

The Kids Are Not Alright: Leveraging Existing Health Law to Attack the Opioid Crisis Upstream

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THE KIDS ARE NOT ALRIGHT: LEVERAGING EXISTING HEALTH LAW TO ATTACK THE OPIOID CRISIS UPSTREAM

*Yael Cannon**

Abstract

The opioid crisis is now a nationwide epidemic, ravaging both rural and urban communities. The public health and economic consequences are staggering; recent estimates suggest the epidemic has contracted the U.S. labor market by over one million jobs and cost the nation billions of dollars. To tackle the crisis, scholars and health policy initiatives have focused primarily on downstream solutions designed to help those who are already in the throes of addiction. For example, the major initiative announced by the U.S. Surgeon General promotes the dissemination of naloxone, which helps save lives during opioid overdoses.

This Article argues that the urgency and gravity of the opioid crisis demand a very different approach. To stop the epidemic, interventions are needed long before people are on death's doorstep. Rather, it must focus on upstream interventions that stop people from becoming addicted in the first place.

To accomplish this, we should leverage an existing legal infrastructure that is already capable of such a preventive response. Although largely overlooked as a tool in tackling this epidemic, children's Medicaid, known as the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, provides a mechanism to identify at-risk children and the treatment necessary to shift their life trajectories off of the road to addiction. This Article lays out a blueprint for the ways in which EPSDT, the largest provider of children's health insurance in the country, facilitates best practices in substance abuse prevention through (1) regular mental health and substance abuse screening in the doctor's office and (2) the provision of medically necessary treatment for children at risk for and engaged in opioid and other substance abuse.

This upstream approach is consistent with Lifecourse Health Development theory, which emphasizes strategies that address risk factors and burgeoning health conditions in childhood before they become debilitating. Indeed, through the Medicaid statute and its

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legislative history, executive branch guidance, and judicial precedent, all three branches of the federal government have endorsed the power of Medicaid EPSDT to address health conditions early and preventively. This Article argues that this existing infrastructure should be leveraged so that at-risk children can access mental health and substance abuse services before a next generation falls victim to the greatest public health crisis of our time.

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INTRODUCTION

Luke¹ is sitting behind bars in a New Mexico juvenile hall, facing delinquency charges for robbing his neighbor’s home. He felt he had no choice but to steal in order to find money to pay the drug dealer who sold him OxyContin®, an opioid prescription pain reliever. The dealer had threatened to hurt his family if Luke failed to pay his debt. At age seventeen, he had recently started taking pain medication to escape the sadness he felt when he thought of his family situation. Both Luke and

1. This story is based on a composite of families who the Author worked with at the University of New Mexico Medical Legal Alliance. Their names and facts from their stories have been changed to protect their identities.

his eight-year-old sister, Melanie, had witnessed physical abuse of their mother by her boyfriend, been neglected at home, and struggled with their father's incarceration and addiction to heroin. While her brother is detained, Melanie is having a hard time at home. Most days, she feels very anxious. She is failing her classes and hates going to school. There are many children like Luke and Melanie across the country,² children who are at high risk for becoming casualties of the opioid crisis.³

The epidemic, which involves both abuse of prescription pain relievers and heroin use,⁴ has now taken hold in every state. In fact, the U.S. Department of Health and Human Services (HHS) has declared it a national public health emergency.⁵ The U.S. Surgeon General recently issued an important advisory on the opioid crisis that promotes an increase in the availability and targeted distribution of naloxone, a drug

2. In my work as a law professor directing medical-legal partnerships in New Mexico and Washington D.C., I have met many children who have been entangled in the opioid crisis and other substance abuse problems. Medical-legal partnerships are a growing movement through which attorneys collaborate with health providers to address health-harming legal needs. NAT'L CTR. FOR MED. LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/> [<https://perma.cc/G8UU-EWL6>].

3. The opioid crisis has strongly impacted New Mexico's youth and adult population. Almost every county in New Mexico has a higher drug overdose death rate than the national average. *Fighting the Opioid Crisis in New Mexico*, OFFICE N.M. ATT'Y GEN., <https://www.nmag.gov/uploads/files/Fighting%20the%20Opioid%20Crisis%20in%20New%20Mexico.pdf> [<https://perma.cc/3HEU-8FZF>]. New Mexico ranks eighth in the country in youth heroin use. N.M. DEP'T OF HEALTH, NEW MEXICO SUBSTANCE ABUSE EPIDEMIOLOGY PROFILE viii (2017), <https://nmhealth.org/data/view/substance/2067/> [<https://perma.cc/7ZNX-ZEHU>]; N.M. HIDTA: INVESTIGATIVE SUPPORT CTR., OPIOIDS: THE FACE OF THE DEMON IN NEW MEXICO 41 (2018), <https://static1.squarespace.com/static/50355cc884ae416826d09054/t/5a767801c830259c53b644f2/1517713518136/NMISC+Opioid+Report+2018.pdf> [<https://perma.cc/J4GY-HXCE>]; see Olivier Uyttebrouck, *New Mexico Teens' Drug Use Among Highest in Nation*, ALBUQUERQUE J. (Aug. 6, 2016, 12:05 AM), <https://www.abqjournal.com/821348/nm-youth-drug-use-rates-among-tops-in-us.html> [<https://perma.cc/7W8V-JQJ2>] (reporting that 3.5 percent of youth in New Mexico use heroin, compared to the national average of 2.1 percent). Further, cases of Neonatal Abstinence Syndrome in infants increased from 3.7 per 1,000 births in 2009 to 8.5 per 1,000 in 2013, higher than the national average of 6.0 per 1,000 births. Jean Y. Ko et al., *Incidence of Neonatal Abstinence Syndrome—28 States, 1999–2013*, 65 MMWR 799, 800 (2016).

4. Opioid abuse may sometimes also lead to heroin use when people graduate from prescription opioids to heroin. *Opioid Abuse and Addiction*, MEDLINEPLUS, <https://medlineplus.gov/opioidabuseandaddiction.html> [<https://perma.cc/G22B-GZVJ>].

5. *HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis*, U.S. DEP'T HEALTH & HUMAN SERVS. (Oct. 26, 2017), <https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html> [<https://perma.cc/TWT5-25W3>] (stating that the acting HHS Secretary Eric D. Hargan declared opioid crisis a nationwide public health emergency, as requested by President Trump).

that can reduce opioid-related overdose deaths.⁶ While naloxone is critical to saving lives when individuals are in the midst of an overdose, it does nothing to address this crisis upstream, long before people are on death's doorstep. If this country is to stop the opioid crisis from claiming the next generation, it needs a nationwide strategy that prevents its children from becoming addicted adults.

Health law scholars have increasingly called for upstream approaches to public health challenges like the opioid crisis,⁷ responding to individualist arguments that health-related regulation should be limited to controlling the spread of communicable diseases.⁸ To that end, policy efforts and legal scholarship have addressed a range of alternatives to the punitive criminal justice approach to substance abuse, such as drug courts that serve as diversion programs for defendants with opioid addiction⁹ and prescription drug monitoring programs that try to prevent opioid over-prescription.¹⁰

This Article proposes a sharply different approach: an upstream health policy solution serving at-risk children and adolescents, drawing on the Life Course Health Development model (LCHD). Rather than a traditional approach to healthcare that involves treating health conditions at the point of disease or disability in adulthood, LCHD emphasizes the identification of risk factors and the treatment of health needs during childhood and adolescence, which are some of the most sensitive periods

6. *Surgeon General's Advisory on Naloxone and Opioid Overdose*, SURGEON GEN. <https://www.surgeongeneral.gov/priorities/opioid-overdose-prevention/naloxone-advisory.html> [<https://perma.cc/PZ26-C4SP>] (recommending that distribution of naloxone, in combination with effective treatment for opioid addiction, will end the epidemic).

7. For examples of opioid crisis scholarship in this area, see generally Jess Alderman et al., *Application of Law to the Childhood Obesity Epidemic*, 35 J. AM. SOC'Y L. MED. & ETHICS 90 (2007); Lawrence O. Gostin & Maxwell Gregg Bloche, *The Politics of Public Health: A Response to Epstein*, 46 PERSP. BIOLOGY & MED. S160 (2003); William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497 (2008); Lindsay F. Wiley, *From Patient Rights to Health Justice: Securing the Public's Interest in Affordable, High-Quality Health Care*, 37 CARDOZO L. REV. 833 (2016).

8. See Richard A. Epstein, *Let the Shoemaker Stick to His Last: A Defense of the "Old" Public Health*, 46 PERSP. BIOLOGY & MED. S138, S139, S144–45 (2003) (“[G]overnment intervention . . . reduce[s] overall social wealth and freedom, and with it the overall health of the population.”); Richard A. Epstein, *In Defense of the "Old" Public Health: The Legal Framework for the Regulation of Public Health*, 69 BROOK. L. REV. 1421, 1445–55 (2004) (same).

9. See Barbara Andraka-Christou, *What Is "Treatment" for Opioid Addiction in Problem-Solving Courts? A Study of 20 Indiana Drug and Veterans Courts*, 13 STAN. J. CIV. RTS. & CIV. LIBERTIES 189, 191 (2017).

10. Frankie M. Griffin, *Prescription Opioids in Arkansas: Finding Legislative Balance*, 68 ARK. L. REV. 913, 945–46 (2016).

in the course of one's health and development.¹¹ Research indicates that children with mental health needs, including those who have suffered trauma, like Melanie, and those who have already initiated substance use in adolescence, like Luke, are at high risk for substance abuse later in life and that prevention and early intervention efforts can improve their prospects.¹²

How can health law and policy enable a nationwide response to the opioid crisis that draws on the lessons of LCHD to identify and treat both children who are at risk for opioid misuse and teens who are already misusing opioids? Especially in this time of legislative inertia and regulatory rollbacks, this nation cannot afford to wait for a new legal or regulatory framework for opioid addiction prevention. Fortunately, a national health prevention system already exists.¹³ This Article argues that children's Medicaid, known as the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit for its statutory requirements,¹⁴ provides a strong existing framework to address this epidemic early and preventively on a national level through identification and treatment of both at-risk children and those already engaged in opioid abuse.

Medicaid must be leveraged as much as possible in the fight against the opioid epidemic, as this crisis disproportionately affects the Medicaid population.¹⁵ The children's Medicaid program offers unique

11. See Robert J. Palisano et al., *Life Course Health Development of Individuals with Neurodevelopmental Conditions*, 59 DEVELOPMENTAL MED. & CHILD NEUROLOGY 470, 470 (2017).

12. Vincent J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults*, 14 AM. J. PREVENTIVE MED. 245, 254 (1998).

13. Although Medicaid is a national program, states are permitted some flexibility in their execution of the program, resulting in a patchwork through which some states are maximizing the program's benefits for its enrollees, including children, more than others. See SAMANTHA ARTIGA ET AL., HENRY J. KAISER FAM. FOUND., CURRENT FLEXIBILITY IN MEDICAID: AN OVERVIEW OF FEDERAL STANDARDS AND STATE OPTIONS 1–2 (2017), <http://files.kff.org/attachment/Issue-Brief-Current-Flexibility-in-Medicaid-An-Overview-of-Federal-Standards-and-State-Options> [<https://perma.cc/8NWB-974B>]. See generally TRICIA BROOKS ET AL., HENRY J. KAISER FAM. FOUND., MEDICAID AND CHIP ELIGIBILITY, ENROLLMENT, RENEWAL, AND COST SHARING POLICIES AS OF JANUARY 2018: FINDINGS FROM A 50-STATE SURVEY (2018), <http://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-Enrollment-Renewal-and-Cost-Sharing-Policies-as-of-January-2018> [<https://perma.cc/PKU2-MCKB>] (discussing Medicaid for children across all fifty states). States should implement children's Medicaid to the fullest extent of the law and use their flexibility to maximize benefits that will result in prevention and mitigation of opioid abuse among at-risk children and youth.

14. 42 U.S.C. § 1396d(r) (2012).

15. In 2015, Medicaid beneficiaries were more likely to abuse or have a dependency on an opioid in the previous year than privately insured adults age 18–64. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, REPORT TO CONGRESS ON MEDICAID AND CHIP 64 (2017), <https://www.macpac.gov/wp-content/uploads/2018/06/June-2018-Report-to-Congress-on-Medicaid-and-CHIP.pdf>

opportunities for prevention and early intervention. Medicaid and the Children's Health Insurance Program¹⁶ provide health insurance coverage to more than 35.2 million children, making those programs the largest payors of children's healthcare in the nation.¹⁷ Up until the age of twenty-one, Medicaid mandates regular check-ups that include screening for mental health and substance abuse needs right in the doctor's office.¹⁸ The Medicaid program also requires that children with identified needs receive all medically necessary treatment for substance abuse and mental health.¹⁹

These requirements set the program apart from adult Medicaid, which does not require regular check-ups and gives states far more leverage to restrict the services it covers.²⁰ All three branches of the federal government have underscored the unique nature of children's Medicaid as a robust program that aims to prevent health problems and intervene to ameliorate them early in life, an approach championed by the LCHD model as a means for improving lifelong health.²¹ Children's Medicaid is

[<https://perma.cc/A5YE-M44G>]. This is primarily due to the higher poverty rates among the Medicaid population, which puts individuals at a higher risk for addiction and its consequences, including overdoses. Nora Volkow, *Addressing the Opioid Crisis Means Confronting Socioeconomic Disparities*, NAT'L INST. ON DRUG ABUSE (Oct. 25, 2017), <https://www.drugabuse.gov/about-nida/noras-blog/2017/10/addressing-opioid-crisis-means-confronting-socioeconomic-disparities> [<https://perma.cc/83YS-9N6Z>] (“[T]he opioid crisis has particularly affected some of the poorest regions of the country . . . and . . . people living in poverty are especially at risk for addiction and its consequences like overdose The [CDC] considers people on Medicaid and other people with low-income to be at high risk for prescription drug overdose.”).

16. The Children's Health Insurance Program (CHIP) does not mandate the same benefits, including the EPSDT program, as Medicaid. However, some states have opted to provide Medicaid benefits, including EPSDT, to children covered by CHIP. See ROBIN RUDOWITZ ET AL., HENRY J. KAISER FAM. FOUND., CHILDREN'S HEALTH COVERAGE: MEDICAID, CHIP, AND THE ACA 2 (2014), https://kaiserfamilyfoundation.files.wordpress.com/2014/03/8570-children_s-health-coverage-medicaid-chip-and-the-aca1.pdf [<https://perma.cc/Q82U-JZD7>]. States, such as the District of Columbia, that provide CHIP through Medicaid-expansion CHIP must provide all Medicaid benefits to CHIP enrollees. See MEDICAID & CHIP PAYMENT & ACCESS COMM'N, STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) 1 (2017), https://www.macpac.gov/wp-content/uploads/2015/03/State-Children%E2%80%99s-Health-Insurance-Program_CHIP-Fact-Sheet.pdf [<https://perma.cc/VES9-9NPY>].

17. *October 2018 Medicaid & CHIP Enrollment Data Highlights*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html> [<https://perma.cc/MAM7-ZW7K>].

18. 42 U.S.C. § 1396d(r).

19. *Id.*; see also CTRS. FOR MEDICARE & MEDICAID, EPSDT—A GUIDE FOR STATES: COVERAGE IN THE MEDICAID BENEFIT FOR CHILDREN AND ADOLESCENTS 2 (2014), https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf [<https://perma.cc/6WD4-F8X2>] [hereinafter CMS].

20. See *infra* Part III.

21. See *infra* Part III.

built on the premise that addressing health needs in childhood can have strong payoffs in producing healthier adults;²² it has the potential to keep the opioid crisis from claiming yet another generation.

Part I of this Article describes the magnitude of the national opioid abuse crisis, the particular vulnerability of adolescents to opioid abuse, and the devastating economic consequences of the crisis. Part II argues that a national prevention response is required, and that this response should draw on the LCHD model to address the opioid crisis upstream. Part III proposes that children’s Medicaid provides an existing infrastructure to facilitate early identification and treatment of childhood risk factors and adolescent opioid abuse. The statute and its legislative history, executive branch guidance, and judicial precedence all support the mobilization of the Medicaid program as a tool to fight the opioid crisis upstream, in line with LCHD theory. Part IV identifies the barriers to implementing children’s Medicaid to address the opioid epidemic and proposes various levers for promoting effective realization of this vision. The conclusion suggests that the LCHD model can provide a broader framework for health policy beyond the opioid crisis, which can be used to address health crises through prevention and early intervention in childhood.

I. THE OPIOID EPIDEMIC: A PUBLIC HEALTH AND ECONOMIC CRISIS

Over the past fifteen years, the rate of opioid use in the United States has soared.²³ While only five percent of the world’s population lives in the United States, this country consumes over eighty percent of the world’s opioids.²⁴ Opioids are a class of drugs that include prescription pain relievers such as oxycodone (OxyContin®), hydrocodone (Vicodin®),²⁵ codeine, and morphine as well as synthetic opioids concocted in clandestine laboratories, such as fentanyl²⁶ and heroin.²⁷ Given that dependence and addiction are significant risks of opioid use, misuse, abuse, and overdose have become national public health

22. See discussion *infra* Part III (legislative history of EPSDT).

23. Andrew Kolodny et al., *The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction*, 36 ANN. REV. PUB. HEALTH 559, 560 (2015).

24. Jane C. Ballantyne & Andrew Kolodny, *Preventing Prescription Opioid Abuse: Letter to the Editor*, 313 JAMA 1059, 1059 (2015); Rebecca Haffajee, *Preventing Opioid Misuse with Prescription Drug Monitoring Programs: A Framework for Evaluating the Success of State Public Health Laws*, 67 HASTING L.J. 1621, 1622 (2016).

25. Kolodny et al., *supra* note 23.

26. *What is Fentanyl?*, NAT’L INST. DRUG ABUSE (June 2016), <https://www.drugabuse.gov/publications/drugfacts/fentanyl> [<https://perma.cc/SA8L-YZ25>].

27. *What are Opioids?*, U.S. DEP’T HEALTH & HUMAN SERVS., <https://www.hhs.gov/opioids/prevention/index.html> [<https://perma.cc/4QPS-PKTQ>].

problems.²⁸ More than two million Americans have an addiction diagnosed as opioid use disorder (OUD) and another ten million are at risk of opioid addiction due to the misuse of drugs.²⁹ The rate of opioid-related overdose deaths has increased six-fold since 1999, with 130 Americans dying every day from an opioid overdose.³⁰

While the impact of the opioid crisis on rural, white communities has been well documented,³¹ the epidemic now affects every state in the nation and is increasingly reaching urban communities and people of color.³² Approximately forty-one percent of drug overdose deaths occur in urban counties, and fifteen percent occur in rural communities.³³

As the epidemic exploded from 1997 to 2011, the number of individuals seeking opioid addiction treatment increased by 900%.³⁴ Despite the scope and gravity of the epidemic, “only [one] in [five]

28. *Opioid Abuse and Addiction*, *supra* note 4.

29. MANATT HEALTH, STATE HEALTH & VALUE STRATEGIES, MEDICAID: THE LINCHPIN IN STATE STRATEGIES TO PREVENT AND ADDRESS OPIOID USE DISORDERS 1 (2018), https://www.shvs.org/wp-content/uploads/2018/03/SHVS_Medicaid-Opioids_Final.pdf; Rebecca Ahrensbrak et al., *Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health*, SAMHSA (Sept. 2017), <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm> [<https://perma.cc/5KTG-AF69>] (“In 2016, an estimated 2.1 million people aged 12 or older had an opioid use disorder, or 0.8 percent of people aged 12 or older . . .”).

30. *Understanding the Epidemic*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 19, 2018), <https://www.cdc.gov/drugoverdose/epidemic/index.html> [<https://perma.cc/6Q33-WL9B>].

31. CHRISTINE HANCOCK ET AL., NAT’L RURAL HEALTH ASS’N, TREATING THE RURAL OPIOID EPIDEMIC 1 (2017), https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/Treating-the-Rural-Opioid-Epidemic_Feb-2017_NRHA-Policy-Paper.pdf [<https://perma.cc/2NH8-RX8X>]; *Opioid Misuse in Rural America*, U.S. DEP’T OF AGRIC., <https://www.usda.gov/topics/opioids> [<https://perma.cc/2B3D-DBDX>]. Rural adolescents are at a greater risk of prescription opioid abuse than urban adolescents. Khary K. Rigg & Shannon M. Monnat, *Urban vs. Rural Differences in Prescription Opioid Misuse Among Adults in the United States: Informing Region Specific Drug Policies and Interventions*, 26 INT’L J. DRUG POL’Y 484, 488 (2015). *But see* Jenna L. McCauley et al., *The Role of Traumatic Event History in Non-Medical Use of Prescription Drugs Among a Nationally Representative Sample of U.S. Adolescents*, 51 J. CHILD PSYCHOL. & PSYCHIATRY 84, 88 (2010) (finding that rural settings were not significant in predicting non-medical use of prescription drugs in adolescents).

32. Rigg & Monnat, *supra* note 31, at 487–88; Eugene Scott, *The Opioid Crisis Isn’t Limited to White Americans in Rural Pro-Trump Counties*, WASH. POST (Oct. 26, 2017), <https://www.washingtonpost.com/news/the-fix/wp/2017/10/26/the-opioid-crisis-isnt-limited-to-white-americans-in-rural-pro-trump-counties/> [<https://perma.cc/NT83-RKZZ>].

33. Nabarun Dasgupta et al., *Opioid Crisis: No Easy Fix to Its Social and Economic Determinants*, 108 AM. J. PUB. HEALTH 182, 184 (2018); Elizabeth Kneebone & Scott W. Allard, *A Nation in Overdose Peril: Pinpointing the Most Impacted Communities and the Local Gaps in Care*, BROOKINGS INST. (Sept. 25, 2017), <https://www.brookings.edu/research/pinpointing-opioid-in-most-impacted-communities/> [<https://perma.cc/C3SD-NMJU>]. Of the remaining overdose deaths, twenty-six percent occur in the suburbs and eighteen percent occur in small metropolitan areas. Dasgupta et al., *supra*.

34. Kolodny et al., *supra* note 23.

people suffering from an OUD receive treatment.”³⁵ There is no question that this crisis requires a far-reaching public health response to ensure that people nationwide can access necessary treatment. Instituting measures to prevent the next generation of Americans from similarly devastating outcomes is increasingly critical.

Young adults comprise the largest population misusing prescription opioid pain relievers,³⁶ and initiation of opioid misuse often begins in adolescence. The rate of illicit drug use among adolescents is high—twenty-five percent higher than that of adults³⁷—and substance use most often begins between seventh and tenth grade.³⁸ Thirteen percent of high school students surveyed reported non-medical usage of prescription drugs within the prior year.³⁹ A study in Los Angeles and New York found that use of a family member’s prescription, typically began at the age of 12.6.⁴⁰ The average age of initiation for intravenous opioid use, such as heroin injection, was 17.7 years.⁴¹

OUD rates, which include both prescription pain reliever and heroin misuse disorder, continue to rise: In 2016, an estimated 153,000 adolescents between the ages of twelve to seventeen and 392,000 young adults aged eighteen to twenty-five met criteria for OUD.⁴² The U.S. Centers for Disease Control and Prevention (CDC) issued guidelines that

35. MANATT HEALTH, *supra* note 29. According to a 2016 surgeon general’s report, 10% of the 21 million Americans who fall into the broader population of individuals with substance-use disorders will receive treatment. See U.S. DEP’T OF HEALTH & HUMAN SERVS., FACING ADDICTION IN AMERICA: THE SURGEON GENERAL’S REPORT ON ALCOHOL, DRUGS, AND HEALTH 4-1 to 4-2 (2016).

