Improving Substance Use Services for Youth

Policy Opportunities for State Medicaid/CHIP Programs

Christal Ramos
URBAN INSTITUTE

Eva H. Allen
URBAN INSTITUTE

Alexa Eggleston
AUDACIA CONSULTING LLC

Sarah Coquillat
URBAN INSTITUTE

Lisa Clemans-Cope
URBAN INSTITUTE

Kimá Joy Taylor
URBAN INSTITUTE

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Adolescence and young adulthood are critical times in individual development and when many substance use disorders begin. Although Medicaid and the Children's Health Insurance Program (CHIP) cover one in three American children and youth, including more than half of children of color (Brooks and Gardner 2020),[1] few studies examine the use of needed substance use services and supports among enrolled youth. Available research suggests unmet needs for substance use services among Medicaid-enrolled youth, particularly youth of color (Alinsky, Zima, et al. 2020; Hadland et al. 2018; Mintz et al. 2020). Historically, substance use services for youth have been stigmatized and undervalued, resulting in health and education systems that ignore substance use issues or punish the individual rather than treating substance use issues effectively, and youth of color are more likely to face harsh consequences associated with substance use than are white youth (Heitzeg 2009). In this brief, we identify policy priorities that would enable state Medicaid/CHIP programs to transform substance use services to more effectively and equitably serve youth, drawing on data from an environmental scan and discussions with subject matter experts. We find that policies aimed at promoting the provision of prevention and early intervention services, improving the capacity and quality of youth substance use services, and expanding access to care in schools and communities present promising opportunities for state Medicaid/CHIP programs to improve access to care for this population. In addition, states can develop, operationalize, and promote youth-centric approaches for addressing substance use concerns that emphasize health-led interventions and incorporate youth input.

Given Medicaid's dominant roles as a payer for substance use services and an insurer for a large share of adolescents and young adults, state Medicaid/CHIP programs have a tremendous opportunity to transform substance use services to more effectively and equitably support the successful

development and well-being of youth beneficiaries. Drawing on information from subject matter experts and a literature scan (box 1), this brief describes several policy priorities by which Medicaid/CHIP could increase access to a full continuum of developmentally and culturally appropriate substance use services among enrolled youth,[2] including prevention, screening, early intervention, harm reduction, treatment, recovery support, and social services.[3] Findings indicate the following key policy priorities:

- Promote the consistent provision of substance use screening and early intervention among adolescents and young adults, including by enforcing the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requirements and providing guidance and training to primary care and school-based health care providers to effectively screen and provide appropriate follow-up to youth.
- Ensure the adequate capacity of high-quality adolescent substance use services, including by addressing behavioral health workforce shortages; promoting youth peer support services; expanding coverage of services to address health-related social needs; and promoting high-quality substance use care with payment reforms, quality measurement, and data collection and analysis.
- Expand access to substance use and social services in school and community settings, including by addressing barriers to school-based health care programs' participation in Medicaid and by developing and operationalizing a framework for youth-centric approaches to addressing substance use concerns.

By leveraging available authorities and resources, Medicaid/CHIP programs have the opportunity to expand and strengthen the effectiveness of the substance use and other health care services available to youth. In the remainder of this brief, we discuss why it is critical to address substance use issues among adolescents and young adults and provide more details about and specific examples of various levers, tools, and strategies Medicaid/CHIP programs have or can develop to improve equitable access to and the quality of a full range of substance use services for youth.

BOX 1

Research Methods

In September 2020 and April 2021, we hosted three discussions with 30 subject matter experts to identify barriers to and policy opportunities for increasing equitable access to the full continuum of high-quality substance use services (defined as prevention, screening, early intervention, harm reduction, treatment, recovery support, and social services) for youth (defined as people ages 10 to 21) enrolled in Medicaid. We identified experts through a scan of relevant publications and our professional networks and sought to represent a range of views, perspectives, and experiences with youth substance use services. Discussion participants had expertise that included adolescent health and substance use services (8 participants), social and educational services for youth (5 participants), school-based health (6 participants), Medicaid policy (4 participants), and youth well-being advocacy and research (12 participants).[4] Experts represented national associations and local agencies and organizations located in

the District of Columbia, Massachusetts, New Mexico, and Virginia. During the same period, we conducted a scan of relevant publicly available information using PubMed and Google to identify peer-reviewed and gray literature published in the US between 2015 and 2020. We also reviewed literature the subject matter experts had recommended. "Substance use," for the purpose of this study, includes use of illicit substances and alcohol, with a focus on alcohol and opioid use.

A limitation of the study is that, given the relatively small number of experts consulted, some important perspectives are likely missing. In addition, the scan was not a systematic review of published peer-reviewed and gray literature, and the literature was not assessed for methodological rigor. Our findings and conclusions should therefore be interpreted with these limitations in mind.

Why It Is Critical to Address Substance Use Issues among Youth

Adolescence and young adulthood are times of remarkable opportunity during which young people are learning and experiencing rapid growth and critical brain development.[5] The changes that occur create a period of intense learning that helps young people consider who they are and who they want to be. Opportunities to explore new terrains help them develop skills essential for well-being as adults. However, experimentation during adolescence can also involve using alcohol and drugs, which can be a barrier to developing such skills and can negatively affect brain development and exacerbate mental and behavioral health conditions (Squeglia and Gray 2016; Turner et al. 2004; Winstanley et al. 2012). In addition, initiation of substance use during adolescence and younger—as young as 11 for about 10 percent of the population—is a risk factor for developing a substance use disorder (SUD; Clemans-Cope, Lynch, Winiski, Epstein, Taylor, et al. 2021). Research indicates that because of the greater likelihood that early exposure to or use of substances will lead to the development of an SUD, adolescence is among the periods of greatest vulnerability to addiction (Buchmann et al. 2009; Johnston et al. 2021; Volkow, Koob, and McLellan 2016).

Opioid use disorder (OUD) and other risky opioid use among adolescents and young adults can have immediate and long-term adverse consequences for the individuals using opioids, their families, and the public, with far-reaching effects on the criminal justice, emergency response, and entire health care systems (NASEM 2019). Factors associated with developing OUD often emerge during adolescence, including nonmedical opioid use; alcohol, tobacco, and illicit drug use; mental health conditions; and adverse childhood experiences, which encompass traumatic experiences such as abuse, neglect, household dysfunction, parental separation, and domestic violence (Barnett et al. 2019; Anda et al. 2008; Darke, Torok, and Ross 2017; Dube et al. 2003; Quinn et al. 2018; Schepis and Hakes 2017).

