Policy for Transformed Lives

State and Local Efforts to Support Young Adult Mental Health

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 ages 18-25 living 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 wellbeing can be undercut. CLASP conducted an in-depth scan and analysis of how selected states and localities are addressing young adult mental health to inform efforts to improve relevant policies. The first brief in our *Policy for Transformed Lives* series focused on young adult mental health describes our methodology, key policy context for featured states and localities, and innovations in each place.

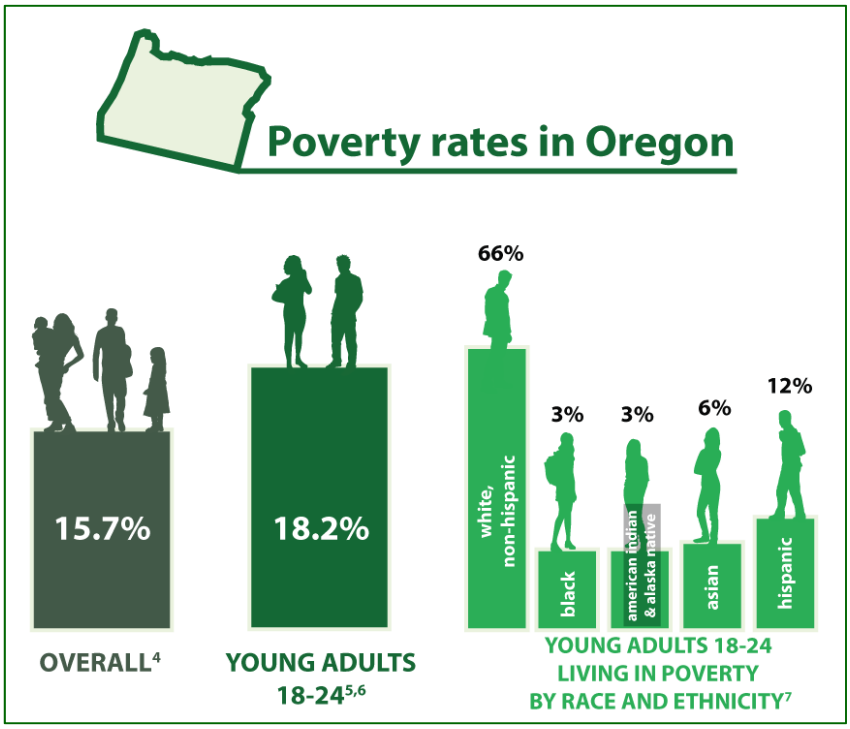
Methodology and State/Local Context

This report features four states and three localities that are diverse by region of the country, population demographics, and policy context. We selected these states and localities largely because expert stakeholders across the country mentioned them repeatedly as places doing good work with youth and young adult mental health. To further narrow our list, we also closely examined existing and pending waivers with the federal Centers for Medicare and Medicaid Services (CMS) introducing work requirements or other measures that limit access to health coverage. Although we did not rule out all states proposing such waivers, we chose to limit our selected jurisdictions to states that have chosen to expand Medicaid through the Affordable Care Act (ACA). One of the ACA's most popular provisions allows young adults to remain on their parents' insurance until age 26; Medicaid expansion provides a parallel support for low-income young adults whose parents don't have or can't afford to enroll them in employer-sponsored coverage. Between 2013 and 2014, the share of young adults who were *uninsured* fell from 35 percent to 24 percent.[2] Medicaid expansion is a necessary policy precursor to meeting the mental health needs of low-income youth and young adults because it substantially improves their access to health coverage and reduces financial barriers to covered mental health services. The selected states and localities by no means represent all the good work happening on behalf of youth and young adults, but each is instructive.

We ultimately held in-depth conversations with stakeholders in four states (Maryland, Michigan, New Mexico, and Oregon) and three localities (Louisville, Los Angeles, and New York City). We conducted over 140 interviews with a wide variety of youth-serving stakeholders, from health, mental health, human services, and youth sectors.[3] Our guiding questions and analysis drew on a literature and document review and on insight, advice, and guidance from an advisory committee including experts on national policy, health, mental health, Medicaid, and young adults.

In choosing the states and localities, we looked at those known for their innovation in supporting and financing mental health services important to youth. Focusing on these states and localities allowed us to highlight emerging ideas and practices, identify barriers and challenges, and learn about the policy and systems supports that could help other states and localities achieve greater impact. The following profiles provide additional context on the four states and three localities chosen and highlights key similarities and differences.

Oregon



State Context

Oregon is a national leader in progressive health care policy:

- In 1994, Oregon expanded the Oregon Health Plan—its Medicaid program—to cover people up to 100 percent of the Federal Poverty Line (FPL)
- Medicaid expansion has transformed health care delivery in the state, significantly reducing the number of uninsured residents.
- Since 2012, health care for Medicaid recipients has been organized into Coordinated Care Organizations in 16 regions

Medicaid Expansion	Yes – Effective January 2014[8]
Pre-ACA Medicaid Eligibility Level for Single Childless Adults	Up to 100% FPL[9]
Post-ACA Medicaid Eligibility Level for Single Childless Adults[10]	Up to 138% FPL
Carve In vs. Carve Out Model[11,12]	Carved-in
Key Waivers Impacting Youth and Young adults	Approved 1115 waiver "Oregon Health Plan" allows for Medicaid billable services for the social determinants of health and the maintenance of Coordinated Care Organizations
Defining Context According to Stakeholders	Recent push to deinstitutionalize children resulted in the closure of most residential treatment facilities

Key considerations identified by stakeholders:

- Oregon has many rural and frontier[1] counties, which bring unique challenges for ensuring equitable access to care
- Oregon's push to deinstitutionalize children resulted in closure of most residential treatment facilities, which has left a gap in support for children and youth with high levels of need.

