MENTAL HEALTH WEEKLY
Essential information for decision-makers

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In This Issue...

The field is applauding the Obama Administration and HHS for issuing the highly anticipated final regulations that define the Mental Health Parity and Addiction Equity Act of 2008. Among its consumer protections, the final rule ensures transparency, and clarifies that parity applies to all plan standards, including geographic limits, facility-type limits, and network adequacy. Mental health groups say they remain committed to ensuring full implementation and enforcement.
. . . *See top story, this page*

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Final parity regulations open door to increased activity on enforcement front

Bottom Line...
Behavioral health organizations intend to educate members on parity regulations and work with local, state and federal officials to ensure enforcement.

The Obama administration's clarification of the long-awaited federal parity rule Nov. 8, and subsequent publication in the *Federal Register* on Nov. 13, has been applauded by members of the behavioral health community who vow to track enforcement efforts and to work with state insurance officials and members of Congress to preserve the intent of the law.

The final rule by the Departments of Health and Human Services (HHS), Labor and Treasury implements the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) and ensures that health plan features like co-pays, deductibles and visit limits are no more restrictive for mental health/substance abuse disorders benefits than they are for medical/surgical benefits.

The final regulation applies to individual and group health plan years beginning on or after July 1, 2014. The regulation doesn't apply to Medicare or Medicaid managed care or alternative benefit Medicaid plans. The Centers for Medicare & Medicaid Services (CMS) issued a letter Jan. 16, 2013, that provided guidance on the applicability of the

See **Parity** page 2

Rosalynn Carter Symposium on MH Policy

Symposium examines challenges, opportunities in ACA enrollment efforts

Bottom Line...
The Carter Center is making available actionable steps on its site in helping the field to work with mental health consumers in need of health care coverage through the ACA.

As government officials scramble to address glitches in the health insurance exchange, attendees at the annual Rosalynn Carter Symposium on Mental Health Law on Nov. 7–8 in Atlanta learned that increasing public awareness about expanded health coverage, forging relations with trusted sources and even redefining the mental health system are among the challenges and opportunities awaiting them during implementation of the Affordable Care Act (ACA).

The twenty-ninth annual symposium, an invitation-only event, attracted nearly 200 mental health professionals, providers, consumers and field leaders to address key components for the field in working (and making the ACA work) for consumers with mental health issues, enrollment and outreach, access, and service delivery.

Presenters included Arthur C. Evans, Ph.D., commissioner of the Philadelphia Department of Behav-

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federal parity law to Medicaid managed care organizations.

The regulation applies to nonfederal governmental plans with more than 100 employees, and to group health plans of private employers with more than 50 employees. States have primary enforcement authority over health insurance issuers, and states will be the primary means of enforcing the implementation of the MHPAEA.

"We were extremely pleased with the final rule," Chuck Ingoglia, senior vice president of public policy and practice improvement at the National Council for Community Behavioral Health (National Council), told *MHW*. "The regulators did a lot of work in analyzing [public] comment and conducted their own study."

The Affordable Care Act (ACA) applies the MHPAEA principle to the individual small-group market as well as to the Medicaid expansion and other benefit plans, Ingoglia said. But the final regulations do not apply to Medicaid plans, said Ingoglia. "We understand that CMS will offer further regulatory guidance. We hope so in order for people to be covered in the Medicaid expansion marketplace," he said.

The National Council appreciates the transparency standard in the final regulations, said Ingoglia. "The standard articulates in the parity language that mental health can't be managed differently than medical/surgical services," he said.

One of the past problems associated with the lack of transparency was having a plan document that would make those comparisons, he said. "The disclosure standard in the final rule will be very helpful in that regard," Ingoglia said. Going forward, consumers will be able to make decisions after examining the plan document to see if mental health and addiction were treated the way the law intended, he noted.

The National Council intends to work more broadly with other mental health and addiction organizations to share information and participate in joint meetings with insurance regulators, he said. The council will also educate its members about how to report parity violations, he said.

