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Unlocking Transformation and Healing: Cost Policy Options for Accessible Youth and Young Adult Mental Health Care

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CLASP
Policy solutions that work for low-income people

Unlocking Transformation and Healing: Background

The Center for Law and Social Policy's (CLASP) youth and young adult mental health framework calls for policy change that increases access to healing, transformative mental health supports for this population.[1] Through our Policy Advancing Transformation and Healing (PATH) initiative, CLASP collaborated with partners over 2019 and 2020 to test this framework, advancing systems and policy changes that support transition-age youth and young adults (ages 16-25). **We identified a set of policy options with broad applicability and strong potential to increase access to transformation and healing for economically marginalized youth and young adults.**

Today, too many young people can't get the mental health care they need.

The challenges that nearly 1.1 million young people experience obtaining mental health services are the result of decades of failed policymaking. Policy choices have created barriers to affordable care for youth and young adults with low incomes, by disproportionately limiting their access to health insurance coverage. In addition, policymakers have codified reimbursement practices that make it difficult to meet young people's needs.

This brief details several policy options to increase the affordability of care by first examining how states can improve health insurance coverage rates for youth and young adults, and then identifying strategies for better reimbursement practices. Our recommendations focus on expanding Medicaid coverage for youth and young adults; advancing better billing models; ending carve outs of behavioral health in Medicaid managed care; and doing more to support mental health parity in Medicaid. Throughout this brief, we are including substance abuse both when we refer to mental health and behavioral health.

Permanently Increasing Health Insurance Coverage Rates for Young Adults

Health insurance coverage is a prerequisite to affordable mental health care. Youth and young adults have made substantial gains in health insurance coverage since the implementation of the Affordable Care Act (ACA). The law made health insurance coverage available for the first time to many young adults living in poverty. A record number of young adults have affordable health care thanks to two major changes under the law: most states expanded access to Medicaid, and the ACA allows young adults to remain on their parents' insurance until age 26. But coverage gaps remain. Young people, and particularly young people of color, still experience higher uninsured rates than other people in America. The policy options that follow outline how states can close these gaps for youth and young adults.

Medicaid Expansion: Key to Closing Coverage Gaps for Young Adults

One of the most popular provisions of the ACA allowed young people to stay on their parents' private insurance until age 26. For low-income young adults whose parents do not have employer-sponsored coverage or cannot afford to enroll their adult children in their health plan, Medicaid expansion offers a parallel support. Under Medicaid expansion, states receive an enhanced federal match rate for providing health insurance coverage through Medicaid to individuals with incomes up to 138% of the Federal Poverty Level (FPL). To date, all but 14 states have expanded Medicaid.[2]

The 14 states that have not yet expanded Medicaid under the ACA significantly contribute to persistent inequities, despite improvements in young people's coverage overall.

The uninsured rate for young adults age 19-25 is still unacceptably high. In 2018, 14.3 percent of 19-25 year-olds were uninsured, almost twice the population national average of those without coverage of 7.9 percent.[3] Further, there are significant disparities by race and ethnicity among young people who lack insurance, including:

Nearly **1 in 3** Native Hawaiian and Pacific Islander young people **(29.4 % uninsured)**

