

State Advocacy Update

Mental Health and Medicaid Budgets Under Assault

With the new fiscal year looming in most states, legislatures are shifting their budget deliberations into high gear. Deficits are projected in all but a handful of states and estimated to be as high as \$50 billion nationwide. Of that amount, \$15 billion in shortfalls are attributed to Medicaid budgets. State legislators have spent the majority of their time haggling over proposals that would cover the growing program to preserve federal matching funds and reduce costs at the same time.

Medicaid Service Cuts Are on the Way

The focus on Medicaid cuts has hurt mental health spending across the nation. Medicaid cuts can affect up to half of mental health expenditures in any given state. Budget proposals to reign in Medicaid growth are resulting in cuts to optional services such as psychiatric rehabilitation and medication; in restrictive formularies or prior authorization requirements for medication; and in higher cost sharing for beneficiaries. In Mississippi, for example, legislators overrode the governor's veto of a budget that cut \$120 million from Medicaid, and advocates are waiting to determine what Medicaid benefits and services they may

be forced to cut beginning July 1.

Legislators and Medicaid administrators are particularly targeting pharmaceutical budgets for cuts as a way to trim expenses for a program that is projected to grow at double-digit numbers into the next decade. Legislation has passed or is nearing passage in more than a dozen states that establishes monthly limits on prescriptions (e.g., Idaho and Mississippi), increases co-payments for Medicaid services (e.g., Kentucky), and authorizes the use of preferred drug lists and prior authorization requirements as Medicaid cost-saving measures (e.g., Kentucky, Maryland, Minnesota, New Mexico). Other states, such as Michigan, Massachusetts and North Carolina, are pursuing such strategies through rule-making procedures, without the input of legislators and with only limited public input.

Although such proposals are proliferating rapidly, mental health advocates are fighting back. Indiana advocates saw success early this session in exempting mental health medications from prior authorization requirements and other restrictions under Medicaid (see related story on page 3-a). And Maryland advocates won the exemption of mental health medications from increased Medicaid cost-sharing requirements.

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Bush Support Gives Parity New Momentum

NMHA Discusses Parity With Senators, White House Staff

President Bush's recent announcement supporting the enactment of mental health parity this year gave enormous momentum to advocates who have long been fighting against insurance discrimination in mental health care.

In an April 29 speech at the University of New Mexico, Bush said that "insurance plans too often place greater restrictions on the treatment of mental illnesses than on the treatment of other medical illnesses ... Health plans should not be allowed to apply unfair treatment limitations or financial requirements on mental health benefits."

NMHA reads the president's statement as broadly supportive of full mental health parity. Note Bush's words: "[I]t is critical ... as we provide full mental health parity, that we do not significantly run up the cost of health care." Although the reference to cost is clearly

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Presidential Support Gives Parity New Momentum

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a nod to the business community and others who have opposed mental health parity, the statement describes the Mental Health Equitable Treatment Act (S. 543), co-sponsored by Sens. Pete Dominici, R-N.M., and Paul Wellstone, D-Minn. That bill and its companion legislation in the House (H.R. 4066), co-sponsored by Marge Roukema, R-N.J., and Patrick Kennedy, D-R.I., not only provide for full mental health parity but also offer ample assurances against any significant cost run-up.

The president's message does, of course, fall short of specifically endorsing the Domenici-Wellstone legislation, which was approved by the Senate last year. And because Bush said he will work with members of Congress "to reach an agreement on mental health parity," there is certainly danger that core elements of the legislation could be diluted or lost. While praising the president's support, NMHA has taken every opportunity—from participating on radio talk shows to meetings with policymakers—to challenge efforts to weaken the bill.

During meetings with the Senate sponsors, NMHA sees a determination, which mirrors that expressed by White House staff, to get a strong bill enacted this year. Although Bush is not proposing or endorsing any specific language, White House staff told NMHA that they hope to play a constructive role by working with all stakeholders. NMHA has underscored how critical it is that a bill not simply outlaw disparities in treatment limitations and financial requirements, but that it end discrimination against people with mental illness.

In the weeks ahead, the greatest challenge will be to the scope of the bill. Various opposing voices within the

business community are generally unified around the message that the Domenici-Wellstone legislation is too broad, that it mandates coverage for all mental disorders, including those that are "not serious."

NMHA counters that the bill aims to end discrimination in health insurance and must therefore prohibit discrimination by diagnosis. To dilute this bill and permit insurers to arbitrarily limit or deny coverage solely on the basis of diagnostic distinctions would be to stigmatize people anew.