Featured Innovation: Coordinated Care Organizations (CCOs)

In Oregon, Coordinated Care Organizations (CCOs) have been the main vehicle for transforming service delivery to Medicaid recipients since 2012. CCOs coordinate care across a range of health domains, including supports for physical health, public health, mental health, substance abuse, and transportation. The state's lottery for expanding health insurance coverage prior to the ACA provided strong evidence of how an integrated approach to health care can improve health outcomes. In 2012, sixteen CCOs were contracted to fully integrate behavioral health services to provide a seamless experience to CCO members.

Oregon is currently developing the next round of CCO contracts, known as "CCO 2.0." The contracts will address on-going challenges to service integration with a focus on four main directives: value-based payments, mitigating social determinants of health, improved behavioral health access, and integrated data systems. The new contracts will seek to increase CCOs' ability to engage in prevention efforts focused on mental health and substance abuse and begin to address community-level health through health improvement plans that benefit entire communities.

CCOs reflect Oregon's efforts to truly transform health care delivery, to push the boundaries of health care, and to innovate around what the effective integration of physical and behavioral health care can mean for a range of outcomes.

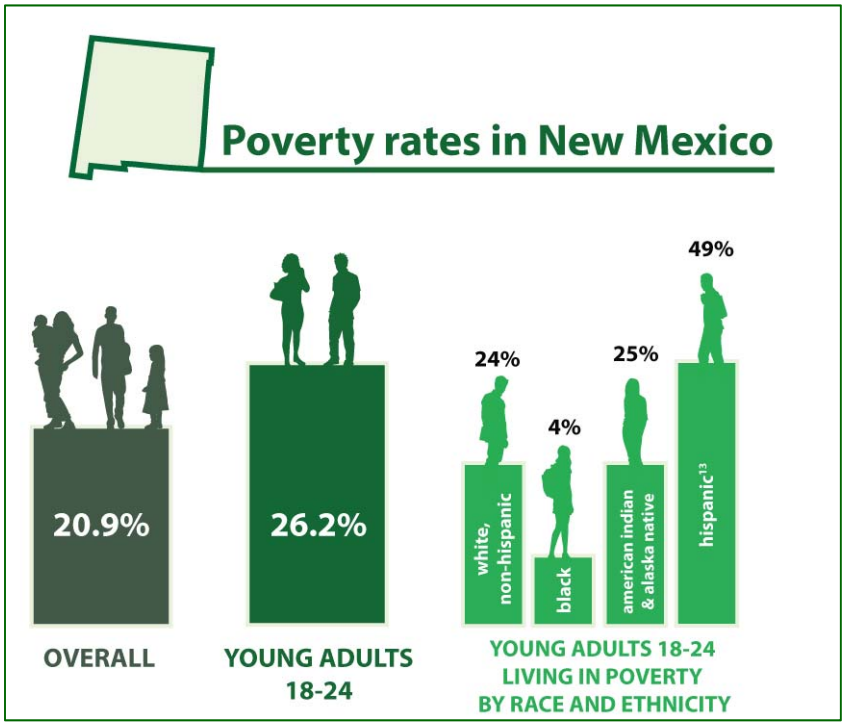
Other Strengths

Social Determinants of Health (1115 Waiver): Oregon's approved 1115 Waiver currently allows CCOs to bill for "health-related services" that address social determinants of health such as food, housing, or employment support. The Oregon Health Authority is developing additonal guidance for CCOs about how to best implement these programs to reduce costs and support better health outcomes. The Medicaid Advisory Committee completed guidance for housing in 2018 and engaged stakeholders for feedback.

Youth Drop-in Centers: In partnership with Youth Era, which is Oregon's Youth Move chapter, CCOs have established a state-wide network of seven youth drop-in centers that support youth and young adults who have experienced trauma or other difficulties, but who do not meet the criteria for the state's early psychosis intervention program. Staffed by certified youth peer specialists whose services are Medicaid billable, these centers are critical to effectively and holistically meeting the needs of transition age youth, preventing incarceration, and providing young people with opportunities to access informal behavioral health supports.

[1] Sparsely populated areas that are geographically isolated from population centers and services

New Mexico



State Context

New Mexico has used Medicaid expansion and federal grant programs to change the culture of support for youth and young adults:

- Created four managed care organizations under Centennial Care—the replacement to the state's Medicaid system initiated in January 2014
- Passed NM Senate and House bills (SM3 and HM9) to begin exploring a potential Medicaid buy-in program for ineligible residents that would require a federal waiver

Medicaid Expansion	Yes – Effective January 2014
Pre-ACA Medicaid Eligibility Level for Single Childless Adults	Up to 200% FPL[14]
Post-ACA Medicaid Eligibility Level for Single Childless Adults	Up to 138% FPL
Carve In vs. Carve Out Model	Carved-in
Key Waivers Impacting Youth and Young adults	Pending 1115 renewal waiver "Centennial Care" refines the state's care coordination efforts and improves the integration of behavioral and physical health
Defining Context According to Stakeholders	2013 Medicaid fraud investigation resulted in the closure of multiple mental health service agencies

Key considerations identified by stakeholders:

- Historically poor, majority-minority state with large rural and frontier counties
- A 2013 Medicaid fraud investigation led to a major disruption in the behavioral health system; although no fraud was ultimately identified, the financial pressure caused the closure of multiple mental health service agencies, and the state has not fully recovered

Featured Innovation: State-Level Youth Engagement

New Mexico, a leader in state-level youth engagement, has taken several steps to ensure that behavioral health services and supports for youth and young adults are youth guided and youth driven. A state-level youth coordinator in the Behavioral Health Division of the Children, Youth and Families Division (CYFD) is responsible for advising the division, planning and coordinating trainings, and leading the New Mexico Youth Move chapter. The state is also implementing youth-developed and youth-led training across the agency for staff in youth engagement principles and practice.

