Policy for Transformed Lives

Barriers to Meeting the Mental Health Needs of Young Adults

CLASP

Policy solutions that work for low-income people

Nia West-Bey, Shiva Sethi & Paige Shortsleeves

November 2018

> Are we a service industry? Or a transformational industry? A service industry is kind of like McDonald's. How many burgers can we sell, as efficiently as possible, provide a quality product so people keep coming back. You know, when you have a line at the cashier, how do you move them quickly and efficiently through. And you're really measuring your success by the number of burgers you sell. Or whatever you want to sell. We do a lot of that, out of necessity. We have to bill for services, so we capture time, we bill in increments of 15 minutes. We capture services. Whether it's an individual service, or a family-based service, or a group therapy service, or in Kentucky we do collateral services which are with teachers and so forth. And then we capture all of that and we measure it ... All that's great for service industries. **But how would we have to change if we were in the business of transforming lives?** Cause that's what we really signed up for.

- Ron Van Treuren, Louisville

Introduction

More than one in five young adults in poverty reported experiencing serious psychological distress within the past year.[1] When young adults' mental health needs are unaddressed, their economic stability, independence, and overall well-being can be undercut. To inform efforts to improve public policy, CLASP conducted an in-depth scan and analysis[2] of how selected states (Maryland, Michigan, Oregon, and New Mexico) and localities (Los Angeles, CA, Louisville, KY, and New York, NY) are addressing young adult mental health. This brief in our *Policy for Transformed Lives* series describes cross-cutting challenges and barriers to effectively meeting the mental health needs of low-income youth and young adults.

We consistently found that certain barriers stand in the way of providing mental health services to youth and young adults across the four states and three localities in our scan. Many of these challenges are intersectional, persistent, and endemic. We believe the crosscutting barriers we examine in this brief are the key areas for advocates, legislators, and policymakers to focus on as they improve mental health policies and services for youth and young adults.

Medicaid Pays for "Health care;" Health Care is Narrowly Defined

Medicaid's purpose, as defined by Title XIX of the Social Security Act, is "to provide health care services."[3] States choose what is included in the definition of health care services, and many states apply a narrow definition derived from a traditional, physical health model. In addition, "health care" can only be provided to those demonstrating "medical necessity;" each state determines its own medical necessity criteria for Medicaid reimbursement.

Many providers reported struggling to care for their patients within the narrow definitions of Medicaid billable services, even though a range of services is included in the medical necessity definitions of all these states (Appendix 1). The term "medical necessity" surfaced as a barrier to providing care. Providers told us they were hamstrung because medical necessity prevented them from billing Medicaid for preventative services, which are often less costly than reactive care, or from addressing concerns that could escalate to the level of medical necessity but weren't quite there yet. For example, one Louisville community-based provider whose organization relies almost entirely on Medicaid depends on a partner organization to provide preventative services. For the sake of continuity for youth and families, they would prefer to provide those services, but couldn't bill effectively for them. The ways in which states define "health care" and "medical necessity," as well as how these definitions are interpreted and implemented can create real and perceived barriers to providing effective care.

Some states and cities we surveyed have used state and local dollars to fill gaps in services, which can create fluctuations in funding levels depending on the priorities of leadership. Other states and cities have a long history of underinvestment in health and mental health services for low-income people. The people we spoke to who are leading effective programs and practices indicated that Medicaid alone could not sustainably fund their organizations. They need substantial investment of state, local, or philanthropic dollars to adequately meet their expenses. Although Medicaid has many challenges, it is the largest source of funding for health services for low-income people, insuring more than one in three young adults living in poverty.[4]

Reimbursement and Workforce

Even when providers can bill Medicaid for their services, low reimbursement rates make it difficult for them to recruit and retain providers and to develop sustainable business models. We spoke to stakeholders who purposefully choose not to bill through Medicaid because of the barriers that the program's rules—as implemented by states—create to effectively meet the needs of youth and families. We also heard that those who do rely on Medicaid as their primary revenue stream can't always offer the comprehensive array of services they would like to provide. Although some states and localities have made progress in integrating non-traditional providers and approaches such as indigenous healers into their Medicaid framework, such non-clinical providers are undervalued in a system so strongly driven by a medical model of health.