The Association for Behavioral Health and Wellness (ABHW) said it appreciates the clarity in the final rule, particularly concerning state and federal parity laws, said Pamela Greenberg, ABHW president and CEO. "If a state parity law gets in the way of complying with the federal law, the state law would go by the wayside," Greenberg told *MHW*. "We already knew that, but we appreciated the clarification."

Greenberg said that the ABHW had not been happy with one previous element of the interim final rule (IFR) related to the Non-Quantitative Treatment Limitation (NQTL). The IFR had a clause allowing exceptions to be made along with the established clinical rationale. The exception clause has now been removed from the final parity rule, Greenberg said.

"We are disappointed that the rule omitted the exception clause but are somewhat comforted by the rules stating that clinically appropriate standards of care can still be taken into consideration when determining parity in NQTLs," said Greenberg. Additionally, parity in NQTLs is not determined by a mathematical test, per the final rule, she said.

Greenberg said ABHW had expressed an interest in having the regulatons allow for tiered networks as long as they were developed on par with medical tiered networks. Tiered networks may have different co-pays to reflect a difference in providers in such areas as quality, performance and consumer feedback. "Tiering is allowed as long as it's not discriminatory between mental health and addiction," Greenberg said.

The timing of the final regulations also works, she said. Although the rule does not go into effect until July 1, 2014, or later, for most people it will begin Jan. 1, 2015, Greenberg

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said. "We do have time to figure this out and make sure we understand it so we can implement it," she said.

Enforcement needed

"If people have concerns about anything, it is about enforcement of the rule," William Emmet, program director of the Kennedy Forum, told *MHW*. "The first line of enforcement is at the state level. We've seen through the implementation of the ACA just how varied states are."

Emmet added, "It's always been the case that most states had fairly lax enforcement capabilities when it comes to health insurance. What we want to do is identify states where enforcement is lax and make sure HHS and the Department of Labor are aware of any barriers [that exist to] enforce the rule and the law."

"I think the new rule does a very good job of requiring criteria for medical necessity determinations to be available to anybody who asks for them," Emmet said. "It has to be done within a certain amount of time. It's a real process for insurers to make that information available."

There is also more transparency in the final rule, he said. "A lot of people find out why they may have been denied," said Emmet.

'I think the new rule does a very good job of requiring criteria for medical necessity determinations to be available to anybody who asks for them.'

William Emmet

National Association of State Mental Health Program Directors (NASMHPD) members will be working with insurance commissioners who have general responsibility in enforcing the regulations, Robert W. Glover, Ph.D., executive director of the NASMHPD, told *MHW*. "We want to make sure our members have a viable relationship with insurance commissioners."

The next steps are to review the regulations and assess other states' experiences, said Glover. The NASMHPD intends to learn more about which states are doing well in parity implementation, like Oregon, and inquiring about lessons learned, he said. The association also intends to work with the CMS and other entities, he added. "We're thrilled that the final regulations have come to fruition," said Glover. "It opens the door for millions of people to access coverage."

"There is a general understanding that the laws are not self-actualizing," added the National Council's Ingoglia. "We intend to work with the Parity Implementation Coalition, the Coalition for Whole Health and state associations around the country for the enforcement of parity." •

To view the final rule, visit https://s3.amazonaws.com/public-inspection.federalregister.gov/2013-27086.pdf.

Two N.M. BH agencies to repay state for Medicaid overbilling

In the latest turn of events involving a New Mexico audit over the summer alleging 15 behavioral health organizations of Medicaid fraud, followed by subsequent payment suspensions, two of those agencies have agreed to pay the state $4.2 million in behavioral health funding alleged to have been improperly billed to the Medicaid system.

The New Mexico Human Services Department (HSD) announced Nov. 4 that Presbyterian Medical Services (PMS) and Youth Development Inc. (YDI) have received the lift on their pay-holds after agreeing to pay back the overpayment amounts. Presbyterian will repay $4 million and YDI will repay $240,000. Both of the agencies are severing ties with TeamBuilders Counseling Services and its various corporate and non-profit affiliates.