The state is a grantee in the "Now is the Time" Healthy Transitions Initiative of the federal Substance Abuse and Mental Health Services Administration (SAMHSA). This grant allows New Mexico to support a range of services in three high-need communities. Local sites offer innovative, youth-friendly services including arts-based programming, outdoor adventure therapy, and drop-in services. The state is currently funding youth peer support services through this grant and is working to support sustainable funding for youth peer support by allowing certified youth peer specialists to bill Medicaid for their services.

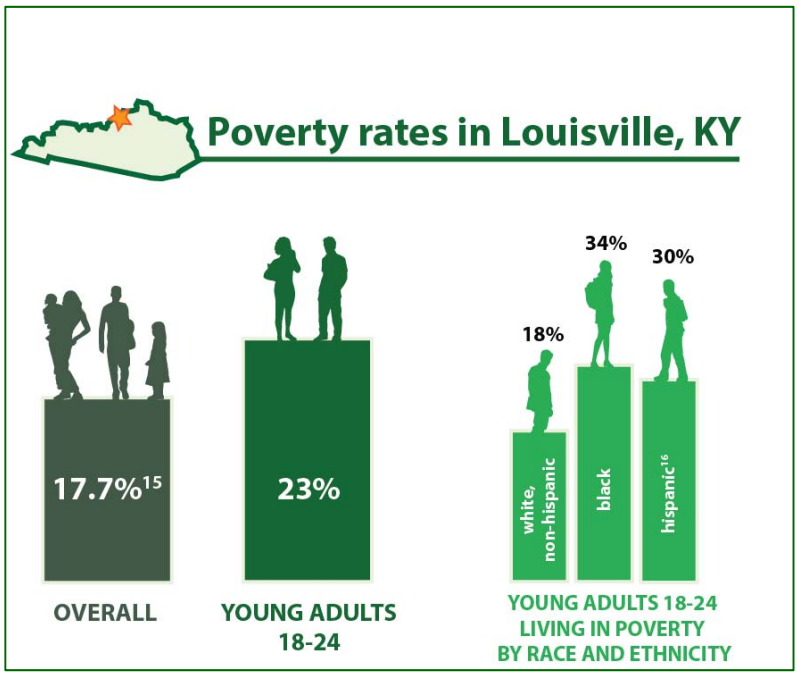
New Mexico stakeholders report a notable culture shift toward flexibility, hope, and effective support for transition age youth because of these innovative, authentic, youth-adult partnerships.

Other Strengths

Prevention: New Mexico has taken some steps toward a prevention framework for youth and young adult mental health. These include the planned widespread introduction in New Mexico school districts of the "Good Behavior Game," an evidence-based intervention that builds social-emotional competencies, and the recent creation of a suicide prevention coordinator position in the Department of Health.

Culturally informed approaches: New Mexico requires all Medicaid providers to prove that they have provided cultural competency training to staff and that they are providing culturally competent services. A number of traditional healing practices of New Mexico Native communities are reimbursable in a range of settings, and the state engages providers focused on specific populations including Latino and LGBTQ youth.

Louisville, KY



Local Context

Louisville's history of commitment to health equity, strong leadership, and collaboration across youth-serving systems has helped to create a meaningful system of supports for youth and young adults that draw on the strengths of a range of partners.

- Louisville is home to the nation's oldest municipal-level Health Equity Agency
- Medicaid expansion significantly increased coverage and reduced emergency room use
- While CMS approved Kentucky's statewide 1115 waiver permitting work requirements for adults receiving Medicaid, the waiver was blocked on June 29, 2018 by a federal judge.

Medicaid Expansion	Yes – Effective January 2014[17]
Pre-ACA Medicaid Eligibility Level for Single Childless Adults	Not covered regardless of income
Post-ACA Medicaid Eligibility Level for Single Childless Adults	Up to 138% FPL
Carve In vs. Carve Out Model	Carved-in
Key Waivers Impacting Youth and Young adults	Approved statewide 1115 waiver "Kentucky HEALTH" imposed work requirements on adults receiving Medicaid; this waiver is currently in litigation
Defining Context According to Stakeholders	Home to the oldest municipal-level Health Equity Agency in the country

Key considerations identified by stakeholders:

- Progressive city in a conservative state with a history of racial segregation
- Concentrated pockets of poverty and community violence

Featured Innovation: Root Cause Analysis

In 2017, the Center for Health Equity in Louisville Kentucky released its third health equity report: "Uncovering the Root Causes of our Health." The report provides an overview of health outcomes for Louisville residents, highlighting specific outcomes for different age groups. For young adults, the report focuses on mental health as a key health outcome.

The report's guiding framework is particularly innovative because it makes the case for the importance of root cause analysis in understanding health outcomes. Using the analogy of a tree, health outcomes are represented by the leaves of the tree. The quality of those leaves is a display of the quality of eleven "root causes" that are the social determinants of health. These root causes are neighborhood development, housing, transportation, criminal justice, early childhood development, education, health and human services, environmental quality, built environment, food systems, and employment and income. The soil that nourishes the roots are the "systems of power," such as racism and sexism, which define how different people experience root causes.

The root cause analysis framework seemed to have deep penetration amongst Louisville stakeholders who resonated strongly to the tree analogy. Root cause analysis has provided a useful guiding framework for cross-agency and cross-sector collaboration in Louisville, a fundamental component of systems change.