Currently, information on access to and use of the full continuum of substance use services and supports for youth is limited. In addition, little is known about the availability of comprehensive and developmentally appropriate care that addresses mental health conditions co-occurring with substance use, as well youth's emotional and social needs, in the community. Medicaid/CHIP, the largest public insurance program for low-income youth, and the educational system, which touches the lives of all

youth, are critical systems charged with supporting the development, health, and well-being of youth. Yet despite these systems' potential to effectively prevent and address substance use among youth, the experts point to a lack of attention to effective substance use care for youth.

Concerning Rates of Substance Use among Youth

Substance use rates among adolescents remain at concerning levels, with more than 15 percent of 8th graders, 30 percent of 10th graders, and 36 percent of 12th graders reporting they had used illicit drugs in the past year in 2020.[6] Rates of substance use among youth of color are generally lower than or the same as those of white youth, except for higher rates for particular substances among American Indian/Alaska Native youth and youth who identify as two or more races (Clemans-Cope, Lynch, Winiski, Epstein, Taylor, et al. 2021). While policy and media attention have focused on OUD because of high overdose mortality rates in the adult population, rates of OUD among youth are low. Among adolescents and young adults enrolled in Medicaid from 2015 to 2018, 0.6 percent had OUD; 3.2 percent had other unhealthy opioid use; 2.5 percent used other nonopioid substances; and 22.3 percent used alcohol, cigarettes, or marijuana without other substances, according to estimates from the National Survey on Drug Use and Health (Lynch, Clemans-Cope, and Winiski, forthcoming). However, these data are known to substantially underestimate the prevalence of substance use disorder, particularly OUD (Barocas et al. 2018). Prevalence of OUD or other unhealthy opioid use was from 1.5 to 24 times higher among Medicaid-enrolled youth with heavy alcohol use, a major depressive episode, or other substance use or health risk factors studied than among other Medicaid-enrolled youth (Lynch, Clemans-Cope, and Winiski, forthcoming).

Underuse of Substance Use Services by Youth

Research supports the effectiveness of various substance use treatment approaches for adolescents (Brewer, Godley, and Hulvershorn 2017; NIDA 2020).It is known that medical provider screenings can identify at-risk adolescents and young adults, and brief interventions in the emergency department and community settings can reduce adolescent marijuana and alcohol use (Bernstein et al. 2009; Levy and Williams 2016; Mason, Sabo, and Zaharakis 2017; McCambridge and Strang 2004). However, we know of no current information about the frequency and places of contact between medical providers and adolescents and young adults with OUD or other risky opioid use (Ford, Bearman, and Moody 1999; Levy and Williams 2016). Some evidence shows that youth with OUD are less likely to receive medications for opioid use disorder (MOUD; i.e., methadone, buprenorphine, naltrexone) than their adult counterparts (Alinsky, Hadland, et al. 2020; Mintz et al. 2020). Furthermore, treatment facilities that offer free and discounted care are less likely to provide MOUD, which means uninsured or underinsured youth are even less likely to receive MOUD than other youth (Alinsky, Hadland, et al. 2020).

Schools are a promising setting for providing substance use services for youth, but they often lack the capacity to identify and adequately treat students' SUD needs (McCance-Katz and Lynch 2019). Moreover, experts we spoke with suggested school environments are often punitive when addressing

substance use, and they attributed this to policies enacted in the 1980s to create drug-free zones around schools and enact zero-tolerance approaches to substance use and other problematic behaviors such as bringing guns to school (Porter and Clemons 2013). Consequently, youth with behavioral health problems, particularly if they are youth of color, may be subject to harsh discipline that may result in their suspension, expulsion, or even jail instead of treatment (Heitzeg 2009; Okonofua, Walton, and Eberhardt 2016; Wallace et al. 2008). The punitive school policy approaches and stigma against youth who use substances have prevented full adoption of health and wellness–based approaches in schools. Additional barriers, such as poverty, discrimination, and trauma, can make it harder to access health care and social supports in the community, which only reinforces inequities and amplifies risks for negative outcomes.[7] These barriers to accessing substance use services are particularly prevalent for low-income families eligible for Medicaid (Kreuter et al. 2021).

Though little research has focused on Medicaid-enrolled youth with an SUD, available evidence points to limited access and inequities in access to evidence-based care. A recent analysis of National Survey on Drug Use and Health data showed that just about half of Medicaid-enrolled youth with unhealthy opioid use or OUD received any substance use screening in the past year, and only 5.6 percent received treatment for unhealthy opioid use and 11.9 percent received treatment for OUD (Clemans-Cope, Lynch, Winiski, Epstein, and Payton 2021). Adolescents and young adults enrolled in Medicaid are also less likely to receive MOUD than those with commercial insurance and have more comorbid SUDs and mental health conditions than adolescents with other types of insurance (Mintz et al. 2020). Another study found that less than one-third of Medicaid-enrolled adolescents and young adults received timely addiction treatment following an opioid overdose, and only 1 in 54 youths received MOUD (Alinsky, Zima, et al. 2020). Research also suggests Medicaid-enrolled Black youth are less likely to receive MOUD than white youth (Hadland, Bagley, Rodean, Levy, et al. 2018; Hadland, Bagley, Rodean, Silverstein, et al. 2018).

Medicaid/CHIP Policy Opportunities to Improve Substance Use Care for Youth

Given that a large share of adolescents and young adults are covered by Medicaid/CHIP, state Medicaid/CHIP programs have a tremendous opportunity to transform substance use services by ensuring the availability of a full continuum of developmentally and culturally appropriate substance use services tailored to support the successful development of adolescents and to allow them to reach their full potential as adults.[8] Moreover, because Medicaid/CHIP disproportionately serves youth from structurally marginalized groups, improvements in substance use services in Medicaid/CHIP could also promote more equitable outcomes across race and ethnicity and income (Brooks and Gardner 2020).[9]

The experts we spoke with and literature we reviewed identified multiple ways in which state Medicaid/CHIP programs could leverage their available authorities, resources, and clout to increase access to a continuum of developmentally appropriate and culturally and linguistically effective substance use services and supports for youth through schools and in the community. For example,

Medicaid/CHIP's role as a major payer of behavioral health services can influence coverage, reimbursement, and delivery of substance use services not only for children and youth covered by the program but for those in the private insurance market (Donohue, Raslevich, and Cole 2020).