More than **1 in 5** Hispanic young people **(21.6% uninsured)**

Nearly **1 in 5** Black young people **(18% uninsured)**

1 in 6 Native (American Indian/Alaska Native) young people **(16% uninsured)**

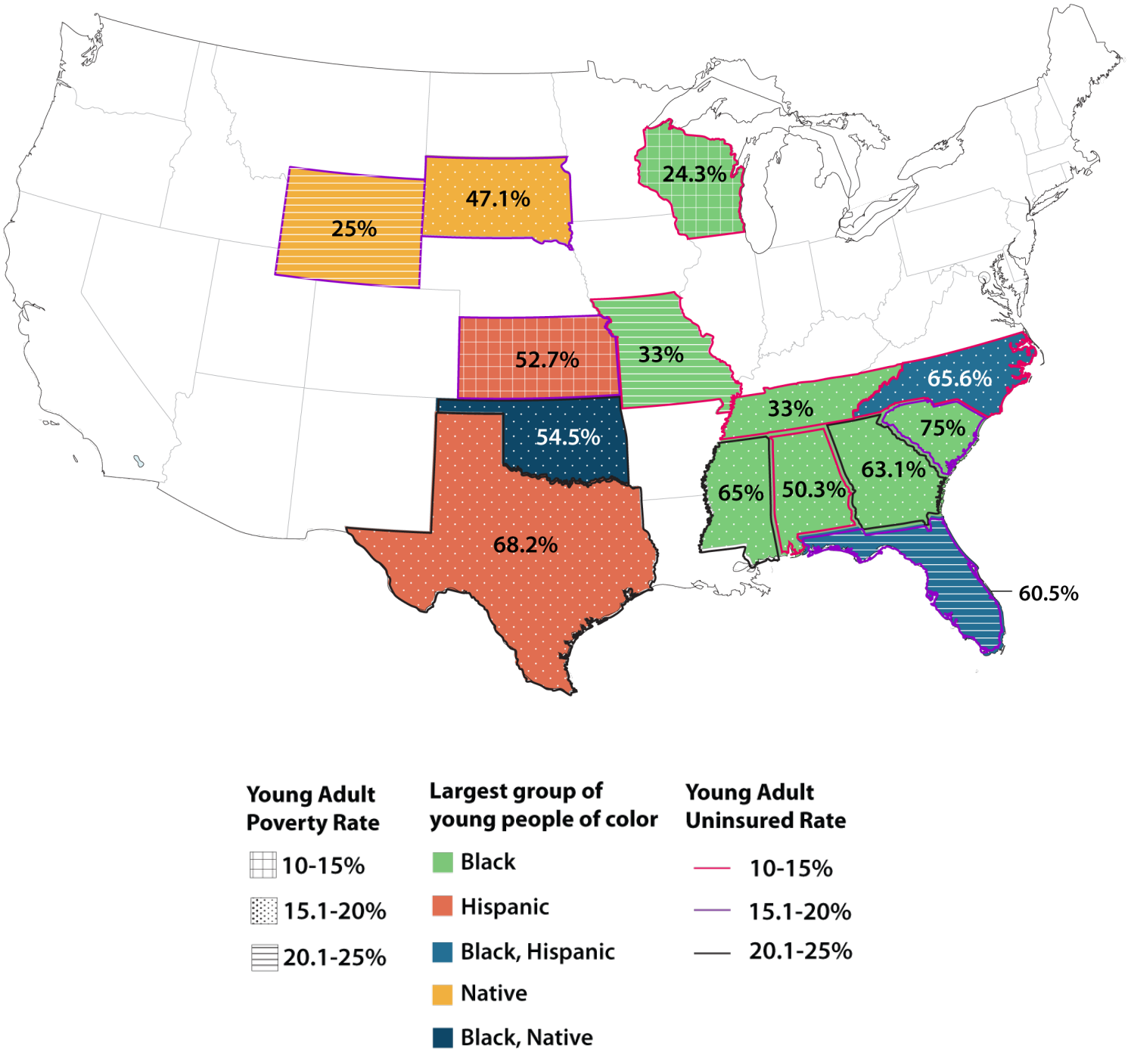
Nearly **1 in 9** Asian American young people **(11.4% uninsured)**

1 in 10 white young people **(10.3% uninsured)**

Nearly all states that have yet to expand Medicaid are in the South or Midwest, and many have large numbers of young adults of color. Most of these "holdout" states—all but three—also have young adult poverty rates above the national average of 15.3 percent. In all 14 states, at least one in four of the young adults living in poverty is a person of color; in some cases, youth of color make up well over half of a state's population of all young people in poverty. All 14 states also have a rate of uninsured young adults nearly two to three times higher than the rate of Americans lacking coverage overall.