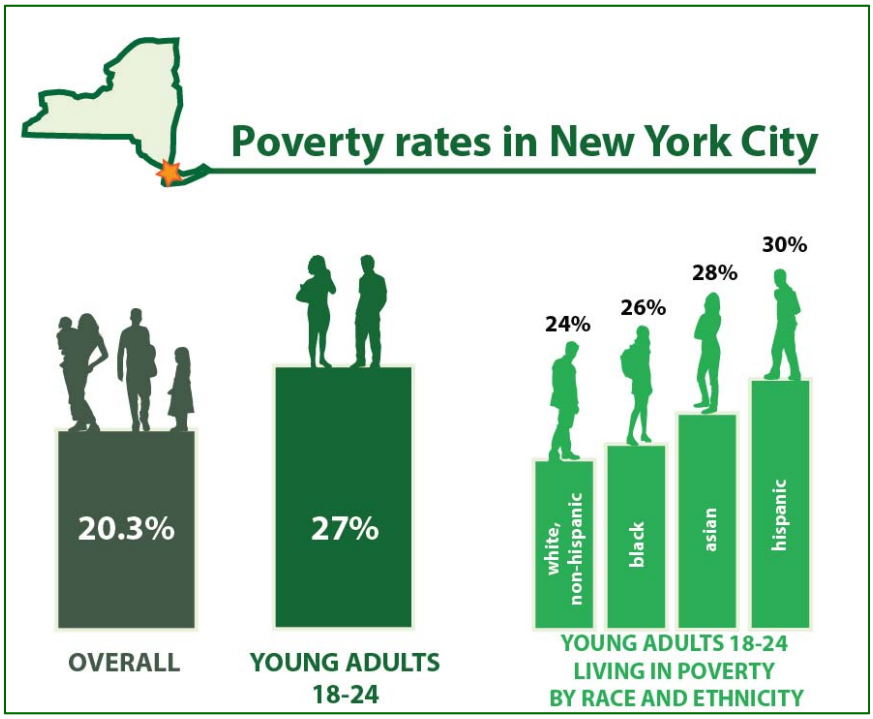
Other Strengths

***Racial Equity**:* Louisville has a citywide racial equity agenda; anyone working for city government is required to take part in racial equity training. A broad cross-section of city leaders described within and cross-agency working groups focused on racial equity. For example, Jefferson County public schools have a diversity, equity, and poverty working group that includes school-based mental health professionals, and the SummerWorks Program initially funded the Racial Equity Youth Council, part of the city's racial equity agenda Racial Equity Youth Council.

***Cross-sector partnership**:* Multiple Louisville stakeholders described a broad commitment across sectors to work together effectively to support young people. These stakeholders also shared a common recognition that young people who end up in deep-end systems (juvenile justice, child welfare, homelessness) had previous experience in other systems. For example, the juvenile detention facility had developed deep partnerships with the youth workforce system and university and public behavioral health providers, all of whom had close partnerships with the schools. The clear connections between youth-serving systems and the professionals leading them suggest a truly coordinated, comprehensive effort to meet young peoples' needs.

Medicaid Billable Youth Peer Support: Through a "Now is the Time" Healthy Transitions Initiative grant, Louisville has a Transition Age Youth Launching Realized Dreams (TAYLRD) Drop-in Center staffed by certified youth peer specialists whose services are Medicaid billable. This Medicaid funding stream will provide the center with sustainable income after the grant ends.

New York City



Local Context

New York City is a massive, progressive, and diverse city in a Medicaid expansion state.

- The city is home to over 8.5 million people
- New York City Health + Hospitals is the largest municipal public health care system in the US.
- Both the city and state have made improving and investing in their mental health systems a priority.

Medicaid Expansion	Yes – Effective January 2014
Pre-ACA Medicaid Eligibility Level for Single Childless Adults	Up to 78% FPL
Post-ACA Medicaid Eligibility Level for Single Childless Adults	Up to 138% FPL[18]
Carve In vs. Carve Out Model	Primarily Carved-in, but varies for certain high needs populations
Key Waivers Impacting Youth and Young adults	Approved statewide 1115 waiver "Medicaid Redesign" allows for restructuring of the state Medicaid plan into managed care programs
Defining Context According to Stakeholders	ThriveNYC was launched in 2015 to address mental health disparities across the city

Key considerations identified by stakeholders:

- Nearly 40 percent of the city's population are immigrants, so services must be available across language and cultural lines.
- The city, the largest in the country, has correspondingly huge systems and bureaucracies that make coordination difficult.
- The city also has the second highest levels of income and wealth inequality among US metro areas.

Featured Innovation: Medicaid Redesign 

Medicaid redesign in New York state is a multifaceted effort to reform mental health services for both youth and adults and will profoundly affect city services. In January 2019, the state will allow greater flexibility on the health conditions for which youth and children can be seen and will increase the number of services that can be billed to Medicaid. Some of the newly eligible services will include alternatives to clinical settings such as community-based crisis interventions.

In addition, New York State's Medicaid redesign includes a transition from quantity-based payments to 80-90 percent value-based payments-flat payments per member based on key outcomes, rather than fees per service provided. This change, expected to be implemented by 2020, will promote lower costs, better care, and better overall health.