In this section, we offer various policies, capacities, and strategies that state Medicaid/CHIP agencies have at their disposal or can develop to improve access, outcomes, and quality of prevention, early intervention, harm reduction and other secondary prevention, treatment, and recovery services for youth. We organized these opportunities around three core priorities: (1) promoting screening and early intervention for substance use concerns, (2) ensuring adequate capacity and high quality of substance use services, and (3) expanding access to substance use and social support services in school and community settings.

Promote Consistent Screening and Early Intervention for Youth with Substance Use Concerns

Even when a benefit is covered by Medicaid/CHIP, our literature scan and input from experts point to other barriers that prevent delivery of substance use services to youth. A prime example is the EPSDT benefit, which requires that Medicaid and many CHIP enrollees under age 21 be periodically screened for mental health conditions, including substance use disorders, as a regular component of comprehensive medical assessments.[10] While preventative services for children are required under the EPSDT benefit, the experts we consulted pointed out that state Medicaid programs tend to emphasize treatment of diagnosed conditions and have limited focus on and reimbursement for prevention and early intervention. For example, programs intended to serve youth with behavioral health issues, including Medicaid Health Homes, are focused on people who have already developed chronic substance use or co-occurring substance use and mental disorders, leaving an important gap in the continuum where there is opportunity for prevention (Center for Health Care Strategies and Mathematica 2021). Furthermore, providers may be reluctant to promptly identify and address substance use problems in youth because of discomfort and stigma around unhealthy youth substance use, perceptions that substance use is a normal rite of passage, a lack of training on identifying unhealthy youth substance use or using validated screening tools, clinician discomfort with medication treatment for youth substance use, and lack of treatment facilities that offer developmentally appropriate substance use services for youth (Alinsky, Hadland, et al. 2020; Bagley et al. 2017; Diaz, Mount Sinai Adolescent Health Center, and ICF 2016; Harris et al. 2012; Meyers et al. 2014).

PROMOTE CONSISTENT PROVISION OF SCREENING WITH THE EPSDT BENEFIT

Medicaid/CHIP agencies can enforce existing requirements and provide incentives to ensure that pediatricians, school-based health centers (SBHCs), primary care providers, and other health professionals screen children and youth for substance use concerns (Wachino and Hyde 2015). A recent review by the US Government Accountability Office of the EPSDT benefit provision found that, overall, only about half of Medicaid enrollees under age 21 receive recommended screenings, with the odds of receiving at least one recommended screening declining as beneficiaries get older; for example, 80 percent of children 2 and younger receive screenings compared with about half of beneficiaries ages 6

to 14, 45 percent of 15-to-18-year-olds, and 22 percent of 19-to-20-year-olds (GAO 2019). These data suggest that states need to improve guidance, training, and oversight of providers and ensure access to developmentally appropriate and culturally and linguistically effective EPSDT services and billing in a wide range of care settings, including SBHCs and substance use treatment organizations. For example, Massachusetts implemented a universal Screening, Brief Intervention and Referral to Treatment (SBIRT) approach in schools in 2016, pursuant to a law enacted by the state legislature, and received Centers for Medicare & Medicaid Services (CMS) approval allowing school districts to bill the program for any Medicaid-enrolled student (i.e., not just students receiving an individualized education program).[11] Universal screening could potentially improve equity and address stigma associated with youth substance use, because all students receive this service regardless of their race or ethnicity, insurance status, or other characteristics. However, outcomes, including referral to treatment or to the criminal justice system, have not yet been evaluated for inequities.

PROVIDE TRAINING AND SUPPORT TO PROVIDERS TO DELIVER SCREENING AND PREVENTION SERVICES

Research indicates both school-based health care and primary care providers need more guidance and training to effectively and systematically screen and provide brief intervention to adolescents and young adults with substance use concerns (Harris et al. 2016; Palmer et al. 2015; Stanhope et al. 2018). One study found that many pediatricians and primary care physicians serving adolescents do not use formal screening tools consistently, and more than half of respondents reported perceiving barriers to effectively referring patients who screened positive for substance use concerns to an SUD specialist (Palmer et al. 2015). Providers also reported they do not always bill for SBIRT given the low Medicaid reimbursement, limiting the data available to monitor when it occurs (Palmer et al. 2015). Providers also indicated that concerns from adolescents' guardians impeded provision of substance use screening or consultation (Hadland, Bagley, Rodean, Levy, et al. 2018; Hadland, Bagley, Rodean, Silverstein, et al. 2018).

These findings suggest that training and technical assistance would help support primary care and school-based health care providers in the provision of substance use screening and brief intervention. The Massachusetts School SBIRT program includes implementation resources and training for school personnel and health care providers.[12] Additional research is needed to understand and address the barriers and challenges states and providers face in implementing this benefit for youth.

Ensure Adequate Capacity of High-Quality Youth Substance Use Services

The historical lack of emphasis on substance use services has resulted in a lack of qualified diverse providers who accept Medicaid/CHIP, particularly substance use and mental health providers, including those who specialize in services for youth (AASA 2019). Medicaid/CHIP programs generally have lower reimbursement rates than Medicare and private insurance (Zuckerman, Skopec, and Aarons 2021). The limited availability of high-quality substance use care providers across the country likely contributes to the lack of availability of these services at schools and in community settings (Bouchery and Dey 2018). For example, in *Student Assistance: A Guide for School Administrators*, the Substance Abuse and Mental

Health Services Administration writes that to implement a student assistance program (i.e., a framework for providing comprehensive services and supports to students experiencing substance use and mental health challenges), schools need to hire or contract with a certified mental health and substance use specialist to provide prevention and intervention services (SAMHSA 2019). As indicated earlier, the limited availability of developmentally appropriate adolescent substance use treatment services to which to refer patients also contributes to pediatricians' and primary care providers' reluctance to screen for substance use problems in youth (Palmer et al. 2015). But experts advised that addressing shortages of youth substance use services needs to go hand in hand with efforts to provide access to and coverage of services that address health-related social needs. Equally important will be ensuring the quality of services provided, including by reforming how services are reimbursed and improving the collection and analysis of data to monitor and address disparities in access to and quality of care.

