National Coalition on Mental Health and Aging
Meeting Minutes
June 29, 2011

Alixe McNeill, Chair of the National Coalition on Mental Health and Aging (NCMHA) and representative of the National Council on Aging (NCOA) called the meeting to order and reviewed the proposed agenda. There were 20members present onsite and 10 via conference call. The meeting began with member introductions.

NCMHA Business

The minutes of the March 2011 meeting were adopted.

The slate for the NCMHA Executive Committee for 2011-2013 terms was approved. Executive Committee members will be: Chair: Alixe McNeill, National Council on Aging (NCOA); Vice Chair: Anita Rosen, American Society on Aging (ASA); At-large: Gail Hunt, National Alliance for Caregiving (NAC), Chris Herman, National Association of Social Workers (NASW), and Willard Mays, National Association of State Mental Health Program Directors/Older Persons Division (NASHMPD/OPD); Consumer Representative: Laurie Young, National Gay and Lesbian Task Force (NGLTF); State/local Coalition Representative: Kimberly Williams, Geriatric Mental Health Alliance of New York; and, Immediate Past Chair: Deborah DiGilio, American Psychological Association (APA). Alixe thanked the NCMHA Nominating Committee composed of Deborah DiGilio, Willard Mays, and Stephanie Reed for their efforts. Alixe also thanked Stephanie Reed, American Association of Geriatric Psychiatry (AAGP), for her great help and service as the Vice Chair and for her years of participation in the Coalition; Stephanie is retiring from AAGP.

Policy Update

James Finley, National Association of Social Workers (NASW) provided the policy update. He began by saying there is currently a strict "cone of silence" over the White House and Congress. To cut or not to cut Medicare is the big issue. One question is what happens to the Medicare Sustainable Growth Rate (SGR) 12-month extension which will expire at the end of this year. It will require over $300 billion to keep Part B practitioner fees at the current rate for the next ten years. The question is will the SGR be included in the Deficit Reduction Debt Ceiling Bill? Democrats want it to be included as they are worried that the provider payment rates will be cut if SGR is considered separately at the end of the year.

The depth of the Medicare cuts being discussed is huge - $600 - $900 billion range. They are saying no benefits will be cut, but that doesn't mean provider fees can't be cut. The Independent Payment Advisory Board (IPAD) is the new rate setting board for Medicare. It is a panel of experts that will make recommendations on Medicare fees for years to come. Many groups are very upset about IPAD and want it repealed. The HHS Secretary voiced strong support for it this week but Republicans see it

as the #1 cut to Health Reform that they want and many providers don't like it either. An NCMHA member raised the point that repealing IPAD seems incongruent with efforts to reduce the budget deficit. Jim concurred. He noted that he expects lots of legislative proposals when the debt ceiling issue arises in July.

Medicaid Changes in the Affordable Care Act (ACA): How Are States Preparing?

Joel Miller, Senior Director of Policy and Healthcare Reform, National Association of State Mental Health Program Directors (NASMHPD) started with the bad news that there are a lot of cross currents about Medicaid reformtoday: you hear different proposals from day to day. The Medicaid program is under siege. It's hard to keep track of the assaults but they can be devastating to public health mental health systems and to older mental health consumers. There are several federal budget proposals that want to disassemble Medicaid. For example, House Budget Chairman Ryan has proposed turning Medicaid into block grants. Other proposals outline massive spending cuts using a hatchet rather than strategically considering options.

We all need to advocate for a fair approach to spending cuts - not one that disproportionally hurts those with mental health issues. Medicaid has been the work horse of the health care system during this recession.

There is also a lot of good news related to Medicaid provisions in ACA. ACA will greatly expand access to health insurance including mental health care and substance use treatment primarily through individual mandate that requires most consumers to secure health coverage. In 2014, Medicaid will expand to 133% of the Federal Poverty Level that adds 16 million newly eligible beneficiaries. Private Health Insurance Exchanges also start-up in 2014 with projected results of 16.5 million people obtaining coverage through 2019. In terms of Medicaid benefits, the newly eligible will not receive regular Medicaid benefits instead the benefits will be modeled on private insurance packages. Mental health and substance abuse treatment benefits required of plans offered through Exchanges apply to the newly eligible. Within the Exchanges, currently mental health care and addiction treatment is included in list of essential benefits that must be covered in the new plans. However, the specifics of the essential benefits are still in question.