Other Strengths

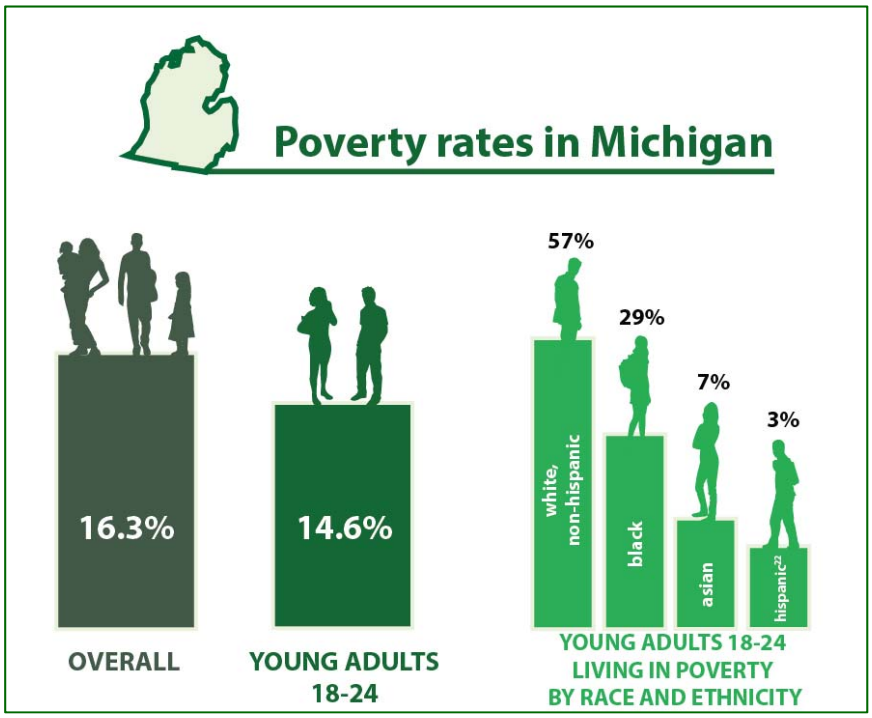
THRIVE NYC: *THRIVE NYC* includes 54 sub-initiatives to combat disparities and increase access to mental health services for specific populations**.** These populations include immigrants, members of the LGBTQI community, homeless youth, and many more. One of the sub-initiatives is "NYC Well," a 24/7 mental health service phone line that offers a wide range of linguistically and culturally competent services. Other sub-initiatives include peer specialist training, mental health first aid training, and mental health service improvements for homeless youth.[19] One advocate noted, "the city is recognizing that to separate issues doesn't make sense, social determinants [of health] play a recognized role and there are growing attempts to coordinate."[20]

Access NYC: Access NYC is a website that aligns multiple departments' work and data. It helps people easily find the services they are eligible for including food assistance, mental health services, and housing services from a total of 15 city departments.[21]

Integrating Physical and Mental Health*:* "Spring into Health" is a joint project between the New York City Department of Youth and Community Development (DYCD) and the NYC Department of Health and Hospitals. The project brings providers into communities for a 'block party' event that allows residents to see the services available to them and promotes both mental and physical health. Providers at Mount Sinai Hospital similarly integrate physical and mental health through co-location, trauma-informed wellness promotion, and Medicaid reimbursement.

Raise the Age*:* In 2017, New York passed a state law that raised the age for automatically trying juveniles as adults from 16 to 18. Various city agencies including the Administration for Children's Services and the Family Court System are currently phasing in this new policy by transitioning youth from corrections systems to the juvenile justice system that provides services like art therapy, treatment for substance dependence, and other interventions.

Michigan



State Context

Michigan is an expansion state with a large population:

- Although overwhelmingly white, the state does have some pockets with large concentrations of minority groups including Arab-Americans and African Americans.
- Certain populations, such as people of color and those from rural communities, continue to experience disparities in access to services.
- Michigan recently submitted a CMS work requirement waiver that would bar many people from getting Medicaid.

Medicaid Expansion	Yes – Effective April 2014[23]
Pre-ACA Medicaid Eligibility Level for Single Childless Adults	Not covered regardless of income[24]
Post-ACA Medicaid Eligibility Level for Single Childless Adults	Up to 138% FPL
Carve In vs. Carve Out Model	Varies by population and services
Key Waivers Impacting Youth and Young adults	Pending 1115 waiver "Pathway to Integration" allows the state to develop and evaluate financing approaches for integrated care and to establish coordination of care models; Approved 1115 Waiver allows benefit restrictions including a 5% co-pay for the expansion population after 48 months of coverage.
Defining Context According to Stakeholders	Historic and continued underfunding of public mental health services

Key considerations identified by stakeholders:

- Historically and currently, Michigan underfunds its schools and mental health services.
- Counties control most funding for mental health services, which leads to significant variation across the state in service quality and availability.

Featured Innovation: School-Based Mental Health Services

All school-based health centers in Michigan have a Masters-level mental health provider. The state has used federal grants from the Safe Schools/Healthy Students (SAMHSA), School Climate Transformation (U.S. Department of Education), and Project Aware (SAMHSA) programs to align and improve mental health services in schools. School systems are also using Medicaid funding to strengthen mental health services by looking at school environments.

Michigan is using other grants from the Department of Education and partnerships with local non-profits to deliver culturally competent messages to minority populations including Arab-American, Latino/a, and LGBTQI populations that have disproportionately low access to mental health services. The state encourages local providers to adjust their programs to best serve their students.

