POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

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Improving Substance Use Prevention, Assessment, and Treatment Financing to Enhance Equity and Improve Outcomes Among Children, Adolescents, and Young Adults

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Access to timely prevention and treatment services remains challenging for many children, adolescents, young adults, and families affected by substance use. The American Academy of Pediatrics recognizes the scope and urgency of this problem and has developed this policy statement for consideration by Congress, federal and state policy makers, and public and private payers. This policy statement updates the 2001 policy statement "Improving Substance Abuse Prevention, Assessment, and Treatment Financing for Children and Adolescents" and provides recommendations for financing substance use prevention, assessment, and treatment of children, adolescents, and young adults.

Prevention, early identification, and treatment of substance use during childhood, adolescence, and young adulthood is key in promoting the sustained health and well-being of these populations.[1] Failure to intervene early or provide age-appropriate substance use services can result in substantial and long-term individual, familial, and intergenerational adverse consequences.[2] Unfortunately, the availability and financing of substance use prevention, assessment, and treatment services does not meet the needs of young people. According to 2019 data from the National Survey on Drug Use and Health, only 8% of adolescents and young adults who needed treatment of substance use actually received substance use treatment.[3] Racial/ethnic disparities in treatment access are linked to social, economic, and criminal justice inequities as well as stigma toward substance use within the health care system.[4–6] Black and Hispanic adolescents and young adults with substance use disorders (SUDs) are disproportionately affected by

abstract

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these inequities and, as of 2021, were less likely than non-Hispanic White youth to receive specialty substance use treatment.[7,8] The majority of adolescents and young adults with opioid use disorder (OUD) do not receive OUD medications, and non-Hispanic Black and Hispanic youth are less likely to receive medications than non-Hispanic White youth.[9–13] Additional training and workforce development around substance use and health equity is necessary if pediatric clinicians are to meet the need for these services in their practice settings. Parallel to this, it is also essential to improve coverage and payment for substance use prevention, assessment, and treatment services for the pediatric population.

PREVALENCE OF SUBSTANCE USE AMONG CHILDREN, ADOLESCENTS, AND YOUNG ADULTS

Substance use affects all age groups across the lifespan. In 2017, approximately 1 in 8 children in the United States lived with at least 1 parent with an SUD.[14] The 2021 Monitoring the Future Study, a long-term study that tracks substance use trends in the United States, shows that rates of substance use among adolescents have been trending downward over the past 4 decades.[15] However, substance use remains common, with alcohol, cannabis, and tobacco being the most frequently used substances by adolescents.[15] In 2021, 11.8% of 12th graders and 4.5% of eighth graders reported binge drinking at least once in the past 2 weeks. Rates of using e-cigarettes (vaping) have increased exponentially over the past decade; in 2021, up to 26.6% of 12th graders reported vaping nicotine and 18.3% reported vaping cannabis in the past year. As many as 19.5% of high school seniors and 4.1% of eighth graders reported using cannabis in the past 30 days. In addition, 12.8% of 12th graders had tried an illicit drug other than cannabis (such as methamphetamines, cocaine, or heroin) at least once in the past year. In 2019, more than 5.9 million adolescents and young adults had an SUD, of which more than 300 000 had an OUD.[3]

Differences in exposure to social-environmental risk and protective factors contribute to disparities in rates of substance use between groups. Examples of substance use risk and protective factors include those related to the social determinants of health (eg, access to quality education, employment, health care, prosocial and faith-based activities), exposure to alcohol and tobacco use and marketing, and social connectedness with family and community.[16] Unique combinations of these social-environmental influences, as well as differences in exposures to generational trauma, childhood trauma, discrimination, racism, and marginalization, contribute to disparities in substance use.[17,18] For example, rates of substance use are higher among sexual and gender minority youth than among heterosexual and cisgender youth.[19] American Indian/Alaska Native adolescents living on or near reservations have rates of alcohol, cannabis, and other drug use that are higher than the national average.[20,21] Rates of alcohol and tobacco use are higher among non-Hispanic White youth than Black or Hispanic youth; however, by adulthood, rates between groups are more similar.[19,22,23] Further, youth with intersectional identities, or those with multiple identities with varying susceptibilities to disadvantage and privilege (eg, sex, age, class, gender identity),[24] have higher risk of developing substance use-related problems than those without. These disparities highlight the importance of fortifying protective factors, such as equitable access to substance use prevention and treatment services, through national, state, and local policy initiatives.