Bottom Line...

The settlement agreement for the two agencies will include training and technical assistance to staff at each company, including assistance in developing new performance measures.

The state audit, released June 24, alleged that 15 of New Mexico's largest behavioral provider organizations — who provide care for 90 percent of the state's population with serious mental illness — overbilled the Medicaid program $36 million over a four-year period ending in 2012 (see *MHW*, July 15).

PMS and YDI were among the behavioral health organizations with the most serious or numerous whistleblower complaints against them, HSD officials said in a release. The complaints included allegations that, in other companies, employees were told to intentionally upcode services as a means of siphoning extra money out of the Medicaid system, told to bill for services never provided, or told to obstruct the reporting of critical incidents to proper authorities and regulations, according to release from HSD.

Following the audit release, N.M. health officials hired five Arizona behavioral health firms to take over

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management of the 15 organizations.

Attorney General Gary King released part of the audit that led to the upheaval in the state mental health system, local news reported Oct. 18. However, virtually all specific information about the 15 New Mexico providers that were audited was blacked out in the audit pages.

New training, oversight

Both PMS and YDI will be subject to intensive new training and oversight of its management until billing and management systems are fully operational and determined to be sound, according to HSD officials.

Both agencies will continue to provide services to their clients, though Valle del Sol will provide temporary oversight of Youth Development Inc. La Frontera, another community-based mental health center, will provide temporary oversight of PMS.

Among other tasks, Valle Del Sol and La Frontera will train and provide technical assistance to staff members at each company, ensure program compliance with state and federal laws and rules, require accurate and timely billing (including pre-submission review of claims), and assist in development of new performance measures.

Valle Del Sol's cooperative effort with YDI includes training behavioral health staff and management on promising best practices for fiscal and programmatic rules and regulations, said Carlos Galindo-Elvira, chief development officer at Valle Del Sol.

"Valle Del Sol of New Mexico has operated since September 13, 2013 under a Memorandum of Understanding (MOU) with Youth Development, Inc. on a temporary basis to provide technical assistance to ensure compliance with state and federal mandates on billing/claims for reimbursement," Galindo-Elvira told *MHW*.

He added, "We work hand-in-hand with YDI to ensure billing errors are minimized and identify areas of improvement. Other areas of assistance include measuring error rates for billing and documentation of services provided." The length of organization's MOU is 45 calendar days with an option for renewal by both parties or as instructed by the New Mexico Human Services Department, said Galindo-Elvira.

YDI response

YDI officials issued a statement announcing the settlement agreement after having worked for four months with HSD on the audit that had been conducted by Public Consulting Group, a Boston-based consulting firm.

'We work hand-in-hand with YDI to ensure billing errors are minimized and identify areas of improvement.'

Carlos Galindo-Elvira

The $240,000 amount settled for is for 8 percent of the amount billed over the last three years, YDI officials said in its statement. According to the U.S. Government Accountability Office (GAO), the national average claim failure rate is between 3 percent and 9 percent, officials stated. "We are working diligently with the state and Valle del Sol to improve to our behavioral health systems in order to reduce that rate to zero," they said.

According to the statement, YDI officials said they did not fully agree with the processes employed by the state and PCG. "Seeking resolution, YDI fully cooperated with HSD in this matter and continued to provide services while payments to it were suspended," they stated. "In the interest of resolving all differences between YDI and HSD amicably, and in order to avoid the time, trouble, expense, delay and uncertainty of the time litigating this matter we believed this was the most prudent path for YDI to take."

Matt Kennicott, spokesperson for the New Mexico Human Services Department, told *MHW* that Presbyterian Medical Services and Youth Development, Inc. are the only two agencies cited in the audit so far to have agreed to pay the state back.

Kennicott said that OptumHealth, which oversees the state's managed care system for behavioral health, tracks consumers being served. "They have not seen a drop-off in the consumers being served," he said.