ADDRESS BEHAVIORAL HEALTH WORKFORCE SHORTAGES

Medicaid/CHIP programs can potentially boost the capacity of substance use service systems in several ways, including by assessing the need to increase reimbursement rates for substance use services, because Medicaid rates are generally low (Zuckerman, Skopec, and Aarons 2021). In Virginia the number of substance use providers participating in Medicaid more than doubled and use of substance use services increased following generous reimbursement increases (Cunningham et al. 2018). In addition, states may reassess the scope of practice and credentialing requirements for midlevel practitioners, such as licensed addiction counselors, nurse practitioners, and physician assistants, to allow such professionals to receive Medicaid/CHIP reimbursement for providing substance use services.[13] Other health care professionals with less professional credentialing tend to be of more diverse racial and ethnic backgrounds than physicians; thus, removing the barriers these professionals face in providing substance use services to youth also has the potential to improve access to culturally and linguistically effective providers (Snyder, Frogner, and Skillman 2018). Research suggests racial concordance between providers and patients is associated with better patient outcomes (Shen et al. 2018; Takeshita et al. 2020).

The unprecedented boom in telehealth services because of the pandemic also presents an opportunity to improve access to substance use care in areas with provider shortages (Moreland, Guille, and McCauley 2021; SAMHSA 2021).[14] Several experts noted that the telehealth option may be particularly important for addressing the stigma associated with receiving treatment (e.g., for youth who do not feel comfortable being seen accessing services in school or in community settings). Furthermore, according to the experts consulted for the study, the use of telehealth—where one can see a provider in a different community or state—could also allow youth to find a provider who speaks their language, is of the same racial or ethnic background, or has other characteristics that are important to the patient. However, telehealth expansion also poses equity challenges related to the digital divide, and ensuring equitable access to telehealth for all adolescents and young adults should be part of the solution (Guth and Hinton 2020).

INVEST IN YOUTH PEER RECOVERY SUPPORT

Community health workers and youth peers with lived experience related to substance use are other key resources to draw on to increase access to culturally and linguistically effective youth substance use services (Simons et al. 2016). As of March 2018, 39 state Medicaid programs covered peer support services for substance use and mental health concerns (Open Minds 2018). However, experts who participated in our discussions noted that a youth in recovery seeking to become an eligible Medicaid provider can encounter considerable red tape, including training and certification requirements and criminal background checks. The medical necessity criteria in Medicaid also limits reimbursement for youth peer support services (Simons et al. 2016). While more research is needed to assess the impacts of peers with lived experiences on treatment and other health and well-being outcomes, the existing evidence points to positive effects of peer support interventions (Eddie et al. 2019; Reif et al. 2014). Youth peer support may be particularly important for engaging adolescents and young adults in prevention of, early intervention for, and treatment of unhealthy substance use and opioid use (Paquette et al. 2019). For example, Project Amp is a four-session intervention that centers young adults in recovery as peers who provide developmentally and culturally appropriate screening, brief intervention, and support services to adolescents with a low-to-moderate risk of substance use (Paquette et al. 2019).[15] A study examining the implementation of Project Amp in various settings concluded that both health care and school settings can effectively incorporate youth peers with lived experiences in conjunction with SBIRT practices (Winn et al. 2019).

ADDRESS HEALTH-RELATED SOCIAL NEEDS

According to the experts consulted for this study, evidence-based strategies in youth substance use prevention that address factors outside health care systems and are based on youth development approaches are not typically reimbursed through Medicaid/CHIP or other health care funding. Substance use treatment providers in one research study indicated that insurance plans do not reimburse enough to cover many of the activities providers undertake when working with adolescents, such as assisting with legal issues and employment, attending meetings at their clients' schools, traveling to meet clients off site, and providing youth with prosocial activities (Acevedo et al. 2020). States could expand Medicaid coverage for health-related social needs, including services tailored to support healthy development of youth such as school supplies, tutoring, and social activities (Hinton and Stolyar 2021; Kenney et al. 2019).[16]

DEVELOP AND TEST ALTERNATIVE PAYMENT MODELS

Some Medicaid/CHIP programs have been shifting toward value-based contracting and alternative payment models that reward providers for high-quality care and outcomes, such as providing incentives (in additional to regular payments) to providers for meeting quality metrics (HCPLAN 2017). Experts consulted for this study believe that value-based payment models, particularly those that aim to incentivize equitable outcomes across race and ethnicity and other key demographic and socioeconomic characteristics, will lead more providers to deliver recommended substance use screenings, preventive care, and other substance use services and supports to youth.

Some value-based payment arrangements for substance use services, including for youth, are emerging (Henderson-Smith, Dormond, and Lange 2018; Pires and Nikkel 2018). For instance, states participating in the Integrated Care for Kids initiative are developing alternative payment strategies to better coordinate and integrate physical and behavioral health care services for children.[17] In another example, coordinated care organizations in Oregon can earn incentive payments based on their performance against a set of core metrics, including screening for alcohol and drug problems and initiating substance use treatment among adolescents (Oregon Health Authority, Metrics Scoring Committee 2020).

Successful implementation of value-based payment models will depend on provider readiness to participate. Providers who have little experience with risk-based alternative payments, such as behavioral health providers and SBHCs, will need to develop the infrastructure to coordinate care, collect and disaggregate data, and analyze and report outcomes (Bailey, Matulis, and Brykman 2019; O'Grady et al. 2020).[18] The flexible federal relief funding provided to school districts under the American Rescue Plan could be used to help build infrastructure and capacity for schools to support value-based payments in Medicaid/CHIP for high-quality substance use care for youth (Johnson and Jackson 2021). For example, the Oregon Health Authority worked with SBHCs to help them obtain recognition as patient-centered primary care homes, which helps prepare and qualify school-based clinics for entering into alternative payment arrangements with coordinated-care organizations and commercial payers (CSHE 2018).