Rate of Young Adults in Poverty and Who Lack Health Coverage in States that have Not Expanded Medicaid

** Percentages represent the proportion of Young adults <100% FPL who are people of color*



In 2018, in states without Medicaid expansion, more than one in three adults living in poverty were uninsured (35.6 percent). This was more than twice the rate of those living in states that had expanded Medicaid, at just over one in six adults (16.9 percent).[4]

Medicaid is the principal pathway to health insurance coverage for young adults, and especially for young adults of color. Among young adults, 18.3 percent who have insurance are enrolled in a public program. This is a higher percentage of public health insurance than any other age group, except children under 19 and adults over 65.

When broken down by race and ethnicity:

33.5% of insured Native young adults have Medicaid

28% of insured Black young adults have Medicaid

27.4% of insured Hispanic young adults have Medicaid

21.9% of insured Native Hawaiian/Pacific Islander young adults have Medicaid

16.7% of insured Asian young adults have Medicaid

16.2% of insured white young adults have Medicaid

All states must expand Medicaid to close persistent and pervasive gaps in health insurance coverage for youth and young adults. Financially, young adults ages 18 to 25 are just beginning to establish themselves in work and careers. Youth and young adults in low-income households are much more likely to be working in part-time, low wage jobs. Their employers are less likely to offer health insurance. When health benefits are offered, they are less likely to be affordable to young people working to establish themselves and maintain an independent household.[5] Until all states expand Medicaid, young adults will continue to experience significant and inequitable coverage gaps.

Equitable Medicaid Expansion Means no Red Tape

> **Burdensome paperwork requirements in states that have expanded Medicaid also contribute to inequities facing young adults in general and young people of color specifically.**

As more states have expanded Medicaid under the Trump Administration, they have often coupled expansion with waiver requests that include barriers to coverage. Such hurdles include:

- work requirements,
- cost-sharing, and
- limiting expansion to individuals earning less than the federally allowed income limit of 138% FPL

(or $17,609 for a single individual).

The red tape requirements included in these proposals are likely to pose particular challenges to young adults. In early adulthood, young people are in a unique developmental period that requires negotiating challenges and establishing independence across a range of life domains.[6] In many cases, emerging adults are also learning, for the first time, how to navigate the health system on their own.[7] To young people, excessive paperwork requirements can act as a major barrier to accessing needed services. Developmentally, young adults have a lower frustration tolerance and are still developing their executive function capacity; as a result, they are more likely to forego services that they are entitled to when confronted with such obstacles.

Waiver proposals that contain onerous paperwork restrictions undermine the health and mental health of vulnerable young adults. Such barriers are not developmentally appropriate and do not acknowledge the existing challenges associated with the transition to adulthood. **States that expand Medicaid must do so without onerous red tape for youth to access coverage.**

Closing Coverage Gaps Requires Coverage for Immigrant Youth

> **Policies that bar Medicaid coverage for large groups of youth and young adults because of their immigration status also maintain health inequities.**

Federal policy barriers keep the following communities from Medicaid coverage:

- Lawful permanent residents, who do not become eligible for Medicaid until they have been in the U.S. for five years (known as the "Five Year Bar");
- People in certain immigrant communities who have been barred from accessing Medicaid in agreements between the U.S. and their home countries, such as some Pacific Islanders, known as Compact of Free Association Migrants; and
- The 1.65 million undocumented youth and young adults[8] who would otherwise be eligible for Medicaid,[9] including nearly half a million young people who have been given relief from deportation under the Deferred Action for Childhood Arrivals (DACA) program.

Some states attempt to fill this gap by using state dollars to provide coverage to immigrants otherwise ineligible for the program. For example, California uses state funds to provide MediCal coverage (its Medicaid program) to immigrants who do not meet federal Medicaid requirements. However, this strategy is the exception—not the rule.

Unless states invest in providing paths to health coverage to immigrant youth and young adults currently excluded from Medicaid, including undocumented young people, coverage gaps in their communities will remain intractable. **Policymakers must end Medicaid limits tied to immigration status so all youth can access needed care.**

Advancing Medicaid Access is a Critical State Strategy to Improve Mental Health Access for Young People

Since Congress passed the ACA in 2010 more than 20 million Americans have gained health insurance coverage.[10] Among them are a significant number of young adults, whose insured rate increased from 65 percent in 2013 to more than 85 percent in 2018. We can do more to close the remaining gap and realize universal health coverage for youth and young adults. Health insurance is key to improving their access to care and ability to achieve better mental health. State policymakers must take advantage of all available tools, including advancing full Medicaid Expansion and seeking positive changes to their Medicaid

programs, to best support coverage for this population.