36. ABT ASSOCS., THE CONRAD N. HILTON FOUNDATION’S YOUTH SUBSTANCE USE PREVENTION AND EARLY INTERVENTION STRATEGIC INITIATIVE 8 (2016), https://hilton-production.s3.amazonaws.com/documents/251/attachments/2016_Evaluation_Report_Youth_Substance_Use_Prevention_and_Early_Intervention_Strategic_Initiative.pdf [<https://perma.cc/W4HY-UMPN>]; *Abuse of Prescription (Rx) Drugs Affects Young Adults Most*, NAT’L INST. DRUG ABUSE, <https://www.drugabuse.gov/related-topics/trends-statistics/infographics/abuse-prescription-rx-drugs-affects-young-adults-most> [<https://perma.cc/YG2M-YUL4>] (last updated Feb. 2016).

37. COREY DAVIS & HECTOR HERNANDEZ-DELGADO, NAT’L HEALTH LAW PROGRAM, MEDICAID AND THE AFFORDABLE CARE ACT: VITAL TOOLS IN ADDRESSING THE OPIOID EPIDEMIC 8 (2017), <https://9kqpw4dcaw91s37koz5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2017/02/SUD-issue-brief-FINAL-1.pdf> [<https://perma.cc/V8SD-USH9>].

38. See BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS 141 (Joseph F. Hagan et al. eds., 4th ed. 2017).

39. ABT ASSOCS., *supra* note 36, at 1.

40. Stephen E. Lankenau et al., *Initiation into Prescription Opioid Misuse Amongst Young Injection Drug Users*, 23 INT’L J. DRUG POL’Y 37, 39–40 (2011). Initiation of opioid misuse typically followed individuals’ first use of alcohol, cannabis, and prescription stimulants but preceded the use of harder drugs like cocaine, methamphetamine, or heroin. *Id.* at 39.

41. *Id.* at 41 tbl.3.

42. Ahrensbrak et al., *supra* note 29.

note that the “risk of opioid medication use in pediatric populations” is a “great concern,” with twenty percent of adolescents who were prescribed opioids as pain relievers reporting misuse “to get high or increase the effects of alcohol or other drugs.”⁴³ Interestingly, although diagnoses of OUD have risen, some recent data suggests a drop in use of and access to opioids: In the last five years, reported opioid use has dropped among 12th graders.⁴⁴ However, in other ways the situation is getting bleaker for teens. 2017 data showed a general decline in perceived risk of harm from opioid prescription drugs,⁴⁵ and those who perceive a low risk are 9.6 times more likely to use opioids non-medically.⁴⁶ Perceived low risk is also a leading indicator of heroin use.⁴⁷ Moreover, hospitalizations for opioid poisoning have doubled among youth ages twelve to seventeen,⁴⁸ and opioid overdose deaths among adolescents are increasing.⁴⁹ In 2015, 4,325 youths between ages fifteen and twenty-four died from drug-related overdoses, and over half of those deaths were a result of opioid use.⁵⁰

Opioid use can be particularly harmful to the developing brain and body of an adolescent⁵¹ because it can fracture developing neural

43. Deborah Dowell et al., *CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016*, 65 MMWR 1, 3 (2016).

44. LLOYD D. JOHNSTON ET AL., UNIV. OF MICH., MONITORING THE FUTURE NATIONAL SURVEY RESULTS ON DRUG USE: 2017 OVERVIEW, KEY FINDINGS ON ADOLESCENT DRUG USE 2 (2018), <http://www.monitoringthefuture.org/pubs/monographs/mtf-overview2017.pdf> [<https://perma.cc/YG8T-KXDQ>]. Similarly, Vicodin use dropped by 51% amongst 8th graders, 67% amongst 10th graders, and 74% amongst 12th graders, and the percent of 12th graders found that opioids are easily accessible dropped from 54% in 2010 to 35.8% in 2017. *Id.* at 71 tbl.6, 116 tbl.18.

45. *Id.* Seventy-three percent of eighth graders surveyed in 2013 perceived occasional use of heroin as high risk, but only twenty-six percent believed occasional use of Vicodin was high risk. Likewise, eighth graders also believed occasional Vicodin use was less risky than occasional marijuana use, daily cigarette use, and moderate alcohol use. Kolodny et al., *supra* note 23, at 567.

46. *Id.* (citing Amelia M. Arria et al., *Perceived Harmfulness Predicts Nonmedical Use of Prescription Drugs Among College Students: Interactions with Sensation-Seeking*, 9 PREV. SCI. 191 (2008)).

47. JOHNSTON ET AL., *supra* note 44, at 27.

48. Sheryl A. Ryan, *Calculating the Real Costs of the Opioid Crisis*, 141 PEDIATRICS 1 (Mar. 5, 2018), <https://pediatrics.aappublications.org/content/pediatrics/141/4/e20174129.full.pdf> [<https://perma.cc/VSW3-G9K6>].

49. *Opioids and Adolescents*, U.S. DEP'T HEALTH & HUMAN SERVS., <https://www.hhs.gov/ash/oah/adolescent-development/substance-use/drugs/opioids/index.html#prevalence> [<https://perma.cc/8ASS-EARH>].

50. *Id.*

51. *Rise in Prescription Drug Misuse and Abuse Impacting Teens*, SAMHSA, <https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/teen-prescription-drug-misuse-abuse> [<https://perma.cc/J36W-XFT4>] (last updated Apr. 19, 2016) [hereinafter *Drug Misuse*].

pathways.⁵² Especially since the brain develops through the age of twenty-five,⁵³ the brain pathway disruptions caused by addiction can lead to lifelong challenges,⁵⁴ including both physical and social adverse consequences, such as abnormalities in brain functioning and development.⁵⁵ Because adolescence is characterized by risk-taking and the adolescent brain is still maturing, teens are particularly vulnerable to substance abuse.⁵⁶ Individuals who begin using substances during adolescence often experience more chronic use and are at a greater risk of developing a substance use disorder (SUD) when compared to those who begin using at a later age; “[i]n other words, the earlier the exposure, the greater the risk.”⁵⁷ As adolescents become young adults, there is an increased risk of opioid misuse and overdose,⁵⁸ which should prompt “a focus on prevention efforts at a younger age to get out ahead of when more serious drug use is established.”⁵⁹

Despite this research and the high level of need, only about one in twelve adolescents in need of OUD treatment receive any care.⁶⁰ The low treatment rates place adolescents at particular risk and prevent the development of comprehensive data on medication assisted treatment for adolescents.⁶¹ In fact

[a] perennial theme across research literatures pertaining to adolescent health is the magnitude of unmet need for treatment among adolescents with substance use disorders

52. *Id.*

53. *Brain Maturity Extends Well Beyond Teen Years*, NPR (Oct. 10, 2011, 12:00 PM), <https://www.npr.org/templates/story/story.php?storyId=141164708> [<https://perma.cc/9J3R-2G6P>].

54. *Drug Misuse*, *supra* note 51. See generally RTI INT’L, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., RESULTS FROM THE 2014 NATIONAL SURVEY ON DRUG USE AND HEALTH: DETAILED TABLES (2015), <https://www.samhsa.gov/data/sites/default/files/NSDUH-DefTabs2014/NSDUH-DefTabs2014.pdf> [<https://perma.cc/79XF-ZSAF>] (discussing the prevalence of mental health problems).

55. L. M. Squeglia et al., *The Influence of Substance Use on Adolescent Brain Development*, 40 CLINICAL EEG & NEUROSCIENCE 31, 31 (2009).

56. ABT ASSOCS., *supra* note 36, at 7; U.S DEP’T OF HEALTH & HUMAN SERVS., *supra* note 35, at 2–21; Dan I. Lubman et al., *Substance Use and the Adolescent Brain: A Toxic Combination?*, 21 J. PSYCHOPHARMACOLOGY 792, 793 (2007).

57. U.S DEP’T OF HEALTH & HUMAN SERVS., *supra* note 35, at 2–22.

58. ABT ASSOCS., *supra* note 36, at 7.

59. *Id.*

60. Kenneth A. Feder et al., *Medication-Assisted Treatment for Adolescents in Specialty Treatment for Opioid Use Disorder*, 60 J. ADOLESCENT HEALTH 747, 747 (2017) (citing Tami L. Mark et al., *Insurance Financing Increased for Mental Health Conditions but Not for Substance Use Disorders, 1986-2014*, 35 HEALTH AFF. 958, 958–65 (2016)); Ahmsbrak et al., *supra* note 29.

61. CHRIS CHRISTIE ET AL., THE PRESIDENT’S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS 25 (2017).

(SUDs) in the United States . . . [S]ervice utilization figures have remained stubbornly persistent over the last decade and beyond and quantify the “treatment gap” for adolescent substance use.⁶²

The treatment gap for adolescents is one of most serious public health issues in the U.S., given the propensity for untreated substance abuse during adolescence to result in cascading health issues during adulthood, which places enormous economic costs on society.⁶³

The White House Council of Economic Advisors estimates the annual cost of non-fatal consequences of opioid misuse at \$72.3 billion⁶⁴ and the total cost of the opioid crisis at \$504 billion each year,⁶⁵ including \$21.4 billion of opioid-misuse-related healthcare costs in 2016, with \$15.1 billion falling on Medicare and Medicaid⁶⁶ and \$7.8 billion in criminal justice costs.⁶⁷ The workforce has contracted by almost one million workers.⁶⁸ Wage losses have led to decreased tax revenue for federal and state governments,⁶⁹ with the federal losses totaling \$10.6 billion in

62. Timothy J. Ozechowski et al., *SBIRT-A: Adapting SBIRT to Maximize Developmental Fit for Adolescents in Primary Care*, 62 J. SUBSTANCE ABUSE TREATMENT 28 (2016).

63. *Id.*

64. COUNCIL OF ECON. ADVISORS, EXEC. OFFICE OF THE PRESIDENT, *THE UNDERESTIMATED COST OF THE OPIOID CRISIS* 7 (2017) <https://www.whitehouse.gov/sites/whitehouse.gov/files/images/The%20Underestimated%20Cost%20of%20the%20Opioid%20Crisis.pdf> [<https://perma.cc/K7X8-W239>]. This includes healthcare and substance abuse treatment costs, as well as criminal justice and worker productivity costs.

65. *Id.* at 7–8.

66. CORWIN N. RHYAN, *THE POTENTIAL SOCIETAL BENEFIT OF ELIMINATING OPIOID OVERDOSES, DEATHS, AND SUBSTANCE ABUSE DISORDERS EXCEEDS \$95 BILLION PER YEAR 2* (2017), https://altarum.org/sites/default/files/uploaded-publication-files/Research-Brief_Opioid-Epidemic-Economic-Burden.pdf [<https://perma.cc/4DYQ-UEJZ>]. These costs include \$12.2 billion in overdose-related costs and \$9.2 billion in indirect costs related to opioid abuse, such as treatment for related diseases such as hepatitis B and C, HIV, tuberculosis, and neonatal abstinence syndrome. *Id.* at 1–3. These estimates equate to a cost of about \$14,810 in 2015 dollars per commercially insured person in the six months preceding and following an initial opioid abuse episode. Noam Y. Kirson et al., *The Economic Burden of Opioid Abuse: Updated Findings*, 23 J. MANAGED CARE & SPECIALTY PHARMACY 427, 437 (2017).

67. RHYAN, *supra* note 66, at 1. Corrections and incarcerations costs accounted for \$3.3 billion of this estimate, with police protection requiring \$2.9 billion, judicial and legal costs of \$1.3 billion, and property losses of \$300 million. *Id.* at 3. In 2013, prescription drug abuse led to \$7.65 billion in criminal justice costs, including \$3.2 billion in correctional facility costs and \$2.8 billion in police costs. Curtis Florence et al., *The Economic Burden of Prescription Opioid Overdose, Abuse and Dependence in the United States, 2013*, 54 MED. CARE 901, 906–07, 913 (2016).

68. Ben Gitis & Isabel Soto, *The Labor Force and Output Consequences of the Opioid Crisis*, AM. ACTION F. (Mar. 27, 2018), <https://www.americanactionforum.org/research/labor-force-output-consequences-opioid-crisis/> [<https://perma.cc/P6G5-V8Y8>].

69. Florence et al., *supra* note 67, at 908.

2016.⁷⁰ Additionally, opioid addiction has led to housing instability⁷¹ and has burdened the foster care⁷² and education systems,⁷³ adding to the growing costs.

Congress has attempted to address this epidemic through the SUPPORT for Patients and Communities Act,⁷⁴ but the legislation falls short in offering upstream, wide-scale, child and youth-focused prevention efforts that are necessary to successfully fight the opioid crisis.⁷⁵ The bulk of the legislation’s provisions focus on addressing treatment for adults already addicted,⁷⁶ and thus the SUPPORT Act is unlikely to effectively prevent or mitigate substance abuse among at-risk children and youth. The Act does provide grant funding for various adolescent substance-abuse and trauma-related programs,⁷⁷ which are in

70. RHYAN, *supra* note 66. This included lost wages from overdoes fatalities, opioid-related incarceration, and loss of productivity due to addiction. *Id.*

71. NAT’L HEALTH CARE FOR THE HOMELESS COUNCIL, MEDICATION-ASSISTED TREATMENT: BUPRENORPHINE IN THE HCH COMMUNITY 1 (2016), <https://www.nhchc.org/wp-content/uploads/2016/05/policy-brief-buprenorphine-in-the-hch-community-final.pdf> [<https://perma.cc/N2LB-5C7R>]; Morgan Olsen, *H(O)ME: Understanding Opioid Addiction and Housing Consequences*, UNIV. WIS.-MADISON: GO BIG READ (Oct. 31, 2016), <https://gobigread.wisc.edu/2016/10/housing-and-the-opioid-epidemic/> [<https://perma.cc/KU6G-6GLQ>] (citing MATTHEW DESMOND, *EVICTED: POVERTY AND PROFIT IN THE AMERICAN CITY* 83–84, 280, 294–95 (2016)); *Substance Abuse and Homelessness*, NAT’L COAL. FOR HOMELESS (July 2009), <http://www.nationalhomeless.org/factsheets/addiction.pdf> [<https://perma.cc/U6FN-ZXET>].

72. *Examining the Opioid Epidemic: Challenges and Opportunities: Hearing Before the S. Comm. on Fin.*, 114th Cong. 8–9 (2016) (statement of Nancy K. Young, Dir., Children & Family Futures, Inc.).

73. RHYAN, *supra* note 66, at 3.

74. Pub. L. No. 115-271, 132 Stat. 3894 (codified in scattered sections of 21, 34, and 42 U.S.C.A.).

75. *See id.* Unfortunately, the Act fails to leverage any of the tools of Medicaid’s EPSDT program to reduce youth substance use or treat adolescents with SUDs.

76. This includes: expanding treatment capacity (expands Medicaid coverage to 30 days for individuals between 21–65 years old receiving care in a treatment facility and lifts 16 bed restriction, *id.* § 5052, and establishes comprehensive treatment and recovery centers, *id.* § 7121); promoting family-focused residential treatment, *id.* §§ 8081, 8083; expanding recovery support services (wrap-around support services, *id.* § 7183, and peer recovery support services, *id.* § 7151); increasing services to pregnant women and mothers who are addicted, *id.* § 1012; and expanding Medicaid services for infants with NAT. *Id.* § 1007; *see also* 41 Key Components of the Opioid Package (H.R. 6), ADDICTION POL’Y F. (Sept. 28, 2018), <https://www.addictionpolicy.org/blog/41-key-components-of-the-opioid-package-h.r.-6> [<https://perma.cc/Q8Y4-9ZNP>] (explaining that the Act “reauthorizes the Drug Free Communities Program,” which “mobilize[s] communities to prevent youth substance use and extends the National Community Anti-Drug Coalition Institute”).

77. The Act reauthorizes the “Drug-Free Communities Program” and extends the “National Community Anti-Drug Coalition Institute,” both of which are educational programs aimed to help communities prevent youth substance use. *See* SUPPORT for Patients and Communities Act §§ 8203–04 (codified in scattered sections of 21 U.S.C.A.); *see also* 41 Key Components of the Opioid Package (H.R. 6), *supra* note 76. The Act also provides grant support for educational

line with a Lifecourse Health Development approach. Yet such piecemeal grant funding will have a much narrower impact than a nationwide initiative to screen and treat risk factors and opioid abuse among all Medicaid-enrolled children. The Act also expands some reporting⁷⁸ and coverage⁷⁹ requirements and instructs HHS to develop guidance for adolescent substance-abuse⁸⁰ and trauma-related services.⁸¹ In carrying out these provisions, HHS should include guidance to assist states, Medicaid Managed Care Organizations (MCOs), and physicians in maximizing Medicaid's screening and treatment requirements for children, including guidance to address the barriers identified in Part IV of this Article, to further the goals of the legislation.

The rise in opioid addiction across the nation is alarming. The high rates of addiction among young adults emerging from adolescence, the vulnerability of youth like Luke and Melanie to opioid misuse, and the unique harm that adolescents suffer in such a critical and sensitive period of life, necessitate a response that looks upstream in the life cycle of this at-risk population. That many facets of the national economy are suffering as a result of the opioid crisis further bolsters the urgency of the need for a public health response that is both preventive and national in scope.

organizations to “increas[e] student access to evidence-based trauma support services and mental health care.” SUPPORT for Patients and Communities Act § 7134(a) (codified at 42 U.S.C.A. § 280h-7(a) (West 2018)).

78. The Act includes provisions that require Medicaid MCOs to report and monitor drug utilization data of opioids or antipsychotic medications, and specifically directs states to implement a monitoring system for the use of antipsychotic medication by children under 18. SUPPORT for Patients and Communities Act § 1004 (codified at 42 U.S.C.A. § 1396a). The Act also instructs the Director of the CDC to collect and report data on adverse childhood experiences through the Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), and other available questionnaires. *Id.* § 7131 (codified at 42 U.S.C.A. § 242t).

79. The Act requires state Medicaid plans to cover Medication-Assisted Treatment, which includes “drugs and biological products, counseling services and behavioral therapy.” *Id.* § 1006(b)(1) (codified at 42 U.S.C.A. § 1396d).

80. The Act directs the Secretary to create a program that will fund and provide technical assistance to local organizations in their work of preventing or treating SUDs for children, adolescents and young adults. *Id.* § 7102(c)(1) (codified at 42 U.S.C.A. § 290bb-7a). Additionally, the Act directs the Secretary to develop and disseminate a set of best practices for the prevention and treatment of substance abuse by children, adolescents, and young adults, specifically for high-risk populations like homeless adolescents. *Id.* § 7102(c)(3).

81. *Id.* § 7135 (codified at 42 U.S.C.A. §280h-8) (directing the Secretary of Health and Human Services to “disseminate information, resources, and, if requested, technical assistance to early childhood care and education providers and professionals working with young children on . . . ways to properly recognize children who may be impacted by trauma . . . and . . . how to respond appropriately”).

II. MOVING THE FOCUS UPSTREAM: CHILDREN AND LIFECOURSE HEALTH DEVELOPMENT

Because the opioid crisis is so far reaching, harming not only those addicted, but also their families and communities and the national economy,⁸² this country needs an upstream response that is in line with the “new public health” framework. Legal scholars have increasingly embraced this “new public health” model that addresses the more social, collective nature of health law institutions, instruments, and norms.⁸³ In response to more individualistic paradigms, which center around patient rights and professional autonomy and suggest limiting regulatory action to the control of communicable diseases, health law scholars like Larry Gostin, Gregg Bloche, Lindsay Wiley, and Bill Sage call for a broader approach drawing on the “state’s interest in preserving life and health.”⁸⁴ Sage advocates that health policy should embrace “regulatory duties,” arguing that the predominant approach centered on “relational duties” between physician and patient has caused a “fragmented collection of inaccessible services with uneven quality” in this nation.⁸⁵ Wiley has added to this framework, proposing a “health justice” approach to health law that focuses not only on access to quality healthcare, but on social, economic, and environmental factors and more prevention-oriented health policy.⁸⁶ For example, to address diabetes, Wiley has discussed preventive innovations such as zoning restrictions on fast food restaurants aimed at making communities more conducive to healthy lifestyles to better avert and manage diabetes.⁸⁷ Jess Alderman has similarly supported the imposition of nutritional standards on products marketed at

82. Perhaps some individualists could see similarities between this epidemic and communicable diseases in requiring some regulation, although they may take issue with government interventions in the crisis, like Robert Crawford and Petr Skrabanek have with the intrusiveness of restrictions on tobacco and cigarette use, and similarly argue that individuals can take personal responsibility to make healthier decisions. See PETR SKRABANEK, *THE DEATH OF HUMANE MEDICINE AND THE RISE OF COERCIVE HEALTHISM* 15–16 (1994) (“[I]n Western democracies, the state goes beyond education and information on matters of health and uses . . . various forms of coercion to establish norms of a ‘health lifestyle’ for all[,] . . . [but] [a]s Karl Popper pointed out . . . all attempts to maximise the happiness of the people must lead to totalitarianism.”); Robert Crawford, *Health as a Meaningful Social Practice*, 10 *HEALTH* 401, 419 (2006); Robert Crawford, *Healthism and the Medicalization of Everyday Life*, 10 *INT’L J. HEALTH SERVS.* 365, 368 (1980).

83. Wiley, *supra* note 7, at 878 n.207.

84. Gostin & Bloche, *supra* note 7, at S172; Sage, *supra* note 7, at 521; Wiley, *supra* note 7, at 837, 875.

85. Sage, *supra* note 7, at 510, 521.

86. Wiley, *supra* note 7, at 881–82.

87. Lindsay F. Wiley, *Applying the Health Justice Framework for Diabetes As A Community-Managed Social Phenomenon*, 16 *HOUS. J. HEALTH L. & POL’Y* 191, 207–08 (2016).

children to address childhood obesity upstream.⁸⁸ Gostin and Bloche explain that this new public health model looks upstream at causal connections between poor health and powerful institutions, imposing regulations on tobacco companies, fast-food chains, and industrial polluters.⁸⁹

The opioid crisis similarly demands upstream responses that examine the connections between poor health and powerful institutions. Many of the current responses to the opioid crisis center on downstream approaches that fail to address the underlying cause of addiction or move efforts to protect the next generation forward.⁹⁰ Special drug courts that provide diversion from the traditional criminal justice system,⁹¹ increased access to naloxone to save lives during an overdose,⁹² Good Samaritan laws protecting those who report an overdose to first responders,⁹³ and supervised injection and syringe exchange programs⁹⁴ do not seek to intervene early or prevent addiction. While all of these initiatives are important tools in fighting the opioid epidemic, they all intervene downstream, sometimes even at the point when an individual is already facing imminent death.

More upstream efforts, such as regulation of overprescribing physician practices known as “pill mills,”⁹⁵ prevention of patient “doctor shopping,”⁹⁶ education of health care providers,⁹⁷ and initiatives to

88. Alderman et al., *supra* note 7, at 98.

89. Gostin & Bloche, *supra* note 7, at S172.

90. See Lawrence O. Gostin et al., *Reframing the Opioid Epidemic as a National Emergency*, 318 JAMA 1539, 1539 (2017) (“Current response efforts include . . . surveillance, reduced medical prescribing, and counseling or treatment for persons at risk or already addicted.”).

91. Andraka-Christou, *supra* note 9.

92. Barbara Andraka-Christou, *Improving Drug Courts Through Medication-Assisted Treatment for Addiction*, 23 VA. J. SOC. POL’Y & L. 180, 227 n.344 (2016).

93. Corey S. Davis & Derek H. Carr, *The Law and Policy of Opioids for Pain Management, Addiction Treatment, and Overdose Reversal*, 14 IND. HEALTH L. REV. 1, 32–33 (2017).

94. Scott Burris et al., *Federalism, Policy Learning, and Local Innovation in Public Health: The Case of the Supervised Injection Facility*, 53 ST. LOUIS U. L.J. 1089, 1100 (2009).

95. Griffin, *supra* note 10, at 946. Examples of pill mills include a Massachusetts doctor who accounted for thirty-three percent of the entire state’s OxyContin prescriptions in 2004 and a Houston doctor that wrote 17,000 painkiller prescriptions in 2005 (making \$1.7 million in cash). *Id.* at 947.