"A huge barrier is reimbursement doesn't always cover what it needs to cover to provide services; it's tough for them because the majority of their clients are Medicaid, and Medicaid just doesn't pay what some of the others do. That's a barrier for them…"[5]

– Medicaid policymaker

Low-reimbursement rates and the undervaluing of providers outside of a traditional medical model, in turn, contribute to pervasive workforce challenges. Lack of staff with expertise in high demand fields like child psychiatry and behavioral health, especially in rural areas, is a serious problem. For example, one interviewee in Michigan told us that there were no child psychiatrists in the Upper Peninsula. Louisville education stakeholders described how efforts to integrate telehealth providers into schools for mental health crisis assessments had substantially cut wait times for these evaluations. Implementation, however, was a slow process that required a year of preparation to put appropriate equipment, security, and legal protocols in place.

"If you've spent time in mental hospitals and were incarcerated and you've come out the other side and want to help other people, you're like gold, but the system isn't giving the respect or the salary. We need a new system of measurements that actually value people's hard-earned life experience and provide high quality training to hone their gifts."[6]

– Youth peer specialist

We frequently heard that behavioral health staff were overworked and underpaid, often leading to high turnover rates. Stakeholders also indicated that diversity in the mental health workforce was a major barrier, one that non-traditional providers like certified peers can help to address. However, interviewees repeatedly said that non-clinical staff, including peer-to-peer providers, are often undervalued, undertrained, and underpaid by mental health systems.

Almost No One is Good at Investing in Prevention

State and local stakeholders almost universally identified the need to "get upstream" of mental health challenges and the critical role of preventative approaches in realizing better health outcomes and increased cost savings. Stakeholders expressed concern that their systems made very little investment

in prevention and frustration about the limited political energy behind preventative strategies. Juvenile justice stakeholders in many places lamented that the justice system is too frequently the entry point to services, after young people have been systematically failed by a host of other systems. Despite tacit acknowledgement that investment in prevention is better for young people and less expensive—in the context of (perceived) limited resources—it is difficult to persuade decision makers to invest in prevention when the benefits often accrue to other systems or over a much longer timeframe.

"When everyone's struggling budget-wise [prevention]'s the first thing that goes out the window."[7]

- Child welfare stakeholder

The limited attention and support for preventative mental health efforts is typically isolated in the education system, or in some cases, the public health sector. For example, New Mexico has taken some steps to advance a prevention framework for youth and young adult mental health. These efforts include the planned widespread introduction of the "Good Behavior Game," an evidence-based intervention that builds social-emotional competencies, to school districts in New Mexico and the newly created suicide prevention coordinator position in the Department of Health.

Despite some progress incorporating preventative frameworks into physical health, our selected jurisdictions didn't report comparable efforts in the realm of mental health.

Justice System as Entry Point to Services

Nearly across the board, justice system stakeholders expressed frustration that their system serves as the entry point to mental health service for young people, particularly for young people of color. Race and racism play a key role here. Young people are often forced to enter the justice system because there's not a crisis response mechanism outside of the justice system. When there's a mental health emergency, the justice system is often the first (or only) system to get involved although it may not be the best equipped to respond to mental health crisis. The trauma associated with entering and cycling through the justice system often exacerbates mental health challenges, and the historically tenuous relationship between law enforcement and many communities of color only makes law enforcement less appropriate responders to mental health emergencies. Related to this point, we found that young adults are often penalized or chastised in mental health systems. Justice system service providers universally called for policy shifts that divert young people experiencing a mental health crisis to more appropriate resources.

"If you're a white middle-class kid you might be diagnosed with a mental health issue but if you're a kid of color you're probably going to be arrested."[8]

- Community mental health association leader

> ***"We still treat mental health needs as a punishment and use it as a leveraging tool. If someone doesn't take their diabetes medication they aren't penalized, but they are if they don't take their mental health medications."[9]***
>
> ***- Justice system stakeholder in New York City***

Cross-Sector Collaboration

"I don't think there's one magic wand that can be waved but it's going to take everyone being at the table."[10]

- Community mental health association stakeholder

All our featured states and localities mentioned at least some cross-sector collaboration. Where cross sector collaboration was weak or difficult, youth and young adults experienced a less coherent system. The most notable missing stakeholder across states and localities was K-12 education. Although some education systems were making efforts to improve mental health supports for youth, these efforts were often isolated from those of other partners, and it was difficult to interview education stakeholders in many of our featured states and localities. Similarly, we were able to engage city and county-level executive branch stakeholders but were unsuccessful in engaging governors' offices in conversations around mental health policy.