Adolescence and young adulthood are vulnerable developmental periods for the onset of both SUDs and other mental health disorders. Among adolescents and young adults presenting for substance use treatment, up to ~75% also have another co-occurring mental health diagnosis.[25,26] Mental health disorders that commonly co-occur with SUDs in adolescents and young adults include attention deficit/hyperactivity disorder, conduct disorder, and/or depression.[27] Earlier age of onset of substance use is associated with a higher likelihood of developing SUDs and co-occurring mental health diagnoses, highlighting the need for prevention and early intervention services that begin in childhood.[28]

PREVENTION, EARLY INTERVENTION, AND TREATMENT OF SUBSTANCE USE AMONG CHILDREN, ADOLESCENTS, AND YOUNG ADULTS

There is growing evidence that primary prevention, early intervention, and treatment carries significant benefit for the individual and society.[1,29] Substance use primary prevention strategies include those that begin in early childhood; for example, family-based prevention programs such as Triple P, Family Check-up, and the Incredible Years have been shown to enhance protective factors that decrease substance use initiation risk.[30] Both Triple P and the Incredible Years are feasible to implement in primary care settings.[31,32] Family-based primary prevention programs for school-aged children and early adolescents, such as the Strong African-American Families Program, Strengthening Families, and Familias Unidas Preventive Interventions, have been shown to reduce substance use during adolescence.[30]

Indicated prevention interventions (those that are targeted toward adolescents showing early signs of behavioral problems), such as Functional Family Therapy or Multisystemic Therapy, have also been shown to reduce substance use. The American Academy of Pediatrics (AAP) published a clinical report and policy statement that addresses universal screening, brief intervention, and referral to treatment (SBIRT). SBIRT allows clinicians to intervene early with adolescents and young adults who use substances and link them to appropriate treatment interventions.[33] Lack of access to appropriate treatment sources is a major barrier to SBIRT implementation. Integrated behavioral health care, wherein both behavioral and medical providers function together as members of the care team, is an evidence-based strategy for delivering substance use services within primary care.[34] Research has shown that brief interventions delivered by behavioral health clinicians embedded in primary care are effective in reducing substance use and improving treatment initiation among adolescents.[35,36]

Cognitive behavioral therapy and family-based treatment are also evidence-based treatments that have been shown to decrease substance use and related problems.[37] For youth with SUDs and co-occurring mental health diagnoses, integrated treatment of both disorders has been shown to result in superior outcomes compared with separate treatment of each diagnosis.[38] The AAP has published policy statements recommending buprenorphine for the treatment of OUD in adolescents and nicotine replacement therapy for adolescents with moderate or severe tobacco use disorder.[39,40] Although there has been limited research specifically examining the impact of harm reduction interventions such as naloxone and syringe exchange programs on opioid-related harms in adolescents and young adults,[41] evidence has shown that these programs reduce risk of overdose as well as HIV and hepatitis C infection among people who inject drugs.[42–44]

REVIEW OF POLICIES THAT AFFECT THE CARE OF CHILDREN, ADOLESCENTS, AND YOUNG ADULTS AFFECTED BY SUBSTANCE USE

Several health care policies address the known financing barriers to receiving substance use services. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that requires health insurance issuers that provide SUD or other mental health benefits to provide this coverage on par with medical/surgical benefits. For example, if a person's health insurance plan allows unlimited medical appointments for conditions such as diabetes mellitus, then the plan must also allow for unlimited medical visits for a substance use condition such as alcohol use disorder. The MHPAEA does not require that substance use services be included as part of the scope of benefits within all health insurance plans, nor does it ensure the quality, availability, or timeliness of treatment services. Individual states can enact additional laws to further require private insurers to cover SUD treatment. State-level parity laws have been shown to be associated with a 26% increase in the number of adolescents with SUD in treatment.[45]

The 2010 Patient Protection and Affordable Care Act (ACA) gave all 50 states the opportunity to extend Medicaid eligibility to adults who are not pregnant or disabled, increase income-based eligibility to all households with income less than 138% of the federal poverty level, and include coverage of adult dependent children until 26 years of age. The law also required state Medicaid programs to cover tobacco cessation counseling and medications for pregnant women. Medicaid expansion to adults has been demonstrated to have positive effects on children's coverage and care.[46] As of February 2021, 38 states and the District of Columbia have accepted these federal funds to expand their Medicaid population.[47] The ACA also mandated that individually purchased health insurance plans and insurance plans in small group markets cover a list of "essential health benefits," which include substance use treatment and other mental health treatment services.