96. *Id.* at 943. Importantly, patients with a history of doctor shopping are at an increased risk of a drug-related death. SAMHSA’S CTR. FOR THE APPLICATION OF PREVENTION TECHS., PREVENTING PRESCRIPTION DRUG MISUSE: PROGRAMS AND STRATEGIES 28 (2016), <https://www.samhsa.gov/capt/sites/default/files/resources/preventing-prescription-drug-misuse-strategies.pdf> [<https://perma.cc/ZLG5-6NA9>] [hereinafter SAMHSA CTR.] (citing G.L. Peirce et al., *Doctor and Pharmacy Shopping for Controlled Substances*, 50 MED. CARE 494–500 (2012)).

97. SAMHSA CTR., *supra* note 96, at 18. Unfortunately, most providers receive little or no training in recognizing substance abuse or in proper prescribing practices for opioids. Griffin,

engage the public in reducing the number of prescription drugs in households, such as prescription medication “take-back” programs,⁹⁸ are all helpful components of a national prevention response. However, they do nothing to examine or attempt to prevent the individualized root causes of the opioid crisis in childhood and adolescence.

This Article suggests a more radical upstream response by addressing a different set of questions that explores the role of risk factors for addiction in individuals and the importance of childhood and adolescence as intervention points. How can health policy facilitate treatment of addiction long before the point of workplace impact, before the need for harm reduction, before the prospect of an overdose looms, or before a daunting intergenerational impact? Better yet, how can health policy help to prevent individuals from becoming addicted in the first place? How can health policy target those individuals most at risk for opioid addiction earlier in their lives so that their underlying needs are addressed and they are therefore better equipped to avoid addiction if they are prescribed pain relievers? In addition to the significant prevention approaches described above, the U.S. needs to add to its health policy tools by employing an upstream response that intervenes earlier in the lives of those most likely to misuse opioids—in the lives of children like Luke and Melanie—an approach informed by the Life Course Health Development (LCHD) model.

As a result of medical research, “[t]he last 50 years have witnessed a transformation in our understanding of the causes of disease and contributors to health,”⁹⁹ leading to greater interest in the identification of a model that could theorize health promotion in the context of disease development.¹⁰⁰ In response, in 2002, Neal Halfon and Miles Hochstein

supra note 10, at 926. As a result, several states have enacted mandatory prescriber education laws. Kolodny et al., *supra* note 23, at 566. Other states have implemented “educational program[s] on recommended opioid prescribing practices developed for and presented to health care workers.” SAMHSA CTR., *supra* note 96, at 23; Griffin, *supra* note 10, at 929.

98. States have used anti-prescription-drug campaigns to encourage the general public to “only take opioid medications in accordance with doctors’ orders” and paired those campaigns with “take-back” events encouraging individuals to remove unused or expired prescriptions from their homes. *See, e.g.*, THE SYCAMORE INST., THE OPIOID EPIDEMIC IN TENNESSEE PART 3 OF 3: THE ENVIRONMENT FOR PREVENTION AND TREATMENT 1–2 (2017), <https://www.sycamoreinstitute.tn.org/wp-content/uploads/2017/08/2017.08.23v2-FINAL-Opioids-in-TN-3-of-3-Prevention-and-Treatment-in-TN.pdf> [<https://perma.cc/88XP-6DA5>]; *accord, e.g.*, Griffin, *supra* note 10, at 926.

99. Neal Halfon et al., *Lifecourse Health Development: Past, Present and Future*, 18 *MATERNAL & CHILD HEALTH J.* 344, 344 (2014); Neal Halfon, *Life Course Health Development: A New Approach for Addressing Upstream Determinants of Health and Spending*, NIHCM FOUND. (Feb. 2009), https://www.nihcm.org/pdf/ExpertVoices_Halfon_FINAL.pdf [<https://perma.cc/3HYX-9779>] (“The past two decades have witnessed phenomenal advances in our understanding of how health and disease develop.”).

100. *See* Halfon et al., *supra* note 99, at 344–45; Halfon, *supra* note 99.

proposed the Life Course Health Development model.¹⁰¹ This approach conceptualizes how health develops over an individual's lifetime and places greater focus on the impact of early-life health factors, both biological and environmental.¹⁰² LCHD synthesizes research from biological, behavioral, and social science disciplines to define health development as a “dynamic process that begins before conception and continues throughout the lifespan.”¹⁰³ As a result, LCHD aims to shift health policy's focus from the treatment of diseases in their later stages¹⁰⁴ to more effective prevention strategies aimed at optimizing health development.¹⁰⁵

Two key concepts of the LCHD model should inform health policy responses to the opioid epidemic. The first, a core principle of LCHD, is the identification of risk and protective factors to prevent health problems.¹⁰⁶ Risk factors are negative conditions such as exposure to trauma or drugs that lower health-development trajectories.¹⁰⁷ Protective factors, in contrast, are positive conditions, such as the consistent support of a child by a caring adult, which can help raise developmental trajectories.¹⁰⁸ Health-development outcomes are understood through the LCHD lens as the product of competing exposures to risk and protective factors over time.¹⁰⁹ The recognition of risk factors and interventions to address them are critical to enhancing health outcomes,¹¹⁰ and such actions must be a part of an upstream response to the opioid crisis.

A second key concept of LCHD is the timing of risk and protective exposures and the emphasis on “sensitive,” or “critical” periods.¹¹¹ LCHD posits that exposures to risk and protective factors during sensitive periods in life may “encode the functions of organs or systems that become manifest in health and disease later in life.”¹¹² In essence, when

101. Neal Halfon & Miles Hochstein, *Life Course Health Development: An Integrated Framework for Developing Health, Policy, and Research*, 80 MILBANK Q. 433, 433 (2002).

102. See Halfon et al., *supra* note 99, at 350–51; Robert J. Palisano et al., *Life Course Health Development of Individuals with Neurodevelopmental Conditions*, 59 DEVELOPMENTAL MED. & CHILD NEUROLOGY 470, 470 (2017) (reviewing Halfon et al., *supra* note 99) (“Life course health development (LCHD) is an emerging biopsychosocial model that conceptualizes health development occurring through transactions between the person and environment over time.”).

103. Halfon et al., *supra* note 99.

104. *Id.* at 350; Halfon, *supra* note 99.

105. See Halfon et al., *supra* note 99, at 350; Halfon & Hochstein, *supra* note 101, at 434–35.

106. See Halfon & Hochstein, *supra* note 101.

107. *Id.* at 451.

108. See *id.*

109. See *id.*

110. See Halfon et al., *supra* note 99, at 350; Halfon & Hochstein, *supra* note 101, at 434–36.

111. See Halfon & Hochstein, *supra* note 101, at 449–50.

112. Michael C. Lu & Neal Halfon, Commentary, *Racial and Ethnic Disparities in Birth Outcomes: A Life-Course Perspective*, 7 MATERNAL & CHILD HEALTH J. 13, 16 (2003).

a person is in a highly critical period in life, there is a “programming mechanism” through which the body is highly sensitive and therefore more likely to be programmed for later health.¹¹³ These sensitive periods are stages of functional development “when a regulatory pathway is being constructed or modified and the developing organism is particularly responsive and sensitive to favorable or unfavorable environmental factors.”¹¹⁴

For example, in what is known as Barker’s hypothesis, David Barker posited that fetal undernutrition raises the risk of adult diseases through suboptimal programming of blood pressure regulation, glycemic control, and cholesterol metabolism at the fetal stage, making that stage a critical period.¹¹⁵ LCHD sees health development as a synthesis of this programming mechanism resulting from experiences in life and a cumulative mechanism through which we adapt to stress over time (known as “allostatic load”).¹¹⁶

In particular, early transition periods in life, including young childhood and adolescence, are “rapid change creating periods of enhanced vulnerability”¹¹⁷ that can more readily alter developmental trajectories, meaning that risk factors can have a “relatively greater effect on future health.”¹¹⁸ LCHD suggests that health policy should view childhood and adolescence as sensitive and critical periods, during which laws and policies can have a strong impact upstream by addressing risk factors and treating addiction early in life. The LCHD model supports prevention and early intervention efforts targeting at-risk children and substance-abusing adolescents as an effective approach to reducing opioid abuse.

Particularly given the high and wide-ranging economic implications of the opioid crisis, upstream health policy approaches in line with the LCHD model should ultimately yield cost savings despite the initial investments. Research shows that programs that involve screening and referrals to treatment for substance abuse have strong return on investment and are well worth the referrals to treatment for substance abuse in primary care settings, as there were between \$6.70 and \$40.00 in societal benefits.¹¹⁹

113. See Halfon & Hochstein, *supra* note 101, at 449.

114. *Id.* at 450.

115. See DJP Barker, *The Fetal and Infant Origins of Adult Disease*, 301 *BMJ* 1111, 1111 (1990); Paula Braveman & Colleen Barclay, *Health Disparities Beginning in Childhood: A Life-Course Perspective*, 124 *PEDIATRICS* S163, S164 (2009); Lu & Halfon, *supra* note 112.

116. See Lu & Halfon, *supra* note 112, at 16–18.

117. Halfon & Hochstein, *supra* note 101, at 454–55.

118. *Id.* at 455.

119. The authors note that “[w]hen considering injury prevention, reduced hospitalizations and the impact on chronic health conditions it is possible we could realize over \$5 benefit for

The provision of these interventions preventively and early in life, pursuant to the LCHD model, is also supported by the work of Nobel Laureate economist James Heckman, who has argued that investment in the mental and physical well-being of children from an early age is crucial to improving adult outcomes, which are economically beneficial to individuals and society.¹²⁰ The “Heckman Equation” calls for investment in resources for low-income families, such as those on Medicaid, and early development of children’s social and emotional skills, especially during the sensitive and critical period of the first five years of life.¹²¹ Heckman argues that the result is a “more capable, productive and valuable workforce that pays dividends to America for generations to come.”¹²² According to Heckman, the earlier the investment in a child’s life, the larger the return.¹²³ Heckman’s research shows that programs that invest comprehensively in young children have benefits that far outweigh the costs; one such program he studied generated a benefit of \$7.30 for every dollar spent, with a rate of return of 13.7% per annum.¹²⁴

To get as upstream in the lifecourse as possible, as Heckman proposes, and to prevent opioid misuse whenever possible, the LCHD model suggests that identification of risk factors and early intervention to address them can improve prospects for a healthier, addiction-free life for those most at risk. Therefore, health policy needs to ensure that teens and adults who are misusing opioids receive the necessary treatment, but also that the needs of younger children who are at higher risk for substance abuse later in life are addressed. Similarly, the United States Department

every \$1 spent directly to Medicaid’s bottom line.” Somebody Finally Asked Me: True Talk: Power of Prevention, *Cost-Benefit Impact of SBIRT in Georgia*, GEORGIANS FOR A HEALTHY FUTURE 5 (Nov. 1, 2016).

120. See Gabriella Conti & James J. Heckman, *The Economics of Child Well-Being*, in HANDBOOK OF CHILD WELL-BEING: THEORIES, METHODS AND POLICIES IN GLOBAL PERSPECTIVE 363, 381–82 (Asher Ben-Arieh et al. eds., 2014); *Talking the Heckman Equation*, HECKMAN, https://heckmanequation.org/assets/2011/05/Hkmm_framecheatsheet-4.pdf [<https://perma.cc/4WPA-SCAC>].

121. See Conti & Heckman, *supra* note 120, at 392–93 & fig.14.11.

122. *The Heckman Equation*, HECKMAN, <https://heckmanequation.org/the-heckman-equation/> [<https://perma.cc/L6MT-W2D>].

123. See Conti & Heckman, *supra* note 120, at 392.

124. See Jorge Luis García et al., *The Life-Cycle Benefits of an Influential Early Childhood Program* 54–64 (CESR-Schaeffer, Working Paper No. 2016-18, 2016), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2884880 [<https://perma.cc/2SEH-XZLE>]. In a recent study of the long-term benefits of two North Carolina preschool programs from the 1970s that provided comprehensive developmental resources, including health care, to African American children ages five and under, Heckman and his co-authors found that there were great long-term benefits to those who received the additional high-quality resources. See *id.* at 1, 8, 21–23. Participation led to positive effects on education, employment, labor income, crime, and health, especially for male children. *Id.* at 4–5, 6 fig.1.

of Health and Human Services recommends early intervention be provided not only to those engaged in substance abuse, but also to youth at risk of or showing signs of substance misuse or a mild substance use disorder.¹²⁵

Fortunately, there is ample research indicating two major opioid abuse risk factors that can be addressed in childhood. One risk factor is childhood mental health challenges, including those related to trauma histories.¹²⁶ The second is initiation, in adolescence, of other forms of substance use, including alcohol and marijuana abuse.¹²⁷ A preventive health policy to address the opioid crisis should ensure that children are screened for these risk factors and provided with necessary interventions to address them.

First, a child’s mental illness puts her at risk for substance abuse.¹²⁸ Adolescents with mental health diagnoses are more likely to misuse opioids in particular.¹²⁹ Individuals with anxiety, like Melanie, along with those with depressive disorders, are two to three times more likely to use and remain on opioids.¹³⁰ The recent SUPPORT for Patients and Communities Act’s requirement for states to monitor the use of

125. See U.S DEP’T OF HEALTH & HUMAN SERVS., *supra* note 35, at 4–5.

126. See ELIZABETH B. ROBERTSON ET AL., NAT’L INST. ON DRUG ABUSE, PRINCIPLES OF SUBSTANCE ABUSE PREVENTION FOR EARLY CHILDHOOD: A RESEARCH-BASED GUIDE 26 (2016); Felitti et al., *supra* note 12, at 249–50.

127. See Brett R. Harris, *Talking About Screening, Brief Intervention, and Referral to Treatment for Adolescents: An Upstream Intervention to Address the Heroin and Prescription Opioid Epidemic*, 91 PREVENTIVE MED. 397, 398 (2016).

128. See ROBERTSON ET AL., *supra* note 126.

129. See U.S DEP’T OF HEALTH & HUMAN SERVS., *supra* note 35, at 4–5; Kathleen T. Brady et al., *Prescription Opioid Misuse, Abuse, and Treatment in the United States: An Update*, 173 AM. J. PSYCHIATRY 18, 21 (2016) (“Factors associated with increased risk of prescription opioid abuse in cross-sectional studies include . . . psychiatric disorders (e.g., depression, bipolar disorder) . . .”); Thomas Ciesielski et al., *A Tool to Assess Risk of De Novo Opioid Abuse or Dependence*, 129 AM. J. MED. 699, 703–04 (2016); Jennifer Harman Ehrentraut et al., *Opioid Misuse Behaviors in Adolescents and Young Adults in a Hematology/Oncology Setting*, 39 J. PEDIATRIC PSYCHOL. 1149, 1149–50, 1156 (2014) (focusing on opioid abuse risk factors for pediatric cancer patients); Laura P. Richardson et al., *Mental Health Disorders and Long-Term Opioid Use Among Adolescents and Young Adults with Chronic Pain*, 50 J. ADOLESCENT HEALTH 553, 554 (2012); Lynn R. Webster & Rebecca M. Webster, *Predicting Aberrant Behaviors in Opioid-Treated Patients: Preliminary Validation of the Opioid Risk Tool*, 6 PAIN MED. 432, 438 (2005); Ahrensbrak et al., *supra* note 29.

130. See Richardson et al., *supra* note 129; Ahrensbrak et al., *supra* note 29. Some experts believe there is a bidirectional association such that mental health disorders both predict and are predicted by non-medical prescription and opioid use. See *Opioid Overdoses, Depression Linked*, SCIENCE DAILY (Oct. 3, 2018), <https://www.sciencedaily.com/releases/2018/10/181003162709.htm> [<https://perma.cc/56YV-ELEE>]. “Adverse selection” occurs when doctors are more likely to prescribe opioids to the very patients who are at a high risk for opioid abuse and dependence. See Richardson et al., *supra* note 129. Additionally, younger age predicts increased risk of de novo abuse or dependence in opioid users. See Ciesielski et al., *supra* note 129, at 703.

antipsychotic medications by Medicaid beneficiaries under the age of eighteen may help states better identify at-risk children, which could be leveraged by the EPSDT program.¹³¹ A recent study suggests that some adolescents are self-medicating with opioids as a result of mental health issues.¹³² Inappropriate classroom behavior, academic failure, and poor social coping skills, all of which can be associated with unmet social-emotional needs, are risk factors for substance abuse.¹³³ Even infants who suffer from mental health challenges may face higher risk of substance abuse later in life.¹³⁴ Unfortunately, the mental health and substance abuse treatment needs of many children go unmet. A national survey showed that a quarter of adolescents with a major depressive episode and a substance abuse disorder did not receive either mental health care or specialty substance abuse treatment.¹³⁵ Addressing the mental health needs of infants, children, and adolescents should play a key role in opioid abuse prevention.

Childhood trauma, like that experienced by Melanie and Luke, similarly correlates with increased opioid use later in life,¹³⁶ and its mental health effects should be addressed as part of opioid abuse prevention. Traumatic childhood experiences can set the stage for future substance use or escalate it to an addiction.¹³⁷ A large body of research examines the prevalence and impact of certain forms of trauma, known

131. SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, § 1004(a)(2), 132 Stat. 3894, 3909 (2018) (codified at 42 U.S.C.A. § 1396a (West 2018)).

132. See David C. Sheridan et al., *Association of Overall Opioid Prescriptions on Adolescent Opioid Abuse*, 51 J. EMERGENCY MED. 485, 486, 488 (2016). Researchers propose several possible other drivers for the connections between adolescent mental health and opioid misuse. One theory is that depression and anxiety are associated with an increased number of physical symptoms, including pain. See Mark D. Sullivan, *Depression Effects on Long-Term Prescription Opioid Use, Abuse, and Addiction*, 34 CLIN. J. PAIN 878, 879–80 (2018). Additionally, physicians may be more willing to use chronic opioid therapy for patients with mental health disorders if they attribute symptoms and impairment as related to the pain. See *id.* Anxiety and depression are more common among parents of youth with mental health disorders, which may result in increased treatment seeking by parents. See Denis Campbell, *Why Do More Young People Have Mental Health Problems?*, GUARDIAN (Nov. 22, 2018, 7:49 PM), <https://www.theguardian.com/society/2018/nov/22/why-do-more-young-people-have-mental-health-problems> [https://perma.cc/HYR5-M83H]. Some researchers posit that certain substances may trigger a mental disorder that may not have otherwise occurred. See U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 35, at 2–23. It is also possible that SUDs and mental health issues could be caused by shared, overlapping factors. See *id.*

133. ELIZABETH B. ROBERTSON ET AL., NAT'L INST. ON DRUG ABUSE, PREVENTING DRUG USE AMONG CHILDREN AND ADOLESCENTS: A RESEARCH-BASED GUIDE 9 (2003).

134. See ROBERTSON ET AL., *supra* note 126, at 23 (explaining that during infancy, having a difficult temperament, insecure attachment, or uncontrolled aggression can be risk factors).

135. See Ahrnsbrak et al., *supra* note 29.

136. See Dasgupta et al., *supra* note 33.

137. See U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 35, at 2–21.

as adverse childhood experiences (ACEs), including household instability, such as parental incarceration, mental illness and substance use, and neglect, and emotional, physical, and sexual abuse.¹³⁸ The original ACEs studies by the CDC and Kaiser Permanente, as well as subsequent follow-up studies, found that these forms of childhood trauma are surprisingly common and increase a person’s risk of poor health outcomes, including substance abuse.¹³⁹ The results of the ACEs studies specifically indicate that a higher number of ACEs (known as a “high ACE score”) increases the risk that a child will eventually use, inject, and become addicted to illicit drugs.¹⁴⁰ An increase in the number of ACEs has similarly been correlated with a lower age of opioid use initiation and a higher likelihood of overdose.¹⁴¹ The stress caused by trauma “may act on the same stress circuits in the brain as addictive substances, which may explain why they increase addiction risk.”¹⁴² The ACEs research provides a clear example of the effectuation of the LCHD model, demonstrating a strong relation between childhood trauma and the development of a wide range of health problems throughout a person’s lifespan.¹⁴³

In New Mexico there are many youths, like Luke, with both trauma histories and substance abuse disorders in the state’s juvenile justice systems. Research the author conducted, together with colleagues from the University of New Mexico, the New Mexico Sentencing Commission, and the state’s Children, Youth and Families Department, examined the trauma histories and related needs of youth who were

138. See ROBERTSON ET AL., *supra* note 133, at 8 (noting that “factors that affect early development in the family are probably the most critical” and finding that family-related risk factors for substance abuse include “a caregiver who abuses substances, suffers from mental illness, or engages in criminal behavior”); Brady et al., *supra* note 129 (“Factors associated with increased risk of prescription opioid abuse in cross-sectional studies include . . . exposure to violence or sexual assault . . . and a family history of substance use disorder.” (citation omitted)); Felitti et al., *supra* note 12, at 249, 250 tbl.2.

139. Felitti et al., *supra* note 12, at 245, 249, 250 tbl.2, 254.

140. Shanta R. Dube et al., *Childhood Abuse, Neglect, and Household Dysfunction and the Risk of Illicit Drug Use: The Adverse Childhood Experiences Study*, 111 PEDIATRICS 564, 565, 567 (2003) (studying original ACEs plus emotional and physical neglect and parental separation or divorce); Felitti et al., *supra* note 12, at 249, 250 tbl.2; Sunny H. Shin et al., *Patterns of Adverse Childhood Experiences and Substance Use Among Young Adults: A Latent Class Analysis*, 78 ADDICTIVE BEHAVS. 187, 191 (2018).

141. See Michael D. Stein et al., *Adverse Childhood Experience Effects on Opioid Use Initiation, Injection Drug Use, and Overdose Among Persons with Opioid Use Disorder*, 179 DRUG & ALCOHOL DEPENDENCE 325, 326 (2017).

142. U.S DEP’T OF HEALTH & HUMAN SERVS., *supra* note 35, at 2–21.

143. *Adverse Childhood Experiences*, SAMHSA, <https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences> [<https://perma.cc/LJ6M-PWWK>].

incarcerated in New Mexico's juvenile justice system.¹⁴⁴ Eighty-six percent had experienced four or more traumatizing adverse childhood experiences, a score that the original ACEs study linked to an alarming panoply of poor health and mental health outcomes.¹⁴⁵ Almost a fifth of boys and nearly a quarter of the girls had seven or more of these traumatic events, an ACE score for which there is no research to indicate the gravity of possible poor outcomes because an ACE score of seven is literally off the charts.¹⁴⁶ Addiction affected almost every single youth in the study, as 96.4% had been diagnosed with a substance abuse disorder.¹⁴⁷ It is not surprising that so many young people had a substance abuse disorder; decades of ACEs research connects these trauma histories in childhood with high rates of substance abuse later in life.¹⁴⁸ Some researchers have proposed integrating strategies to address ACEs into substance abuse prevention efforts,¹⁴⁹ which will be an important component of an upstream response.

Of the ten traumatic experiences that comprise the list of ACEs, research shows that parental substance abuse leads to the strongest increase in both early initiation of substance abuse during adolescence and in lifetime use.¹⁵⁰ In short, children like Melanie and Luke who have a parent who misuses opioids are at higher risk for becoming opioid users and addicts themselves.¹⁵¹ Moreover, children who have parents

144. Yael Cannon et al., *Adverse Childhood Experiences in the New Mexico Juvenile Justice Population 1* (2016), <https://nmjc.unm.edu/reports/2016/adverse-childhood-experiences-in-the-new-mexico-juvenile-justice-population.pdf> [<https://perma.cc/E5LK-Z2P4>].

145. *Id.* at 6–7.

146. *Id.* at 5, 6 fig.3.

147. *Id.* at 9.

148. Felitti et al., *supra* note 12, at 245 (“Persons who had experienced four or more categories of childhood exposure, compared to those who experienced none, had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt”); *see, e.g.*, Namkee G. Choi et al., *Association of Adverse Childhood Experiences with Lifetime Mental and Substance Use Disorders Among Men and Women Aged 50+ Years*, 29 *INT’L PSYCHOGERIATRICS* 359, 359 (2017) (finding association between ACEs and lifetime mental and SUDs); Dube et al., *supra* note 140, at 564 (finding ACE score has strong relationship to risk of drug initiation from early adolescence into adulthood and to problems with drug use, drug addiction, and parenteral use).