The Domenici-Wellstone bill already gives insurers latitude to limit coverage on the basis of medical necessity. But to allow them to require parity coverage only for specific "serious" diagnoses would be like health insurance covering heart disease but not high blood pressure, or lung cancer but not bronchitis.

Although President Bush has given parity new momentum, advocates cannot rest. It is more important than ever to build the list of co-sponsors for this legislation, particularly among Republicans. That task has hopefully become a little easier. Within a day after Bush's announcement, three more House Republicans, one of whom had never before supported a parity bill, signed up to co-sponsor the Roukema-Kennedy parity legislation.

NMHA will continue to build on this momentum up to and beyond its Annual Conference, June 5-8 in Washington, D.C., where mental health advocates will travel en masse to the "Mental Health Parity Now!" Rally on Capitol Hill June 6 (visit <http://www.nmha.org> for more information). **SAU**

Advocacy Resources

NMHA is committed to providing mental health advocates and stakeholders with quality information that helps promote positive policy changes in states and communities. Below is a list of resources MHAs can use to help support their advocacy efforts. Most of these materials are available on the Internet. If you have problems accessing any of the following items online, contact the Advocacy Resource Center at 800-969-6642 and select option 6, or e-mail shcrinfo@nmha.org.

Medicaid

- From The Commonwealth Fund—"The American Public Human Services Association Medicaid Health Plan Employer Data and Information Set Database Project" available at http://www.cmwf.org/programs/quality/partridge_aphsa_hedis_1999.pdf.
- From the National Health Law Program—"Children's Health Under Medicaid: A National Review of Early and Periodic Screening, Diagnostic and Treatment," updated Sept. 2001, executive update available at <http://www.healthlaw.org/pubs/child1998healthxsum.html>.

Medicaid and Managed Care

- From the Center for Mental Health Services—"Estimating the Cost of Preventive Services in Mental Health and Substance Abuse Under Managed Care" available at <http://www.mentalhealth.org/publications/allpubs/SMA-023617/default.asp>.
- From the Kaiser Family Foundation—"Why States Are Trying to Control Medicaid Spending on Prescription Drugs and How Florida Is Attempting To Do It" available at <http://www.kff.org/sections.cgi?section=kcmmu>.

Indiana Safeguards Open Access to Prescription Drugs

New Law Prevents Medicaid Restrictions on Mental Health Medications

Preserving open access to medications is one of the top challenges to mental health advocates this year. With an unprecedented \$15 billion shortfall in Medicaid budgets nationwide and data showing rapidly escalating pharmaceutical budgets as a source of those deficits, policymakers are slashing budgets by restricting access to medications. To date, more than a dozen states have considered legislation to implement restrictive formularies, fail-first requirements, prior authorization and increased cost-sharing policies—and many more are doing so through new regulations.

To combat these proposals, mental health advocates have sought to exempt mental health medications from these restrictions. Indiana advocates have won such an exemption after a prolonged legislative fight and a gubernatorial veto in 2001. Led by the MHA of Indiana, they reached agreement with the state Medicaid agency to issue language that exempts mental health medications from the state's restrictive formulary policy for fee-for-service Medicaid. The language was enacted into law (H.B. 1233) on March 12 and took effect immediately. The new law:

- Defines mental health medications broadly to include antidepressants, antipsychotics, and anti-anxiety drugs, and includes cross-indications, new drugs and new drug categories as they are discovered.
- Prohibits restrictions on access to these medications, including prior authorization.
- Ensures that brand name drugs will not require prior authorization.
- Permits limitations on mental health medications only to prevent fraud, abuse, waste and inappropriate utilization, or to promote disease management, and allows such limitations only when it is in the best interest of the recipient and quality of care.

Advocates attribute their success to persistent negotiation with legislators and the governor's office, and to the leadership and support of the state's new Medicaid director. For more information on these efforts, contact Steve McCaffrey at the MHA of Indiana at 317-638-3501.

In addition, NMHA offers several resources for advocates on this issue, including a brochure titled *Pennywise & Pound-Foolish: Restricting Access to Psychotropic Medications*, and a summary of model policies considered during the 2001 legislative session titled *Protecting Consumer Access to Psychotropic Medications*. Both publications and other technical assistance are available by contacting NMHA's Advocacy Resource Center at 800-969-6642, option 6, or at shcrinfo@nmha.org. [SAU](#)

New Indiana Law Protects Mental Health Medications from Medicaid Restrictions

Section 3. 405 IAC 5-24-8.5 IS ADDED TO READ AS FOLLOWS:

Prior Authorization; other drugs

Sec. 8.5. (a) Except as provided in section 8.6 of this rule, the office may, in compliance with all state and federal laws that may govern Medicaid prior authorization programs, establish prior authorization requirements for other drugs covered under Medicaid...