Temporary Medicaid Access through Presumptive Eligibility

Until we achieve universal health coverage, one promising strategy to insure more youth and young adults is to expand and aggressively implement Medicaid presumptive eligibility policies.

> **Presumptive eligibility (PE) and hospital presumptive eligibility (HPE) allow individuals to temporarily enroll in Medicaid coverage based on the presumption that they are eligible for coverage.**

Those who qualify receive covered health services without delay and are encouraged to apply for permanent coverage. Presumptive eligibility ends when permanent coverage has been approved or denied, or the time frame for presumptive eligibility has expired.

Overview of Presumptive Eligibility (PE) and Hospital Presumptive Eligibility (HPE)

HPE and PE	PE	HPE
• Allow individuals to temporarily enroll in Medicaid coverage based on the presumption that they are eligible for coverage. • Coverage is usually provided for a maximum of sixty days. • Usually one period of presumptive eligibility coverage is allowed per twelve months or per pregnancy.	• Created as a state option in 1986. • Thirty states and DC currently have presumptive eligibility.[11] • Only available to certain populations, usually limited to pregnant women and/or children. • Multiple entities can be qualified to screen for PE. Qualified entities differ by state, but can include Federally Qualified Health Centers (FQHCs) and Behavioral Health Organizations (BHOs), child care facilities, schools, and direct service providers.	• Created by the Affordable Care Act (ACA) in 2010. • All fifty states have hospital presumptive eligibility. • All populations are eligible. • Hospitals are the only qualified entities to screen for HPE. • Hospitals are encouraged to participate, but are not required to do so.[12]

How PE and HPE Work

Presumptive Eligibility and Hospital Presumptive Eligibility policies have unique screening protocols, specific coverage periods, and are limited to certain communities. Here is a closer look at these PE and HPE details:

- **Screening process**: Qualified entities screen individuals for presumptive eligibility. Screening only requires self-attestation, meaning the qualified entity doesn't need to verify the information an individual provides. Entities that can become qualified for PE differ by state, with all hospitals

acting as qualified entities for HPE.

- **Coverage period**: The coverage period for presumptive eligibility is usually a maximum of sixty days. Generally, the coverage period ends on the last day of the month following the month in which PE or HPE was initially approved. For example, if an individual enrolls in presumptive eligibility in February, their coverage will end on March 31.[13]
- **Eligible populations**: The Affordable Care Act (ACA) allowed states that already had presumptive eligibility to extend it to groups of people beyond pregnant women and children. Under the ACA, people eligible for PE may now also include parents, former foster children, individuals in need of family planning services, and other adults.

Expanding Priority Populations for Presumptive Eligibility

- The ACA allowed states to extend presumptive eligibility to all populations.
  - **Nine states** made parents eligible: Idaho, Indiana, Iowa, Montana, New Hampshire, New Jersey, Ohio, West Virginia and Wyoming.
  - **Six states** made adults without children eligible: Indiana, Montana, New Hampshire, New Jersey, Ohio, and West Virginia.[14]
- Eligibility requirements can differ between groups of people, specifically regarding income requirements.

PE and HPE: Key Tools to Connect Young People to Coverage and Care

Presumptive eligibility is an especially critical tool for young adults due to their high uninsured rates. Young people with low incomes may delay enrolling in coverage due to administrative burdens and numerous pressing competing priorities. Therefore, young people without insurance may forgo seeking routine medical care and lack a regular source of primary care. Hospital presumptive eligibility allows young people to gain coverage if they need to seek immediate care in a hospital setting. Presumptive eligibility for young adults allows them to seek medical care in non-emergency settings and enroll in temporary coverage at places they're likely to already be (e.g. schools, youth-serving agencies, etc.). In either case, presumptive eligibility works best when young people are encouraged and given the resources to apply for permanent coverage.