The state's attorney general's office is still investigating, said Kennicott. The new announcement involving the two agencies has no bearing on the continuing criminal investigation being conducted by state and federal authorities into the conduct of all 15 companies that were audited, said HSD officials. •

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ioral Health and Intellectual DisAbility Services; Joe Parks, M.D., chief clinical officer of the Missouri Department of Mental Health; Steven S. Sharfstein, M.D., president and CEO of Sheppard Pratt Health System; and U.S. Health and Human Services (HHS) Secretary Kathleen Sebelius, who announced the government's release of the long-awaited and detailed regulations about the federal parity law.

The Affordable Care Act is instrumental in establishing behavioral health coverage within the healthcare system, Joel Miller, executive director and CEO of the American Mental Health Counselors Association (AMHCA), told attendees. The expanded healthcare marketplace is resulting in a number of changes in how mental health is delivered in the United States, said Miller. "What

better way to dramatically reduce stigma?" he noted.

About 13.5 million adults with mental illness are eligible for health insurance coverage through the Medicaid expansion or the new state health insurance exchanges, said Miller.

"The trickiest part is how to do a good job of deploying the mental health workforce," said Miller. "We're going to need the entire workforce working together if [the ACA] is to be implemented appropriately. There'll be plenty of business to go around for every mental health practice."

Miller added that promoting cross-training of the workforce, adopting evidence-based practices and building a diverse workforce are essential, he said. Many people see a primary care physician for coordinating their mental health conditions, he said. "Maybe primary care physicians are not quite ready for the influx of consumers as a result of the expanded coverage," he said.

There are four kinds of operatives leading to high-quality affordable health care: coverage integration, access service infrastructure, delivery integration and quality improvement, Miller said.

Miller told attendees to think about doing a better job of redesigning and redefining the mental health system. "You should also [examine] lessons learned and best practices that work in developing a better way to deliver integrated care," he said.

"The coverage expansion provision in the ACA is transformative by its very nature for people with mental health conditions," he said.

Miller encouraged attendees to make sure they are "rolling up their sleeves," sitting at the table and working with coalitions to ensure that enrollment is occurring. "Healthcare reform is mental health reform," he said.

Coverage concerns

There have been improvements in part about getting into coverage, but the ACA is a leap compared to all those things. Coverage remains a consistent problem with people who do access care, said Kevin Malone, analyst in the Office of Policy, Planning, and Innovation at the Substance Abuse and Mental Health Services Administration (SAMHSA).

Open enrollment is essential, Malone said. "If we don't act right now, this chance will pass us by and we will be leaving people out in the cold," he said.

Tapping into strategic partnerships with organizations such as SAMHSA and the National Alliance on Mental Illness (NAMI) is key to making sure that the uninsured get the message that coverage is available, said Jessica Kendall, MPH, outreach director of Enroll America, a nonpartisan organization looking to maximize the number of uninsured Americans who enroll in health care coverage made available by the ACA.

Kendall pointed to some success stories, noting that Oregon has already reduced its uninsured population by 10 percent and Arkansas by 14 percent, she said. "We can always do better," she said. The field can help consumers through the process, such as by volunteering at call centers and helping consumers fill out paper applications, if online problems persist.

Even having voice-mail messages telling them about the application process, where to go and that coverage is available, rather than having callers listen to music on the other end, can help, she said. "It's not just about finding them; it's about keeping them enrolled," she said.

"The Essential Health Benefit must include mental health and substance abuse disorders at parity," said Ron Manderscheid, Ph.D., executive director of the National Association of County Behavioral Health and Developmental Disability Directors, during his presentation on service access. "That's a major change for us."

Service organizations will change from separate specialty services to integrated health homes and medical homes, he said. "Service quality assessment will assume much more importance," Manderscheid said.

Public health approaches will also become important, said Manderscheid. "Population and community interventions will become commonplace to facilitate prevention and promotion," he said. Additionally, behavioral healthcare and public health representatives will work together, he said.