Under ACA, states have the option to provide newly-eligible Medicaid beneficiaries with a "benchmark" benefits package—typically more limited than traditional Medicaid benefits—rather than the full Medicaid benefit package. However, a traditional Medicaid benefits package is more appropriate for those with severe mental illnesses. The marked difference in service needs between those with mild/moderate and severe mental illness highlight key challenges states face in trying to develop benefit packages under reform. Out of 16 million newly eligible for Medicaid under ACA, 4-5 million have diagnosed mental health conditions. The message we need to bring is that mental health NEEDS to be defined as an essential, not an optional, benefit. Joel also stressed the importance of the rehabilitative services option available to states under traditional Medicaid (the "rehab option") in providing many services needed by those with severe illnesses. The flexibility allowed under this service category enables states to finance a range of psychosocial services, such as peer specialist counseling, family psycho-education, and supported employment.

If states do not plan well, there may be inconsistencies between what benefits are offered under the state Exchange, the Medicaid expansion, and traditional Medicaid. This inconsistent coverage will be problematic when individuals inevitably oscillate between the Exchange, the Medicaid expansion and traditional Medicaid qualifying levels. State behavioral health authorities (SBHAs) should encourage their state to coordinate planning of the Exchange and Medicaid expansion mental health and substance abuse treatment benefits to be consistent with one another and with traditional Medicaid. Consistency in benefits offered means a more dependable benefit for persons in treatment. This is

especially important for those with mental health and substance abuse disorders, as interruptions in treatment may disrupt recovery efforts.

In addition to a significant expansion in Medicaid eligibility, ACA gives states new authority to address behavioral health concerns within the Medicaid population through expanded "optional" Medicaid benefits, Medicaid waivers, and state plan amendments. Given the tough economic climate, some state Medicaid programs may be reluctant to expand benefits and programs offered under Medicaid. SBHAs should be prepared to offer data to state Medicaid directors on how the following opportunities for expanding Medicaid benefits could reduce costs and improve care.

Federal law requires state Medicaid programs to provide a mandatory minimum level of benefit coverage, such as inpatient hospital services and family planning services and supplies. In addition, states can elect to offer certain "optional" Medicaid services. There are 18 categories of optional Medicaid benefits, including diagnostic, screening, preventive and rehabilitative services ("preventive services"). Effective January 1, 2013, ACA expands the scope of optional "preventive services" under Medicaid to include, among other things, any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force. (Note: this is for *traditional* Medicaid, and does not apply to beneficiaries receiving benefits through the Medicaid expansion.) ACA also provides new opportunities to design service delivery to better meet the needs of Medicaid beneficiaries with mental health needs. There is potential for new service delivery models such as health homes to improve integration of care, a critical component of treating individuals with mental illness. The changes ACA makes to Medicaid home and community-based services will be pivotal to states covering important components of a recovery-focused mental health system and promotion of evidence-based practices. ACA established a new state option, effective January 1, 2011, that allows states to establish health homes for enrollees with chronic conditions, including mental health conditions. There is also the opportunity for improvements in Home and Community-Based Services that can support development of a recovery-based model of care, such as the 1915(i) state option that allows states to provide HCBS as a state option, rather than requiring them to obtain a federal waiver to provide such services (as in the past).

However, effectively serving newly-eligible adults with serious mental health needs calls for building capacity in the current mental health system. There is insufficient capacity and coordination in the current public mental health system to adequately serve the newly-eligible population with mental health needs. States are faced with key decisions about how their mental health programs, as well as other state agencies such as housing and criminal justice, will work in conjunction with Medicaid to meet the needs of newly-insured adults with mental illness.

Targeted outreach and enrollment may be necessary to reach newly-eligible adults with mental illness and substance use disorders. Under health reform, states are responsible for conducting outreach and enrollment to populations potentially eligible for Medicaid. Most of the newly eligible with mental illnesses—especially those with serious mental illness—will most likely be reached through their current mental health provider when they access services, rather than through general outreach campaigns.

Several challenges exist in transitions between sources of coverage for the population with mental illness. The low-income population is likely to experience fluctuations in income that will make a person's eligibility for Medicaid or Health Insurance Exchange insurance subsidies change over time. In Massachusetts, for example, the state found that 9,000 people (out of 1.3 million who participate in both programs) move between their Commonwealth Care program and the Connector each month. Individuals with mental illness might have a particularly difficult time with transitions between providers.