Youth and Young Adult Centered Implementation[15]

While presumptive eligibility only provides coverage for sixty days at most, it does provide immediate access to health care services. It can also encourage young people to learn if they qualify for and can enroll in permanent coverage. The following strategies can help to maximize the impact and effectiveness of presumptive eligibility:

1) **Establish PE for everyone who is eligible for Medicaid**: Key groups of people, such as former foster youth and adults without children should be made eligible for PE. States can also consider creating presumptive eligibility specifically for transition-age youth and young adults.

2) **Develop a web-based enrollment site and simplify the application process**: Many states use a shortened form for presumptive eligibility rather than a full Medicaid application. This form requires minimal information, often asking only for a person's income level and state residency. States should not include a citizenship question when screening for eligibility. Once completed, an individual's eligibility should be promptly transferred to the state's eligibility and claims system to ensure there are no gaps in coverage.

3) **Create systems to ensure enrollment into permanent coverage, when possible, without**

overburdening qualified entities: Some states have developed an effective infrastructure to help people enroll in Medicaid, from compensating one-on-one support to ensuring a streamlined application process. For example, in New Hampshire, qualified entities are paid to assist families in completing and submitting a regular application. In Iowa, a web-based enrollment site automatically transfers information on people enrolled in presumptive eligibility to a new application for permanent coverage. The newly initiated application is then assigned to a state Medicaid eligibility worker to process.

However, hospitals themselves should not be required to ensure people using PE/HPE enroll in more permanent coverage options.[16] Requiring hospitals to take on this role places an undue burden on hospital workers. Further, aiming to force this task on hospitals by imposing penalties on eligibility workers may limit their willingness to screen for eligibility.

4) **Expand the list of qualified entities to enroll young people in PE, by piloting partnerships with youth-serving organizations**: Under Hospital Presumptive Eligibility (HPE), only hospitals can act as "qualified entities." However, the list of possible qualified entities under a larger PE system is broad. They could include health care providers; child care facilities; schools; organizations that administer other assistance, such as nutritional benefits or housing assistance; or direct service providers (e.g. Boys and Girls Clubs of America). Different states have different requirements for qualified entities.

5) **Allow multiple eligibility periods within a 12-month time frame for transition age youth**: States can better support the health needs of young people facing the steepest economic barriers by allowing PE and HPE to be used more than once a year. States can look to existing models for innovative ideas. California's HPE allows youth who are minors to enroll in two determination periods per year. In New York, the state's HPE provisions do not include any explicit limit on the number of eligibility periods a person can use each year.

6) **Invest in ongoing PE trainings and in dedicated staff to support PE sites**: States should develop an infrastructure and secure funding to support effective PE implementation. They can ensure PE assistors are able to share their experiences with others in their state. For example, Colorado and New Hampshire have centralized offices to support PE sites. New Mexico and Connecticut both have regular convenings where assisters can discuss PE and learn from one another's experiences. States should also offer financial support to PE agencies to incentivize them to help individuals complete a PE application and a regular Medicaid application.

Presumptive eligibility policies can provide temporary, immediate coverage and place young people with low incomes on a path to permanent health coverage. Without health insurance coverage, they will not be able to afford mental health care. States must take steps like expanding PE and HPE to maximize youth access to health coverage, as it is foundational to improving their access to care.

Reimbursement Policies to Increase Youth Access to Mental Health Services

Historically, payment has been one of the biggest barriers to effectively delivering mental health services to youth and young adults.[17] In both physical and behavioral health, payment strategies are traditionally based on a model that focuses on counting services and time, rather than improving people's health.[18]

As a result, many states' Medicaid programs have billing structures that include:

- Prohibitions on billing for multiple services from different providers in one day
- Inequitable reimbursement rates for behavioral health providers
- Fifteen-minute increment billing that limits reimbursement to time in an office with a provider
- Limits on billing for case management and care coordination
- Requirements for a formal diagnosis to demonstrate medical necessity and bill for behavioral health services

Lining up financial incentives across physical and behavioral health systems is critical to effectively meet the needs of youth and young adults. States have adopted a number of approaches to improve financial alignment, including by adopting same-day billing policies; carving-in behavioral health in managed care (where the same managed care entity is responsible for physical and behavioral health, either directly or through contracts); and enforcing parity rules.