DEVELOP AND TEST YOUTH-CENTRIC MEASURES OF HIGH-QUALITY SUBSTANCE USE CARE

Experts we consulted said that Medicaid/CHIP programs need to establish performance, quality, and outcome measures of substance use services and supports for youth that can be tied to reimbursement and incentive payments for high-quality care. The most common behavioral health and substance use measures tend to focus on substance use and opioid use disorders in adults and may not be appropriate for youth, particularly those at low or moderate risk of developing an SUD (NQF 2019a, 2019b). Yet prevention and early intervention are critical to ensuring adolescents and young adults do not develop SUDs and other comorbid conditions. As such, the experts emphasized that measures focused on screening youth for risky behaviors, delivering brief interventions and other secondary prevention services (if not using harm reduction), and referring youth to developmentally appropriate and culturally and linguistically effective follow-up services are equally important (see earlier reference to the Oregon incentive measures). It will be important for Medicaid/CHIP agencies to experiment in developing and testing new youth-centric processes and outcome measures for substance use services. For example, to incentivize youth-centric health and well-being approaches, outcomes such as not using alcohol and drugs could be replaced with outcomes reflecting a reduction in risky behaviors (e.g., lower weekly intake of alcohol, avoiding driving under influence) and overall wellness (e.g., school engagement, self-reported mental health status). The agencies should also involve youth and providers serving youth in deciding how substance use service outcomes are defined and measured.

IMPROVE DISAGGREGATED DATA ON SUBSTANCE USE SERVICES AND OUTCOMES FOR YOUTH

Experts shared that the data we can use to better understand how frequently and effectively substance use services are being delivered to youth through Medicaid/CHIP are scarce. While evidence-based substance use approaches and services for youth exist, no information is available to determine how many schools or communities use them, how many youth are being reached, and whether such approaches and services affect population-level outcomes, including whether those outcomes are equitable across racial and ethnic groups, immigration status, disability, sexual orientation and gender identity, income, and other characteristics. Data on race and ethnicity and other demographic characteristics and social needs of Medicaid/CHIP beneficiaries are not being collected systematically (Machledt 2021; Ng et al. 2017). According to experts, though some data may exist at the local or state level or in certain federal funding programs, they do not get aggregated and disaggregated or reported in a way that is useful to enact policy or practice change or make other system improvements. State Medicaid/CHIP programs need to invest in the collection, analysis, and sharing of more comprehensive and granular data to understand receipt of health care and substance use services by beneficiaries, such as by collecting more standardized information on race and ethnicity or other demographic information to identify and address disparities (Machledt 2021).[19] In addition, state Medicaid/CHIP programs can facilitate regular analysis of such data to identify and address the specific substance use–related needs of different youth populations. For example, Washington State developed the Children's Behavioral Health Dashboard to monitor behavioral health needs, characteristics, and outcomes of youth enrolled in Medicaid to inform how behavioral health services are designed and delivered (Washington State Department of Social and Health Services 2021).

Expand Access to Substance Use Services and Supports in Schools and in the Community

Before the Affordable Care Act (ACA), coverage of substance use services was an optional Medicaid benefit and, as a result, many states provided only limited substance use service coverage (Boozang, Bachrach, and Detty 2014). In addition to mandated coverage under the ACA, states are seeking to cover a full continuum of substance use services through Medicaid (Bailey et al. 2021). It is unclear to what extent these changes are including improvements to youth substance use services and increasing access to care in places where youth are, like schools. Generally speaking, state Medicaid/CHIP agencies have various options to cover services for youth with substance use concerns (Wachino and Hyde 2015). To improve access to a continuum of substance use and recovery support services for adolescents and youth, the experts consulted for this study advised that services need to be easily available in school and community-based settings. However, experts also acknowledge much groundwork needs to be done to improve the school climate and to develop and implement a shared framework for addressing substance use concerns in youth in ways that meet adolescents' and young adults' developmental, social, emotional, and cultural needs and preferences.

COVER YOUTH SUBSTANCE USE SERVICES DELIVERED IN SCHOOLS

States can use several Medicaid authorities to cover substance use services for youth, including through school-based services. A joint bulletin from the Substance Abuse and Mental Health Services Administration and CMS issued in July 2019 provided guidance to schools on addressing mental health and substance use in schools (McCance-Katz and Lynch 2019). Specifically, section 1905(a) of the Social Security Act says state plan services can be leveraged to provide care in schools. In 2014, CMS released guidance newly allowing Medicaid reimbursement for covered services under the approved state plan provided to Medicaid beneficiaries, even if there is no charge for the service (free care).[20] This reversal of the previous policy, which prohibited payment for free care, opens the door for schools to seek reimbursement for covered services provided to all students enrolled in Medicaid. As of July 2021, CMS had approved 10 updated state plans to update those states' school-based Medicaid programs on this basis of the updated guidance, and many other states had acted to expand their programs (Healthy Schools Campaign 2020; Mays and Stahl 2021).

The literature suggests that implementation and expansion of school-based health services can be particularly effective in ensuring that children and adolescents have equitable access to comprehensive health care by removing barriers such as arranging transportation, having to miss school, or parents having to get time off from work (CPSTF 2016; Knopf et al. 2016).[21] Whereas SBHCs are often mentioned in the literature as a promising setting for substance use services, they reach a relatively small subset of total youth and historically have had limited expertise to address substance use; in 2017, SBHCs provided access to services in approximately 10 percent of US public schools (Love et al. 2019). Several SBHCs have begun to address substance use through the implementation of SBIRT, which is a positive development in the opinion of the experts we spoke with. According to some, one benefit of SBHCs is that they tend to operate autonomously on school grounds, and therefore youth may trust them more because of their added health confidentiality protections.