405 IAC 5-24-8.6 Prior authorization limitation and other; antianxiety, antidepressant, antipsychotic agents

(a) Central nervous system drugs classified by Drug Facts and Comparisons...as antianxiety, antidepressant, or antipsychotic agents, or any drugs cross-indicated...to these classifications will not be placed on prior authorization in the fee for service Medicaid program. Drugs classified in any new category or classification of central nervous system agents...created after the effective date of this rule, when prescribed for the treatment of mental illness (as defined in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association), will not be placed on prior authorization in the fee for service Medicaid program. As used in this subsection, "cross-indicated" means a drug that is being used for a purpose generally held to be reasonable, appropriate, and within community standards of practice, even though the use is not included in the FDA-approved labeled indications for the drug.

(b) Brand name multisource drugs described in subsection (a) shall not be subject to prior authorization under section 8 of this rule.

(c) A recipient enrolled in the fee for service Medicaid program shall have unrestricted access to the drugs described in this section except as provided in Section 11.

405 IAC 5-24-11 Limitations on quantities dispensed and frequency of refills

Sec. 11 Nothing in this rule prohibits the office from placing limits on quantities dispensed or frequency of refills for any drug for purposes of preventing fraud, abuse waste, overutilization, inappropriate utilization or implementing disease management. In formulating any such limitations, the office will take into account quality of care and the best interests of Medicaid recipients...

405 IAC 5-24-12 Risk-based managed care

Sec. 12 The use of prior authorization programs or formularies in risk-based managed care shall be subject to IC 12-15-35-46 and IC-15-35-47 and are not governed by this rule.

Federal Update: NMHA Steps Up Federal Advocacy On Mental Health Funding

Bush Administration's FY 2003 Budget Imperils Mental Health Programs and Services

With the federal appropriations process moving forward and a crowded legislative calendar facing members of Congress, NMHA continues to press for increased mental health and substance abuse funding for next year. It has also made comprehensive mental health parity legislation a top advocacy priority for this year, along with other key objectives related to juvenile justice, welfare reform, special education and veterans' affairs.

NMHA Responds to FY 2003 Budget

NMHA has called on Congress to reverse the administration's FY 2003 spending plan, which will threaten access to needed care for people with, or at risk for, mental disorders. In press releases, media statements, Legislative Alerts and other publications, NMHA has cited the failings of the administration's Substance Abuse and Mental Health Services Administration budget, along with its plans for

other community mental health program terminations, spending cuts and funding freezes (see <http://www.nmha.org> for these publications).

Reducing federal support at a time when state and local mental health systems face their own severe budget pressures and increased demand for services will leave people with mental health needs in ever-greater jeopardy. NMHA has stepped up efforts to push for additional funding for mental health programs and asked Congress to:

1. Make mental health a funding priority and provide substantial increases for mental health programs. Flat funding and cuts under the FY 2003 spending plan for the Center for Mental Health Services (CMHS) is a profound concern. Overall funding for mental health services in real dollars is declining as need for services is increasing, and

NMHA Briefs Members of Congress on Children's Issues

To prepare for upcoming legislative battles on funding for children's mental health programs, NMHA held a congressional briefing at the U.S. Capitol March 20 to educate policymakers about the importance of children's mental health and the federal programs that support it.

"Although we know that children's mental health problems are real, only one-third of children with them receive any care," said NMHA President and CEO Michael Faenza, who moderated the briefing. "Time and again, the effectiveness of federal children's mental health programs

has been proven, but these programs are often the targets of budget cuts, as they are again this year."

Staff from more than 14 congressional offices attended the briefing. In

addition, more than 20 members of Congress, including Reps. Granger and David Obey, D-Wis., and Sen. Tom Harkin, D-Iowa, served on a host committee for the event.

Representatives of the programs at risk of being cut stressed the success of their initiatives and called for continued federal funding. Reps. Sheila Jackson-Lee, D-Texas, Marge Roukema, R-N.J., Jim McDermott, D-Wash., and Kay Granger, R-Texas, and Sen. Paul Wellstone, D-Minn., also spoke out in support of children's mental health programs. In addition, Mary Jane England, M.D., president of Massachusetts' Regis College and NMHA board member, outlined the depth of the needs of children with serious emotional disturbances.