Medicaid expansion provides a window of opportunity to revisit coverage and payment policies and to implement strategies to promote high quality mental health care, including evidence based practices implementation. In terms of payment, ACA authorizes the Center for Medicare and Medicaid Innovation ("CMMI") to implement the Medicaid Global Payment System Demonstration Project. Under this demonstration, participating states will adjust the payments made to an eligible safety-net hospital system or network from a fee-for-service payment structure to a global capitated payment model. Per ACA, a demonstration project in five states was supposed to operate during fiscal years 2010 through 2012. However, ACA did not appropriate funding, and HHS has not announced that it will provide funding for this demonstration project.

The Medicaid Emergency Psychiatric Demonstration Project will study the effects of allowing Medicaid payment for the inpatient stabilization of a serious mental health related problem. Participating states would be required to provide Medicaid payment for inpatient stabilization for psychiatric patients aged 21 to 64 who express suicidal or homicidal gestures and are considered a danger to themselves or others. ACA directly appropriates $75 million for this demonstration project, to be distributed to states between October 1, 2010 and December 31, 2015. A demonstration project to evaluate integrated care around a hospitalization, will evaluate the use of bundled payments for reimbursing providers with respect to an episode of care that requires a Medicaid beneficiary to be hospitalized. The bundled payment will cover the entire episode of care, including the hospitalization and concurrent physician's services provided to a beneficiary during a hospitalization.

ACA also authorizes demonstration projects related to incentives for prevention of chronic disease in Medicaid demonstration projects. There will be grants to states to provide incentives to Medicaid beneficiaries of all ages who participate in prevention programs and demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors. CMS is currently inviting proposals from states to compete for grant awards under this program.

Joel further discussed the implications for older adults with mental illness. ACA could address funding issues for older adults with mental illness. Several provisions aimed at other demographic segments are applicable to older adults. We need to look at "Big Picture" and why ACA and changes in the larger health care system matter for older adults with mental illness. We need to be at the table for all of these very important changes that are going to be occurring.

Joel concluded by recommending what NCMHA member organizations can do to preserve ACA as NASMHPD and many others believe it is the best financing and funding hope for older adults with mental illness:

- Don't Get Hung Up on Medicare vs. Other Age Groups
- Remember 55-65 Age Group
- ACA Provisions have Remarkable Applicability Across the Board
- Monitor Developments
- Attend/Participate in State Planning Meetings
- Comment on Rules
- Meet with Legislators and Regulators
- Get Involved Politically

NASPHD is in process of developing resource management policies that can be distributed to states. There is also a lot of information available on its website, www.nasmhpd.org . For follow-up questions and further information, contact Joel at: Joel.miller@nasmhpd.org, 703-739-9333.

State Coalition Perspectives on ACA

Willard Mays (Indiana) commented that states are concerned about increasing fiscal burdens they face. They will need to look at cutting optional benefits, so the challenge will be seeing that mental health and substance abuse treatment benefits are not curtailed. He noted that Mental Health and Substance Abuse Treatment Block Grants from SAMHSA are now put into funding these services. When many ACA provisions are implemented in 2014, what will happen to the block grants? Will they still exist, if the premise is that folks will get covered services under ACA? This is worrisome especially as older adults are not explicitly listed in any of SAMHSA's current priorities.

Kimberly Williams (New York) noted that New York has one of the largest groups of Medicaid beneficiaries. Major changes are taking place already. There is now a global cap on Medicaid programs at $15 billion. Community mental health has been protected thus far. All of Medicaid is moving into managed care. Behavioral Health Organizations will be developed to work with the severely mentally ill but the problem is that it is not integrated with the physical health care system Utilization controls on mental health clinical services will probably reduce the number of visits covered yearly. Services provided offsite were going to be paid at a 50% increased rate but now these visits will be just for certain populations and older adults are not included. Home health services will also be moved into managed care, as will long term care. There is also expansion in the area of health homes.

Charlotte Kaufman (Illinois) noted that her state is also moving toward Medicaid managed care. They are waiting to see how the state will deal with Accountable Care Organizations (ACOs) and health homes. It remains to be seen if mental health agencies are going to have to work independently as health reform rolls out. Older adults are really being hurt. She also noted that the SAMHSA no longer include older adults as a targeted population.

Lila Starr (Iowa) added that the 2007 SAMHA Block Grant rule required that states report on the mental health status of older adults and state efforts related to mental health and substance abuse with older adults. This is the only vehicle that states currently have to report back to SAMHSA on the mental health needs of older adults. This is a very important source of data from which to make policy decisions and allocate funding, and we may be losing it.