A second major barrier was the lack of effective collaboration between the child-serving and adult-serving behavioral health systems. Service delivery is especially problematic during the transitional ages of 16-17 and transitional periods of 18 through the early 20s. Certain agencies that manage juvenile justice, youth homelessness, and child welfare often have strict requirements to cut off services after ages 18 or 21. We heard from stakeholders in Los Angeles that many young adults struggle when they abruptly stop receiving services, with some ending up incarcerated, homeless, or hospitalized. Even when young adults who leave child systems continue to receive services through adult-serving agencies, the stark contrast between the services provided and lack of coordination between the two system causes many young adults to leave the system.

Meeting the Needs of a Diverse Population

Disparities in access by race, geographic region, language, and immigration status pervade the delivery of mental health services. Lack of culturally or linguistically relevant services, fear of retribution for use of government programs, and stigma all contribute to these disparities. Such community-level barriers underscore that insurance is not the only thing barring young people from getting services. Many stakeholders spoke positively about the Affordable Care Act because it expanded insurance to young people but noted that just being insured was not enough for people to get the services they need.

"So much of it [mental illness] is a response to poverty, and oppression or racism…we're doing harm by using clinical language to talk about people's lives."[11]

- Youth peer specialist

Many of our interviewees discussed the unique challenges of meeting the needs of youth and young adults in both rural and urban communities. In rural, frontier, or reservation communities we frequently heard about limited funding and a lack of services and providers. While urban environments often have mental health services, they also have long waiting lists, confusing bureaucracies, and lack of coordination across systems, all of which keep many young people from getting care.

These disparities in access to mental health services do not exist in isolation –many of the same disparities exist in public health and the social determinants of health more broadly. One of the most significant of these determinants is poverty. Interviewees repeatedly mentioned the clinical approach itself as overly rigid and a contributor to certain people and populations feeling alienated from mental health services.

Conclusion

The question posed in Louisville, "How would we have to change if we were in the business of transforming lives?" is essential for understanding how to better align Medicaid policy with the needs of low-income youth and young adults. Currently, it is difficult to fund the innovations that work for low-income youth and young adults through Medicaid because much of what works is not seen as "health care," and the young people who need it don't demonstrate "medical necessity" as defined or interpreted by states. Other factors impeding local and state innovation include low reimbursement rates; the challenges of building a diverse, culturally informed, and adequately valued workforce; lack of attention to prevention; reliance on the justice system to function as the mental health system; missing or poorly functioning cross-sector partnerships; and failure to systemically attend to the unique context created by race and geography. Each of these challenges cuts across geographic barriers and presents an opportunity for advocates and policymakers to work together to improve mental health services for youth. In the same way that providers "signed up" for transforming lives, state and local policymakers can take the bold step of signing up for transformational policymaking to begin dismantling these barriers.

Appendix 1. State Medical Necessity Definitions

Oregon

Under the Oregon Administrative Rules: "(127) "Medically Appropriate" means services and medical supplies that are required for prevention, diagnosis or treatment of a health condition that encompasses physical or mental conditions, or injuries and which are:

1. Consistent with the symptoms of a health condition or treatment of a health condition;
2. Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community, evidence-based medicine and professional standards of care as effective;
3. Not solely for the convenience of an Oregon Health Plan[12] (OHP) client or a provider of the service or medical supplies; and
4. The most cost effective of the alternative levels of medical services or medical supplies which can be safely provided to a Division client or Primary Care Manger (PCM) Member in the Primary Health Plan's or Primary Care Manager's judgment.

New Mexico

In New Mexico, medically necessary services are defined in regulation as clinical and rehabilitative physical or behavioral health services that:

- Are essential to prevent, diagnose or treat medical conditions or are essential to enable the individual to attain, maintain or regain functional capacity;
- Are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the individual;
- Are provided within professionally accepted standards of practice and national guidelines; and
- Are required to meet the physical and behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider or the payer"

The state does not have distinct definitions for children, oral health services, or behavioral health services.