The 2016 Comprehensive Addiction and Recovery Act was undertaken in response to the opioid crisis and provides grant support for programs that expand education, prevention, treatment, or recovery services. Initiatives within the legislation that affect pediatric populations include those that support opioid misuse prevention programs for youth, access to OUD medications for adolescents and young adults, and treatment strategies for pregnant and postpartum women with OUD. The 2018 Substance Use disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act also includes provisions to improve access to evidence-based SUD prevention and treatment services, including medications for the treatment of OUD. In response to lawsuits filed by cities and states against opioid drug manufacturers and prescribers, public health experts have also identified opioid settlement funds as a potential source of revenue to support increased local access to care among those affected by OUD.[48]

FINANCING CHALLENGES FOR CHILDREN, ADOLESCENTS, AND YOUNG ADULTS AFFECTED BY SUBSTANCE USE

As of 2019, 5.1% of children younger than 18 years were uninsured, 41.4% had public insurance coverage, and 55.2% had private health insurance coverage.[49] Among young adults, 15.1% were uninsured, 20.3% had public insurance coverage, and 65.8% had private health insurance.[49] With the MHPAEA and the ACA in place, both public and private insurance plans (excluding those plans that are exempt from the ACA requirements) that choose to provide coverage for substance use and other mental health treatment should cover these services at a level comparable to medical or surgical diagnoses. This coverage should be available for children, adolescents, and young adults up to 26 years of age or until 18 years of age in states that did not expand their Medicaid programs with federal support.[50]

Despite these legislative milestones, continued lack of insurance coverage (uninsurance) and inadequate coverage (underinsurance) leave a substantial number of children, adolescents, and young adults without sufficient insurance coverage to access and pay for prevention, assessment, and treatment services for substance use.[51] Despite reduced disparities in uninsurance since the passage of the ACA, as of 2018, Hispanic and American Indian/Alaska Native children were still significantly more likely than White children to lack insurance coverage.[52] Undocumented immigrant children continue to lack eligibility for insurance coverage in many states.[53] Many individuals without insurance rely on a "safety net" system of care, such as federally qualified health centers, "free" clinics, emergency departments, and Hill-Burton facilities and hospitals. Compared with care for insured patients, care for uninsured patients tends to be more limited, episodic, and without the benefits of a patient-centered medical home.[54]

Discontinuity of insurance disproportionately affects the ability of specific populations, such as adolescents exiting foster care or juvenile detention, to access timely prevention and treatment services.[55,56] Although Medicaid is the largest source of publicly funded insurance in the United States, eligibility requirements vary from state to state, leading to varying insurance coverage for children between states and systematic geographic inequities in access to substance use treatment. To address these systematic inequities, the AAP has published policy statements on the provision and funding of health care services for children, adolescents, and young adults from birth to the age of 26 years.[57,58]

Among those who are insured, limitations in the scope of benefits, high out-of-pocket costs, and inadequate payments create barriers to substance use care for children, adolescents, and young adults. When substance use or other mental health services are provided at a health maintenance visit or along with other medical services, insurers frequently do not pay separately for each of these services when provided on the same date. Even if substance use services are included as a covered benefit, the coverage may not be "sufficient in the type, amount, frequency, duration, setting, and scope to enable care that achieves the best clinical outcome."[58,59] In other words, optimal treatment of SUDs may require a greater number of outpatient visits and/or inpatient days than are specified within the patient's health insurance plan. Optimal treatment may also include prevention services, assessment, early intervention, relapse prevention, crisis intervention, group therapy, family therapy, partial hospitalization or day treatment, or residential care, which may not be included as a covered benefit. Limitations on the number of follow-up visits or inpatient hospital days may interfere with access to high-quality care that may be needed for complete treatment and recovery. In the case of OUD, high out-of-pocket costs for medications, such as buprenorphine, may deter some adolescents from adequately accessing this evidence-based form of medication treatment.

Both private and public health insurance plans "carve out" benefits related to substance use via contracts between the health plans and third-party providers of these services. When the primary insurer carves out these services, contracting entities may not always have sufficient numbers of specialty physicians, nonphysician clinicians, psychologists, social workers, or counselors in their networks to provide the needed care for pediatric populations.