ADDRESS BARRIERS TO PARTICIPATION IN SCHOOL-BASED MEDICAID PROGRAMS

According to a recent analysis of Medicaid policies, more than half of states and the District of Columbia had policies in place that could present barriers to SBHCs' participation in Medicaid (Wilkinson et al. 2020). The report further noted that health and education leaders in states that allowed Medicaid billing for services provided in school settings reported that dealing with Medicaid/CHIP was complex and administratively burdensome. Another study conducted by the School Superintendents Association similarly found that many school districts, particularly rural and small districts, did not seek Medicaid reimbursement because of the high administrative burden and complex billing procedures (AASA 2019). In February 2021, the AASA, in collaboration with the Healthy Schools Campaign, submitted a letter to CMS requesting, among other things, that CMS address administrative burdens and reimbursement complexities, such as documentation requirements associated with claiming Medicaid reimbursement and fee-for-service billing methodologies, that may prevent many school districts from participating in school-based Medicaid programs.[22]

Other ways Medicaid/CHIP programs can ease administrative burdens associated with billing for school-provided health services include allowing enrollees to obtain services from SBHCs without

requiring a prior authorization or referral from their primary care physician (School-Based Health Alliance 2021). States with managed-care programs can implement policies to ensure managed-care plans reimburse SBHCs even if out of network (School-Based Health Alliance 2021). Several states, including Illinois, Louisiana, Maryland, Michigan, and North Carolina, have implemented such policies and have made sample policy documents available for other states to use.[23] Further, some states also recognize the SBHC as a provider type, which allows state Medicaid/CHIP agencies to track services provided in school settings and hold SBHCs accountable for quality improvement (School-Based Health Alliance 2021). Arizona Medicaid officials provided behavioral health providers with training and guidance materials on billing procedures as part of the expansion of school-based behavioral health services, which contributed to a notable increase in behavioral health services provided to youth.[24]

ENSURE AVAILIBILITY OF SUBSTANCE USE SERVICES IN COMMUNITIES WHERE YOUTH ARE

However, experts reported that not all youth are comfortable accessing mental health and substance use services in school settings. In fact, research suggests a lack of full uptake of available services by students is a challenge for implementing SBHCs (CPSTF 2016). In addition, as was emphasized in our panel discussions, not all adolescents are in traditional school settings; often referred to in the literature as "disconnected" or "opportunity" youth, such young people may be receiving their education through alternative settings or be participating in community-based systems such as workforce development programs (Burd-Sharps et al. 2017; Mendelson et al. 2018). According to experts, training staff at community-based organizations about substance use would likely benefit a wide-ranging group of youth, including those not in school. For example, YouthBuild employment and training programs funded by the US Department of Labor integrate substance use services, including screening and brief intervention (Miller et al. 2018).[25]

DEVELOP AND OPERATIONALIZE A FRAMEWORK FOR YOUTH SUBSTANCE USE SERVICES

Though adolescence is a critical period of development, experts we talked to emphasized that the needs, preferences, and opinions of the diverse groups of people who are no longer children but not yet adults are seldom centered in educational and health care settings. The experts argued that to develop a system of substance use care that is developmentally and culturally responsive to youth, policymakers, educators, and health care providers must prioritize and engage diverse adolescents and young adults (across all intersections) to develop principles for providing services to youth. These would include actively involving youth in treatment plans and goal setting and respecting their privacy (e.g., not notifying parents unless required by law). The Center for Law and Social Policy's 10 core competencies for youth-centered mental health systems include approaches such as trauma-informed care, positive youth development, authentic youth engagement, and cultural responsiveness, and they focus on prevention, unmet health-related social needs, and wellness (West-Bey and Bunts 2020). These could serve as an initial template for developing youth-centric substance use service systems.

In addition, guidance is lacking regarding developmentally appropriate and culturally and linguistically effective harm reduction, treatment, and recovery services for adolescents and young adults diagnosed with substance use and/or opioid use disorders. Recently released priorities for substance use care for young adults emphasized access to evidence-based substance use treatment,

harm reduction, and recovery support services and family engagement in treatment, comorbid psychiatric conditions, and criminal justice reform (Silverstein et al. 2021). Such priorities could be tailored and updated to include adolescents, ideally with input and collaboration of diverse adolescents and young adults affected by unhealthy substance use.

Experts indicated that Medicaid/CHIP programs can use their leverage as dominant payers for youth services by working with state licensing boards, medical associations, managed-care plans, and other stakeholders to develop and provide guidance, technical assistance, and training to health providers on youth-centric practices and approaches. Agencies can also use their clout with state policymakers and other state agencies and coalitions (e.g., education departments, children's cabinets, and opioid task forces) to highlight the importance of addressing unhealthy substance use among youth and to promote and coordinate youth-centric approaches and outcome measures for substance use prevention, treatment, harm reduction, and recovery services with specific attention to health equity.

According to discussants, implementing developmentally appropriate and culturally and linguistically effective school-based interventions based in therapeutic and compassionate approaches will require moving away from approaches such as zero-tolerance policies and promoting a school climate of healing and well-being. This would involve broader efforts to educate school leadership, educators, staff, and parents about substance use as an "adolescent onset" health condition. The experts also emphasized the importance of addressing substance use in youth through a therapeutic, nonpunitive framework. Otherwise, youth may not feel comfortable disclosing their substance use for fear of punishment or other forms of retribution. Experts said this may be particularly true for young people of color, who are disproportionately affected by punitive school discipline policies. Reforming punitive school approaches to youth substance use can decrease inequities and promote an environment where all youth have equal opportunity to thrive and receive services and support for behavioral health concerns.[26]

Conclusion

Given the large share of youth enrolled in Medicaid/CHIP, state Medicaid/CHIP programs are uniquely well positioned to help address concerning rates of substance use and underuse of substance use services among youth. Medicaid/CHIP programs have not been effective in providing substance use services to youth. The most important policy priorities include promoting consistent screening of adolescents and young adults for substance use concerns using the EPSDT benefit, ensuring adequate capacity and quality of substance use services through workforce development and payment and delivery system reforms, and expanding access to substance use care and social supports in schools and community settings. Importantly, Medicaid/CHIP programs can be leaders in developing, operationalizing, and promoting the use of youth-centric approaches for addressing substance use concerns that incorporate input from youth on where, how, and by whom services should be provided and how outcomes should be defined and measured.

While the school may seem an ideal setting for addressing unhealthy substance use, the prevalent approaches and policies are such that students are more likely to be dismissed or punished for substance use than offered help (Prins et al. 2021). For schools to be an effective setting for the delivery of substance use services and supports, youth must feel safe seeking the help they need without fearing punishment or entering the school-to-prison pipeline, as has been particularly the case for boys and young men of color (Wilson 2014). Thus, we need broader efforts to reform school policies and climate and to educate school leadership, educators, staff, and parents about appropriate, health-based, and therapeutic responses to substance use issues.