Other Strengths

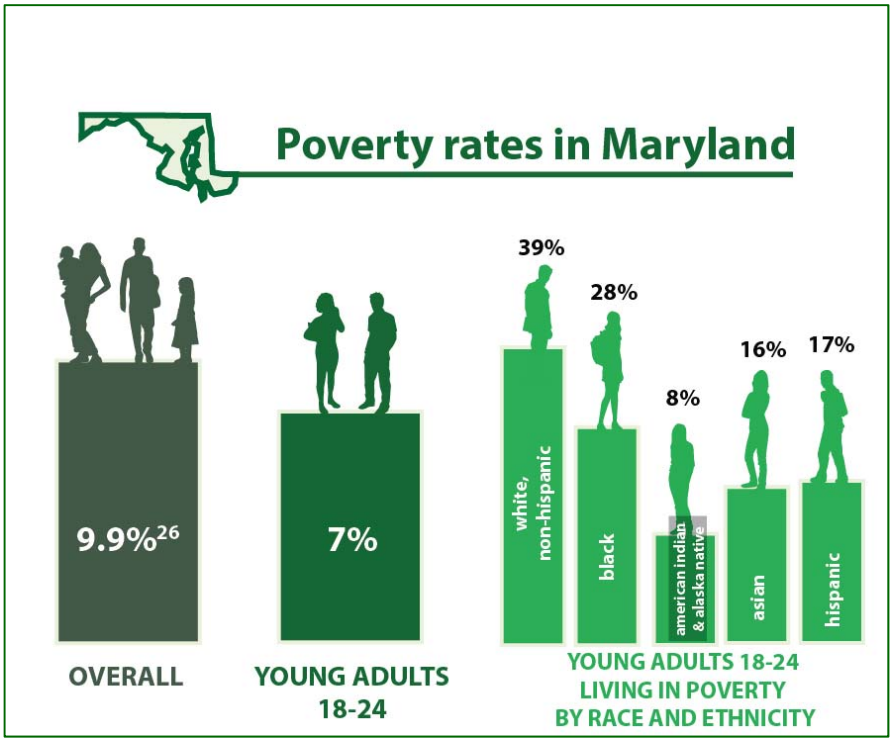
Mental Health and Juvenile Justice Screening Initiative: Michigan's Department of Health and Human Services launched the Mental Health and Juvenile Justice Screening Initiative[25] in 2017. The initiative selected seven public mental health system sites serving 11 counties to provide mental health screenings to children who are either at risk of entering or have already entered the juvenile justice system. Each of the sites has its own screening and prevention goals. Sites have a shared goal of promoting juvenile justice diversion and/or lessening system penetration for those already introduced to the juvenile justice system. Sites have flexibility to partner with different systems including family courts, school districts, and child welfare and have already made numerous referrals.

Trauma-informed services: Through a governor's office initiative, Michigan has implemented trauma-informed services in all child-serving systems after conducting pilot trauma-informed county initiatives. The community mental health system encourages all local staff to be trained to deliver trauma informed cognitive behavioral therapy.

Serving the Uninsured: Michigan's legislature appropriates general funds to provide services to non-Medicaid-eligible adults and children who have intellectual/developmental disabilities and serious mental illnesses. The state also uses 1915c waivers to make children with severe emotional disturbances who do not meet parental income requirements but otherwise qualify Medicaid-eligible. Those waivers both make those children eligible and provide access to a wide variety of intensive home and community-based services. 1915c waivers have been particularly helpful for children in the child welfare and juvenile justice systems.

Incorporation of Youth Voices: Michigan centers the voices of impacted communities in the state's mental health work in multiple ways. At the Michigan Association of Community Mental Health Boards, one-third of the advisory council are required to be people served either directly or through their families. School-based health centers have youth and community advisory councils. The Michigan Department of Health and Human Services (DHHS) managed care providers use strengths-based holistic assessments instead of deficit or treatment-based assessments for the children it serves. This allows DHHS to integrate youth peer support, housing support, employment help for parents, truancy work, and food security work into its mental health services.

Maryland



State Context

Maryland has used the opportunities provided by Medicaid expansion and several innovative waivers to create a culture of peer support for youth and young adults:

- Maryland was one of ten states to participate in the 1915(c) Psychiatric Residential Treatment Facility Demonstration Waiver. Through this project, Maryland provided home and community-based services for children and youth with emotional disturbances and their families. This led to the closure of many residential treatment facilities across the state.
- In 2014, Maryland elected to expand Medicaid eligibility, which caused the state's uninsured rate to decline from 10.1 percent in 2012 to 6.7 percent in 2015.
- Maryland has contracted with Regional Care Coordination Organizations in jurisdictions across the state to provide mental health services to youth and young adults, varying the quality and types of services provided in each county.

Medicaid Expansion	Yes – Effective January 2014
Pre-ACA Medicaid Eligibility Level for Single Childless Adults	Up to 116% FPL[27]
Post-ACA Medicaid Eligibility Level for Single Childless Adults	Up to 138% FPL
Carve In vs. Carve Out Model	Carved-out
Key Waivers Impacting Youth and Young adults	Approved 1915 (b) waiver "Mental Health Targeted Case Management" allows for care coordination services for children, youth, and adults with serious mental illness
Defining Context According to Stakeholders	Medicaid expansion increased coverage without increasing reimbursement rates or engaging more providers

Key considerations identified by stakeholders:

- While Medicaid expansion allowed more young adults to gain coverage, the state did not raise its reimbursement rates and did not recruit any more providers. Thus, as more people gained coverage, they still could not obtain services due to lack of providers and practices that accept new Medicaid patients. This is particularly true in rural areas of the state, as providers and services are largely concentrated in urban Baltimore County and Montgomery County.
- Governor Hogan's call to streamline government services led to integration, merging, and elimination of various mental health programs, including the Care Management Entity program.
- In January 2017 Governor Hogan became the nation's first governor to declare a state of emergency due to the opioid epidemic, which allowed Maryland to take a multifaceted approach to addressing substance abuse treatment.