149. *See, e.g.*, THE SYCAMORE INST., *supra* note 98, at 2.

150. Dube et al., *supra* note 140, at 569 tbl.3. However, the ACEs are so interconnected that it was difficult to fully assess each ACE individually. *Id.* at 566.

151. *See* Webster & Webster, *supra* note 129, at 437–38; Lorna Collier, *Young Victims of the Opioid Crisis*, *AM. PSYCHOL. ASS’N: MONITOR ON PSYCHOL.* (Jan. 2018), <http://www.apa.org/monitor/2018/01/opioid-crisis.aspx> [<https://perma.cc/V6PA-FRP7>]; Marian Wright Edelman, *Children and the Opioid Crisis*, *HUFFINGTON POST* (Oct. 27, 2017, 5:02 PM), https://www.huffingtonpost.com/entry/children-and-the-opioid-crisis_us_59f39e1be4b06acda25f49cf [<https://perma.cc/ZXR4-2QQK>] (citing ACE studies generally).

misusing opioids often suffer from complex trauma, which can impact their mental health, even if they never choose to use.¹⁵²

In particular, national concern is growing over babies who were exposed to opioids in utero. In the United States, every fifteen minutes a baby is born suffering from neonatal abstinence syndrome (NAS), which involves withdrawal from opioids.¹⁵³ Children born with NAS may be at particularly high risk of substance abuse because they have suffered trauma due to parental substance abuse. Research about prenatal drug exposure also suggests greater potential for increased substance use by those infants later in life.¹⁵⁴

The SUPPORT for Patients and Communities Act also has several provisions that may provide the foundation for a nationwide strategy for monitoring, addressing, and better understanding childhood trauma; this includes a grant program to improve trauma-support services for students in educational environments,¹⁵⁵ a directive for the CDC to collect data on adverse childhood experiences,¹⁵⁶ and the development of guidance for educational professionals working with children who have experienced trauma.¹⁵⁷ At the very least, the SUPPORT Act's acknowledgement of the link between childhood trauma and addiction is a step in the right direction. At the most, the SUPPORT Act could help inform the EPSDT program on how to more effectively intervene and treat childhood trauma before addiction takes form.

152. See Collier, *supra* note 151.

153. *Dramatic Increases in Maternal Opioid Use and Neonatal Abstinence Syndrome*, NAT'L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/related-topics/trends-statistics/infographics/dramatic-increases-in-maternal-opioid-use-neonatal-abstinence-syndrome> [https://perma.cc/LWZ2-5VLS] (last updated Jan. 2019).

154. Research on prenatal exposure to nicotine and marijuana suggests that prenatal exposure to those drugs potentially increases drug use in offspring. See Denise J. Maguire et al., *Long-Term Outcomes of Infants with Neonatal Abstinence Syndrome*, 35 NEONATAL NETWORK 277, 282 (2016). However, there is no published data that confirms or demonstrates higher rates of subsequent drug abuse for infants diagnosed with NAS or infants with prenatal opioid exposure. *Id.* More research following NAS infants into adulthood is needed. *Id.* There may also be transgenerational epigenetic changes (changes to how a genetic sequence or gene is expressed, independent of the actual genetic sequence) that possibly affect subsequent drug use. See generally F.M. Vassoler et al., *The Impact of Exposure to Addictive Drugs on Future Generations: Physiological and Behavioral Effect*, 76 NEUROPHARMACOLOGY 269, 269, 273 (2013) (discussing trans-generational epigenetic changes and drug use). There are also increased costs related to birth, infancy, and maternal health for infants born with NAS. Stephen W. Patrick et al., *Neonatal Abstinence Syndrome and Associated Health Care Expenditures*, 307 JAMA 1934, 1939 (2012).

155. SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, § 7134, 132 Stat. 3894, 4051-55 (codified at 42 U.S.C.A. § 280h-7 (West 2018)).

156. *Id.* § 7131 (codified at 42 U.S.C.A. § 242t).

157. *Id.* § 7135 (codified at 42 U.S.C.A. § 280h-8).

Beyond mental health and trauma-related concerns, a second major risk factor for opioid abuse involves use and misuse of other substances. Most addictions are found to have started with early initiation of alcohol and marijuana use.¹⁵⁸ In fact, adolescents who use alcohol and marijuana are two to three times more likely to later abuse prescription opioids.¹⁵⁹ Alcohol and drug use during adolescence is also associated with future use of heroin, a higher likelihood of abuse or dependence in adulthood, academic problems, and poorer mental health.¹⁶⁰ Prevention efforts to target the opioid epidemic must include interventions to stop adolescents from using and abusing any substance before they advance to a harder drug.¹⁶¹

Consequently, an upstream health policy approach to the opioid epidemic should not only involve the treatment of adolescents already engaged in opioid abuse, but should also focus on identifying children with risk factors, including those with mental health needs and those who have begun alcohol and drug use. In line with the LCHD model, a national health policy response to the opioid crisis should strategically include preventive efforts to help children with these risk factors.

III. MEDICAID AS AN UPSTREAM RESPONSE TO IDENTIFY AND ADDRESS THE NEEDS OF AT-RISK AND SUBSTANCE-USING CHILDREN AND ADOLESCENTS

Medicaid should play a key role in a preventive health policy response to the opioid epidemic, as it offers a particularly suitable response to addressing the crisis early through a focus on children. Screening and treatment provisions already exist and have earned the support of all three branches of government as a means for improving children's health generally and behavioral health in particular. "Behavioral health" conditions include both mental health and substance abuse disorders.¹⁶²

158. See Brett R. Harris, *Talking About Screening, Brief Intervention, and Referral to Treatment for Adolescents: An Upstream Intervention to Address the Heroin and Prescription Opioid Epidemic*, 91 PREVENTIVE MED. 397, 398 (2016).

159. *Id.* (citing Fiellin et al., *Prior Use of Alcohol, Cigarettes, and Marijuana and Subsequent Abuse of Prescription Opioids in Young Adults*, 52 J. ADOLESCENT HEALTH 158–63 (2013)).

160. Elizabeth J. D'Amico et al., *Screening in Primary Care: What Is the Best Way to Identify At-Risk Youth for Substance Use?*, 138 PEDIATRICS 2 (Nov. 18, 2016), <https://pediatrics.aappublications.org/content/pediatrics/138/6/e20161717.full.pdf> [<https://perma.cc/ES3A-JZM9>].

161. Harris, *supra* note 158.

162. CTRS. FOR MEDICARE & MEDICAID SERVS. & SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CMS PRODUCT NO. 12005, A ROADMAP TO BEHAVIORAL HEALTH: A GUIDE TO USING MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES 7 (2017), <https://www.cms.gov>.

Medicaid must be leveraged in the fight against the opioid crisis because Medicaid beneficiaries are more likely to abuse or experience addiction to opioids than are privately insured adults.¹⁶³ Largely connected to higher risks resulting from conditions of poverty,¹⁶⁴ almost twelve percent of adults and six percent of children and adolescents enrolled in Medicaid have a SUD, higher than the general population (8.5% and 5%, respectively).¹⁶⁵ State-level data shows that Medicaid beneficiaries have a higher risk of overdose and adverse effects from opioids than the general population. In Maryland, for example, Medicaid enrollees have over twice the number of opioid or heroin-related emergency department visits than any other type of payer.¹⁶⁶ As a result of higher risk, which is closely connected to risks associated with the conditions of poverty, the Medicaid population has a greater need for treatment. In fact, Medicaid finances roughly twenty-one percent of all addiction treatment, which is greater than treatment covered by private insurers combined (eighteen percent).¹⁶⁷

gov/about-cms/agency-information/omh/downloads/coverage-to-care-behavioral-roadmap.pdf [https://perma.cc/R7JF-EYFK].

163. MEDICAID & CHIP PAYMENT & ACCESS COMM’N, REPORT TO CONGRESS ON MEDICAID AND CHIP 18 (2018), <https://www.macpac.gov/wp-content/uploads/2018/06/June-2018-Report-to-Congress-on-Medicaid-and-CHIP.pdf> [https://perma.cc/A5YE-M44G] (“Compared to privately insured individuals, Medicaid beneficiaries age 18–64 have a higher rate of opioid use disorder (OUD) and are prescribed pain relievers more often than individuals with other sources of insurance.”). This is primarily due to high poverty rate among the Medicaid population, as poverty puts individuals at a higher risk for addiction and its consequences, such as overdoses. See Volkow, *supra* note 15.

164. Volkow, *supra* note 15.

165. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., HHS PUB. NO. SMA 15-4927, BEHAVIORAL HEALTH TRENDS IN THE UNITED STATES: RESULTS FROM THE 2014 NATIONAL SURVEY ON DRUG USE AND HEALTH 1, 2, 22 (2015), <https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf> [https://perma.cc/R3QK-KSCH]; SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., HHS PUB. NO. 14-4863, THE NSDUH REPORT: SUBSTANCE USE AND MENTAL HEALTH ESTIMATES FROM THE 2013 NATIONAL SURVEY ON DRUG USE AND HEALTH 4 (2014), <https://store.samhsa.gov/system/files/nsduh14-0904.pdf> [https://perma.cc/RGW4-DK8X]; Davis & Hernandez-Delgado, *supra* note 37, at 10; *Reducing Substance Use Disorders*, MEDICAID.GOV, <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/reducing-substance-use-disorders/reducing-substance-use-disorders.html> [https://perma.cc/YJA2-DBN7].

166. Erin McMullen, *Maryland Medicaid and Opioid Epidemic*, MD. DEP’T OF HEALTH (June 23, 2016), <https://mmcp.dhmd.maryland.gov/Documents/MMAC%20presentation%20DUR%20and%20Overdose%20Jun%202016.pdf> [https://perma.cc/U3CR-Z5TZ].

167. JULIA ZUR & JENNIFER TOLBERT, THE OPIOID EPIDEMIC AND MEDICAID’S ROLE IN FACILITATING ACCESS TO TREATMENT 6 (2018), <http://files.kff.org/attachment/Issue-Brief-The-Opioid-Epidemic-and-Medicoids-Role-in-Facilitating-Access-to-Treatment> [https://perma.cc/M8HZ-TF5A]. The Proportion of Total Spending on Addiction Treatment Services in 2014, by Payer, were: 29% other state/local; 18% Medicare and other federal funds (such as block grants); 21% Medicaid; 18% private insurers; 9% out-of-pocket. Tami L. Mark et al., *Insurance Financing*

Several states have opted into Medicaid expansion under the Affordable Care Act,¹⁶⁸ which provides states enhanced federal funding to furnish Medicaid coverage to individuals with slightly higher incomes who are living in poverty.¹⁶⁹ Many states that have opted to expand Medicaid under the Affordable Care Act have found that Medicaid serves as an important source of coverage and access to treatment for individuals with SUD.¹⁷⁰ To address the treatment needs of those covered by Medicaid, several states have sought Medicaid waivers and State Plan Amendments¹⁷¹ to expand the scope and improve the delivery of SUD

Increased for Mental Health Conditions but Not for Substance Use Disorders, 1986-2014, 35 HEALTH AFF. 958, 960–62 (2016).

168. Pub. L. No. 111-148, 124 Stat. 119 (2010); ZUR & TOLBERT, *supra* note 167, at 1–2. The 2018 federal poverty level was \$16,753/year for an individual. *Id.*

169. For the states that have expanded Medicaid, the federal government paid 100% of costs of newly eligible Medicaid enrollees. The enhanced federal funding per year is as follows: 100% for 2014–2016, 95% for 2017, 94% for 2018, 93% for 2019, 90% for 2020 on. ROBIN RUDOWITZ, UNDERSTANDING HOW STATES ACCESS THE ACA ENHANCED MEDICAID MATCH RATES 1–2 (2014), <http://files.kff.org/attachment/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates-issue-brief> [<https://perma.cc/F72M-EH2Z>].

170. DAVIS & HERNANDEZ-DELGADO, *supra* note 37, at 11–12. In Ohio, nearly 500,000 individuals have received SUD services because of the State’s expansion. *Id.*; *Medicaid Expansion Covers Nearly 500,000 Ohioans for Mental Health, Drug Treatment*, COLUMBUS DISPATCH (July 17, 2016, 10:57 AM), <http://www.dispatch.com/content/stories/local/2016/07/17/medicaid-expansion-covers-nearly-500000-for-mental-health-drug-treatment.html> [<https://perma.cc/JTU5-JMZY>]. Ohio’s expansion also led to improvements in access to care and financial security for expansion enrollees with OUDs. BRIAN NEALE, CTRS. FOR MEDICARE & MEDICAID SERVS., SMD No. 17-003, STRATEGIES TO ADDRESS THE OPIOID EPIDEMIC 3–4 (2017), <https://www.medicare.gov/federal-policy-guidance/downloads/smd17003.pdf> [<https://perma.cc/7YQC-JQLH>]. After expanding in 2014, Kentucky saw a 700% increase in Medicaid beneficiaries using SUD treatment and services. PEGGY BAILEY, BUILDING ON ACA’S SUCCESS WOULD HELP MILLIONS WITH SUBSTANCE USE DISORDERS 3 (2017), <https://www.cbpp.org/sites/default/files/atoms/files/4-11-17health4.pdf> [<https://perma.cc/ZTM8-HYHH>]. Lastly, in West Virginia, “more than half of Medicaid enrollees with an OUD are in the expansion group.” MANATT HEALTH, *supra* note 29, at 2. In that state, the share of individuals with an SUD who were hospitalized but uninsured fell from twenty-three percent in 2013 to five percent in 2014 after the state expanded. BAILEY, *supra*.

171. *See, e.g.*, 42 U.S.C. § 1396n(i)(1) (2012) (“[A] State may provide through a State plan amendment for the provision of medical assistance for home and community-based services (within the scope of services described in [§ 1396c](4)(B) . . . for which the Secretary has the authority to approve a waiver and not including room and board) for individuals eligible for medical assistance under the State plan . . .”). Section 1115 waivers for OUD and SUD treatment allow states to allocate Medicaid funds towards substance use or mental health treatment in institutions for mental disease (IMD). *See Section 1115 Waivers for Substance Use Disorder Treatment*, MACPAC, <https://www.macpac.gov/subtopic/section-1115-waivers-for-substance-use-disorder-treatment/> [<https://perma.cc/QQC8-G2TP>]. The waiver allows states to receive reimbursement for their IMD spending so long as the state meets outlined criteria and is timely in reporting its progress on the six standardized milestones. *Id.* Currently, nineteen states have approved SUD Section 1115 waivers and nine states having pending waiver applications. *Id.* The

services¹⁷² through demonstration projects often targeted at subsets of the general Medicaid population.¹⁷³

Many of these Medicaid innovations to combat the opioid epidemic do not explicitly include changes to the services or delivery of care afforded to children and adolescents in particular. However, medically necessary services for children at risk for and engaged in substance abuse should be provided under children’s Medicaid whether or not those services are enumerated in a state’s Medicaid plan and whether or not the state imposes any limitations on adult services.¹⁷⁴ In other words, special waivers and changes to states’ Medicaid plans are not required for children. Medicaid law, through the EPSDT benefit, already requires that

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, or SUPPORT Act, further supports the use of Section 1115 waivers. Section 5051–52 of the SUPPORT Act allows individual states from October 1, 2019 to September 30, 2023 to use Medicaid funds for up to thirty days of care in Institutions for Mental Disease (IMD) per year per eligible adult aged twenty-one to sixty-four with SUDs. See MARYBETH MUSUMECI & JENNIFER TOLBERT, FEDERAL LEGISLATION TO ADDRESS THE OPIOID CRISIS: MEDICAID PROVISIONS IN THE SUPPORT ACT 6 (2018), <http://files.kff.org/attachment/Issue-Brief-Federal-Legislation-to-Address-the-Opioid-Crisis-Medicaid-Provisions-in-the-SUPPORT-Act> [<https://perma.cc/36HT-FECU>]. Medicaid funds are allowed to be used for services provided outside of IMDs as well for individuals receiving IMD SUD care. *Id.*

172. See, e.g., *Combatting the Opioid Crisis: Improving the Ability of Medicare and Medicaid to Provide Care for Patients: Hearing Before the Subcomm. on Health of the H. Comm. on Energy & Commerce*, 115th Cong. 5 (2018) (memorandum by Majority Staff); DEBORAH BACHRACH ET AL., STATE HEALTH REFORM ASSISTANCE NETWORK, MEDICAID: STATES’ MOST POWERFUL TOOL TO COMBAT THE OPIOID CRISIS, STATE HEALTH & VALUE STRATEGIES 4 (2016), <https://www.shvs.org/wp-content/uploads/2016/07/State-Network-Manatt-Medicaid-States-Most-Powerful-Tool-to-Combat-the-Opioid-Crisis-July-2016.pdf> [<https://perma.cc/N2L3-LC6P>]; MARYBETH MUSUMECI, KEY THEMES IN MEDICAID SECTION 1115 BEHAVIORAL HEALTH WAIVERS 2 (2017), <http://files.kff.org/attachment/Issue-Brief-Key-Themes-in-Medicaid-Section-1115-Behavioral-Health-Waivers> [<https://perma.cc/6CLP-9FE5>]; Lisa Clemans-Cope et al., *Experiences of Three States Implementing the Medicaid Health Home Model to Address Opioid Use Disorder—Case Studies in Maryland, Rhode Island, and Vermont*, 83 J. SUBSTANCE ABUSE TREATMENT 27, 28 (2017); Emma Sandoe, *What is the IMD Exclusion that Everyone is Talking About?*, HARV. L.: BILL HEALTH (Feb. 27, 2016), <http://blogs.harvard.edu/billofhealth/2016/02/27/what-is-the-imd-exclusion-that-everyone-is-talking-about/> [<https://perma.cc/QS5D-CDDZ>]; see also 42 U.S.C. § 1315(a)(1) (2012) (allowing waiver for “experimental, pilot, or demonstration” projects).

173. NAT’L CONFERENCE OF STATE LEGISLATURES, UNDERSTANDING MEDICAID SECTION 1115 WAIVERS: A PRIMER FOR STATE LEGISLATORS 4 (2017), http://www.ncsl.org/Portals/1/Documents/Health/Medicaid_Waivers_State_31797.pdf [<https://perma.cc/MR5G-V8PS>].

174. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., COVERAGE OF BEHAVIORAL HEALTH SERVICES FOR YOUTH WITH SUBSTANCE USE DISORDERS 5 (2016), <http://files.constantcontact.com/57c33206301/45d5dcfc-adb4-438b-ae2-9312344ac00c.pdf> [<https://perma.cc/HSC3-FANZ>] (“Coverage for SUD services is available under EPSDT [the children’s Medicaid benefit] regardless of whether services are provided under the Medicaid state plan and regardless of any restrictions states may impose on coverage for adult services . . .”).

children are screened for behavioral health needs and afforded all medically necessary treatment.

In addition to the breadth of coverage under children's Medicaid, the scope of the population covered also positions Medicaid to serve as a tool in combatting the opioid epidemic. More than 32 million American children receive their healthcare through Medicaid,¹⁷⁵ a program intended by Congress to be "the nation's largest preventive health program for children."¹⁷⁶ All children under the age of eighteen with a family income of 133% of the federal poverty line or lower have a right to Medicaid coverage simply based on their families' level of poverty.¹⁷⁷ States must provide coverage to those children, and many states have opted to provide Medicaid coverage to a more expansive group of children from families with slightly higher incomes.¹⁷⁸

Every state participates in the Medicaid program and receives a federal match for its expenditure based on a formula through which states receive, from the federal government, a certain number of cents per dollar they spend.¹⁷⁹ The match rate is based on average income levels in the state.¹⁸⁰ States with a higher percentage of low-income individuals receive a higher reimbursement rate from the federal government.¹⁸¹

States have flexibility around a specific set of factors related to the administration of the program. For example, states can decide which services they will cover for adults in their Medicaid state plans that are submitted to the federal government for approval.¹⁸²

States can also choose whether to administer the Medicaid program through direct funding for specific services (known as "fee for service") or through contracts with private Medicaid Managed Care Organizations, which operate as the health insurance companies for the states' Medicaid beneficiaries.¹⁸³

175. SUZANNE MURRIN, U.S. DEP'T OF HEALTH & HUMAN SERVS., OEI-05-13-00690, CMS NEEDS TO DO MORE TO IMPROVE MEDICAID CHILDREN'S UTILIZATION OF PREVENTIVE SCREENING SERVICES 2 (2014). More recent data does not disaggregate Medicaid enrollment from CHIP enrollment; nearly 35.2 million children are enrolled in CHIP or the Medicaid program in the 48 states that reported child enrollment data for October 2018. *October 2018 Medicaid & CHIP Enrollment Data Highlights*, *supra* note 17.

176. *Frew v. Gilbert*, 109 F. Supp. 2d 579, 588 (E.D. Tex. 2000) (quoting H.R. 3299, 101st Cong. § 4213 (1989)), *vacated sub nom. Frazar v. Gilbert*, 300 F.3d 530 (5th Cir. 2002), *rev'd sub nom. Frew ex rel. Frew v. Hawkins*, 540 U.S. 431 (2004).

177. 42 C.F.R. § 435.118(b)-(c) (2018).

178. *Id.* § 435.229.

179. *Id.* § 433.10(b).

180. *Id.*

181. *Id.*

182. *State Plan*, MACPAC, <https://www.macpac.gov/subtopic/state-plan/> [<https://perma.cc/TX4F-Z3S4>].

183. ANDY SCHNEIDER & DAVID ROUSSEAU, THE KAISER COMM'N ON MEDICAID & THE

However, states have less flexibility when it comes to the benefits that children must be provided under Medicaid. All children with Medicaid are entitled to EPSDT services, which include a comprehensive set of medical benefits for eligible individuals up to twenty-one years old.¹⁸⁴

First, EPSDT requires regular comprehensive screening at the doctor’s office in appointments known as well-child visits. When a child goes to the doctor, she must receive more than a basic physical; the doctor must perform a full medical examination that includes a developmental screening, which assesses the child’s mental health and substance abuse needs.¹⁸⁵ Periodicity schedules, which are set by the state after consultation with child health experts and organizations, indicate the ages at which certain screens should take place and the minimum frequency at which they should occur.¹⁸⁶

EPSDT also requires states to provide “other necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and mental illnesses and conditions discovered by the screening services.”¹⁸⁷ While states can choose the menu of services they will cover for adults by deciding what to include in their State Medicaid plans, *all* medically necessary services in the federal statutory listings must be provided to children, regardless of whether they are covered under the State Medicaid plan.¹⁸⁸ Thus, the medical necessity

UNINSURED, MEDICAID FINANCING 84, <https://kaiserfamilyfoundation.files.wordpress.com/2013/05/mrbfinancing.pdf> [<https://perma.cc/4QHQ-3REW>]. Thirty-nine states administer their Medicaid programs through contracts with Managed Care Organizations. KATHLEEN GIFFORD ET AL., HENRY J. KAISER FAM. FOUND., STATES FOCUS ON QUALITY AND OUTCOMES AMID WAIVER CHANGES 2 (2018), <http://files.kff.org/attachment/Report-States-Focus-on-Quality-and-Outcomes-Amid-Waiver-Changes-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2018-and-2019> [<https://perma.cc/7VCW-K98V>].

184. Federal regulation defines children as individuals under the age of 21, but States can set the age limit at 18 (“under the age of 21, or, at the option of the State, under the age of 20, 19, or 18”). 42 U.S.C. § 1396d(a)(i) (2012).

185. *See* 42 U.S.C. § 1396d(r)(1)(B)(i); 42 C.F.R. § 441.56(b)(1).

186. 42 U.S.C. § 1396d(r)(1)(A)(i)–(ii). Periodicity schedules set the floor for screening schedules, not the ceiling, and providers can choose to screen more frequently under Medicaid.