Medicaid and CHIP play pivotal roles in shaping the scope and quality of health care services for youth. Policies and investments outlined in this brief can potentially have a positive impact on youth outcomes and reduce the cost of addiction to society by intervening during a critical developmental period. By strengthening and expanding clinical and nonclinical benefits, improving service capacity and quality, and ensuring availability of substance use services and supports across different settings and levels of care, Medicaid/CHIP agencies can help provide the resources needed to improve the effectiveness of the substance use and other health care services available to youth. Designing and implementing these approaches with a focus on and input from youth can potentially meet the diverse needs and preferences of our nation's youth in terms of their race, ethnicity, language, sexual orientation, and gender identity.

Though this brief focuses on the roles Medicaid and CHIP can play in supporting effective substance use services for youth, the policy priorities discussed herein have implications for substance use services among youth covered by private health insurance as well. And, as indicated throughout this report, parents, schools, health care providers, and community-based organizations need to be on the same page in destigmatizing and prioritizing evidence-based treatment and supports for youth with substance use issues, particularly given that the pandemic is exacerbating mental health and substance use concerns for youth (Panchal et al. 2021). The time is now to focus on providing effective prevention, screening, brief intervention, treatment, harm reduction, and recovery services for our adolescents and young adults. A failure to act could have devastating consequences for generations to come, particularly for youth in low-income families and for Black, Hispanic/Latinx, and Native American youth.

Notes

[1] Tricia Brooks, "Medicaid and CHIP Provide Health Coverage to More than Half of Children of Color," *Say Ahhh!* (blog), Georgetown University Health Policy Institute, Center for Children and Families," July 27, 2020, https://ccf.georgetown.edu/2020/07/27/medicaid-and-chip-provide-health-coverage-to-more-than-half-of-children-of-color/; and "Health Insurance Coverage of Children 0-18," Kaiser Family Foundation, accessed December 8, 2021, https://www.kff.org/other/state-indicator/children-0-18/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[2] For the purposes of this paper and because of its focus is on the Medicaid population, we define youth enrolled in Medicaid as people between ages 10 and 21. However, definitions of "youth" vary. The available literature and data on substance use prevalence in youth are typically available for people ages 12 and older, where

adolescents are most often defined as people ages 12 to 17, and young adults are most often defined as people ages 18 to 25.

[3] "An Introduction to the ASAM Criteria for Patients and Families," American Society of Addiction Medicine, accessed December 21, 2021, https://www.aetna.com/document-library/healthcare-professionals/documents-forms/asam-criteria.pdf.

[4] The numbers do not add up to 30 because several discussants have expertise in multiple subjects.

[5] "The Core Science of Adolescent Development," University of California, Los Angeles, Center for the Developing Adolescent, accessed December 8, 2021, https://developingadolescent.semel.ucla.edu/core-science-of-adolescence.

[6] "Monitoring the Future Study: Trends in Prevalence of Various Drugs," National Institute on Drug Abuse, December 17, 2020, https://www.drugabuse.gov/drug-topics/trends-statistics/monitoring-future/monitoring-future-study-trends-in-prevalence-various-drugs.

[7] "The Core Science of Adolescent Development," Center for the Developing Adolescent.

[8] "Who Enrolls in Medicaid and CHIP?," Medicaid.gov, accessed December 8, 2021, https://www.medicaid.gov/state-overviews/scorecard/who-enrolls-medicaid-chip/index.html#child-enrollment.

[9] Brooks, "Medicaid and CHIP Provide Health Coverage to More than Half of Children of Color," *Say Ahhh!* (blog).

[10] The EPSDT benefit is not required in separate CHIP programs. Currently, all but two states (CT, WA) use Medicaid to serve some or all children enrolled in CHIP. For more information, see "CHIP State Program Information," Medicaid.gov, accessed December 8, 2021, https://www.medicaid.gov/chip/state-program-information/index.html; "CHIP Program Structure by State," Medicaid.gov, accessed December 8, 2021, https://www.medicaid.gov/chip/downloads/chip-map.pdf; and "Birth to 5: Watch Me Thrive!: CMS Efforts to Ensure Children Receive Developmental and Behavioral Screening," Centers for Medicare & Medicaid Services, accessed December 8, 2021, https://www.medicaid.gov/sites/default/files/2019-12/cms_fact_sheet_dev_screening.pdf.

[11] See "SBIRT in Schools," MASBIRT, accessed December 8, 2021, https://www.masbirt.org/schools; and "Massachusetts State Plan Amendment (SPA) #: 16-012," Centers for Medicare & Medicaid Services, accessed December 8, 2021, https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MA/MA-16-012.pdf.

[12] "SBIRT in Schools," MASBIRT.

[13] National Conference of State Legislatures (NCSL), "Utilizing Addiction Counselors to Improve Access to Behavioral Health Services," NCSL blog, August 29, 2019, https://scopeofpracticepolicy.org/behavioral-health-providers/utilizing-addiction-counselors-to-improve-access-to-behavioral-health-services/; and "Behavioral Health Providers Overview," NCSL, accessed December 8, 2021, https://scopeofpracticepolicy.org/practitioners/behavioral-health-providers/.

[14] Michelle Marino, "Treating Youth's Substance Use Disorder Using Telehealth," HealthCity, December 8, 2020, https://healthcity.bmc.org/population-health/treating-youths-substance-use-disorder-using-telehealth.

[15] For more about Project Amp, see https://c4innovates.com/who-we-are/our-projects/project-amp/.

[16] For example, some Medicaid managed-care plans offer supports for school and after-school activities. See "Introducing Carolina Complete Health," Carolina Complete Health, accessed December 21, 2021, https://www.carolinacompletehealth.com/discovercarolinacompletehealth.html?utm_source=discovercarolinacompletehealth.com&utm_campaign=Discover%20Carolina%20Complete%20Health&utm_medium=Referral.

[17] "Integrated Care for Kids (InCK) Model," Centers for Medicare & Medicaid Services, accessed May 4, 2021, https://innovation.cms.gov/innovation-models/integrated-care-for-kids-model.