'In states that do not expand Medicaid, people with the greatest need will have nothing.'

Howard H. Goldman, M.D., Ph.D.

Medicaid expansion

To date, 25 states have opted for the Medicaid expansion under the ACA. "In states that do not expand Medicaid, people with the greatest need will have nothing," Howard H. Goldman, M.D., Ph.D., professor of psychiatry at the University of Maryland School of Medicine, told attendees during a dinner conversation at the symposium.

Long-term care services, supported services and a universal system of rehabilitation services are important components of a specialized behavioral health system, he said. "We need to keep our eye on things we're at risk of losing if we don't pay attention," Goldman said.

Goldman explained that sup-

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ported employment and other wrap-around services that can be implemented with the ACA were programs the field had wanted to do for a long time but could not do in Medicaid.

Healthcare reform

"We need to have a system of comprehensive services that cut across silos to address all issues, such as acute care and cardiovascular disease," said Kenneth Thorpe, Ph.D., Robert W. Woodruff Professor and chair of the Department of Health Policy and Management at Emory University. "We need to do a better job of working with and providing better-quality care to patients."

In responding to a question about how hopeful he is about Accountable Care Organizations (ACOs) and patient homes and the efforts by those service delivery initiatives to drive down costs, Thorpe noted that there are thousands of pilots that currently exist. It may take from five to ten years to figure out the results of these various pilot programs, he said.

"We need to have a sense of urgency to implement best practices," added Thorpe. "We have so much existing data on things that work; we need leadership to put those things in place."

Goldman noted a number of "well-bred" models that currently exist to treat depression and other mental health disorders. Mental health workers, nurses, social workers, psychiatrists and others need to engage in working collaboratively in hospitals and manage their work with patients, he said. "We need to find some way to working to build better integration between providers and health systems and hospitals," said Goldman. Peers are an important way of expanding the workforce, he said.

In response to a question from Andy Miller of *Georgia Health News* about how the ACA fits in with the parity movement, Goldman said it was impressive to see fundamental reform and incremental changes.

However, he expressed concerns about pilot projects that can be delayed from five to ten years. "My frustration is with pilot delays for a decade until we see results," he said. "We have great models of healthcare delivery. We need to change our mentality from piloting to implementation." •

Data program to help Fla. providers improve care, reduce costs

A behavioral health data analysis program is poised to help Florida community mental health providers define, measure and analyze more effectively the care they have been providing, with an ultimate goal to improve patient access to services and lower overall operating costs.

The Florida Council for Community Mental Health (FCCMH) and Netsmart, a national provider of clinical solutions for health and human services organizations, announced Nov. 5 a first-of-its-kind initiative that will enable the FCCMH to analyze aggregate de-identified data from its provider members across the state and identify cost, productivity and outcomes in real time.

The product, Enlighten Analytics, is an interactive behavioral health business intelligence platform developed by the Centerstone Research Institute (CRI). It captures and reports outcomes and other data in simple-to-interpret charts and graphs, effectively turning the massive amounts of complex data collected by providers into meaningful, actionable information, say Netsmart officials.

'It is a very worthwhile expenditure, which is why our providers will do it. They understand this from a business standpoint.'

Bob Sharpe

To date, nine of the FCCMH's 60 member agencies have already signed up to participate in the program, which will allow the program to be deployed at each of the participating agencies to drive efficiencies and productivity. Results of the ongoing analysis will be used by providers to detect trends, identify patient needs and develop effective treatment programs.

"The nine agencies will be uploading real-time data into their practice," Bob Sharpe, president and CEO at the FCCMH, told *MHW*. Florida providers typically do not have enough information about their services, the populations they serve and data about the outcomes they're receiving — all of which served as an impetus for this new partnership, Sharpe explained.

Sharpe said that there has also not been a university or some other entity that would step in to help fill in the data gaps that they have as a provider group. "I want to get all [providers] reporting data using Enlighten Analytics as a database," he said.