Louisville

According to the Kentucky Administrative Regulations, to be medically necessary or a medical necessity, a covered benefit shall be:

1. Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition; including pregnancy;
2. Appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice;
3. Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider, or for cosmetic reasons;
4. Provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;
5. Needed, if used in reference to an emergency medical service, to exist using the prudent layperson standard;

6. Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 U.S.C 1396d(r) and 42 C.F.R. Part 441 Subpart B for individuals under twenty-one (21) years of age; and
7. Provided in accordance with 42 C.F.R. 440.230.

New York

New York state law provides a definition of medical necessity:

> "Medical assistance" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department.

The state does not have distinct statutory definitions for children, oral health services, or behavioral health services.

Michigan

Michigan relies on the federal medical necessity definition for Early and Periodic Screening, Detection and Treatment (EPSDT), and does not have a general state-level medical necessity definition for Medicaid services.[13] Michigan's Medicaid state plan does contain a medical necessity definition for specific Medicaid services, such as the definition used for physical therapy and psychological services, counseling and social work:

> "Medically necessary services are health care, diagnostic services, treatments and other measures to correct or ameliorate any disability and/or chronic condition."

Maryland

Under the Code of Maryland Regulations, "Medically necessary" means that the service or benefit is:

1. Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
2. Consistent with current accepted standards of good medical practice;
3. The most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and
4. Not primarily for the convenience of the consumer, the consumer's family, or the provider.

Los Angeles

The California Welfare and Institutions Code (Section 14059.5) states that:
"A service is 'medically necessary' or a 'medical necessity' when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain."

Source:

https://nashp.org/medical-necessity/

Acknowledgements

This work was made possible by the generous support of the Kresge Foundation. The authors would like to thank the following CLASP staff: Sivan Sherriffe, communications associate, and Andy Beres, senior communications manager, for their design assistance. We would also like to thank Isha Weerasinghe, senior policy analyst; Suzanne Wikle, senior policy analyst; Stephanie Schmit, senior policy analyst; Whitney Bunts, policy analyst; Kisha Bird, youth team director; Hannah Matthews, deputy executive director for policy, Barbara Semedo, deputy executive director, external affairs and strategic communications, and Tom Salyers, communications director, for their editorial review. Additionally, we would like to thank Andrea Amaechi at the Moriah Group for her research assistance. Lastly, the authors would like to thank our partner reviewers: William Beardslee, Center on the Developing Child-Harvard University, Brandy Kelly-Pryor, Humana Foundation, Michael Ruble, Healthy Transitions New Mexico, Samantha Shepherd, CCO Oregon, Shannon Hall, Community Behavioral Health Association of Maryland, and Bowen Chung, UCLA.

Endnotes

[1] Nia West-Bey and Stephanie Flores, Everybody Got their Go Throughs: Young Adults on the Frontline of Mental Health, CLASP, 2017. https://www.clasp.org/sites/default/files/publications/2017/08/Everybody-Got-Their-Go-Throughs-Young-Adults-on-the-Frontlines-of-Mental-Health.pdf.
[2] Nia West-Bey, Shiva Sethi, and Paige Shortsleeves, Policy for Transformed Lives: State and Local Efforts to Support Young Adult Mental Health, CLASP, 2018.
[3] Title IXX, Grants to States for Medical Assistance Programs, Social Security Act (1935 as amended 2016).
[4] Nia West-Bey and Stephanie Flores, Everybody Got their Go Throughs: Young Adults on the Frontline of Mental Health, CLASP, 2017. https://www.clasp.org/sites/default/files/publications/2017/08/Everybody-Got-Their-Go-Throughs-Young-Adults-on-the-Frontlines-of-Mental-Health.pdf.
[5] Medicaid Stakeholder
[6] Sascha De Bruhl, New York City
[7] Nancy Allen, Oregon
[8] Robert Sheehan, Michigan
[9] Dr. Claire Green Forde, New York City
[10] Karen Williams, Maryland
[11] Sascha De Bruhl, New York City
[12] Oregon Health Plans (OHPs) are Oregon's Medicaid plans.
[13] EPSDT is the child health component of Medicaid that covers prevention and treatment services.