187. *Id.* § 1396d(r)(5).

188. *Id.* (“Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.”); *see* TRICIA BROOKS & KELLY WHITENER, GEO. UNIV. HEALTH POL’Y INST., AT RISK: MEDICAID’S CHILD-FOCUSED BENEFIT STRUCTURE KNOWN AS EPSDT 2 (2017), <https://ccf.georgetown.edu/wp-content/uploads/2017/06/EPSDT-At-Risk-Final.pdf> (“If a screening indicates that further evaluation is needed, children must be provided all medically necessary services to diagnose and treat conditions discovered or reduce the burden of illness.”); GEO. UNIV. HEALTH POL’Y INST., EPSDT: A PRIMER ON MEDICAID’S PEDIATRIC BENEFIT 1 (2017), <https://ccf.georgetown.edu/wp-content/uploads/2018/02/EPSDT-Primer-Fact-Sheet.pdf> [<https://perma.cc/YJ26-4GVM>] (“All physical and mental illnesses or conditions discovered by any

requirement is an important component of children's Medicaid that obliges states to use Medicaid to cover a broader array of mental health and substance abuse services for children.

In addition to the language of the statute itself, the legislative history of EPSDT reveals its intended emphasis on identification and intervention at early and sensitive stages of life as a national strategy for creating a healthier American adult population, reflective of the core principles of LCHD. This history similarly demonstrates how such a wide-reaching regulatory program is well-positioned to address the opioid epidemic. At the time the program was proposed, the White House and Congress were concerned about the variations between states in rates of children being treated for health problems that could lead to chronic illness and disability,¹⁸⁹ as well as maintaining a population healthy enough to serve in the military.¹⁹⁰ In 1964, President Kennedy commissioned a study to examine the reasons behind the military's rejection of fifty percent of the young men who had been recently drafted.¹⁹¹ The study revealed "pervasive evidence of treatable and correctable physical, mental, and developmental conditions."¹⁹² One out

screening or diagnostic procedure must be treated, regardless of whether the health services for such treatment are otherwise covered under the Medicaid state plan."); CHRISTINE P. PETERS, NAT'L HEALTH POL'Y F., EPSDT: MEDICAID'S CRITICAL BUT CONTROVERSIAL BENEFITS PROGRAM FOR CHILDREN 2 (2006) ("Under EPSDT, Medicaid children are entitled to health care screenings and access to all Medicaid-covered services they are found to need, regardless of any Medicaid benefit restrictions imposed on adult beneficiaries by their state.").

189. U.S. DEP'T OF HEALTH, MSA-PRG-21, MEDICAL ASSISTANCE MANUAL: SERVICES AND PAYMENT IN MEDICAL ASSISTANCE PROGRAMS-AMOUNT, DURATION, AND SCOPE OF MEDICAL ASSISTANCE-EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT 1 (1972). The idea of federally sponsoring periodic screening for low-income children first appeared in 1966 in a program analysis from the office of the Secretary of Health, Education, and Welfare (HEW). Anne-Marie Foltz, *The Development of Ambiguous Federal Policy: Early and Periodic Screening, Diagnosis and Treatment (EPSDT)*, 53 MILBANK MEM'L FUND Q. HEALTH & SOC'Y 35, 41 (1975). At that time, the bulk of screening work completed around the country was supported by the Maternal and Child Health Program. *Id.* at 48.

190. See SARA ROSENBAUM ET AL., EPSDT AT 40: MODERNIZING A PEDIATRIC HEALTH POLICY TO REFLECT A CHANGING HEALTH CARE SYSTEM 3 (2008), https://www.chcs.org/media/EPSDT_at_40.pdf [<https://perma.cc/Q5QB-3FJW>].

191. PRESIDENT'S TASK FORCE ON MANPOWER CONSERVATION, ONE-THIRD OF A NATION: A REPORT ON YOUNG MEN FOUND UNQUALIFIED FOR MILITARY SERVICE 5 (1964); SARA J. ROSENBAUM ET AL., GEO. WASH. UNIV. HEALTH POL'Y & MGMT., NATIONAL SECURITY AND U.S. CHILD HEALTH POLICY: THE ORIGINS AND CONTINUING ROLE OF MEDICAID AND EPSDT 1 (2005); see also Medicaid Requirements for State Programs of Early and Periodic Screening, Diagnosis, and Treatment of Individuals Under 21, 44 Fed. Reg. 29, 420 (May 18, 1979) (codified at 42 C.F.R. pt. 441) ("Major studies conducted during the mid-1960's demonstrated that permanent harm was done to the nation's poor children because treatable medical problems were not detected at early stages of illness.").

192. ROSENBAUM ET AL., *supra* note 191.

of ten men rejected by the military had conditions that could be entirely cured with health care,¹⁹³ and many lived in extreme poverty with limited education.¹⁹⁴

Consequently, President Johnson argued that the government should “attack the roots of poverty” and that no American citizen “shall reach the age of twenty-one without the health . . . that will give him an opportunity to be an effective citizen and a self-supporting individual.”¹⁹⁵ Johnson declared that the U.S. should “try new methods of child development and care from the earliest years” before illness or disability became too serious to cure.¹⁹⁶ He addressed Congress with a twelve-point plan to “discover, as early as possible, the ills that handicap our children” and provide “continuing follow-up and treatment so that handicaps do not go neglected.”¹⁹⁷ As advocated by LCHD and important to an effective response to the opioid crisis, the EPSDT program aimed from the start to improve child health and development preventively, not only to “finance treatment for diagnosed illnesses” downstream.¹⁹⁸

In the mid-1970s, as Congress re-examined healthcare, statements on the House and Senate floor echoed the LCHD goals of prevention and early intervention during critical and sensitive periods of childhood. Representative Ralph E. Metcalfe argued that “the EPSDT program, is among the most necessary . . . of all health programs,” explaining that “[t]he importance of preventive health care for children . . . cannot be overestimated.”¹⁹⁹ In discussing the 1989 amendments that broadened the

193. *Id.* at 9.

194. *Id.* at 10.

195. Lyndon B. Johnson, President, Statement on the Report of the Task Force on Manpower Utilization (Jan. 5, 1964), <https://www.presidency.ucsb.edu/documents/statement-the-president-the-report-the-task-force-manpower-utilization> [<https://perma.cc/T24S-T74B>].

196. Lyndon B. Johnson, President, State of the Union Address (Jan. 10, 1967), <https://www.infoplease.com/homework-help/us-documents/state-union-address-lyndon-b-johnson-january-10-1967> [<https://perma.cc/S4EU-WKXY>].

197. Lyndon B. Johnson, President, Special Message to the Congress Recommending a 12-Point Program for America’s Children and Youth (Feb. 8, 1967), <http://www.presidency.ucsb.edu/ws/index.php?pid=28438&st=Medicaid&st1=Johnson> [<https://perma.cc/27XR-U9X7>]. In that address, Johnson states that his programs “seek to strengthen American families” and that “the future of many . . . children depends on the work of local pub-lic health services . . .” *Id.*

198. ROSENBAUM ET AL., *supra* note 191, at 4. While the overall legislation is commonly known as the Social Security Amendments of 1967, the title portion of the Act states that one of its purposes is “to improve the public assistance program and programs relating to the welfare and health of children.” Social Security Amendments of 1967, Pub. L. No. 90-248, 81 Stat. 821 (1968). The header of the section containing the EPSDT provision is “Improvement of Child Health,” and that section is referred to in the bill as the “Child Health Act of 1967.” *Id.* at 921.

199. *Getting Ready for National Health Insurance: Shortchanging Children: Hearings Before the Subcomm. on Oversight & Investigations of the H. Comm. on Interstate & Foreign Commerce*, 94th Cong. 45 (1975) (statement of Rep. Ralph E. Metcalfe).

scope of services provided to children under Medicaid, the House Subcommittee on Health and the Environment called EPSDT “the most important publicly financed preventive child health program ever enacted by Congress.”²⁰⁰ With EPSDT, children are supposed to get the “the right care . . . at the right time in the right setting.”²⁰¹

EPSDT’s legislative history focused on improving the “capacity of the health care system to identify, assess, and treat children with early signs of physical and mental health conditions that may affect growth and development.”²⁰² Like the LCHD approach, the EPSDT benefit was designed to ensure that children receive early detection and care so that health problems can be avoided or diagnosed and treated as early as possible during critical and sensitive periods of life.²⁰³ Consequently, EPSDT is well-positioned to address the opioid crisis by detecting and treating substance abuse and risk factors early in life to facilitate an effective upstream response involving both prevention and early intervention.

A. Required Screening and Brief Interventions

Medicaid EPSDT requires regular, comprehensive, holistic screening and health education at periodic check-ups at the doctor’s office.²⁰⁴ Screening is a procedure to identify individuals at risk of a health condition or individuals who already have one, and the results can form the basis of a corresponding plan of care.²⁰⁵ Regular screening allows for the effectuation of EPSDT’s unique preventive standard, which considers treatment necessary not only once a child is seriously ill but also “at the earliest possible time that an intervention is deemed to be medically beneficial to prevent the onset or worsening of a disabling condition.”²⁰⁶

200. *Medicare and Medicaid Initiatives: Hearing on H.R. 800 and H.R. 833 Before the Subcomm. on Health & the Env’t of the H. Comm. of Energy & Com.*, 101st Cong 146 (1989) (discussing the EPSDT benefit).

201. *CTRS. FOR MEDICARE & MEDICAID*, *supra* note 19, at 1.

202. *BROOKS & WHITENER*, *supra* note 188, at 1; *accord* H. COMM. ON WAYS AND MEANS, 90TH CONG., SECTION-BY-SECTION ANALYSIS AND EXPLANATION OF PROVISIONS OF H.R. 5710 12 (Comm. Print 1967).

203. *CTRS. FOR MEDICARE & MEDICAID*, *supra* note 19, at 1; *see* U.S. DEP’T OF HEALTH, *supra* note 189; *EPSDT: An Overview*, COMMONWEALTH FUND (Sept. 1, 2005), <http://www.commonwealthfund.org/publications/data-briefs/2005/sep/epsdt--an-overview> [<https://perma.cc/MRJ2-M9S5>].

204. *CTRS. FOR MEDICARE & MEDICAID*, *supra* note 19, at 4.

205. *See id.* at 4–5.

206. Edward L. Schor et al., *Medicaid: Health Promotion and Disease Prevention for School Readiness*, 26 HEALTH AFF. 420, 423 (2007) (quoting SARA ROSENBAUM ET AL., THE COMMONWEALTH FUND, HEALTH POLICY AND EARLY CHILD DEVELOPMENT: AN OVERVIEW 9 (2001)); *see also* Sara Rosenbaum et al., *Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP*, J. HEALTH & BIOMEDICAL L. 1, 14 (2004) (“In sum, both

EPSDT screening ensures that children's health issues are identified, diagnosed, and treated early, before they can hinder development or become more costly,²⁰⁷ a standard in line with the LCHD approach and not found in any other health insurance program.

Screening also facilitates the identification of risk factors, as promoted by the LCHD model. It allows providers to look holistically at children, providing a mechanism for identifying children with opioid abuse risk factors, such as children with mental health needs or those who are involved in other forms of substance abuse, as well as identifying those already abusing opioids. In addition to support from the statutory language and legislative history of EPSDT's embodiment of this upstream approach, executive branch guidance and judicial precedent support the use of EPSDT to fight the opioid crisis through identification of children engaged in substance abuse and those who are at risk. Indeed, guidance from all three branches of the federal government makes clear that EPSDT already requires screening and brief intervention in line with best practices for substance abuse detection among adolescents.

The National Institute on Drug Abuse, a federal agency, has issued "Principles of Adolescent Substance Use Disorder Treatment," which recommends early identification through quick, easily administered, and valid screening methods to identify issues that can be addressed early on and the use of routine annual medical visits to ask about drug use.²⁰⁸ Screening, Brief Intervention, Referral and Treatment (SBIRT) programs have been used to facilitate this early identification and connect people to treatment.²⁰⁹ SBIRT is a best practices approach to preventing initiation and reducing substance use before it becomes more serious.²¹⁰ SBIRT begins with universal screening to identify those at risk for substance abuse and those already engaged in it.²¹¹

historically and legally, the term 'medical necessity' in a Medicaid child health context is grounded in concepts of early intervention to ameliorate physical and health conditions, and is a bar against arbitrary limits on diagnosis and treatment unrelated to the recommendations of treating conditions.").

207. See PETERS, *supra* note 188, at 7 ("EPSDT services are also intended to detect and correct health conditions that can hinder a child's development . . .").

208. NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF ADOLESCENT SUBSTANCE USE DISORDER TREATMENT: A RESEARCH-BASED GUIDE 9 (2014), https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/podata_1_17_14.pdf [<https://perma.cc/9CQH-HRYV>].

209. BUREAU OF SUBSTANCE ABUSE SERVS., SBIRT: A STEP-BY-STEP GUIDE 1 (2012), <https://www.masbirt.org/sites/www.masbirt.org/files/documents/toolkit.pdf> [<https://perma.cc/8GEL-BW38>].

210. Harris, *supra* note 158, at 397.

211. *Id.* at 398.

The executive branch has endorsed the use of SBIRT by primary care doctors. The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) explains that

SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers . . . provide opportunities for early intervention with at-risk substance users before more severe consequences occur.²¹²

The American Academy of Pediatrics has formally recommended that pediatricians conduct SBIRT for adolescents in the doctor's office.²¹³ Recent evidence shows that SBIRT for adolescents reduces alcohol and marijuana use, decreases initiation, and reduces intentions to use.²¹⁴ Screening for and early treatment of opioid abuse have been found to reduce the risk of overdose, psychosocial deterioration, and medical complications.²¹⁵ SBIRT is a low-cost and minimal-risk intervention when compared with other opioid-use interventions.²¹⁶ The SBIRT framework lies at “the center of conversations around substance use prevention and early intervention” and provides a “public health approach to identifying and addressing substance use and related risks.”²¹⁷ Implementation of SBIRT has led to increased substance abuse screening—and subsequently treatment—for adolescents.²¹⁸

212. *About Screening, Brief Intervention, and Referral to Treatment (SBIRT)*, SAMHSA, <https://www.samhsa.gov/sbirt/about> [<https://perma.cc/W8XP-TY25>] (last updated Sept. 20, 2017).

213. See Sharon J.L. Levy et al., *Substance Use Screening, Brief Intervention, and Referral to Treatment*, 138 PEDIATRICS e1 (June 20, 2016), <https://pediatrics.aappublications.org/content/pediatrics/138/1/e20161211.full.pdf> [<https://perma.cc/S4XW-AJP9>].

214. Harris, *supra* note 158.

215. Kolodny et al., *supra* note 23, at 567.

216. Harris, *supra* note 158.

217. ABT ASSOCS., *supra* note 36, at 2.

218. See generally ABT ASSOCS., *supra* note 36 (summarizing the progress made towards reaching the strategic initiative's goals); LEA AYERS LAFAVE ET AL., NH YOUTH SBIRT INITIATIVE, PREVENTING YOUTH SUBSTANCE MISUSE THROUGH INTEGRATED PRIMARY CARE: STRATEGIES FOR S-BI-RT IMPLEMENTATION (2018), http://sbirtnh.org/wp-content/uploads/2018/06/NH-Youth-SBIRT_Implementation-Strategies_6.1.18-1.pdf [<https://perma.cc/D53F-4TP3>] (discussing the strategies of SBIRT implementation in New Hampshire); THE NAT'L ASS'N OF STATE ALCOHOL & DRUG ABUSE DIRS., STATE SUPPORT OF YOUTH SBIRT AND SBIRT-LIKE PREVENTION PROGRAMS: REPORT OF CASE STUDIES (2015), <http://nasadad.org/wp-content/uploads/2015/04/State-Youth-SBIRT-and-SBIRT-Like-Case-Study-Report-Final.pdf> [<https://perma.cc/Y7JY-ZE28>] (discussing case studies of youth SBIRT and SBIRT-like prevention programs); NAT'L COUNCIL FOR BEHAVIORAL HEALTH, REDUCING ADOLESCENT

Fortunately, Medicaid EPSDT already requires that these best practices be implemented in the doctor's office through regular screening of all enrolled children for both their physical and mental health needs, including substance abuse. Executive branch guidance endorses this approach.²¹⁹ The U.S. Centers for Medicare and Medicaid Services (CMS) explains that EPSDT screenings must include a behavioral health assessment, which is comprised of age-appropriate mental health and substance abuse screening.²²⁰

SUBSTANCE ABUSE INITIATIVE: ADOLESCENT SBIRT IMPLEMENTATION IN THE BEHAVIORAL HEALTH SETTING FINAL REPORT (2017), <https://www.thenationalcouncil.org/wp-content/uploads/2017/11/Rasai-Exec-Report-FINAL.pdf> [<https://perma.cc/63CG-W2LQ>] (discussing the Reducing Adolescent Substance Abuse Initiative (RASAI) developed by the Conrad N. Hilton Foundation); Sharon Levy et al., *Screening Adolescents for Alcohol Use: Tracking Practice Trends of Massachusetts Pediatricians*, 11 J. ADDICTION MED. 427 (2017) (tracking the practice trends of Massachusetts pediatricians in relation to screening adolescents for alcohol use).

219. While the federal executive branch has historically supported and expansively interpreted EPSDT's screening requirements, under the current administration of President Donald Trump, HHS has embraced greater flexibility on the part of states to administer Medicaid, which could give states more choices about how to comply with Medicaid requirements and could weaken EPSDT requirements. *Secretary Price Committed to Greater Medicaid Flexibility for States*, HHS.GOV (Mar. 10, 2017), <https://www.hhs.gov/about/news/2017/03/10/secretary-price-committed-greater-medicaid-flexibility-states.html> [<https://perma.cc/2233-DMTY>]. Most of the rhetoric aimed at giving states more flexibility has focused on able-bodied adults, rather than children, but could serve to discredit the whole Medicaid program, particularly if changes from the legislative or executive branch result in a change from Medicaid's current entitlement structure to a capped program or a block grant, through which states might have to make difficult decisions about to whom Medicaid should be provided and what benefits would be included for enrollees. See BROOKS & WHITENER, *supra* note 188, at 6. Some states are also seeking to limit the population served by Medicaid, such as the work requirements initiated by Arkansas and Kentucky and coverage time limits initiated by Maine, which have been approved by HHS. See Hannah Katch, *Governor LePage's Medicaid Proposal Would Harm Low-Income Mainers*, GEO. U. HEALTH POL'Y INST.: SAY AHHH! BLOG (Oct. 2, 2017), <https://ccf.georgetown.edu/2017/10/02/governor-lepages-medicaid-proposal-would-harm-low-income-mainers/> [<https://perma.cc/7U5D-BM4L>]; Andy Schneider, *Surprise! CMS Approves Kentucky Work Requirement Waiver Again*, GEO. U. HEALTH POL'Y INST.: SAY AHHH! BLOG (Nov. 21, 2018), <https://ccf.georgetown.edu/2018/11/21/surprise-cms-approves-kentucky-work-requirements-waiver-again/> [<https://perma.cc/XU7N-694G>]. These changes have prompted lawsuits against HHS. See Schneider, *supra*. Despite the Kentucky work requirement waiver vacated by Judge Boasberg, it has since been reapproved by CMS. *Id.* Arkansas's work requirement waiver has resulted in the disenrollment of thousands of individuals and Kentucky's waiver is likely to lead to similar results. *Id.*

220. CINDY MANN, CTR. FOR MEDICAID AND CHIP SERVS., PREVENTION AND EARLY IDENTIFICATION OF MENTAL HEALTH AND SUBSTANCE USE CONDITIONS 2 (2013), <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf> [<https://perma.cc/E589-YTTL>].

For younger children, CMS indicates that screening should assess social-emotional development,²²¹ and for adolescents, it should examine the potential presence of challenges with peer relations, psychological and psychiatric problems, as well as SUDs.²²² This guidance from the executive branch clearly dictates that that “[e]arly detection and treatment of behavioral health issues, including mental illness and substance use disorders, is important in the overall health of a child and may reduce or eliminate the effects of a condition when identified and treated early”²²³ and recommends trauma screening as a key tool for identifying and addressing unmet needs.²²⁴ When these screening procedures yield detection of a lower-level need requiring brief intervention in the doctor’s office, EPSDT also offers an existing, statutorily required framework. The program requires that doctors provide health education in well-child visits,²²⁵ which is a cost-effective and cost-saving brief intervention for substance abuse.²²⁶

Judicial precedent reinforces the comprehensiveness of the required screenings and emphasizes that they should include behavioral health to identify and address related needs early and preventively, embodying key principles of the LCHD model. Judges have particularly emphasized the importance of childhood and adolescence “to the course of lifelong health, embraced by LCHD proponents as “critical and sensitive periods.”²²⁷

As far back as 1973, a class action lawsuit alleged failures by Indiana to effectively implement EPSDT.²²⁸ The district court determined that “Indiana’s ‘somewhat casual approach’ . . . did not conform to the aggressive search for early detection and treatment . . . mandated by the 1967 [EPSDT] statute.”²²⁹ Underscoring Congress’s “special

221. CTRS. FOR MEDICARE & MEDICAID SERVS., STATE MEDICAID MANUAL § 5123.2(A)(1) (2011).

222. *Id.*; CTRS. FOR MEDICARE & MEDICAID, *supra* note 19, at 4.

223. Letter from George H. Sheldon et al., Dep’t of Health & Human Servs., to State Medicaid Dirs. 11 (July 11, 2013), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-07-11.pdf> [<https://perma.cc/H6DY-LXEN>]. HHS promulgated this guidance letter “to encourage the integrated use of trauma-focused screening, functional assessments and evidence-based practices (EBPs) in child-serving settings for the purpose of improving child well-being.” *Id.* at 1.

224. *Id.* at 5.

225. CTRS. FOR MEDICARE & MEDICAID, *supra* note 19, at 4.

226. Sion Kim Harris et al., *Screening and Brief Intervention for Alcohol and Other Abuse*, 25 ADOLESCENT MED. 126, 141 (2014).

227. *See, e.g.*, Halfon & Hochstein, *supra* note 101.

228. *Stanton v. Bond*, 504 F.2d 1246, 1246 (7th Cir. 1974).

229. *Bond v. Stanton*, 655 F.2d 766, 769 (7th Cir. 1981) (quoting *Stanton*, 504 F.2d at 1251); *see also Stanton*, 504 F.2d at 1251 (“Indiana’s somewhat casual approach to EPSDT hardly conforms to the aggressive search for early detection of child health problems envisaged by Congress. It is difficult enough to activate the average affluent adult to seek medical assistance

emphasis . . . on a large-scale preventive screening,”²³⁰ the Seventh Circuit faulted Indiana for failing to have a system for determining whether EPSDT-eligible children were receiving complete screens.²³¹ The court emphasized the mental health component of the screening, instructing Indiana to take aggressive steps to implement the screening “necessary to identify individuals with potential or apparent physical or mental health problems”²³² so that the state could “make services available so that young people can receive medical care before health problems become chronic and irreversible damage occurs.”²³³

Similarly, in requiring the District of Columbia to establish a tracking system to ensure that EPSDT-eligible children receive complete screens, the U.S. district court emphasized the early treatment goals of the EPSDT program and explained that its purpose “is to ensure that poor children receive comprehensive health care at an early age, so that they will develop fewer health problems as they get older.”²³⁴ Out of concern that Texas was not effectively implementing EPSDT, another federal judge described screening as the “cornerstone of the program.”²³⁵ In *Rosie D. v. Romney*,²³⁶ the federal district court scolded the state of Massachusetts for failing to effectively assess the mental health needs of children²³⁷ and prompted policy change to ensure formal mental health screening in the doctor’s office.²³⁸

until he is virtually laid low. It is utterly beyond belief to expect that children of needy parents will volunteer themselves or that their parents will voluntarily deliver them to the providers of health services for early medical screening and diagnosis. By the time an Indiana child is brought for treatment it may too often be on a stretcher. This is hardly the goal of ‘early and periodic screening and diagnosis.’”)