Same Day Billing: Essential for Integrated Care

Our Community-based Care brief described the importance of integrated community-based care for meeting the needs of youth and young adults. Same-day billing strategies are essential to financing integrated care. Under federal rules, Medicaid can cover physical and behavioral health services on the same day or by the same provider; several states, however, choose to prohibit multiple providers from billing for services in the same day. While some states allow same-day billing, barring the practice creates a barrier to providing comprehensive, coordinated, integrated care for youth and young adults.

State bans on same-day billing in Medicaid can push mental health care out of young adults' reach.

Health providers risk losing reimbursement when billing for more than one service by different providers. As a result, young people with multiple or complex care needs are not able to address them on the same day or in the same location. This puts another obstacle to health care in the path of young people seeking services, which may be especially difficult to those experiencing financial strain or mental health challenges. In 2015, up to 75 percent of adults who had a behavioral health challenge during a primary care visit refused a referral to an offsite provider.[19] The number is likely higher for young people. Young adults with low incomes are unlikely to be able to follow up on another day at another location, leaving their health needs unmet. Incomplete care also increases the risk that they will access more expensive emergency room services, which is costly to states.

States can clear the path to ensure youth have access to multiple services on the same day by:

- "Turning on" health and behavioral health assessment/intervention (HBAI) billing codes. These codes allow behavioral health specialists to bill Medicaid on the same day a person sees a physician, for mental health or substance abuse services secondary to a primary care

diagnosis.[20]
- Updating their state Medicaid plans to join the majority of states that allow providers to bill for more than one type of service on the same day.

The Case for Carved-in Behavioral Health in Medicaid Managed Care

As of 2018, 74 percent of people enrolled in Medicaid were covered through a private managed care plan.[21] Some states choose to "carve out" or separate behavioral health from physical health in their managed care structure, meaning that the state contracts with a specialty Managed Care Organization (MCO) to manage its Medicaid behavioral health benefit. A state might choose this option for the expert knowledge the MCO has in providing specialized services. Creating separate benefits for physical and behavioral health care reflects a desire to manage the behavioral health benefit within different limits and in different ways from medical or surgical benefits.[22]

This separation can impede access to care. It also hampers efforts to incentivize cost-effective alternatives and innovation. At the beginning of 2017, eleven states continued to carve out behavioral health coverage from Medicaid health plans.

Carving-out behavioral health from other care impedes coordinated care for young people enrolled in Medicaid.

Behavioral health carve-outs can lead to less coordinated care for the individual enrolled in Medicaid, as they often do not receive all of their physical and behavioral care from the same entity. Lack of care coordination can cause providers to miss symptoms, risking a person's health. Carve-outs also impede integrated care; this separation contributes to youth and young adults experiencing fragmented and inefficient care.[23]

As states continue to review their decisions about using managed care for people with specialty needs (including mental health), and the goal of improving integrated care, they must reconsider the structural use of carve outs.[24] States that "carve-in," behavioral health in their Medicaid managed plans can more equitably provide a range of interventions that are fully coordinated.

Some states have successfully taken this integrated approach. For example, since 2012, Oregon's Coordinated Care Organizations (CCOs) have transformed the delivery of health services to people enrolled in Medicaid. CCOs coordinate care across a range of health domains, including supports for physical health, public health, mental health, substance abuse, and transportation.

Mental Health Parity in Medicaid to Support Youth Access to Trusted Providers

The 2008 Mental Health Parity and Addiction Equity Act required certain health plans to cover mental health care at a level equal to other health services.[25] Federal statute requires Medicaid programs to comply with mental health and substance abuse parity requirements, but only in the context of managed care. Since behavioral health services are often provided through a fee-for-service structure rather than managed care, these changes have yet to bring about payment equity between mental and physical health care. Enforcement mechanisms at the federal level, and state resources dedicated to enforcement, are also lacking. As a result, mental health services continue to be reimbursed at demonstrably lower rates than physical health services.