The briefing was co-sponsored by the American Academy of Child and Adolescent Psychiatry, Children and Adults With Attention-Deficit Hyperactivity Disorder, the Federation of Families for Children's Mental Health and the National Association of School Psychologists.



Melanie Powell-Brazil, program director of the Cleveland Municipal School District's Project SYNERGY!, spoke at NMHA's congressional briefing. Project SYNERGY! is funded through the federal Safe Schools/Healthy Students Initiative, which is at risk of being cut.

even though research demonstrates that mental health treatment benefits individuals, families and society as a whole. In particular, we strongly urge Congress to expand funding for the Children's Mental Health Services Program (to \$140 million), and for school and community-based violence prevention initiatives (to \$150 million).

2. Restore proposed \$2 million cut in funding that supports Consumer Technical Assistance (TA) Centers and provide increases. The FY 2003 budget would end all funding next year for the five centers that provide technical assistance to help mental health consumers around the country achieve independence through recovery from mental illness. If our goal is to have people with mental illness get jobs, a place to live and become productive citizens, we should not eliminate a successful program focused on consumers and their path to recovery.
3. Restore proposed \$5.5 million cut in funding that supports the Community Action Grant program and provide increases. These modest grants, ranging from \$50,000 to \$150,000, allow local communities to improve mental-health service delivery by implementing proven, evidence-based practices for adults with serious mental illnesses and children with serious emotional disorders.
4. Maintain knowledge development as a key component of SAMHSA's mission. One of SAMHSA's core missions is to develop an "evidence base" on the effectiveness of services and their delivery mechanisms, but the administration's FY 2003 budget abandons responsibility for this vital objective. SAMHSA plays a critical role in translating mental health research findings into community practice, and is obligated by law to perform this function.

Next Steps for Mental Health Advocates

The House will likely consider the funding bill before the July 4 break. Because this is an election year, the budget time line could change drastically, depending on the political climate. NMHA's nationwide affiliate network should take every opportunity before election day to urge their members of Congress to reject the \$17 million cut to Programs of Regional and National Significance at CMHS and to make mental health a funding priority by providing meaningful increases to mental health programs.

Other Federal Advocacy Activities

- **Site visits.** NMHA regularly leads key congressional staff on tours of Safe School/Healthy Students (SS/HS) sites, and other mental health-funded sites, including a mental health crisis center in Baltimore, Md. These site visits are invaluable advocacy tools that help promote the mental health programs we support. NMHA will lead another local SS/HS site visit in the spring for congressional appropriations staff.
- **Coalition work.** The Mental Health Liaison Group (MHLG), a coalition of 40 mental health groups, including NMHA, developed a funding campaign to increase CMHS funding by 50 percent over the next three years. The group aims to replicate the success of the NIH campaign, which successfully doubled NIH's budget. The MHLG publishes an annual appropriations recommendation document that highlights the entire federal mental health funding portfolio.
- **Congressional visits.** The MHLG will set up spring visits with key congressional staff, including appropriations staff, to deliver the MHLG appropriations document and make a case for increased funding for mental health programs. NMHA and its affiliate network will conduct congressional visits during NMHA's "Advocacy Day" at its Annual Conference on June 6 and highlight the need for mental health services (see cover story).
- **District visits.** Members of Congress plan to go home to their districts during Memorial Day Weekend, the week of Fourth of July and the entire month of August. These are great opportunities for affiliates to meet with their congressional members back home and set up visits to their MHAs or local mental health program (e.g., SS/HS sites or a Children's Mental Health Systems of Care Center). SAU

Join advocates from around the country at the

Mental Health Parity Now! Rally

12 noon, June 6, on grounds of the U.S. Capitol in Washington, D.C.

More info: call 800-969-NMHA (6642) or visit <http://www.nmha.org>.

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States are also attempting to alter eligibility and optional benefits structures with little or no public input. Under the Health Insurance Flexibility and Accountability (HIFA) Initiative, states can cut optional benefits to certain eligible individuals in an effort to expand coverage to more state citizens (see the spring issue of *State Advocacy Update*). Ten states have submitted such waivers and two—Arizona and

Utah—have been approved so far. In addition, there are a rising number of proposals to expand Medicaid administrative authority and bypass regulatory procedures to reduce Medicaid services. This would potentially allow program changes with no public input. Mississippi and Oklahoma, for example, may take such emergency measures if additional state funds are not appropriated.