230. *Bond*, 655 F.2d at 769; see also *Stanton*, 504 F.2d at 1250 (“The mandatory obligation upon each participating state to aggressively notify, seek out and screen persons under 21 in order to detect health problems and to pursue those problems with the needed treatment is made unambiguously clear by the 1967 act and by the interpretative regulations and guidelines.”).

231. *Stanton*, 504 F.2d at 1246.

232. *Bond*, 655 F.2d at 769 (quoting MSA-PRG-21, § 5-70-20(B)(1)); see 42 C.F.R. § 441.56(a) (1980).

233. *Stanton*, 504 F.2d at 1249 (quoting MSA-PRG-21, § 5-70-20(A)).

234. *Salazar v. District of Columbia*, 954 F. Supp. 278, 303 (D.D.C. 1996).

235. *Frew v. Gilbert*, 109 F. Supp. 2d 579, 606 (E.D. Tex. 2000), *vacated sub nom. Frazar v. Gilbert*, 300 F.3d 530 (5th Cir. 2002), *rev’d sub nom. Frew ex rel. Frew v. Hawkins*, 540 U.S. 431 (2004).

236. 410 F. Supp. 2d 18 (D. Mass. 2006).

237. *Id.* at 25 (explaining that Congress “imposed a mandatory duty” on states to provide EPSDT-eligible children with serious emotional distress with medically necessary services for their mental health disease).

238. These changes resulted in a 2.5% increase in the number of children identified as having a behavioral health issue and a 10.1% increase in the number of children receiving behavioral health services within six months of a well-child visit. See JUDITH SAVAGEAU ET AL., CLINICAL TOPIC REVIEW: BEHAVIORAL HEALTH SCREENING FOR CHILDREN WITH WELL VISITS 1 (2009);

In these ways, guidance from all three branches of the federal government have reinforced the importance of the EPSDT screening requirement as a way to detect risk factors and burgeoning health conditions early. The federal legislative, executive, and judicial branches have also reinforced that EPSDT should particularly ensure that physicians screen for mental health and substance abuse needs and provide brief interventions where appropriate. These requirements make EPSDT well-positioned to carry out the screening and brief intervention components of the SBIRT substance abuse prevention program and effectuate the LCHD model to combat the opioid crisis upstream.

B. *Referrals and Medically Necessary Mental Health and Substance Abuse Treatment*

Where screening indicates the need for more extensive evaluation and mental health or substance abuse services, the SBIRT substance abuse prevention program's final component requires "[r]eferral[s] to treatment."²³⁹ EPSDT provides a framework for this component of SBIRT because it requires referrals to treatment after needs are detected through screening.²⁴⁰ Indeed, after diagnosis of any health condition, such as post-traumatic stress disorder in an at-risk child or opioid use disorder in an adolescent, EPSDT mandates that states "arrang[e] for . . . corrective treatment," either "directly or through referral to appropriate agencies, organizations, or individuals."²⁴¹ In this way, "screening services provide

Judith A. Savageau et al., *Behavioral Health Screening Among Massachusetts Children Receiving Medicaid*, 178 J. PEDIATRICS 261, 261–62, 264 (2016) [hereinafter Savageau et al., *Behavioral Health*].

239. See Levy et al., *supra* note 213, at e9–10; accord 42 U.S.C. § 1396a(a)(8) (2012).

240. 42 U.S.C. § 1396a(a)(43)(C) ("A state plan for medical assistance must . . . provide for . . . arranging for . . . corrective treatment the need for which is disclosed by such child health screening services . . .").

241. See *id.* There may be concern that beyond referrals for treatment, physicians may make referrals to child protective services, pursuant to their responsibilities as mandatory reporters, if they learn about issues that lead them to suspect child abuse or neglect. While this may be a risk of this approach, if these issues go untreated, many of these families may ultimately end up entangled in the child welfare system regardless. There may also be concern that physicians might make referrals to the criminal justice system for parents or young adults they suspect of engaging in substance abuse, or to the juvenile delinquency system for children about whom they have similar suspicions. Such action would contradict the responsibilities of physicians to keep patient information confidential and might weigh against the responsibility of physicians to act in the best interests of their patients and to facilitate treatment. See, e.g., Carol Ford et al., *Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine*, 35 J. ADOLESCENT HEALTH 160, 160, 163–64 (2004) ("Confidentiality protection is an essential component of health care for adolescents because it is consistent with their development of maturity and autonomy and without it, some adolescents will forgo care [A] professional who breaks confidentiality merely because it is 'good for the patient,' without a strong and

the crucial link to necessary covered treatment . . . [t]he affirmative obligation to connect children with necessary treatment makes EPSDT different from Medicaid for adults. It is a crucial component of a quality child health benefit.”²⁴²

Executive branch guidance underscores that Medicaid is an important tool for the funding of treatment services for children with mental health and substance abuse conditions. The U.S. Department of Health and Human Services indicates that “Medicaid is an important source of reimbursement for services and support to children and youth who have experienced complex trauma and have behavioral health needs requiring treatment.”²⁴³ When trauma or mental health needs have been identified, “access to quality mental health services can help reduce the risk that a child may initiate drug use to ‘self-medicate.’”²⁴⁴ SAMHSA has underscored the robust nature of the requirement that children receive all medically necessary mental health and substance abuse services, indicating that “[o]nce a behavioral health need is identified and diagnosed through a[n] [EPSDT] screening or assessment, the child or youth also is entitled to treatment with any allowable Medicaid service—even one not included in the child or youth’s home state Medicaid State Plan.”²⁴⁵

persuasive reason, engages in inappropriate paternalism (i.e., interference with a person’s freedom of action based on a wish to benefit them). [This is not] morally defensible.”); Levy et al., *supra* note 213, at e2 (“Confidentiality practices in the medical home are important facilitators to SBIRT practices and the care of an adolescent disclosing substance use. Protection of their confidential health care information is an essential determinant of whether adolescents will access care, answer questions honestly, and engage in and maintain a therapeutic alliance with health care professionals. Adolescents may disclose substance use or other high-risk behaviors as a way to reveal that they want help or feel unsafe, possibly even in their own home, so a prime consideration for the pediatrician is whether maintaining confidentiality or disclosing confidential health information is in the patient’s best interest.” (footnotes omitted)); *Adolescent Health Care, Confidentiality*, AAFP, <https://www.aafp.org/about/policies/all/adolescent-confidentiality.html> [<https://perma.cc/7EWX-3CLQ>] (“The AAFP believes that adolescents’ access to confidential healthcare is important for their health and well-being, while also recognizing the benefit of supportive parental involvement. Family physicians should be aware of their community’s standards regarding adolescent confidentiality. State laws vary, but in general, in areas of care where the adolescent has the legal right to give consent to health services, confidentiality must be maintained.”).

242. CTFS. FOR MEDICARE & MEDICAID, *supra* note 19, at 5 (footnote omitted).

243. Letter from George H. Sheldon et al., *supra* note 223, at 2.

244. JEFFREY LEVI ET AL., TR. FOR AM.’S HEALTH, REDUCING TEEN SUBSTANCE MISUSE: WHAT REALLY WORKS 47 (2015), https://hilton-production.s3.amazonaws.com/documents/196/attachments/TFAH-2015-TeenSubstAbuse_FINAL.pdf?1454094165 [<https://perma.cc/2PAW-ZSQP>].

245. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., MEDICAID HANDBOOK: INTERFACE WITH BEHAVIORAL HEALTH SERVICES, MODULE 3: THE MEDICAID BEHAVIORAL

SAMHSA has specifically emphasized the important role that EPSDT plays in ensuring access and coverage of SUD interventions and treatments across the continuum of services necessary to address SUDs and those at risk.²⁴⁶ In 2015, SAMHSA and CMS jointly issued an Informational Bulletin addressing the range of SUD services for youth covered under Medicaid.²⁴⁷ That bulletin and subsequent SAMHSA documents describe what is known as the “continuum” of treatment services necessary to effectively treat SUD among youth and adolescents,²⁴⁸ including services that fall into the five levels of care developed by the American Society of Addiction.²⁴⁹ These levels of care include: (1) early intervention, (2) outpatient services, (3) intensive outpatient/partial hospitalization services, (4) residential/inpatient services, and (5) medically managed intensive inpatient services, and have become the “nomenclature for describing the continuum of addiction services.”²⁵⁰ Within these levels of care, SAMHSA and CMS specifically recommend a range of services for adolescents, such as individual or group therapy, family counseling, case management, life skills training, behavioral aides, psychiatric rehabilitation, day treatment, residential treatment, and mobile crisis treatment.²⁵¹

EPSDT covers all of these services because it unequivocally requires all medically necessary services recommended by the child’s healthcare provider²⁵² so long as they are listed in the Medical Assistance provision

HEALTH SERVICES BENEFIT PACKAGE 6 (2013), https://store.samhsa.gov/system/files/sma13-4773_mod3.pdf [<https://perma.cc/R5Y4-7YGE>].

246. *Id.* (“Virtually any service that is deemed *medically necessary* through an assessment or screening and is recommended by a physician, psychologist, social worker, nurse, or other licensed health care practitioner is covered by Medicaid under EPSDT.”).

247. VIKKI WACHINO & PAMELA S. HYDE, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., COVERAGE OF BEHAVIORAL HEALTH SERVICES FOR YOUTH WITH SUBSTANCE USE DISORDERS 1 (2015), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-26-2015.pdf> [<https://perma.cc/AXP3-Q2E2>].

248. SAMHSA followed the joint Bulletin with a 2016 brief issued in partnership with the National Technical Assistance Network for Children’s Behavioral Health, which elaborated on the recommendations and resources discussed in the joint Bulletin. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 174.

249. *What is the ASAM Criteria?*, ASAM, <https://www.asam.org/resources/the-asam-criteria/about> [<https://perma.cc/LY9H-S24V>].

250. *Id.*

251. *See* 42 U.S.C. § 1396d(a)(4)(B) (2012); *id.* § 1396d(a)(19); *id.* § 1396a(a)(43); *id.* § 1396n(g)(2); 42 C.F.R. § 440.230 (2018); *see also* Yael Zakai Cannon, *There’s No Place Like Home: Realizing the Vision of Community-Based Mental Health Treatment for Children*, 61 DEPAUL L. REV. 1049, 1081–82 (2012) (“EPSDT covers . . . group therapy, individual therapy, family counseling, case management, living skills training, in-home behavioral aides, enhanced behavioral support and supervision, psychiatric rehabilitation, day treatment, mobile treatment, and crisis intervention.”).

252. 42 U.S.C. § 1396d(r)(5).

of the Social Security Act, where EPSDT is codified.²⁵³ Each of the services recommended for adolescents by SAMHSA and CMS is covered within that Medical Assistance provision, meaning that any time a physician deems one of those services necessary for a child at risk of or already engaging in opioid abuse and can provide supporting documentation, Medicaid should cover the services. Therefore, the law itself and executive branch guidance endorse Medicaid as an important source of coverage for substance abuse prevention and treatment services for children.

Judicial precedent underscores the requirement that children timely receive medically necessary behavioral health treatment in order to improve their health, further supporting a vision of EPSDT as a framework ripe for upstream treatment to combat the opioid crisis. Judges have emphasized that the “language of the EPSDT provisions is mandatory, not precatory,” describing “what the state must do, not what it may do”²⁵⁴ and that “EPSDT services are not optional, and may not be limited.”²⁵⁵ Because the only limit on “EPSDT services is the requirement that they be ‘medically necessary,’ the scope of EPSDT program is broad.”²⁵⁶

A number of cases have underscored the requirement for medically necessary behavioral health treatment and the preventive dimensions of that requirement, which make the program ripe for combatting the opioid crisis. First, courts have consistently held that mental health treatment services are within the broad range of services covered by the EPSDT.²⁵⁷

253. *Id.* at § 1396d(a); *see also* CTRS. FOR MEDICARE & MEDICAID, *supra* note 19 (“[Services] include[] physician, nurse practitioner and hospital services; physical, speech/language, and occupational therapies; home health services, including medical equipment, supplies, and appliances; treatment for mental health and substance use disorders . . .”).

254. *John B. v. Menke*, 176 F. Supp. 2d 786, 800 (M.D. Tenn. 2001); *see Wilder v. Virginia Hosp. Ass’n*, 496 U.S. 498, 502 (1990); *Frew v. Gilbert*, 109 F. Supp. 2d 579, 662–63 (E.D. Tex. 2000), *vacated sub nom. Frazar v. Gilbert*, 300 F.3d 530 (5th Cir. 2002), *rev’d sub nom. Frew ex rel. Frew v. Hawkins*, 540 U.S. 431 (2004).

255. *John B.*, 176 F. Supp. 2d at 800.

256. *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 26 (D. Mass. 2006).

257. *See, e.g., Katie A. ex rel. Ludin v. L.A. Cty.*, 481 F.3d 1150, 1154 (9th Cir. 2007) (stating that States must provide all twenty-eight services listed under 42 U.S.C. § 1396d(a) when such services are “medically necessary,” including several mental and behavioral health services); *Collins v. Hamilton*, 349 F.3d 371, 375 (7th Cir. 2003) (providing that under language of EPSDT and its regulations, psychiatric residential treatment facilities are “included within the ambit of covered EPSDT services”); *N.B. ex rel. Buchanan v. Hamos*, No. 11 C 6866, 2012 WL 1953146, at *1 (N.D. Ill. May 30, 2012) (“[S]tate[s] must provide [under the EPSDT] ‘necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate . . . mental illness and conditions . . .’” (fourth alteration in original) (quoting 42 U.S.C. § 1396d(r)(5) (2012))); *Emily Q. v. Bonta*, 208 F. Supp. 2d 1078, 1090 (C.D. Cal. 2001) (“States’ EPSDT

As a result, relevant litigation has often focused on whether a state adequately made those services available. Courts have been persistent in requiring states to take “aggressive” steps to ensure that all medically necessary mental health treatment services are available to eligible children.²⁵⁸ In doing so, courts have ordered states to increase the utilization of mental health treatment services²⁵⁹ and adequately cover the cost of mental health treatment services to assure availability.²⁶⁰

The case law, along with the statute, the legislative history, and executive branch guidance, align with the vision of EPSDT as a program intended to effectuate the principles of LCHD by detecting through screening children at risk for opioid abuse, including those with mental health needs and those engaged in early initiation of substance use, as well as those already misusing opioids. Guidance from the three branches of federal government also recognizes that prevention and early intervention through medically necessary behavioral health treatment at these sensitive and critical times in life are key to improving lifelong health. EPSDT already requires that children are screened and treated for opioid abuse risk factors and opioid abuse using best practices, such as SBIRT and the continuum of services within the recommended levels of care. At this moment, the program is well-poised to serve as an upstream tool in combatting the opioid epidemic.

IV. BARRIERS AND TOOLS FOR IMPROVEMENT

If Medicaid EPSDT provides a strong existing infrastructure for identification and treatment of at-risk and substance-abusing children and adolescents, why isn't this approach being leveraged to the fullest extent possible to fight the opioid epidemic upstream? There is a dearth of data

programs must provide children with diagnostic and treatment services ‘to correct or ameliorate . . . mental illnesses and conditions . . .’” (quoting 42 U.S.C. § 1396(r)(5) (2000)).

258. *Emily Q.*, 208 F. Supp. 2d at 1089; *see also Katie A.*, 481 F.3d at 1158 (discussing the obligation placed on states by 42 U.S.C. § 1396a(a)(43)(C) to provide for arranging, directly or through referral, necessary corrective treatment under the EPSDT, including mental health treatment services); *Collins*, 349 F.3d at 374 (stating States are “required to furnish” medically necessary services, including for mental health illnesses); *Rosie D.*, 410 F. Supp. 2d at 25 (stating that Congress “imposed a mandatory duty” on states to provide EPSDT-eligible children with serious emotional distress with medically necessary services for their mental health disease. (quoting S.D. *ex rel. Dickson v. Hood*, 391 F.3d 581, 589 (5th Cir. 2004))).

259. *See Emily Q. v. Bonta*, No. CV 98-4181AHM(AJWx), 2011 U.S. Dist. LEXIS 104057, at *5 (C.D. Cal. Sept. 14, 2011) (requiring California to engage in “significant effort” to increase the utilization and quality of therapeutic behavioral services).

260. *See Collins*, 349 F.3d at 376 (ordering Indiana to pay for psychiatric residential treatment facilities under EPSDT because they were medically necessary mental health services); *Rosie D.*, 410 F. Supp. 2d at 52 (ordering Massachusetts to cover mental health home and community-based services needed by children with serious emotional distress).

that allows us to clearly understand the extent to which Medicaid EPSDT is currently being implemented to address the opioid crisis or even being utilized by Medicaid beneficiaries at all. The limited data that is available is not encouraging.

Despite the clear direction from all three branches of government that Medicaid should facilitate comprehensive mental health and substance abuse screenings for all beneficiaries, a nine-state study by HHS's own Office of Inspector General found that nearly half of those states failed to include any mental or substance use prompts in their EPSDT screening tools,²⁶¹ and almost sixty percent of children received incomplete screens.²⁶² Nearly three decades ago, HHS set a goal that eighty percent of child Medicaid beneficiaries in each state would be provided the required EPSDT screenings,²⁶³ but the latest data from 2017 indicates that the national average EPSDT screening participation ratio was only fifty-eight percent.²⁶⁴ Many states have a participation ratio that is significantly lower; for example, in 2016, only thirty-five percent of South Dakota beneficiaries and forty-nine percent of Colorado beneficiaries received the required screening.²⁶⁵

With regard to brief intervention and referral to treatment, providers perform much worse.²⁶⁶ One issue is that providers are often unable to

261. Rafael M. Semansky et al., *Behavioral Health Screening Policies in Medicaid Programs Nationwide*, 54 PSYCHIATRIC SERVS. 736, 737 (2003).

262. U.S. DEP'T OF HEALTH & HUMAN SERVS., OEI-5-08-00520, MOST MEDICAID CHILDREN IN NINE STATES ARE NOT RECEIVING ALL REQUIRED PREVENTIVE SCREENING SERVICES 14 (2010) (finding that nearly sixty percent of children who received EPSDT medical screenings were given incomplete screenings).

263. MURRIN, *supra* note 175.

264. Screening participation ratios reported every fiscal year on the CMS Form 416, nationally and for states, are calculated by the number of EPSDT eligible individuals who receive at least one EPSDT screening divided by the total number EPSDT eligible individuals. CTRS. FOR MEDICAID & MEDICARE SERVS., ANNUAL EPSDT PARTICIPATION REPORT FORM CMS-416 (NATIONAL) FISCAL YEAR: 2017, at 2 (2017).

265. *Id.* at 17, 128. Only 284,448 of 683,792 Colorado citizens eligible for EPSDT received one initial or periodic screen. CTRS. FOR MEDICAID & MEDICARE SERVS., COLO. FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT 2-3 (2016), <https://www.colorado.gov/pacific/sites/default/files/EPSDT%20CMS%20416%20Report.pdf> [<https://perma.cc/E8YA-U49M>]. In addition, although infants have a screening participation ratio exceeding 80% in most states, nineteen- and twenty-year-olds have a much lower ratio, dropping into the single digits in many states. Kelly Whitener, *EPSDT: A Primer on Medicaid's Pediatric Benefit*, GEO. U. HEALTH POL'Y INST.: SAY AHHS! BLOG (Mar. 4, 2016), <https://ccf.georgetown.edu/2016/03/04/what-is-epsdt-medicaid-benefit-big-idea/> [<https://perma.cc/9MJV-YKVN>].

266. Harris, *supra* note 158. For more discussions of this phenomenon, see generally Brett R. Harris, *Communicating About Screening, Brief Intervention, and Referral to Treatment: Messaging Strategies to Raise Awareness and Promote Voluntary Adoption and Implementation Among New York School-Based Health Center Providers*, 37 SUBSTANCE ABUSE 511 (2016); Brett

properly identify substance use risk among adolescents because they are often not relying on standardized guidelines. Without proper identification, providers cannot perform brief interventions or make referrals to treatment.²⁶⁷ However, even when providers are able to identify substance use risk, many do not initiate brief interventions or referrals.²⁶⁸ Finally, even when referrals to treatment are made, many adolescents do not engage in treatment.²⁶⁹

As discussed above, there are massive mental health and substance use treatment gaps in the U.S., especially for adolescents. For example, in 2016, the estimated 2.2 million people aged 12 or older who received substance use treatment at a specialty facility represented only 10.6% of those who needed treatment.²⁷⁰ The adolescent treatment gap is even more profound. Only 8.2% of adolescents aged 12 to 17 and 7.2% of

R. Harris et al., *Results of a Statewide Survey of Adolescent Substance Use Screening Rates and Practices in Primary Care*, 33 *SUBSTANCE ABUSE* 321 (2012).

267. See Areej Hassan et al., *Primary Care Follow-up Plans for Adolescents With Substance Use Problems*, 124 *PEDIATRICS* 144, 144 (2009) (finding that despite possessing results of standardized screenings that indicated a group of adolescents likely had alcohol or drug use problems, primary care providers only identified 4.8% of the adolescents as having problematic substance use); Celeste R. Wilson et al., *Are Clinical Impressions of Adolescent Substance Use Accurate?*, 114 *PEDIATRICS* e536, e538 (2004) (comparing providers' clinical impressions of adolescents' level of substance use with diagnostic classifications from a structured diagnostic interview and finding that the providers' clinical impressions were correct for eighteen of the 101 adolescents with a problem substance use diagnosis, ten of the fifty adolescents with an abuse diagnosis, and zero of the thirty-six adolescents with a dependence diagnosis).

268. NAT'L COUNCIL FOR BEHAVIORAL HEALTH, *supra* note 218, at 17; see Brett R. Harris et al., *Screening, Brief Intervention, and Referral to Treatment for Adolescents: Attitudes, Perceptions, and Practice of New York School-Based Health Center Providers*, 37 *SUBSTANCE ABUSE* 161, 164 (2016) (surveying thirty-eight New York school-based health center providers performing SBIRT and finding that among the nineteen providers who reported that their school-based health center practiced any part of the SBIRT model, only four (10.5%) reported performing both brief interventions and referral to treatment in addition to screening); Hassan et al., *supra* note 267, at 147 (finding that amongst adolescents perceived by primary care providers to have an alcohol or other drug use problem after substance use screening, 19.6% did not receive a recommendation for an active intervention). See generally Lisa S. Meredith et al., *Influence of Mental Health and Alcohol or Other Drug Use Risk on Adolescent Reported Care Received in Primary Care Settings*, 19 *BMC FAM. PRAC.* (Jan. 9, 2018), <https://bmcfampract.biomedcentral.com/track/pdf/10.1186/s12875-017-0689-y> [<https://perma.cc/W7KL-5PBK>] (surveying 1,279 diverse adolescents who reported a doctor visit in the past year and finding that “only a third of those at risk for [alcohol or other drug] AOD use (yellow or red flag on the PESQ) who were screened for AOD use reported receiving some type of intervention”).

269. See Stacy Sterling et al., *Specialty Addiction and Psychiatry Treatment Initiation and Engagement: Results from an SBIRT Randomized Trial in Pediatrics*, 82 *J. SUBSTANCE ABUSE TREATMENT* 48, 50 (2017) (finding that among 333 adolescents who were referred to specialty addiction or psychiatry treatment after screening positive for substance use and/or mental health problems during teen well check, only 27% initiated treatment).