Suboptimal payment rates and funding also serve as a barrier to achieving optimal substance use screening, prevention, and treatment services.[50,59,60] Substance use services are medically necessary; therefore, payment for these services and payment should be sufficient to appropriately compensate physicians and nonphysician clinicians for these services. Although Medicaid benefits include coverage of substance use services, payment rates have been very low and, as a result, serve as a disincentive to provide pediatric substance use services.[61,62] Publicly supported substance use services are often underfunded and typically available only for youth with serious emotional disturbances.[63] Many young people, particularly those who are just beginning to use

substances, may not qualify for Medicaid-funded services. Moreover, children who are privately insured but without adequate substance use and other mental health benefits are seldom eligible for Medicaid-funded services.

Assessment and treatment of SUDs often involves a team, including primary care physicians, psychologists, psychiatrists, addiction specialists, clinical social workers, drug and alcohol counselors, and community- and hospital-based programs. In the primary care setting, pediatricians are seldom able to receive adequate payment for providing counseling and education services for substance use. Insurance plans may require 15 to 30 minutes of counseling time to pay pediatricians for SBIRT or other services related to counseling and early intervention; lack of adequate payment for the time needed to appropriately perform the service is a barrier to SBIRT implementation in busy primary care settings.[64,65] Integrated behavioral health models, which encompass consultation, care coordination, and colocation of behavioral health clinicians in primary care, are difficult to implement because of lack of payment for collaborative care services, behavioral health "carve-out" contracts not allowing clinicians to bill for certain services in primary care, and lack of payment for medical and behavioral health visits provided on the same day.[66]

Compounding these difficulties is the overall shortage of ambulatory and inpatient substance use services for children, adolescents, and young adults. In the hospital setting, limited availability of ambulatory and inpatient substance use services contributes to increased emergency department visits for nonurgent substance use-related concerns and lengthened hospital stays for youth with SUDs admitted for medical and psychiatric stabilization.[67]

Finally, difficulty in maintaining confidentiality in billing and referral processes adds another barrier for many youth seeking substance use services.[68] The primary care pediatrician can screen for substance use, provide assessment, initiate treatment, and refer to other specialists for further assessment and/or treatment. The confidentiality of these data are protected under the Health Insurance Portability and Accountability Act of 1996 Privacy Rule and state-specific privacy laws.[69] Patients receiving care within federally assisted SUD treatment programs are further protected by 42 CFR Part 2 regulations, which prohibit unauthorized disclosures of SUD-related patient records, except in limited circumstances.[69] Details on health care billing and insurance claims, such as the explanation of benefits, may disclose sensitive and confidential information to the parent as the policy holder of the insurance plan and therefore serve as a barrier to seeking services.[70,71]

Alternative payment models, such as value-based payment models, may offer a cost-effective approach to financing substance use services in the future.[72,73] A systematic review of 27 studies published between 1997 and 2019 showed that alternative payment models were associated with improvements in behavioral health process-of-care outcomes (eg, treatment initiation) and lower spending; however, very few payment models focused on pediatric populations.[74] These data support the need for further research to determine how to optimally design and implement pediatric-specific alternative payment models that target substance use services for children, adolescents, and young adults.

FINANCING RECOMMENDATIONS

Many changes need to be made to the financing and delivery of substance use care to improve the availability of services for all children, adolescents, and young adults. These changes are critical for advancing health equity and improving outcomes related to substance use. The AAP supports the following recommendations that address the needs of all children, adolescents, and young adults, regardless of insurance status, as well as specific recommendations that apply to those with private insurance, those with Medicaid or Children's Health Insurance Program (CHIP) coverage, and those who are uninsured.

Recommendations for National and State Policy Makers

To Improve Coverage of Substance Use Services:

- Enact and enforce additional laws, in addition to the Mental Health Parity and Addiction Equity Act of 2008, that promote full parity between medical services and substance use services so that coverage of the management of substance use and SUDs is equal to the coverage of other chronic conditions.
- Expand the eligibility criteria of states' substance use programs to include children with all levels of substance use and other mental health risk.
- Earmark a reasonable share of state block grants for prevention, assessment, and treatment services for children and adolescents.
- Identify and use new revenue sources, such as taxes on state legalized cannabis or opioid settlement funds obtained by states and local governments, to directly address the public health issues posed by SUDs, such as the need for harm reduction services.