NMHA Promotes Psychiatric Advance Directives

NMHA's Board of Directors in March approved a new policy position promoting the use and enforcement of advance directives for people diagnosed with mental illnesses. This new policy provides advocates with an important tool to raise awareness about psychiatric advance directives and their value to consumers and practitioners, as well as to family members, friends and legal professionals. A copy of the position statement is available on NMHA's Web site at www.nmha.org/position/advancedirectives.cfm.

What Is an Advance Directive?

A psychiatric advance directive offers a clear written statement of a person's medical treatment preferences or other expressed wishes. It can also be used to assign decision-making authority to a proxy who can act on the person's behalf if he or she becomes incapacitated. When correctly implemented and executed, psychiatric advance directives have great potential to:

1. Promote individual autonomy and empowerment in the recovery from mental illness.
2. Enhance communication between individuals and their families, friends, healthcare providers and other professionals.
3. Protect people from receiving ineffective, unwanted, or possibly harmful treatment.
4. Help prevent crises and the use of involuntary treatment or interventions such as restraint or seclusion.

How Can Advocates and Consumers Use and Promote Advance Directives?

NMHA has developed a comprehensive toolkit of information for those interested in finding out more about psychiatric advance directives. The toolkit includes:

- **Issue Summary on Psychiatric Advanced Directives.** This document provides an in-depth

discussion of some major issues surrounding psychiatric advance directives.

- **NMHA Position Statement on Psychiatric Advance Directives.**
- ***Psychiatric Advance Directives: Considerations for Legislation.*** Because model legislation does not exist, this document clarifies the important elements of psychiatric advance directives legislation.
- **Glossary of Terms.** This brief glossary defines some of the key terms regarding psychiatric advance directives.
- **Psychiatric Advance Directives Worksheet.** This worksheet allows consumers to develop the basic contents of a psychiatric advance directive for themselves.
- **Psychiatric Advance Directives PowerPoint Presentation.** This sample presentation will help advocates and consumers educate stakeholders about psychiatric advance directives.
- ***Advance Directive for Mental Health Care: An Analysis of State Statutes,*** by Robert Fleishner for the National Association of Protection and Advocacy Systems. This 1998 article addresses some of the policy issues related to psychiatric advance directives and provides a state-by-state analysis of advance directive laws.

For more information on psychiatric advance directives, or to obtain a copy of the "Psychiatric Advance Directives Toolkit," contact NMHA's Advocacy Resource Center at 800-969-6642, option 6, or at shcrinfo@nmha.org. Or visit www.nmha.org/position/advancedirectives.cfm.

Mental Health Budget Cuts Add Insult to Injury

In addition to growing strains on Medicaid budgets, state mental health agencies are being subjected to across-the-board agency cuts and other administration-ordered cost containment strategies (e.g., hiring freezes). The result has been cuts to mental health budgets that range nationally from 3 percent to 8 percent, according to the National Association of State Mental Health Program Directors (NASMHPD). In fact, the only states in which mental health budgets have not decreased are those with court orders to maintain spending for services.

Examples of state cost-cutting efforts abound. Agencies in Montana were recently asked to submit proposals for across-the-board cuts by May 10 to bridge an \$80 million budget gap caused by revenue shortfalls. Under recently enacted budgets, Iowa agencies sustained a 5.3 percent cut; Nebraska agencies were cut by 3 percent. In Massachusetts, mental health will be hit with an 8.5 percent cut (\$50 million) under a recently proposed budget for fiscal year 2003.

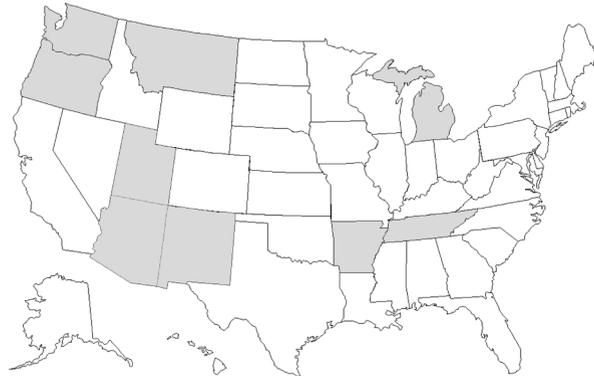
In Ohio, where a strong advocacy coalition successfully forestalled cuts in the state mental health department this year, advocates say that fiscal year 2003 poses a new battle. According to the state Medicaid agency director, Medicaid is growing at 9 percent per year and Ohio revenues are growing by only 4 percent. Targets for potential budget cuts next year: nursing homes, hospitals and prescription drugs.