270. Ahrensbrak et al., *supra* note 29.

young adults aged 18 to 25 who needed substance use services received treatment at a specialty facility in the past year.²⁷¹

Unfortunately, Medicaid does not provide a sufficient level of opioid addiction treatment to its beneficiaries. Although Medicaid beneficiaries receive inpatient and outpatient treatment at a higher rate than privately insured individuals,²⁷² only about thirty-two percent of Medicaid enrollees suffering from opioid use disorder receive treatment.²⁷³ As of 2016, thirty-eight percent of all U.S. counties lacked a SUD treatment facility,²⁷⁴ and only sixty percent had at least one outpatient SUD facility that accepted Medicaid.²⁷⁵ As with mental health, communities of color are also more likely to experience these gaps; counties containing a higher percentage of Black and Hispanic residents are less likely to have any access to a SUD outpatient facility that accepts Medicaid.²⁷⁶ The case law detailed above similarly reveals gaps in behavioral health services for children enrolled in Medicaid in a number of states where judges have had to intervene to require states to comply with EPSDT.²⁷⁷

While the available data is highly concerning, more data is needed to understand the gaps in mental health and substance abuse screening, brief intervention, referrals to treatment, and treatment utilization among child and adolescent Medicaid beneficiaries. There is no national, standardized data available to indicate whether these services were received by Medicaid beneficiaries under the age of twenty-one. Neither of the two most commonly used national data sets describing the receipt of EPSDT services (the CMS-416 form and CMS Child Core Set data sets) offer insight into how many adolescents receive behavioral health screenings or whether children who attended EPSDT well-child visits had their behavioral health conditions diagnosed and treated accordingly.²⁷⁸

Most Medicaid coverage is delivered through managed care organizations (MCOs), which are private entities that contract with state

271. *Id.*

272. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 15, at 61 (“Medicaid beneficiaries with an opioid use disorder have higher treatment rates than privately insured with the same condition.” (citation omitted)); see STATE HEALTH ACCESS DATA ASSISTANCE CTR. (SHADAC), UNIV. OF MINN., ANALYSIS FOR MACPAC OF 2015 NATIONAL SURVEY ON DRUG USE AND HEALTH (NSDUH) (2017).

273. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 15, at xiv (“Only about 32 percent of Medicaid enrollees with an opioid use disorder were receiving treatment in 2015.”).

274. CHRISTIE ET AL., *supra* note 61, at 32.

275. Janet Cummings et al., *Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States*, 71 JAMA PSYCHIATRY 190, 190 (2014).

276. *Id.* at 192.

277. See *infra* Part III.

278. See Kelly Whitener, *Using Data to Document and Improve EPSDT Participation*, GEO. U. HEALTH POL'Y INST.: SAY AHHS! BLOG (June 30, 2016), <https://ccf.georgetown.edu/2016/06/30/using-data-document-improve-epsdt-participation/> [<https://perma.cc/9K8F-WYCE>].

Medicaid agencies to provide the required services specified by a state.²⁷⁹ The flexibility that states have in crafting their contracts with MCOs is a major driver of the variation across states in delivery of EPSDT benefits to children.²⁸⁰ MCOs receive a fixed monthly payment for each person they enroll and in exchange agree to provide or arrange for healthcare services to be delivered to Medicaid beneficiaries.²⁸¹ Because of this arrangement, through which MCOs assume a financial risk by receiving a set payment for each beneficiary regardless of the services each beneficiary will require, the MCO contracting structure has been criticized because MCOs may be incentivized through this structure to spend the least amount of money per beneficiary so that they can retain as much funding as possible.²⁸² Through a measurement system known as HEDIS, many states do require their MCOs to report whether adolescents who have been diagnosed with a new episode of alcohol or drug abuse or dependence received timely treatment.²⁸³ However, this data is not compiled nationally. Moreover, there are currently no HEDIS measures that enable monitoring of the number of children receiving mental health or substance use screenings and brief interventions. Because of this lack of national data, it is impossible to identify the gaps in care within and across states and monitor the results of improvement efforts.²⁸⁴ More data should be collected by states and the federal government to fully understand the extent to which children enrolled in Medicaid are being screened for behavioral health needs and the required treatment is being provided.

Despite the dearth of data, there is some research available to indicate the range of barriers to EPSDT utilization, including barriers experienced by families, physician training barriers, structural barriers in the administration of the program, and a scarcity of treatment services.

279. See ANDY SCHNEIDER, GEO. U. HEALTH POL'Y INST., HOW CAN WE TELL WHETHER MEDICAID MCOs ARE DOING A GOOD JOB FOR KIDS? 1 (2018), <https://ccf.georgetown.edu/wp-content/uploads/2018/02/How-Can-We-Tell-Whether-Medicaid-MCOs-are-Doing-a-Good-Job-for-Kids.pdf> [<https://perma.cc/9RQB-G3N2>].

280. See *id.* at 3.

281. See *id.* at 1.

282. *Id.* at 2. See generally J. David McSwane & Andrew Chavez, *The Preventable Tragedy of D'ashon Morris: When a Giant Health Care Company Wanted to Save Money, a Foster Baby Paid the Price*, DALL. NEWS (June 3, 2018), <https://interactives.dallasnews.com/2018/pain-and-profit/part1.html> [<https://perma.cc/RC9A-ZS7W>] (describing an MCO's denial of necessary medical treatment to a child in foster care, resulting in what was a preventable death).

283. See NCQA, SUMMARY OF MEASURES, PRODUCT LINE & CHANGES 6, 10 (2018), https://www.ncqa.org/wp-content/uploads/2018/07/20180101_HEDIS_Changes_2018.pdf [<https://perma.cc/2CUH-NMAE>].

284. See, e.g., TERYN MATTOX ET AL., RAND CORP., RAND TOOL: CANDIDATE QUALITY MEASURES TO ASSESS CARE FOR ALCOHOL MISUSE 1–2 (2016), https://www.rand.org/content/dam/rand/pubs/tools/TL100/TL197/RAND_TL197.pdf [<https://perma.cc/R2CY-K5RU>].

A. Family Barriers

States are required to use effective methods of communication to notify all children and their families who are enrolled in Medicaid, including pregnant women who are covered by Medicaid,²⁸⁵ about the EPSDT program. However, there are no standardized or federally mandated processes for how families must be notified.²⁸⁶ Given that Medicaid beneficiaries, like other low-income populations, may have lower literacy rates and other barriers that would make it difficult for them to respond to a single notice in the mail,²⁸⁷ many parents are unaware that their children are entitled to such comprehensive services.²⁸⁸ States should follow federal guidance recommending the use of a variety of methods of communication to reach families,²⁸⁹ and they should ensure that written communications are accessible by those with lower literacy levels.

Even when families are aware of EPSDT, other barriers can keep them from accessing its services. Some families may struggle to make appointments for EPSDT care, support for which states must only provide if requested.²⁹⁰ Children generally need parents to bring them to appointments, but the work schedules of low-income parents, particularly those in service and labor industries, can be uncompromising and inflexible.²⁹¹

285. 42 U.S.C. § 1396a(a)(43) (2012) (requiring States to notify eligible children under twenty-one of benefits they are entitled to); *id.* § 705(a)(5)(F)(iv) (requiring states to ensure eligible pregnant women and infants are identified and are assisted in applying for Medicaid); *Early Periodic Screening, Diagnosis, and Treatment*, HRSA, <https://mchb.hrsa.gov/maternal-child-health-initiatives/mchb-programs/early-periodic-screening-diagnosis-and-treatment> [<https://perma.cc/LC9T-CW3Z>].

286. *Early Periodic Screening, Diagnosis, and Treatment*, *supra* note 285.

287. MACPAC, CHAPTER 4: MONITORING ACCESS TO CARE IN MEDICAID 134 (2017), <https://www.macpac.gov/wp-content/uploads/2017/03/Monitoring-Access-to-Care-in-Medicaid.pdf> [<https://perma.cc/HK9C-VCTE>] (“Medicaid beneficiaries, like other low-income individuals, may have lower health literacy, more transportation and child care difficulties, and other factors that affect their ability to access health care.”); *see also* Roberta Riportella-Muller et al., *Barriers to Use of Preventative Services for Children*, 111 PUB. HEALTH REP. 71, 74 (1996) (reporting that among a sample of 110 families that received EPSDT information by mail, a third felt inadequately informed for a variety of reasons including not recalling the notification, considering it junk mail, not understanding the mail).

288. KAISER COMM’N ON MEDICAID FACTS, EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES 2 (2005), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/early-and-periodic-screening-diagnostic-and-treatment-services-fact-sheet.pdf> [<https://perma.cc/55G7-YBPR>].

289. *Early Periodic Screening, Diagnosis, and Treatment*, *supra* note 285.

290. Riportella-Muller et al., *supra* note 287.

291. *Id.* at 73.

Transportation can also be a hardship.²⁹² While states are required to provide travel assistance for EPSDT care and services when necessary,²⁹³ finding assistance or actually receiving timely assistance may be difficult.²⁹⁴ Families in rural areas may still need to travel a distance for services,²⁹⁵ and long travel time or cost can be burdensome.²⁹⁶ Parents report that encountering transportation problems when seeking mental health services can be especially discouraging, and if there are already very few options, parents may feel that the benefits are not worth the obstacles.²⁹⁷ As part of their response to the opioid crisis, states should ensure care coordination services are effectively made available to families to assist with these barriers.²⁹⁸

While federal law mandates that language services be made available to individuals with limited English proficiency, states are not required to reimburse providers for translation services,²⁹⁹ and those services may not always be adequate,³⁰⁰ creating greater barriers for children and parents for whom English is a second language. Language differences and cultural barriers can impede effective screening and proper diagnoses, particularly with mental and health substance abuse screening,

292. *Id.* at 71, 75.

293. CTRS. FOR MEDICARE & MEDICAID, *supra* note 19, at 17; *Early Periodic Screening, Diagnosis, and Treatment*, *supra* note 285.

294. *See* CTRS. FOR MEDICAID & MEDICARE SERVS., INCREASING THE PHYSICAL ACCESSIBILITY OF HEALTH CARE FACILITIES 2 (2017) (finding that 22% of medical facilities were inaccessible to individuals in a wheelchair).

295. *See* CHRISTIE ET AL., *supra* note 61, at 32 (finding that across all United States counties, 38% did not have a SUD treatment facility, and in the most rural counties, 55% did not have a SUD treatment facility).

296. Lonnie R. Snowden et al., *Increasing California Children's Medicaid-Financed Mental Health Treatment by Vigorously Implementing Medicaid's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program*, 46 MED. CARE 558, 559 (2008) (finding mental health access in areas with little to no services, such as rural America, patient EPSDT screening and services practices were less than urban access).

297. *See* LeaAnne DeRigne, *What Are the Parent-Reported Reasons for Unmet Mental Health Needs in Children?*, 35 HEALTH & SOC. WORK 7, 7, 10 (2010); Julia L. Mendez et al., *Parental Engagement and Barriers to Participation in a Community-Based Preventive Intervention*, 44 AM. J. CMTY. PSYCHOL. 1, 1, 6 (2009).

298. With thirty-nine states outsourcing coordination to MCOs, three-fourths of the Medicaid population now receives their services through contracts with MCOs. GIFFORD ET AL., *supra* note 183. It is important to ensure coordination is occurring for individuals to receive proper care.

299. CTRS. FOR MEDICARE & MEDICAID, *supra* note 19, at 18 (discussing that translation services cannot be billed separately and must be linked to medical billing code covered by Medicaid).

300. *See* Alice S. Carter et al., *Assessment of Young Children's Social-Emotional Development and Psychopathology: Recent Advances and Recommendations for Practice*, 45 J. CHILD PSYCHOL. & PSYCHIATRY 109, 117 (2004) (discussing the different cultural connotations words have that are not readily apparent which can cause problems even if a translator is present).

which rely more on language and communication than a physical examination and often necessitate disclosure of sensitive information.³⁰¹ States should ensure that providers have access to effective interpretation services.

Cultural competency training is also especially important for physicians, as more than sixty percent of children on Medicaid belong to minority groups.³⁰² Children, adolescents, and parents of immigrant families and racial and ethnic minorities may be mistrustful of physicians and reluctant to share what may be considered private matters.³⁰³ In some cultures, mental health is so heavily stigmatized that parents may not want a physician to screen their child for behavioral health needs.³⁰⁴ Peer pressure or other stigmatizations may also lead adolescents to refuse screenings.³⁰⁵ The presence of a parent in the appointment can further change the physician-adolescent dynamic, and adolescents may communicate untruthfully to their physicians.³⁰⁶ Adolescents are more likely to be open when disclosure is guaranteed to be confidential and may find self-reporting computerized screenings more favorable.³⁰⁷ In addition to cultural competency, medical education and provider trainings should cover best practices for addressing stigma and confidentiality concerns.

Long waitlists to schedule appointments can also frustrate access.³⁰⁸ The longer individuals remain untreated, the more difficult treatment

301. See U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY 31–32 (2001) (explaining that relying on verbal communication necessary for mental health assessment creates great potential for miscommunication and misunderstanding); Carter et al., *supra* note 300 (discussing the different cultural connotations words have that are not readily apparent which can cause problems even if a translator is present).

302. See BROOKS & WHITENER, *supra* note 188, at 5 fig.2.

303. See CHILDREN'S DEF. FUND, THE BARRIERS: WHY IS IT SO DIFFICULT FOR CHILDREN TO GET MENTAL HEALTH SCREENS AND ASSESSMENTS? 3 (2003); U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 301, at 29 (citing one study that found “almost half of African Americans” feared hospitalization, and thus, did not seek mental health treatment); U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 86–87 (1999).

304. See, e.g., CHILDREN'S DEF. FUND, *supra* note 303, at 4; U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 301, at 63.

305. See CHILDREN'S DEF. FUND, *supra* note 303, at 4; Paul J. Chung et al., *Preventive Care for Children in the United States: Quality and Barriers*, 27 ANN. REV. PUB. HEALTH 491, 505 (2006) (noting multiple stigmatizations).

306. See, e.g., Harris et al., *supra* note 226, at 128 (stating that a parent should be asked to leave when the questions that will be asked are highly sensitive).

307. See *id.* at 137–38 (reporting that studies find adolescents may be more comfortable using computerized screening on their own before appointments, but only to the extent they know the data is confidential and secure).

308. See Riportella-Muller et al., *supra* note 287.

becomes,³⁰⁹ and post-screening barriers may hinder an individual from receiving care. Children and adolescents can have low adherence to mental health or substance use treatments if not implemented the same day those needs are identified, particularly if their parents are already struggling with stressful life situations or with their own behavioral health issues.³¹⁰ Follow-up communication after the screening can be helpful in making sure that treatment is effectuated.³¹¹

B. *Physician Education and Training*

Little has been documented about how physicians who serve Medicaid beneficiaries are educated about the EPSDT program. Pediatricians may underutilize screenings due to limited education about EPSDT.³¹² While CMS has disseminated EPSDT guides to state Medicaid agencies,³¹³ whether that information reaches providers and beneficiaries is still largely unreported. Moreover, medical education curricula do not always include or place weight on topics such as substance use, mental health and treatment options,³¹⁴ and physicians report feeling ill-equipped to provide proper care without knowing how or when to utilize screening tools.³¹⁵ Though SBIRT was promoted and incentivized a decade ago and has been recommended by the American Academy of Pediatrics, this approach to substance abuse prevention has not been nationally integrated into medical education and many pediatricians are unaware of it.³¹⁶ Inadequate education can also make it difficult for providers to know how to engage adolescents in substance

309. See U.S. DEP'T OF HEALTH & HUMAN SERVS., NAT'L INST. OF MENTAL HEALTH, TREATMENT OF CHILDREN WITH MENTAL ILLNESS: FREQUENTLY ASKED QUESTIONS ABOUT THE TREATMENT OF MENTAL ILLNESS IN CHILDREN 1 (2009).

310. See, e.g., Teri Pearlstein et al., *Postpartum Depression*, 200 AM. J. OBSTETRICS & GYNECOLOGY 357, 358–59 (2009) (finding that postpartum depression is directly linked to the behavioral health of a young child and the longer a mother does not receive care, the more likely the child is to suffer development impairments and not receive care); Riportella-Muller et al., *supra* note 287, at 73.

311. See Harris et al., *supra* note 226, at 146–47.

312. See U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 262, at 1, 18–19; see also U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-09-578, MEDICAID PREVENTIVE SERVICES: CONCERTED EFFORTS NEEDED TO ENSURE BENEFICIARIES RECEIVE SERVICES 17–18 (2009) (finding that reported rates of preventive screenings that occurred during well-child checkups were low and within a two year period about 41% of eligible children ages two through twenty did not have full well-child checkups).

313. See, e.g., MURRIN, *supra* note 175, at 5.

314. CHRISTIE ET AL., *supra* note 61, at 22.

315. See, e.g., Savageau et al., *Behavioral Health*, *supra* note 238, at 265; Semansky et al., *supra* note 261, at 738.

316. See CHRISTIE ET AL., *supra* note 61, at 22; Harris, *supra* note 158.

abuse screening, which can deter physicians from screening altogether.³¹⁷ Physicians may similarly be unaware of the referral services a child or adolescent may need if there is a positive screen.³¹⁸

Insufficient training and lack of familiarity with standardized tools are frequently cited as barriers to substance use screening.³¹⁹ CMS has suggested that physicians use Bright Futures, a comprehensive resource and periodicity schedule for screening of children created by the American Academy of Pediatrics,³²⁰ but there is no single method or approach that pediatric providers are mandated to follow.³²¹ The lack of standard screening protocol asks the physician to determine what screening tools to use, which requires additional time they already feel they do not have.³²²

Evidence suggests that provider training can help mitigate these barriers.³²³ For example, a recent study compared SBIRT implementation among pediatricians trained to provide SBIRT with pediatricians providing usual care and found that the trained pediatricians had significantly greater rates of screening and brief intervention.³²⁴ A recent report on Massachusetts pediatricians suggests that a significant number of national, statewide, and local SBIRT training initiatives reduced the number of providers reporting “lack of knowledge” as a barrier to

317. See Shari Van Hook et al., *The “Six T’s”: Barriers to Screening Teens for Substance Abuse in Primary Care*, 40 J. ADOLESCENT HEALTH 456, 459 (2007) (concluding that time pressure and lack of training in how to handle positive screens for adolescents are major barriers, possibly deterring providers from screening teens they may suspect have substance use issues).

318. See Melissa D. Klein et al., *Can a Video Curriculum on the Social Determinants of Health Affect Residents’ Practice and Families’ Perceptions of Care?*, 14 ACAD. PEDIATRICS 159, 159, 164 (2014).

319. Levy et al., *supra* note 213, at e4.

320. CTRS. FOR MEDICARE & MEDICAID, *supra* note 19, at 4.

321. See CHILDREN’S DEF. FUND, *supra* note 303, at 2; Semansky et al., *supra* note 261, at 736 (finding that states participating in EPSDT largely create their own approaches to mental health screening with twenty-three states not requiring any specific tools in screening). When states are adopting their periodicity schedules, they should consult with professional organizations like the American Academy of Pediatrics and explore the unique needs of adolescents to develop appropriate periodicity schedules and tools to screen for mental health and substance abuse needs. See CTRS. FOR MEDICARE & MEDICAID, *supra* note 19, at 4. They should also be reviewed and kept up to date. *Id.*

322. See Sarah McCue Horwitz et al., *Barriers to the Identification and Management of Psychosocial Issues in Children and Maternal Depression*, 119 PEDIATRICS e208, e212 tbl.3 (2007) (reporting that a majority of physicians surveyed agreed that lack of time was a barrier to treating child and adolescent mental health problems).

323. See *id.* at e208, e214 (suggesting that continuing education is needed).

324. Stacy Sterling et al., *Implementation of Screening, Brief Intervention, and Referral to Treatment for Adolescents in Pediatric Primary Care: A Cluster Randomized Trial*, 169 JAMA PEDIATRICS 2, 6 (Nov. 2, 2015), <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2467333> [<https://perma.cc/GER7-C862>].

substance abuse screening from 52% to 36.2% and increased the number of providers who used a valid screening tool from 43.1% to 56.2%.³²⁵ The same report also “suggests promise” for the effectiveness of broad provider educational strategies such as policy statements and guidelines to change clinical practice.³²⁶

Governors across the nation have called for the federal government to establish wide-reaching training programs on behavioral health screening and to incorporate such programs into *all* medical education.³²⁷ Federal funding from SAMHSA “ha[s] focused on training providers and residents to integrate” SBIRT screenings into their practices, and promoting screenings through state grants.³²⁸ For example, SAMHSA “has funded over 43,000 SBIRT screenings in Tennessee between October 2011 and March 2017.”³²⁹ Efforts in New Hampshire and the District of Columbia to train physicians on behavioral health screening of adolescents have yielded impressive results in terms of increased screenings.³³⁰ The federal and state governments, along with medical schools, should prioritize such trainings as a strategy to combat the opioid crisis.

C. *Structural Challenges: Medicaid Reimbursement and Billing Practices*

In addition to concerns about insufficient knowledge and training, physicians also indicate that they lack time during well-child visits to screen for mental health and substance abuse concerns.³³¹ Inadequate time is generally connected to low reimbursement rates for well-child visits because low rates lead physicians to keep those visits time limited.³³² Providers similarly express concern about “poor payment for the mental health services they provide.”³³³ States and Medicaid health

325. Levy et al., *supra* note 218, at 431.

326. *Id.* at 432.

327. CHRISTIE ET AL., *supra* note 61, at 13.

328. *See, e.g.*, THE SYCAMORE INST., *supra* note 98, at 3.

329. *Id.*

330. *See* CHILDREN’S LAW CTR., EVALUATING DC’S PROGRESS IN MEETING CHILDREN’S MENTAL HEALTH NEEDS 2 (2016), https://www.childrenslawcenter.org/sites/default/files/Childrens_Law_Center_MH_Update_2016.pdf [<https://perma.cc/FTA6-W9X9>]; LAFAVE ET AL., *supra* note 218, at 8, 26 (2018); D.C. Dep’t of Behavioral Health, *Performance Oversight Responses*, COUNCIL D.C., http://dccouncil.us/wp-content/uploads/2018/budget_responses/AllQNA.pdf [<https://perma.cc/899W-BDAN>].

331. *See* D’Amico et al., *supra* note 160; Harris et al., *supra* note 226, at 127.

332. Jane Meschan Foy et al., *Enhancing Pediatric Mental Health Care: Strategies for Preparing a Primary Care Practice*, 125 PEDIATRICS S87, S92 (2010).

333. *Id.*

plans, known as managed care organizations, have the tools to incentivize providers to conduct mental health and substance abuse screenings.³³⁴

The majority of children insured under Medicaid are enrolled in managed care organizations,³³⁵ which are responsible for providing medically necessary benefits, through their network, to all enrolled beneficiaries.³³⁶ In return, MCOs receive a capitation payment for each enrollee from the state based on rates determined by historical spending levels, health status, geographic location, and other risk factors.³³⁷ States dictate the terms of Medicaid service delivery and can require certain practices through their MCO contracts.³³⁸ For example, Oregon connects financial incentives to managed care performance measures,³³⁹ which improved the percentage of members over age twelve who received SBIRT.³⁴⁰ Financial incentives can also be offered directly to providers. For example, Meridian Health Plan of Illinois pays providers more when members successfully attend substance abuse treatment appointments after diagnosis.³⁴¹

Despite some of these innovations, it is not always clear if and how MCOs provide behavioral health treatment. Although child beneficiaries must receive all medically necessary services, children’s receipt of behavioral health services can be hard to track because state agencies sometimes “carve[.]” them out to separate contracting entities, rather than

334. *Advocate Toolkit: Funding Screening, Brief Intervention and Referral to Treatment (SBIRT) with Young People*, COMMUNITY CATALYST 14, <https://www.communitycatalyst.org/resources/publications/document/2018/Funding-Youth-SBIRT-Toolkit.pdf> [<https://perma.cc/EH74-WSPU>].

335. KAISER COMM’N ON MEDICAID & THE UNINSURED, MEDICAID MANAGED CARE: KEY DATA, TRENDS, AND ISSUES 1 (2012), <https://kaiserfamilyfoundation.files.wordpress.com/2012/02/8046-02.pdf> [<https://perma.cc/RV4Q-RHM>] (finding that as of 2008, at least 60% of Medicaid children were enrolled in managed care organizations and 65.9% of all Medicaid beneficiaries).