Featured Innovation: Peer-to-peer Support 

On Our Own Maryland, created in 1986, provides technical assistance to a network of twenty-three affiliated peer-operated wellness and recovery centers across the state that are owned, operated, and staffed by individuals with lived experience with mental health and/or substance abuse issues. Through its 1915 waivers and local initiatives to reform mental health care, Maryland has demonstrated its commitment to peer-to-peer support for youth and young adults and their families. Using its previous SAMHSA Systems of Care Expansion Planning Grant, the state hired peer systems navigators that worked with young adults and their families. When the grant expired, the state's Behavioral Health Administration continued to fund the valuable program through the state's general fund.

Maryland renewed its commitment to peer support in 2014 by including family peer support services in the 1915(i) State Plan for Home and Community-Based Services. This funded peer support partners providing a range of individualized services, including those that ensure the family's opinions and perspectives are incorporated into the youth's plan of care and that educate the family on navigating systems of care for their children. With the rise of peer support programs, the Maryland Behavioral Health Administration worked with the Maryland Addiction and Behavioral Health Professional Certification Board to create a peer recovery specialist certification in 2014. This certification is recognized throughout Maryland and across the United States, which allows for career development opportunities beyond the state. This certification is allowing peer recovery specialists to become recognized as legitimate mental health and substance abuse professionals.

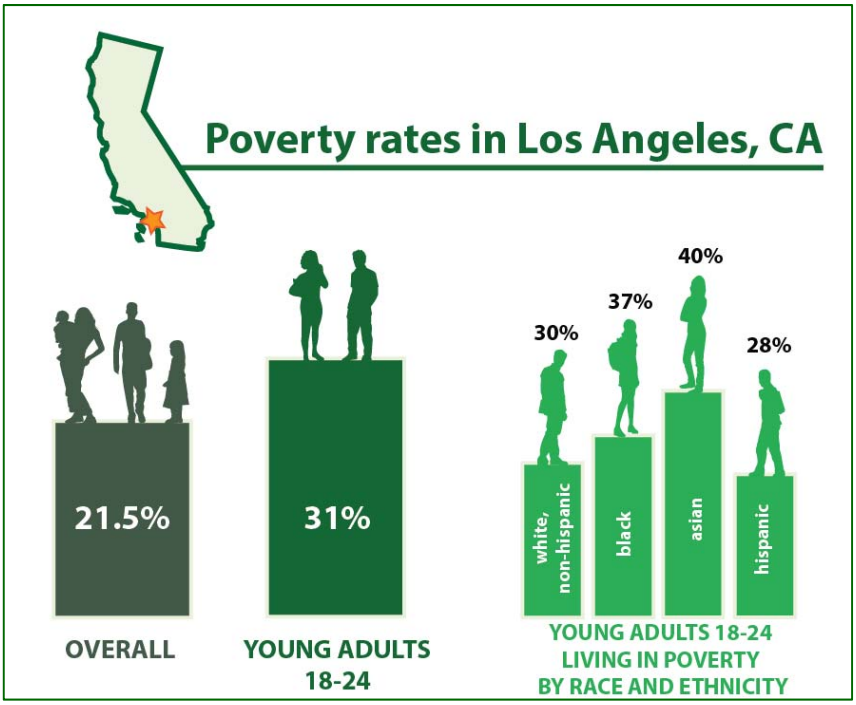
In 2018 the state legislature passed House Bill 772, which requires the Secretary of Health to convene a workgroup to research and make recommendations on reimbursement of certified peer recovery specialists. This amendment to the Medicaid state plan would increase wages for peer recovery specialists and further legitimize this workforce.

The state's prioritization of peer-to-peer support for youth, young adults, and their families reflects its efforts to transform the health care workforce and expand the services typically covered through Medicaid.

Other Strengths

Youth Voice and Engagement: On Our Own Maryland has also taken steps towards engaging transition age youth through the Transitional Age Youth Outreach Project. This Project introduces youth to peer support services and teaches youth to advocate for a behavioral health system that adequately addresses their needs while honoring their voices. This Project provides a way for transition age youth to become involved while also providing youth with the skills and language necessary to meaningfully engage.

Los Angeles, California



Local Context

Los Angeles has a long history of providing mental health services to the underinsured and uninsured by drawing on public-private partnerships and innovative funding streams:

- California received CMS approval to begin early Medicaid expansion in 2010. The state created a county-based coverage expansion program, the Low-Income Health Program (LIHP). In Los Angeles County, 129,813 new individuals enrolled in LIHP by the end of 2013. When ACA coverage expansion began in 2014, those covered through LIHP were auto-enrolled in Medi-Cal or transferred to Covered California, the state's ACA health care marketplace.
- Los Angeles County is considered a "provider" county, as it directly owns and operates inpatient hospitals and clinics, and provides health care coverage to a much broader group of people than is required. It also relies heavily on contracted clinics, particularly for individuals under 21. The Los Angeles County Department of Health is the second largest municipal health system in the nation, with 19 health centers, four hospitals, and partnerships with many community-based clinics.

Medicaid Expansion	Yes – Effective January 2014
Pre-ACA Medicaid Eligibility Level for Single Childless Adults	Up to 133% or between 133% and 200% FPL[28]
Post-ACA Medicaid Eligibility Level for Single Childless Adults	Up to 138% FPL
Carve In vs. Carve Out Model	Carved-out
Key Waivers Impacting Youth and Young adults	Approved statewide 1115 demonstration waiver "California Medi-Cal 2020" allows for health care delivery improvements, including whole person care integration
Defining Context According to Stakeholders	*Katie A. vs Bonta et al*. completely transformed how the LA County Department of Children and Family Services provides mental health services to young adults

Key considerations identified by stakeholders:

- The Los Angeles County Department of Mental Health is the largest such department in the country, serving over 250,000 unique individuals a year. The sheer size of this system and other countywide systems leads to data sharing issues that make tracking clients' referrals and progress difficult.
- The *Katie A. vs. Bonta et al*. class action lawsuit completely transformed the Los Angeles County Department of Children and Family Services. After losing the lawsuit, the County was ordered to provide intensive community and home-based health services for children in foster care through Medicaid and to close institutions such as MacLaren Children's Center.