The analysis program will enable providers to manage their clinical operations and overall outcome measurements, he said. The goal is to get at least 20 FCCMH member agencies on board in the first year, and ultimately all of the FCCMH members, added Sharpe.

The program can enable Florida state agencies to retrieve key information on the population served, what type, what the costs are for funding the services, and, more importantly, what they accomplish by providing care, he said. "Are we cutting down on hospital readmissions?" he noted. "Are we shortening the length of time [patients] are in state hospitals?" The analysis can also help pinpoint the numbers of consumers with mental illness who are employed, for example, he said.

Sharpe added, "This involvement also serves as a way of advocating for additional funding." Funding for state community mental health services continues to be a problem, said Sharpe, noting that Florida ranks 49th in per capita mental health spending.

The information culled from the data analysis program can help both the state legislature and Gov. Rick Scott "feel confident" about investing more in community mental health services, said Sharpe. "It is a very worthwhile expenditure, which is why our providers will do it. They understand this from a business standpoint. We expect a lot from this effort," he said.

There is a one-time fee and an annual subscription fee for providers who purchase the program, said Sharpe. "It's priced well," he said. "You really can't put a price tag on your ability to manage your agency and report to others about what you're doing. Our provider group understands that." Some of the providers who have signed on are currently in the setup phase, he said. "It's been a pretty quick start-up," he said.

Empowering agency leaders

One of the key goals of the new partnership is to empower leaders of the agencies in the Florida council to be able to analyze information across clinical, operational and financial domains, said Scott Green, vice president and general manager of Netsmart's Care Pathways program. Providers will be able to look at revenue trends, for example, and identify various types of performances at different member agencies, he said.

"Most clients use data [based on information] from a minimum of one-month to two- to three-month lag time," Green told *MHW*. "They're reacting after the fact." This program will allow them to analyze the data in real time and take action in a timely manner, he said.

The council has set its designs on being able to look across clinical and operational domains and examine the cost of care being delivered for special populations across the state, said Green. "This is a unique first partnership where a group of agencies, like the FCCMH, allow council members to look at an aggregate data set with a powerful business tool," he said.

Green added, "Having an aggregate view of clinical, financial and operational data from across different client sites for council members also makes this very unique." Additionally, part of the appeal for the use of the program, he said, is due to peer-sharing opportunities among council members. "They can share best practices and turn those [practices] into research-based initiatives," he said.

The program is not just about harnessing data, said Green. It's about examining it and shifting the trajectory of care using Enlighten Analytics data and seeing if outcomes are appearing in a particular part of the state, for example, or an agency, and capturing the reason behind the shared information, he said. •

Carter symposium emphasizes forging new alliances

As the troubled rollout of the Affordable Care Act's (ACA's) online marketplace continues, there's a lack of knowledge and infrastructure in place for enrolling and engaging consumers, said David Shern, president and CEO of Mental Health America (MHA), in summarizing some of the common themes to emerge at the Rosalynn Carter Symposium on Mental Health Policy (see story beginning on page 1).

For example, consumers need to learn more about navigators that are being deployed around the country to help them in enrolling in health insurance plans under the ACA. "We have an extremely complicated health system, which points to lots of possibilities about doing the job more effectively than we had in the past," Shern told attendees.

The enrollment and engagement process requires people to understand features of the ACA, he said. "Individuals are kind of distrustful of the federal government," said Shern. "The goal is to enroll them and keep it simple and straightforward. Go where people are and play on trusted relationships."

Using peers is another trusted source in helping consumers with enrollment, said Shern. "We really need to think about champions and new alliances. The field needs to also embark on a strong, shared interest with the insurance industry."

Creating a sense of urgency and increasing public awareness are important, said Shern. "Think of people you might not think about as allies in moving forward in the engagement process," he said. The media could become another trusted resource in communicating plans, he said.

One of the working groups discussed changing the term "medical necessity," which implies acute care, to "health necessity," which encompasses overall care, said Shern. "We need to think systematically about prevention and intervention," said Shern. "We want to have an inclusive service system that broadly supports our science base."