[18] Jonathan Brown and Allison Wishon Siegwarth, "Helping Behavioral Health Providers Succeed in Value-Based Payment," Mathematica blog, November 5, 2020, https://www.mathematica.org/blogs/helping-behavioral-health-providers-succeed-in-value-based-payment.

[19] Elizabeth Lukanen and Emily Zylla, "Exploring Strategies to Fill Gaps in Medicaid Race, Ethnicity, and Language Data," State Health and Value Strategies, October 1, 2020, https://www.shvs.org/exploring-strategies-to-fill-gaps-in-medicaid-race-ethnicity-and-language-data/.

[20] Cindy Mann (director, Centers for Medicare & Medicaid Services), letter to state Medicaid directors, regarding "Medicaid Payment for Services Provided without Charge (Free Care)," December 15, 2014, https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf.

[21] See "About School-Based Health Care," School-Based Health Alliance, accessed December 8, 2021, https://www.sbh4all.org/what-we-do/school-based-health-care/aboutsbhcs/.

[22] AASA; Healthy Schools Campaign; AIDS Alliance for Women, Infants, Children, Youth & Families; American Academy of Pediatrics; American Association for Marriage and Family Therapy; American Association for Psychoanalysis in Clinical Social Work; American Association of Suicidology; American Federation of Teachers; et al., letter to the Centers for Medicare & Medicaid Services, regarding updating school-based Medicaid guidance, February 16, 2021, https://adaa.org/sites/default/files/Letter%20to%20CMS%20on%20Updating%20School%20Based%20Medicaid%20Guidance.pdf.

[23] "Medicaid Policies That Work for SBHCs," School-Based Health Alliance, accessed December 8, 2021, https://www.sbh4all.org/what-we-do/policy/medicaid-policies-that-work-for-sbhcs/.

[24] Anita Cardwell and Gia Gould, "Through Coordination and Investment, Arizona Substantially Increases Access to School-Based Behavioral Health Services," National Academy for State Health Policy, April 26, 2021, https://www.nashp.org/through-coordination-and-investment-arizona-substantially-increases-access-to-school-based-behavioral-health-services/.

[25] "YouthBuild," US Department of Labor, accessed December 8, 2021, https://www.dol.gov/agencies/eta/youth/youthbuild.

[26] See "Zero Tolerance," School Discipline Support Initiative, accessed December 8, 2021, https://supportiveschooldiscipline.org/zero-tolerance-policy; Dianne McKinley, "Climate and Culture in Schools—from Toxic to Positive," INcompassing Education blog, January 27, 2021, https://incompassinged.com/2017/06/01/climate-and-culture-in-schools-from-toxic-to-positive/; and Libby Nelson and Dara Lind, "The School-to-Prison Pipeline, Explained.," *Vox*, October 27, 2015, https://www.vox.com/2015/2/24/8101289/school-discipline-race.

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About the Authors

Christal Ramos is a former senior research associate in the Health Policy Center at the Urban Institute, where her work focused on a range of topics, including payment and delivery system reforms, health information technology, and opioid use disorder and treatment, particularly in Medicaid. She has experience with both qualitative and quantitative research methods and has played a key role in a number of federal evaluation and technical assistance contracts. Before coming to the Urban Institute, Ramos was a senior research associate in the Health Policy Department at the George Washington University, where she studied health care quality and health disparities.

Eva H. Allen is a senior research associate in the Health Policy Center at the Urban Institute, where her work focuses on the effects of Medicaid policies and initiatives on disadvantaged populations, including people with chronic physical and mental health conditions, pregnant and postpartum women, and people with substance use disorders. Allen has played a key role in several federal demonstration evaluations, as well as research projects on a range of topics, including opioid use disorder and treatment, long-term care services and supports, and health care partnerships with other sectors to address health and social needs of communities. Her current work also includes a focus on incorporating health and racial equity lens in research and policy analysis. Allen is experienced in

qualitative research methods and adept at communicating complex policy issues and research findings to diverse audiences.

Alexa Eggleston is founder of Audacia Consulting LLC, a consulting practice she launched to support strategic advances in improving the lives of young people and those impacted by substance use and addiction. Eggleston has more than 20 years of experience in the nonprofit sector, including more than 10 years in leadership and management positions leading national initiatives, developing and implementing strategic plans to affect policy and practice change, and increasing research translation and implementation. Eggleston led implementation of the Conrad N. Hilton Foundation's youth substance use prevention and early intervention initiative, has served as substance abuse program director with the Council of State Governments Justice Center, and also worked as director of public policy for the National Council for Behavioral Health.

Sarah Coquillat is a research analyst in the Urban Institute's Health Policy Center where her work focuses on a range of topics, including substance use disorder and treatment, particularly in Medicaid, maternal health, and health equity. She has extensive experience with both qualitative and quantitative research methods.

Lisa Clemans-Cope is a senior fellow in the Health Policy Center at the Urban Institute with expertise in behavioral health; substance use disorders, including opioid use disorder; and youth and maternal behavioral health. She leads quantitative research drawing on survey and administrative data as well as qualitative and mixed-methods studies. Her work assesses equity and disparities in behavioral health care and examines access to and the cost and quality of all types of health care for diverse populations, particularly those insured by Medicaid. Clemans-Cope has published research in *Health Affairs*, the *New England Journal of Medicine*, the *Journal of General Internal Medicine*, *Inquiry*, *Academic Pediatrics*, *Pediatrics*, *Public Health Reports*, the *Journal of Substance Abuse Treatment*, *Drug and Alcohol Dependence*, and the *Journal of Perinatology*.

Kimá Joy Taylor is a nonresident fellow at the Urban Institute and founder of Anka Consulting, a health care consulting firm. Taylor collaborates with Urban Institute researchers on a number of topics, including racial disparities in screening and treatment practices for parents with substance use disorder, management of neonatal abstinence syndrome at hospitals in California, and prevention and early detection of mental and behavioral health problems among adolescents and young adults. She most recently served as the director of the Open Society Foundations' National Drug Addiction Treatment and Harm Reduction program. Before joining the Open Society Foundations, Taylor served as deputy commissioner for the Baltimore City Health Department, a health and social policy legislative assistant for Senator Sarbanes, and a pediatrician at a federally qualified health center in Washington, DC.

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500 L'Enfant Plaza SW
Washington, DC 20024

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