Featured Innovation: Investment in Innovative Pilot Models 

In Los Angeles, the state's Mental Health Services Act (MHSA) has been key for transforming cross-sector partnerships and connecting different systems of care to improve health care delivery. Passed in 2004 and commonly referred to as the Millionaire's Tax, MHSA imposes a 1 percent income tax on personal income in excess of $1 million to help support mental health services. Since being enacted, MHSA has generated approximately $15 billion for increased funding, personnel, and other resources to support county mental health programs and to monitor progress towards statewide goals for children, transition age youth, adults, older adults, and families. Key MHSA-funded services include prevention and early intervention services that aim to prevent the onset and consequences of mental illness and full-service partnership services that take the "housing first" approach to improve mental health outcomes for those with serious mental illness who experience homelessness.

A provision of MHSA funds Innovative (INN) Programs that are "novel, creative, and/or ingenious mental health practices/approaches that contribute to learning." INN Programs allow counties to pilot new approaches and models that can inform both current and future mental health practices and approaches. This provision of MHSA has allowed Los Angeles County to expand services for transition age youth and to launch INN Programs with cross-sector partners, such as the Los Angeles County Department of Children and Family Services and the Los Angeles Homeless Services Authority.

Through MHSA funding of INN Programs, Los Angeles County has experimented with improving cross-sector partnerships that engage atypical partners in nontraditional ways to better serve youth and young adults.

Other Strengths

Transition Age Youth Programming: The Los Angeles Department of Mental Health has a Transition Age Youth Division that provides mental health and supportive services to youth ages 16 to 25 who are unserved or underserved. Many of these initiatives, including countywide Transition Age Youth Drop-In Centers, are supported through MHSA funding. These initiatives provide an array of services and supports, such as counseling, transportation, housing assistance, and employment support, in residences and communities across the county.

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] Jessica Gehr, *Why the Affordable Care Act Is Critical to Young Adults*, CLASP, 2017, http://www.clasp.org/resources-and-publications/publication-1/Why-the-ACA-Is-Critical-for-Young-Adults.pdf.
[3] Nia West-Bey, Shiva Sethi, and Paige Shortsleeves, Policy for Transformed Lives: State and Local Efforts to Support Young Adult Mental Health, CLASP, 2018.
[4] https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml.
[5] United States Census Bureau, *CPS Table Creator, 2018,* https://www.census.gov/cps/data/cpstablecreator.html
[6]https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_SF4_B17024&prodType=table.
[7] United States Census Bureau, CPS Table Creator.
[8] Adults were only eligible for more limited coverage under the Oregon Health Plan Standard waiver program.
[9] Adults were only eligible for more limited coverage under the Oregon Health Plan Standard waiver program.
[10] Centers for Medicare and Medicaid Services, Medicaid, CHIP, and BHP Eligibility Levels, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/index.html.
[11] Vernon K. Smith, Kathleen Gifford, et al., *Medicaid Reforms to Expand Coverage Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015-2016,* Kaiser Family Foundation, 2015, https://www.kff.org/report-section/medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-managed-care-reforms/.
[12]The primary carve-out is the exclusion of behavioral health services from the physical health plan's capitation rate. Behavioral health services are instead paid fee-for-service (FFS) by the state or managed by a managed behavioral health organization in some type of capitated arrangement. In a primary behavioral health carve-out, the state Medicaid program delegates some or all behavioral health benefits to a separate management entity (private or governmental). In a carve-in model, behavioral health care financing is integrated with physical health. Most states carve-out mental health medication.
[13] Not enough data for the poverty rate of Asian young adults
[14] To be eligible for this limited subsidized coverage under the State Coverage Insurance waiver program, adults had to have income below the eligibility threshold and work for participating employers.
[15] Data for the Louisville / Jefferson County Metro Area
[16] Not enough data for the poverty rate of Asian young adults

[17] Kentucky Health received 1115 waiver from the federal government on January 12, 2018 imposing work requirements. On June 29, 2018, the waiver was vacated following a ruling in the *Stewart et al*., vs. *Azar et al.* lawsuit.
[18] New York implemented the Essential Plan for adults who do not qualify for Medicaid with incomes between 138% and 200% FPL.
[19] The City of New York*, ThriveNYC Year Two Update*, 2018, https://thrivenyc.cityofnewyork.us/wp-content/uploads/2018/02/Thrive-Year-2-Web-Version.pdf.
[20] New York City stakeholder
[21] https://access.nyc.gov/
[22] Not enough data for the poverty rate of American Indian and Alaska Native young adults
[23] SB987 passed in 2018, enacting Medicaid work requirements effective 2020. Michigan would need an approved 1115 waiver to enact work requirements.
[24] Through the Adult Benefits Waiver Adult Medical Program, MI provided limited outpatient benefits to roughly 62,000 childless adults with income below 35% FPL.
[25] Michigan stakeholder
[26] Although Maryland has a relatively low poverty rate, there are multiple regions with the state with significantly higher levels of poverty than the rest of the state. According to 2017 ACS Data, the city of Baltimore had a 23.1 percent poverty rate. United States Census Bureau, *American Fact Finder,* 2018, https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml.
[27] This coverage only included basic primary care services under the Primary Adult Care waiver program.
[28] California expanded coverage through two programs: the Medicaid Coverage Expansion up to 133% FPL and the Health Care Coverage Initiative between 133% and 200% FPL. Both offered more limited benefits.