Lack of parity limits the network of mental health providers who young people most trust.

Certified youth peer support specialists are a vital group of mental health professionals for young people. They draw on their own experiences with trauma and mental health challenges to support their young clients who are navigating similar circumstances. Youth and young adults have identified them as key supports.[26]

As a profession, certified youth peer support specialists face hurdles that stem from Medicaid policies that don't meet parity standards. These challenges include:

- Unsustainable reimbursement rates, and
- Low wages.

Other providers who are valuable to young people, including family support specialists and community health workers, face similar challenges. These fiscal barriers lead to high turnover rates and a chronic shortage of professionals to fill open positions. Consequently, many young people cannot access care that is meaningful to them and covered by Medicaid.

States can advance parity through legislation and by collaborating with federal partners.

States can implement parity enforcement mechanisms that help to reduce these reimbursement disparities. Some are already working to advance this goal: Several states, including New Hampshire, Colorado, Connecticut, and Minnesota, have introduced state-level legislation to improve parity reporting and enforcement.[27] Substance Abuse and Mental Health Services Administration (SAMHSA) has also issued guidance to states on best practices to enforce parity requirements.[28] Until mental health services are enforceable in Medicaid to the same extent as other health insurance providers, young people will continue to experience barriers to comprehensive, developmentally appropriate, culturally responsive care.

Policy Recommendations: Advancing Coverage and Improving Cost Reimbursement Practices

Several policy solutions exist for states to build paths to coverage for young people living in poverty, and to ensure mental health providers are fairly compensated. As described throughout this brief, CLASP recommends the following approaches to strengthen and close gaps in Medicaid mental health services:

- Adopt full Medicaid Expansion to 138% of the federal poverty level, without imposing burdensome paperwork requirements.
- Use state dollars to provide mental health coverage for youth regardless of their immigration status.
- Strengthen existing hospital presumptive eligibility (HPE) policy through pilot partnerships between hospitals and behavioral health providers to qualify youth for HPE at the hospital and provide behavioral health services onsite.
- Avoid or remove citizenship questions on the presumptive eligibility application; not all states include a citizenship question in their HPE/PE screening.
- Submit a waiver or state plan amendment to expand PE to benefit transition-age youth. Such an expansion should limit regulations to maximize flexibility in the program and ensure youth-serving systems can become qualified entities to screen for PE.
- Update Medicaid state plans to permit same-day billing of different services across physical and mental health.

- Carve behavioral health care into Medicaid managed care contracts, rather than carving it out.
- Pass state-level parity provisions that include reporting and enforcement mechanisms.

Conclusion

State and local policymakers can reshape the mental health policy landscape to one that advances transformation and healing for youth and young adults. The goal of such a system is to change young people's lives by acknowledging and reducing the threats that they experience. ***Policy choices must facilitate access to life-changing supports, or risk perpetuating further harm.*** The cost of mental health services has long been a barrier to young people living in poverty. In 2018, 42 percent of young people who felt they needed, but did not receive, mental health services went without care because they did not think they could afford it.[29] In this context, boosting health insurance coverage is a necessary component to improve pathways to care, and continuing to make policy choices that block young people from obtaining health insurance coverage is incompatible with equitable outcomes for youth and young adults.

At the same time, coverage alone is not enough. Another critical step includes removing payment barriers that impact providers' ability to deliver care in ways that best meet the needs of youth and young adults. As state and local policymakers look to clear barriers to young peoples' transformation and healing, they must remove affordability hurdles by improving coverage and cost reimbursement.

As documented throughout this brief, some states have exercised each of these options, but none are universal. State and local leaders can immediately review their existing coverage and cost reimbursement policies and look for opportunities to strengthen them to increase equitable access to care for youth and young adults. Exercising the policy recommendations outlined in this brief will help ensure that state and local mental health policies create pathways to transformative, healing experiences for young people who need them most. In doing so, we can advance towards a future that supports accessible youth and young adult mental health, well-being, and healing on a national scale.

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