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Developing recommendations

Organizers of the symposium split the attendees into four groups to develop actionable recommendations in the areas of enrollment and outreach, access and service delivery. The Carter Center intends to publish the final recommendations on its website, www.cartercenter.org, within the next couple of weeks, along with a complete webcast of the symposium, said Lei Ellingson, associate director of the Carter Center.

"The groups discussed capitalizing on existing relationships in order to encourage consumers to sign up for health insurance coverage, particularly with organizations already working with mental health consumers, such as peer-run organizations, faith-based groups and charitable organizations," Ellingson told *MHW*.

The Georgia Department of Community Health (DCH), for example, is currently developing an online system so that if consumers sign up for Medicaid, they will also be pointed to other services they may be eligible for. "They won't have to contact the DCH all over again in order to sign up for other programs. They would be able to do it all on one site," she said. "That would be very helpful."

People looking for housing go to local Housing and Urban Development (HUD) offices and area agencies, Ellingson said. During that time they could hear more about health coverage opportunities, she said.

Ellingson said one idea that came up in all of the working groups was the need to reach out to young, healthy adults. "The groups pointed out that the idea of prevention doesn't necessarily resonate with young people," Ellingson said. "They don't think about being 50, 60 years old or older."

Ellingson noted that young people do not typically resent having to pay Social Security and having it taken out of their salary. "The thought is that something like that could become sort of a routine with [health plan premiums]," she said.

"There was no real consensus about how to enroll young people," said Ellingson. "We've got to change the message; it cannot just be about prevention."

"This was a very optimistic, upbeat symposium," said Ellingson. "It's not a cure-all." Carter Center officials sent surveys to participants in order to gauge their response to the symposium and determine what type of role the Carter Center will play going forward. Also, the center would like to learn from participants if they made connections with other participants or plan to embark on new activities, noted Ellingson. •

Coming up...

The **Department of Child and Family Studies at the University of South Florida** will host its 27th Annual Children's Mental Health Research & Policy Conference **March 2–5, 2014** in **Tampa Fla.** Visit **http://cmhconference.com** for more information.

The **Anxiety and Depression Association of America** will be holding its Anxiety and Depression Conference 2014, with the theme of "Personalized Treatments for Anxiety and Mood Disorders," **March 27–30, 2014** in **Chicago**. For more information visit **www.adaa.org/conference**.

State News

Wisconsin health care advocates question gov. on Medicaid cuts

Wisconsin health care advocates want Gov. Scott Walker to say what will happen with 77,000 adults being shifted off Medicaid in January if they are not able to get coverage through the new health insurance exchange in time, the Associated Press reported Nov. 8. Walker opposes the federal health care overhaul law, which relies on the exchanges to increase coverage for people who don't get insurance through their jobs or government programs. Like most governors, Walker chose to have the federal government run the state's exchange. Advocates ask Walker to spell out his contingency plans if enrollment on the exchange continues to be difficult or if the federal government creates conditions under which Walker's plan can't be implemented.

In case you haven't heard...

The National Eating Disorders (NEDA) is applauding Abercrombie & Fitch's decision earlier this month to expand its clothing line to include larger sizes. The upscale clothing manufacturer's move follows a major outcry — and declining profits — after a 2006 comment from CEO Mike Jeffries was widely recirculated in the media earlier this year, saying that the upscale clothing chain catered only to "cool" and "attractive" kids. A Change.org petition, launched by NEDA's Proud2Bme teen ambassador Benjamin O'Keefe, 19, who has suffered from an eating disorder himself, calling for the retailer to "stop telling teens they aren't beautiful and to make clothes for teens of all sizes," generated more than 80,000 signatures. NEDA, O'Keefe and other teen activists met with A&F executives to discuss the company's "hurtful and discriminatory" comments and to ask for change. The news also inspired an extensive and ongoing boycott by consumers, and garnered support from Ellen DeGenerese and Kirstie Alley.