State and Local Mental Health and Aging Coalition Survey

Kimberly Williams, of the Geriatric Mental Health Alliance of New York and the State /local Coalition representative of the NCMHA Executive Committee, reported on the survey she conducted. The purpose of the survey was: to identify new state and local mental health and aging coalitions; obtain updated information for existing coalitions; and identify details about their work including membership, structure, major activities, sources of funding, technical assistance needs, barriers, and interest in participating in the National Coalition.

Respondents were representatives from state and local mental health and aging coalitions, both active and inactive. The survey was disseminated via email to the NCMHA membership list and to members of the National Association of State Mental Health Program Directors' Older Persons Division. Participants were asked to complete an online survey and follow-up emails were sent to generate a higher response rate. Twenty-two states with 37 active state or local coalitions responded to the survey: California, Connecticut, Florida, Georgia, Hawaii, Iowa, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Maryland, Missouri, New Hampshire, New York, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Texas, and Virginia.

The vast majority of the coalitions have both individual and organizational members. Most coalitions have between 25-50 members. Coalitions serve both the entire state (17) and portions of states (22). Twenty respondents said that there were other local Coalitions that also serviced parts of their state.

Of the 26 respondents who said they have a leadership structure,that leadership consisted of: "Others" (18) primarily local health providers; mental health advocacy organizations (14); consumers and/or consumer organizations (12); and association for the area agencies on aging (11).

Their major coalition activities are: networking (33), education (30), training (25), advocacy (23), and hosting conferences (21). The most common source of coalition funding was "none." So, sustainability is a major issue. Funding sources were: other (12), state government (9), federal government (7), and philanthropic organizations (6). Twenty-four respondents said that they did not use Mental Health Block Grant funds to fund their activities and seven did. The coalitions' top five areas of need for technical assistance are: sustainability (26), advocacy (18), policy development and analysis (18), membership and recruitment (17); and mission, goals, plans and strategies (15). The respondents identified the following impediments to addressing the mental health needs of older adults: lack of financial resources (30), poor access to services, e.g., not enough services, lack of transportation (29), lack of integrated service (29); stigma, ageism, and/or lack of knowledge about geriatric mental health (28), and not viewed as a significant priority, particularly by their states (28). Fourteen respondents were not members of the NCMHA but all but one were interested in joining. Kim will work with the Executive Committee to determine next steps related to the survey.

The Geriatric Mental Health Foundation of New York is also going to use the information collected as part of its National State Based Advocacy Project. Its goals are to: develop geriatric mental health advocacy toolkit for mental health and aging coalitions; and provide education and technical assistance on how to develop and carry out an advocacy plan to mental health and aging coalitions in five states.

After these survey results, the lack of block grant funding was raised again by a state representative. It was also mentioned that it would be interesting to know the form of funding from state and local sources that some coalitions do receive.

It was mentioned that in the 1990's and early 2000's the AARP Foundation and NCMHA received grant funding to provide technical assistance to state and local coalitions and two handbooks were developed. Deborah DiGilio will look through the early NCMHA materials and share this information with Kimberly.

Member Updates

National Association of State Units on Aging (NASUA) - Rex O'Rourke & Sara Tribe explained that there was a huge turnover after the 2010 Elections of the administrators of state units on aging. Over 30 of their members left their state positions so the association is working with many new state administrators. They are conducting six trainings throughout country this year on topics including the mental health needs of older adults and people with disabilities. States have varying levels of interest in mental health and aging. In addition, two-thirds of their member agencies monitor Health and Community Based Services (HCBS) waivers. On September 17th they are planning a HCBS meeting.

American Psychological Association (APA) - Deborah DiGilio described plans for an AoA-APA webinar on addressing the mental health needs of family caregivers and using the APA Family Caregiver Briefcase (http://www.apa.org/pi/about/publications/caregivers/index.aspx) as a resource.

American Society on Aging (ASA) – Anita Rosen reported that there is a June 30th deadline for 2012 ASA/NCOA meeting abstracts. The Mental Health and Aging Network (MHAN) will do six sessions. NCHMA will do one session and is open for suggestions for presentation topics

National Association of State Mental Health Program Directors (NASMHPD) – Marcia Marshall announced that their SAMHSA/CMHS Community Support Resource Center will be closing at the end of this summer as funding will end. They provide technical assistance to the SAMHSA's 10 Targeted Capacity Expansion and Evidence Based Practices grantees.

The meeting was adjourned at 12:20 p.m.