These cuts could potentially damage an already underfunded mental health system. In South Carolina, for example, the Department of Mental Health has sustained \$30 million in budget cuts over the last 18 months and has been ordered to cut an additional 2.5 percent (\$4.6 million). The impact on the system is palpable: More than 200 public and private psychiatric beds have closed; there are four- to five-hour waits in emergency rooms for placements; and 12- to 13-week waiting lists for community mental health services; and a growing list of people in jail are waiting for forensic beds.

Other Policy Choices Can Help States

At press time, more than half of the states have either tapped or have proposed drawing on state reserves to overcome deficits. Many states have also used tobacco settlement money to resolve fiscal imbalances. The most controversial proposals—particularly in an election year—

States that have applied for or received HIFA waivers



Arkansas
Arizona*
Michigan
Montana
New Mexico
Oregon
Tennessee
Washington
Utah*
*approved

involve increasing state revenues. More than a dozen states are considering tax increases to tobacco products, gasoline, alcohol and other items in an attempt to increase faltering state revenues and shore up budgets. Such proposals are in heavy debate and forcing states into special session.

Advocates Must Be Prepared

As budget negotiations conclude across the country, advocates must devote themselves to preparing for the next budget battle. These plans might include opening a dialogue with Medicaid officials to ensure that cuts in services do not affect people with mental illness; planning coalition activities during the election cycle that draw attention to the underfunded mental health system; and documenting the impact of a state's budget cuts on community services and subsequent increases in emergency room visits, hospitalizations, and incarcerations, all of which drain state economies.

To help advocates confront these issues, NMHA offers several tools: A fact sheet titled *Pay for Services or Pay a Greater Price* outlines the costs to the healthcare system and society as a whole when mental health is under-funded. A brochure, *A Call for Investment: Expanding Community-based Mental Health Services*, outlines the benefits of public investment in community mental health. Another brochure, *Pennywise & Pound-Foolish: Restricting Access to Psychotropic Medications*, argues in favor of open access to medication. These documents and other technical assistance are available by contacting NMHA's Advocacy Resource Center at 800-969-6642, option 6, or at shcrinfo@nmha.org. **SAU**

Spring Healthcare Reform Advocacy Trainings Call Advocates to Action

NMHA's Healthcare Reform Advocacy Trainings have offered technical support to state mental health coalitions for nearly seven years. Through collaboration with state and local affiliates, these trainings empower advocacy groups to effectively counter state legislative and regulatory policies that threaten access to quality mental health care. A summary of trainings held this spring follows:

Alabama—In March, the MHA of Alabama gathered stakeholders from across the state to develop strategies for strengthening their advocacy for comprehensive health insurance parity and children's mental health issues specific to all children's systems, services and supports (i.e., mental health, education, substance abuse and child welfare).

Tennessee—Also in March, the MHA of Tennessee convened a meeting with state mental health coalition members to address the need to secure adequate appropriations to shore up the state's public mental health system in the wake of shortfalls and gubernatorial efforts to reorganize Tennessee's Tenn-Care Medicaid program.

South Carolina—During April, the MHA of South Carolina met with representatives of the state's mental health coalition to examine national and states trends in mental health funding and community-based services. They also developed strategies for securing level funding for mental health services and for countering legislative efforts to restrict access to mental health medications.

Indiana—Also in April, the MHA of Indiana hosted a regional meeting of MHA executives to examine national and state trends in Medicaid managed care and the expansion of community-based mental health services under the Medicaid Psychiatric Rehabilitation Option.

Tarrant County, Texas—MHA of Tarrant County in April met with advocates representing state and local systems to examine national and state trends in justice systems, and to explore the needs of mental health consumers in justice systems. This training laid the ground for a comprehensive statewide meeting of mental health stakeholders organized by the MHA and slated to occur in May.

Montana—In May, the MHA of Montana will convene a meeting of state mental health coalition members to explore national trends and state strategies for influencing, developing and implementing *Olmstead* planning throughout the state.

If you anticipate problems regarding legislation or regulatory policy, or if you need to create or expand your mental health coalition, please feel free to contact us for assistance. NMHA is ready to help.

For more information, contact Terri Odom, NMHA's director of Healthcare Reform Training, at 703-838-7554 or todom@nmha.org. 



The *State Advocacy Update* is a quarterly publication of the National Mental Health Association's Healthcare Reform program.

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