To Improve Payment for Substance Use Services:

- Work with payers to ensure that separate payments are made for all covered services, including preventive, medical, substance use, and other mental health services, including those that are provided on the same day.
- Create financial incentives for coordination of substance use treatment between primary care and behavioral health care (eg, transferring some behavioral health dollars into primary care). For children who are underinsured and uninsured, create mechanisms for cost sharing between public and private insurers.
- Support payment mechanisms that incentivize the development and use of integrated behavioral health models within pediatric primary care.
- Continue to study the use of alternative payment models and encourage implementation of such models if appropriate.

To Improve Access and Availability of Services and Reduce Health Care Inequities:

- Create an integrated system of referral and treatment of substance use that is consistent with the referral and treatment process of other chronic diseases and includes gender-, language-, and culturally appropriate care.
- Expand Medicaid and CHIP eligibility and enrollment to reduce the rate of uninsured and ensure adequacy and equity in coverage of substance use benefits from state to state. Expansion of eligibility and benefits will require advocacy at the state and federal levels.
- Expand public insurance coverage that includes substance use services as a covered benefit to children and youth who have undocumented immigration status.
- Increase funding of state substance use and mental health programs for children and adolescents on the basis of comprehensive needs assessment within local communities.
- Establish clear delineation of responsibilities for children involved with multiple state agencies (eg, child protective services, juvenile justice system) who require court-ordered treatment.
- Require public and private payers to support the development and use of telemedicine through equitable payment and coverage for substance use prevention, assessment, and treatment services for children, adolescents, and young adults.
- Require payers to provide adequate payment for language interpretation services for spoken languages and American Sign Language provided during substance use-related health care.
- Expand access to naloxone by requiring insurers to include low- or no-cost naloxone as a pharmacy benefit with minimal out-of-pocket costs and no requirement for prior authorization.
- Support the funding of research that examines how health care financing systems can mitigate racial/ethnic, gender, socioeconomic, and geographic disparities in substance use prevention, assessment, and treatment services among children, adolescents, and young adults.

Recommendations for Public and Private Payers

To Improve Coverage of Substance Use Services:

- Offer substance use benefits sufficient in amount, duration, and scope to reasonably achieve their purpose.
- Extend private insurance benefits to include a broader array of substance use prevention, assessment, and treatment services.
- Reduce cost-sharing requirements for substance use services to encourage their use.
- Provide comprehensive coverage and remove prior authorization for all evidence-based pharmacologic and nonpharmacologic treatment approaches for nicotine, alcohol, cannabis, and opioid use disorders in adolescents and young adults.

To Improve Payment for Substance Use Services:

- Provide reasonable payment for counseling, coordination, and consultation procedure codes to enable primary care pediatricians to provide evidence-based prevention services for substance use.
- Adjust capitation rates to consider substance use service needs and recommended clinical guidelines for length of care for children and adolescents rather than relying on historic use rates to establish capitation amounts.
- Provide payment for screening and brief intervention practices incorporated into medical home health maintenance appointments.

To Improve Access and Availability of Services:

- Improve preauthorization and utilization review criteria to be consistent with national standards on the treatment of substance use among youth developed by the AAP, the Substance Use and Mental Health Services Administration, the National Institute on Alcohol Use and Alcoholism, and the American Society of Addiction Medicine.
- Offer the continuum of substance use services, from prevention to treatment, for children and adolescents in state Medicaid plans and contracts using a variety of benefit categories, including Early and Periodic Screening, Diagnosis, and Treatment expanded services.

- In CHIP programs, offer wraparound benefits, such as intensive, individualized care management benefits, to allow expanded behavioral health coverage for those who meet certain risk criteria.
- Simplify and coordinate processes for families attempting to access substance use and other mental health services for their children across public and private insurance plans and programs.
- Encourage the use of a primary care medical home for patients in which health maintenance and substance use screening can be accomplished.
- Guarantee that public and private health insurance networks include pediatricians and safety net nonphysician clinicians trained or experienced in child and adolescent substance use prevention, assessment, evaluation, and management services.
- Adopt medical record and billing procedures to protect the confidentiality of children and adolescents.
- Target outreach efforts to ensure that Medicaid- and CHIP-eligible adolescents are able to access care using their insurance coverage.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
ACA: Patient Protection and Affordable Care Act
CHIP: State Children's Health Insurance Program
MHPAEA: Mental Health Parity and Addiction Equity Act of 2008
OUD: opioid use disorder
SBIRT: screening, brief intervention, and referral to treatment
SUD: substance use disorder

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