proposed fee schedule for behavioral health services. The Department currently relies on taxpayer funded services and cannot bill individuals or private insurance because the Territory lacks a formal fee structure. Officials estimate that, if approved, the revenue generated from Phase 1 of the proposed fee schedule could save Guam $7.5 million annually. As a result of a 2001 court ruling, a federal management team currently oversees Guam's behavioral health care system (Guam News via PNC, 4/30).
- **Illinois Governor proposes $2.7 billion in Medicaid savings, affects behavioral health**. On April 19, Governor Pat Quinn (D) proposed $2.7 billion in Medicaid savings, designed to address the state's long-term funding needs as well as $1.9 billion in Medicaid bills anticipated for the end of FY2012. The governor's proposal would eliminate $1.35 billion in spending through program cuts, reductions, and other efficiencies as well as $675 million through provider reimbursement reductions. In addition, Governor Quinn's proposal would generate an estimated $675 million from a $1 per-pack cigarette tax increase and a 100 percent federal revenue match. Among other changes, Governor Quinn's proposal would eliminate readmissions to hospital detoxification services within 30 days of an initial admission and place a moratorium on new admissions to the state-only institutions of mental disease (IMDs) and intermediate care nursing facilities. Additional information on the proposal is available through the governor's factsheet and list of spending reductions (Office of Governor Quinn, 4/19; Reuters, 4/19; Chicago Tribune, 4/20).
- **Iowa Health, Wellmark to form ACO**. On April 26, **Wellmark Blue Cross Blue Shield** and **Iowa Health System** announced plans to form an accountable care organization (ACO). The new ACO would join Iowa's largest insurer with the state's largest hospital and clinic system. A spokesperson for Wellmark said the company will announce plans for a similar agreement with Mercy-Des Moines. Earlier in April, the University of Iowa Hospitals and Mercy Medical Center in Cedar Rapids also announced plans to form an ACO in Iowa (Des Moines Register, 4/26).
- **Kansas submits Medicaid 1115 waiver, delays implementing managed care for individuals with development disabilities**. On April 26, the Kansas Department of Health and Environment formally submitted the state's "KanCare" Section 1115 Medicaid Demonstration application. If approved by CMS, the demonstration would move Kansas' entire Medicaid program to managed care beginning in 2013, with the exception of long-term services for individuals with intellectual and developmental disabilities. After advocacy groups and legislative leaders expressed concern over transitioning those services too soon, Governor Sam Brownback's (R) administration agreed that they will be "carved out" of the new managed care system until 2014. The governor's administration estimates that the transition to KanCare will save $838 million over five years (Office of Governor Brownback, 4/27; Kaiser Health News, 4/26b). Additional detail on KanCare is available from the state's executive summary.
- **New Jersey overbilled Medicaid $61 million for HCBS, OIG finds**. On April 23, the **HHS Office of the Inspector General** (OIG) released a report concluding that New Jersey improperly claimed $61 million in federal reimbursements for home and community based services (HCBS) delivered to residents with disabilities under the state's Medicaid 1915(c) Community Care

Waiver Program. Examining services provided from 2005 through 2007, the OIG found that New Jersey billed for unallowable clients and services, including some ineligible services for individuals with intellectual and developmental disabilities. The report concludes that the state should refund the funds to the federal government and recommends corrective action to prevent future errors (HHS OIG, 4/23; Bloomberg via Businessweek, 4/27).

- **New Mexico submits Medicaid Section 1115(a) waiver application**. On April 25, the New Mexico Human Services Department submitted its official application for a Medicaid Section 1115(a) Research and Demonstration waiver. Dubbed **Centennial Care**, if approved by CMS, the new program would streamline the state's existing Medicaid services, featuring greater care coordination, health homes, and provider payment reforms. New Mexico's Medicaid services currently operate under 12 separate waivers and a fee-for-service (FFS) program, with behavioral health services authorized by a 1915(b) managed care waiver. Under the new proposal, New Mexico would continue to deliver behavioral health services through managed care but no longer under the 1915(b) waiver (Santa Fe New Mexican via Insurancenewsnet.com, 4/27; New Mexico HSD, 2/21)
- **Wisconsin: CMS approves Medicaid premium increases**. On April 27, CMS approved changes to Wisconsin's Medicaid program, which state officials estimate will save $28 million. Though CMS scaled back Governor Scott Walker's (R) original proposal, the approved changes will increase BadgerCare Plus premiums to between 3 and 9.5 percent of household income for adults with income over 133 percent of the federal poverty level (FPL). The premium increases will not affect individuals with disabilities or pregnant mothers. In addition, BadgerCare Plus will refuse coverage for one year for any enrollees who miss one month's premium. The premium changes will affect an estimated 44,000 individuals, with some 17,000 enrollees expected to lose coverage because they cannot or will not pay the new premiums (Milwaukee Journal Sentinel, 4/27; Wisconsin State Journal via LaCrosse Tribune, 4/28).

Financing Reports

- "**ACA implementation-monitoring and tracking: Colorado site visit report**" The Urban Institute & the Robert Wood Johnson Foundation. Hill, I. et al. April 12, 2012.
- "**An update on CMS's capitated financial alignment demonstration model for Medicare-Medicaid enrollees**" Kaiser Family Foundation. April 2012.
- "**Bending the health care cost curve in Missouri: Options for saving money and improving care**" Missouri Foundation for Health. (St. Louis Beacon, 4/24).
- "**Benefits of slower health care cost growth for Massachusetts employees and employers**" Blue Cross Blue Shield of Massachusetts Foundation. April 2012 (WBUR, 4/26).
- **Capacity and access limit temporary detention orders in Virginia, OIG issues recommendations**. "Review of emergency services: individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment" Virginia Office of the Inspector General for Behavioral Health and Developmental Services. OIG Report No. 206-11. February 2012 (AP via NECN, 4/18).
- "**Employment-Based health benefits: Trends in access and coverage, 1997-2010**" Employee Benefit Research Institute. Fronstin, P. Issue Brief #370. April 2012 (EBRI; The Hill, 4/24).

- "**Essential Health Benefits**" *Health Affairs* Health Policy Brief. April 25, 2012.
- "**Estimates of individuals with pre-existing conditions range from 36 million to 122 million**" Government Accountability Office. March 2012 (Kaiser Health News, 4/27).
- **"Gaps in health insurance: Why so many Americans experience breaks in coverage and how the Affordable Care Act will help"** The Commonwealth Fund. Collins, Sara R. et al. April 19, 2012 (Kaiser Health News, 4/19).
- **"Massachusetts' proposed demonstration to integrate care for dual eligibles"** Kaiser Family Foundation. April 2012.
- **Medicare solvent until 2014, trustees find**. "2012 Annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds" The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. April 23, 2012 (Kaiser Health News, 4/24b).
- "**Mental health, United States, 2010**" Substance Abuse and Mental Health Services Administration. April 25, 2012 (SAMHSA, 4/25).
- "**Patient cost sharing under the Affordable Care Act**" Kaiser Family Foundation. April 23, 2012.
- **Per capita commercial and Medicare health care costs increased 5.75% over one year**. S&P healthcare economic indices. S&P Indices. April 19, 2012.
- "**Quality improvement with pay-for-performance incentives in integrated behavioral health care**" *American Journal of Public Health* [Epub ahead of print]. Unutzer, J. et al. April 19, 2012 (Medical Express, 4/19).
- "**The diversity of dual eligible beneficiaries: An examination of services and spending for people eligible for both Medicaid and Medicare**" Kaiser Family Foundation. April 18, 2012.