336. See SCHNEIDER, *supra* note 279.

337. BRIDGETTE COURTOT ET AL., THE URBAN INST., MEDICAID AND CHIP MANAGED CARE PAYMENT METHODS AND SPENDING IN 20 STATES 19, 20 tbl.3, 22–23 (2012), <https://aspe.hhs.gov/system/files/pdf/76616/rpt.pdf> [<https://perma.cc/Y95H-FCPS>].

338. See *id.* at 19.

339. Though Oregon’s CCOs differ from managed care organizations, states could adopt similar incentive payment models for their managed care organizations. See K. John McConnell, *Oregon’s Medicaid Coordinated Care Organizations*, 315 JAMA 869, 869 (2016).

340. See OR. HEALTH AUTH., OREGON HEALTH PLAN: SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) GUIDANCE DOCUMENT 5 (2014), https://www.oregon.gov/oha/ph/HealthyPeopleFamilies/Youth/HealthSchool/SchoolBasedHealthCenters/Documents/HS_T/SBIRT_Guidance_Document.pdf [<https://perma.cc/CAH2-F5C8>].

341. See *Meridian Incentive Program*, MERIDIAN (Jan. 1, 2019), <https://corp.mhplan.com/ContentDocuments/default.aspx?x=qnaUA0T9FoxRn6OpIc699Tdx9YYr/CfjwKx25eaVxVc00nVxuitXAzoJx18ihDBBwtSNoK9xWsWw9u8HTctYXQ> [<https://perma.cc/7V7Q-36DX>].

integrate them with other healthcare delivered by an MCO.³⁴² In a carve out, an MCO might not include behavioral health services in its benefits design, but instead subcontract for those services,³⁴³ or the state Medicaid agency might decide to fund behavioral health care differently through a fee for service arrangement.³⁴⁴ These structures can lead to fragmented systems, with lack of coordination, varied payment sources, undefined responsibilities among the participating agencies, miscommunication, and compromised access to services. States should use their contracting authority with MCOs to ensure that responsibilities are clear and coordination and access to services are maximized.

Pediatricians have also expressed concern about a lack of clarity in billing policies and practices,³⁴⁵ including complexities that lead to persistent challenges to successful billing for substance abuse screening, brief intervention, and referrals to treatment.³⁴⁶ Unsurprisingly, payors reported that even when billing codes were in place for those services, providers were not using them.³⁴⁷

Effective provider billing for substance abuse prevention and treatment, including all of the requirements of SBIRT, is essential to their implementation through Medicaid EPSDT. When providers are successfully reimbursed by Medicaid for SBIRT services, they may be more motivated to perform the service.³⁴⁸ Moreover, effective SBIRT

342. VERNON SMITH 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 AND 2016, at 31 tbl. 7 (2015) (listing coverage of select benefits under MCO contracts state by state); U.S. DEP'T OF HEALTH & HUMAN SERVS., OEI-04-97-00340, MANDATORY MANAGED CARE: CHANGES IN MEDICAID MENTAL HEALTH SERVICES 5 (2000), <https://oig.hhs.gov/oei/reports/oei-04-97-00340.pdf> [<https://perma.cc/BA2U-XJRY>] (reporting that states use carve out systems for mental health services for Medicaid beneficiaries, which theoretically provides access to better behavioral and mental health specialists). Because managed care organizations operate as contractual arrangements, fiscal incentives often drive what and how services are funded. See NAT'L ALL. ON MENTAL ILLNESS, MANAGED CARE, MEDICAID AND MENTAL HEALTH 2 (2011), <https://www.nasmhpd.org/sites/default/files/ResourceGuideWhatIsMC.pdf> [<https://perma.cc/6Q7N-RPL7>]; SCHNEIDER, *supra* note 279.

343. See NAT'L ALL. ON MENTAL ILLNESS, *supra* note 342.

344. See *id.*; see also SCHNEIDER, *supra* note 279, at 2 (discussing the implications of these arrangements for Medicaid beneficiaries).

345. E.g., LAFAYE ET AL., *supra* note 218, at 35.

346. See, e.g., *id.* at 35–36.

347. *Id.* at 35.

348. See, e.g., Bertha K. Madras, *Office of National Drug Control Policy: A Scientist in Drug Policy in Washington, DC*, 1187 ANN. N.Y. ACAD. SCI. 370, 391, 395 (2010) (listing recommendations that Madras received upon his departure from ONDCP, including a recommendation “to increase Medicaid share of SBIRT reimbursement as an incentive for States to catalyze SBIRT implementation”); Jiang Yu et al., *Adopting Early Intervention for Substance Use Disorders: A Preliminary Study of Primary Healthcare Professionals in New York State*, 25 DRUGS: EDUC. PREVENTION & POL'Y 475, 481 (2018) (“One important aspect of adopting SBIRT

billing also allows states and MCOs to track the provision of SBIRT services and follow-up care.³⁴⁹ Claims data can help identify high-need patients for care coordination and measure, support, and reward providers who provide SBIRT services.³⁵⁰ Additionally, the ability to track services through billing codes and encounter reporting—a direction in which the federal Medicaid agency is moving—rather than through costly and burdensome medical chart reviews makes it more likely that states and MCOs will track and report on quality and performance measures related to adolescent screening and care.³⁵¹ Successful tracking and reporting can, in turn, incentivize providers to meet performance goals and can help states and MCOs monitor the results of improvement efforts.³⁵²

into primary healthcare appears to be sustaining the effort through billing for the service.”); ABT ASSOCS., *supra* note 36, at 13 (suggesting many issues with Medicaid billing codes and noting that there are “unanticipated roadblocks” that need solutions).

349. *See, e.g.*, JENNIFER RECK & RACHEL YALOWICH, NAT’L ACAD. FOR STATE HEALTH POLICY, UNDERSTANDING MEDICAID CLAIMS AND ENCOUNTER DATA AND THEIR USE IN PAYMENT REFORM 5 (2016), <https://nashp.org/wp-content/uploads/2016/03/Claims-Brief.pdf> [<https://perma.cc/6LCF-E8FJ>]; Holly E. Fussell et al., *Medicaid Reimbursement for Screening and Brief Intervention for Substance Misuse*, 62 PSYCHIATRIC SERVS. 306, 309 (2011).

350. *See* RECK & YALOWICH, *supra* note 349, at 3.

351. *See* ELISABETH WRIGHT BURAK & MIKE ODEH, GEO. U. HEALTH POL’Y INST., DEVELOPMENTAL SCREENINGS FOR YOUNG CHILDREN IN MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM 5, 8 tbl.1 (2018), <https://ccf.georgetown.edu/wp-content/uploads/2018/03/Dev-Screening-3-15.pdf> [<https://perma.cc/SFH9-EH9P>] (noting that “relying solely on medical records review could mean added costs, which may deter a state from reporting the” Child Core Set measure “developmental screenings in the first three years of life,” and that no state who reported this measure in 2016 used medical chart reviews as a sole data collection source); *see also* OR. PEDIATRIC IMPROVEMENT P’SHIP, ISSUES TO CONSIDER: USING CLAIMS DATA TO MEASURE PRIMARY CARE SCREENING AND FOLLOW UP FOR DEPRESSION AND SUBSTANCE ABUSE FOR ADOLESCENTS IN OREGON 3–4 (2014), http://www.oregon-pip.org/resources/Using%20Claims%20Data%20to%20Measure%20Adolescent%20Screening_%20Issues%20to%20Consider.pdf (citing chart review as an issue in evaluating provider behavior for screening adolescents for depression and providing appropriate follow-up). CMS has been investing in a new informational technology infrastructure, Transformed Medicaid Statistical Information System (T-MSIS). *Transformed Medicaid Statistical Information System (T-MSIS)*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/index.html> [<https://perma.cc/WL8E-8ENQ>]. T-MSIS data collection aims to provide better information on beneficiary eligibility, Medicaid and CHIP utilizations, claims, and managed care data among other key data points. *See id.* As of November 2018, all states are currently utilizing T-MSIS and submitting monthly. *Id.* If accurate reporting occurs, each type of service utilization can be effectively tracked and agencies and MCOs can be held accountable through access to reliable and complete data. This would allow tracking of populations that may be high-risk for OUD and determine whether services are being properly utilized.

352. *See* CINDY MANN, CTR. FOR MEDICAID & CHIP SERVS., PREVENTION AND EARLY IDENTIFICATION OF MENTAL HEALTH AND SUBSTANCE USE CONDITIONS 6 (2013), <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf> [<https://perma.cc/28NM-L5GJ>] (“Collecting and reporting on [measures related to screening and early intervention for children and youth with potential mental health and substance use conditions] can

However, states and MCOs may face multiple barriers to effective provider billing for SBIRT. For a provider to bill for a screen or service, the state must activate that billing code and reimburse when providers use that code on their invoices.³⁵³ According to available data, only nine states reimburse through Medicaid for the full range of SBIRT-specific billing codes.³⁵⁴ CMS should disseminate informational bulletins that encourage states to activate SBIRT billing codes and reimburse for them and to include the full range of child and adolescent behavioral health services in their MCO contracts, bulletins which could be disseminated in fulfillment of the SUPPORT Act's requirements that HHS disseminate a set of best practices for the prevention and treatment of substance abuse for high-risk children, adolescents, and young adults.³⁵⁵

Furthermore, in some states, there is confusion among providers as to which billing codes apply to specific types of screenings.³⁵⁶ This lack of clarity can make it difficult for providers to effectively execute and obtain reimbursement for specific screenings and can create challenges for states and MCOs to track which screenings are conducted.³⁵⁷ To address this problem, states and MCOs should ensure that there are clear, unique

help providers to meet quality measurement goals and assist states in their efforts to track whether screening and follow up care occurs.”); MATTOX ET AL., *supra* note 284, at 1.

353. See, e.g., *What is Medical Reimbursement?*, AACP, <https://www.aapc.com/resources/medical-coding/reimbursement.aspx> [<https://perma.cc/3DH8-KNTW>].

354. See *Reimbursement for SBIRT*, SAMHSA, https://www.integration.samhsa.gov/sbirt/Reimbursement_for_SBIRT.pdf [<https://perma.cc/A3S6-DTRB>] (listing and describing several billing codes, including code 99408 as “[a]lcohol and/or substance abuse structured screening and brief intervention services[,] 15 to 30min;” code 99409 as “[a]lcohol and/or substance abuse structured screening and brief intervention services[,] greater than 30min;” and code H0049 as “[a]lcohol and/or drug screening”); *SBIRT Reimbursement – Select Your State*, IRETA, <https://my.ireta.org/sbirt-reimbursement-map> [<https://perma.cc/7XJU-G3F6>].

355. See Pub. L. No. 115-271, 132 Stat. 3894, 4043 (codified at 42 U.S.C.A. § 290bb-7a (West 2018)); CINDY MANN, CTR. FOR MEDICAID & CHIP SERVS., CMS ORAL HEALTH INITIATIVE AND OTHER DENTAL-RELATED ITEMS 3–4 (2013), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-04-18-13.pdf> [<https://perma.cc/T26K-G8GX>]; see also CTRS. FOR MEDICARE & MEDICAID, *supra* note 19, at 6–7 (“States may develop a bundled payment rate to pay for the physical health screening components under one billing code. States may also recognize each component of the EPSDT screening separately. For example, one state pays for the visit itself with one code and pays separately for each individual screening service delivered during the visit. This payment methodology not only encourages providers to perform every component of an EPSDT well-child visit, it also provides the state, through claims, information as to whether the physician actually met the elements of the EPSDT guidelines set out in the periodicity schedules.”).

356. See, e.g., OR. PEDIATRIC IMPROVEMENT P’SHIP, *supra* note 351, at 5.

357. For example, in Oregon, which in 2014 used CPT code 99420, “[a]dministration of health risk assessment instrument (e.g., health hazard appraisal),” providers reported a lack of clarity as to whether multiple code 99420 claims could be submitted for a single well-child visit. *Id.*

codes for substance abuse and mental health screening³⁵⁸ and that providers are trained on the billing code systems so they can enter the necessary data effectively.³⁵⁹

In clarifying the types of screenings that align with certain billing codes, states should also encourage the use of validated behavioral health tools.³⁶⁰ When providers rely on adolescents' answers to unstructured questions and their own clinical impressions instead of a formal, standardized, validated tool, they are far less likely to identify substance use problems or disorders, regardless of their experience.³⁶¹ Massachusetts provides an example, as it changed its regulations to require that providers offer screenings using a state-approved tool.³⁶² Tools approved by states should be validated for screening of both adolescent alcohol and drug use; some tools have only been validated for

358. See MA. DEP'T OF PUB. HEALTH BUREAU OF SUBSTANCE ABUSE SERVS., PROVIDER'S GUIDE: ADOLESCENT SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT FOR ALCOHOL AND OTHER DRUG USE USING THE CRAFFT SCREENING TOOL 4 (2009), <https://www.masspartnership.com/pdf/CRAFFTScreeningTool.pdf> [<https://perma.cc/8PBF-K78B>] ("The CRAFFT is a . . . behavioral health screening tool for use with children under the age of 21 and is recommended by the American Academy of Pediatrics' Committee on Substance Abuse for use with adolescents.").

359. See NEVA KAYE ET AL., NAT'L ACAD. FOR STATE HEALTH POLICY, NEW OPPORTUNITIES AND CONTINUING CHALLENGES: A REPORT FROM THE NASHP EPSDT FORUM 9 (2008), https://nashp.org/wp-content/uploads/sites/default/files/EPSDT_Forum.pdf [<https://perma.cc/E2RT-UDW2>] ("Virginia attributes doubling the amount of claims submitted for developmental screenings in the past year to the fact that the state informed providers of their ability to bill separately for such screens, adding outreach efforts to encourage the use of the screenings.").

360. See Harris et al., *supra* note 268, at 161.

361. See, e.g., Wilson et al., *supra* note 267 (comparing providers' clinical impressions of adolescents' level of substance use with diagnostic classifications from a structured diagnostic interview and finding that the providers' clinical impressions were correct for eighteen of a sampling of over 100 adolescents with a problem substance use diagnosis, ten of the fifty adolescents with an abuse diagnosis, and zero of the thirty-six adolescents with a dependence diagnosis).

362. See JULIANA BELELIEU, TEENSCREEN NAT'L CTR. FOR MENTAL HEALTH CHECKUPS, ROSIE D. AND MENTAL HEALTH SCREENING: A CASE STUDY IN PROVIDING MENTAL HEALTH SCREENING AT THE MEDICAID EPSDT VISIT 7 (2010), <https://www.mass.gov/files/documents/2016/07/tf/rosie-d-white-mhscreening.pdf> [<https://perma.cc/V9G7-RKZB>] ("[P]rimary care providers are required to offer eligible patients a mental health screening using one of the eight [state-approved] tools during well-child visits. MassHealth regulations (130 CMR 450.140 through 450.150) and provider publications, as well as those of contracting Medicaid managed care organizations (MCOs), were amended to reflect the policy changes required to implement mental health screening and referral." (footnote omitted)). SAMHSA provides a list of some of the states that do not reimburse providers for substance use screenings that do not include the use of a state-approved screening tool. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 174, at 2.

alcohol use screening.³⁶³ Although more research is needed to validate tools for adolescent opioid misuse in particular,³⁶⁴ existing screening tools, such as those recommended by the American Academy of Pediatrics for broader substance abuse screening,³⁶⁵ should be examined for adaptability for opioid misuse screening.³⁶⁶

Some of these structural challenges are a result of the culture of state flexibility that has developed in the Medicaid program.³⁶⁷ States have a lot of prerogatives in designing their Medicaid systems, and some state designs have flaws. Through informational bulletins and letters to State Medicaid Directors (known as “SMDs”), CMS should take a stronger role in establishing best practices, as required by the new SUPPORT Act,³⁶⁸ and encouraging the efforts described above at the state level. These changes to billing and reimbursement practices may help states and managed care organizations to respond more effectively to the opioid crisis. These suggested system improvements may incentivize and effectuate billing and reimbursement for SBIRT and mental health screening and treatment; allow states to better track mental health and substance abuse screenings, brief interventions, and referrals to

363. For example, Missouri requires that providers use the CRAFFT Screening Tool (which tests for both alcohol and drug use issues) to be reimbursed for performing SBIRT services on adolescents 13–17 years old—no other SBIRT screening tools are approved by the state for this population. *See* MO. DEP’T OF SOC. SERVS., MO HEALTHNET BILLING INSTRUCTIONS FOR SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT) SERVICES 1 (2015), <https://dss.mo.gov/mhd/cs/health-homes/pdf/billing-instructions-sbirt.pdf> [<https://perma.cc/BFP9-DV3J>].

364. For example, of the few tools that both include questions on drug use and have been developed and tested specifically in adolescents, few have been validated to screen specifically for adolescent drug misuse. *See* CARRIE D. PATNODE ET AL., KAISER PERMANENTE RESEARCH AFFILIATES EVIDENCE-BASED PRACTICE CTR., PRIMARY CARE BEHAVIORAL INTERVENTIONS TO PREVENT OR REDUCE ILLICIT DRUG AND NONMEDICAL PHARMACEUTICAL USE IN CHILDREN AND ADOLESCENTS: A SYSTEMATIC EVIDENCE REVIEW FOR THE U.S. PREVENTIVE SERVICES TASK FORCE 19 (2014), <https://www.ncbi.nlm.nih.gov/books/NBK195068/> [<https://perma.cc/ZY5H-Z3SC>].

365. *See, e.g.*, Levy et al., *supra* note 213, at e5 tbl.2.

366. *See, e.g.*, William C. Becker et al., *Instruments to Assess Patient-Reported Safety, Efficacy or Misuse of Current Opioid Therapy for Chronic Pain: A Systematic Review*, 154 PAIN 905, 913 (2013); Steven D. Passik et al., *Addiction-Related Assessment Tools and Pain Management: Instruments for Screening, Treatment Planning, and Monitoring Compliance*, 9 PAIN MED. S145, S164 (2008); Shannon M. Smith et al., *Instruments to Identify Prescription Medication Misuse, Abuse, and Related Events in Clinical Trials: An ACTION Systematic Review*, 16 J. PAIN 389, 408 (2015).

367. *See* Joan Alker, *Why “State Flexibility” Won’t Do the Trick to Implement Medicaid Cuts*, GEO. U. HEALTH POL’Y INST.: SAY AHHH! BLOG (Mar. 9, 2017), <https://ccf.georgetown.edu/2017/03/09/why-state-flexibility-wont-do-the-trick-to-implement-medicaid-cuts/> [<https://perma.cc/H7C4-7UAY>] (noting the flexibility of states).

368. *See* Pub. L. No. 115-271, 132 Stat. 3894, 4040 (codified at 42 U.S.C.A. § 290bb-7a (c)(3)(B) (West 2018)).

treatment; facilitate more effective use of that data in performance and quality measure; and help local, state, and federal policymakers identify and address gaps.

D. Treatment Gaps

Physicians report that a lack of self-efficacy—not believing that they would be able to achieve anything beneficial—hinders them from screening for substance abuse.³⁶⁹ Physicians may be deterred from screening by a lack of available mental health or substance abuse agencies accepting Medicaid referrals.³⁷⁰ Without community-based and outpatient treatment programs, individuals often end up only receiving services in the emergency room.³⁷¹ Of course, without services, a diagnosis is not helpful and can be further discouraging.³⁷²

Growing the workforce for substance abuse and mental health treatment has been a challenge. EPSDT is not going to solve this problem, but a concerted effort to develop and support the behavioral health workforce is necessary for EPSDT implementation. The turnover rates for substance use counselors and supervisors are high, and it is particularly challenging to fill the shortage of providers with professionals of sufficient experience, education, and cultural competency.³⁷³ There are also specific shortages of child and adolescent mental health specialists, particularly those accepting Medicaid reimbursements. In the U.S., there are only roughly 8,300 psychiatrists specializing in children’s mental health, but over 15 million children who need their services.³⁷⁴ To fulfill the promise of EPSDT, the federal government and states should work together to identify ways to promote workforce recruitment and development in fields and in communities

369. *E.g.*, Harris, *supra* note 158.

370. *See* MARSHA REGENSTEIN ET AL., THE KAISER COMM’N ON MEDICAID & THE UNINSURED, MEDICAID MANAGED CARE FOR PERSONS WITH DISABILITIES: A CLOSER LOOK 27 (2000), <https://kaiserfamilyfoundation.files.wordpress.com/2000/04/2179-medicaid-managed-care-for-persons-with-disabilities-a-closer-look.pdf> [<https://perma.cc/7ZV6-JL4F>]; *Workforce Issues*, AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY, https://www.aacap.org/aacap/resources_for_primary_care/workforce_issues.aspx [<https://perma.cc/VFS8-6AX8?type=image>] (last updated Feb. 2016) (finding that shortages in child and adolescent mental health specialists are pervasive, citing only “8,300 practicing child and adolescent psychiatrists in the US and over 15 million children and adolescents” with needs).

371. *See, e.g.*, MARGARET A. MCMANUS ET AL., MATERNAL & CHILD HEALTH POLICY RESEARCH CTR., IS THE HEALTH CARE SYSTEM WORKING FOR ADOLESCENTS? 16 (2003) (noting that the few inpatient beds that are available for adolescents are virtually inaccessible).

372. *See* Snowden et al., *supra* note 296, at 558 (finding that mental health access in areas with little to no services, such as rural America, discourages provider and patient mental health care practices).

373. *See* Cummings et al., *supra* note 275, at 195.

374. *Workforce Issues*, *supra* note 370.

representing the most critical areas of need. States and institutions of medical education can also prioritize physician training regarding the delivery of early brief interventions, which can help to prevent further progression of serious substance abuse issues in the first place.³⁷⁵

While states are required to ensure that individuals enrolled in Medicaid can access all covered services in a “timely manner,”³⁷⁶ what constitutes a timely manner is not defined. CMS indicates that “States must also ‘take advantage of all resources available’ to provide a ‘broad base’ of providers who treat children”³⁷⁷ and that there must be a “sufficient number, mix and geographic distribution of providers.”³⁷⁸ However, CMS does not provide a minimum number of providers per capita in a geographic location and there is no federally mandated method for monitoring and evaluating access to services for Medicaid beneficiaries.³⁷⁹ These deficiencies likely exacerbate EPSDT underutilization.³⁸⁰

Moreover, discrepancies in standards of medical necessity go unchecked and doctors use their varying discretion.³⁸¹ Without a standardized performance measurement, EPSDT services completed for children may be improperly reported. Thus, CMS should consider adopting a standardized performance measurement to encourage states to prioritize the availability of mental health and substance abuse treatment services as a key tool in fighting the opioid epidemic.

Several courts have ordered states to raise EPSDT reimbursement rates to increase the number of providers in a specific geographical area.³⁸² Without court intervention, states can leverage their Medicaid

375. See ABT ASSOCS., *supra* note 36.

376. See 42 C.F.R. § 438.206 (2018).

377. CTRS. FOR MEDICARE & MEDICAID, *supra* note 19, at 28 (quoting CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 221, § 5220).

378. *Id.* at 31 (citing 42 C.F.R. § 483.206 (2014)).

379. See MACPAC, *supra* note 287, at 131 (noting that there is mandated method and that states have discretion).

380. ROSENBAUM ET AL., *supra* note 190, at 9.

381. See, e.g., *id.*

382. See, e.g., Okla. Chapter of Am. Acad. of Pediatrics v. Fogarty, 366 F. Supp. 2d 1050, 1119 (N.D. Okla. 2005). The court found that Oklahoma “frequently set rates below the levels which [the State] admits are adequate to assure there are enough providers to serve Medicaid enrolled children.” *Id.* at 1106. Thus, the court ruled that Oklahoma had, in violation of the EPSDT, “failed to set physician reimbursement rates at a sufficient level to attract enough providers such that health services are ‘available to [children on Medicaid] at least to the extent that those services are available’ to the insured population” in the same geographic area. *Id.* (alteration in original). In 2005, the court ordered Oklahoma to institute a new fee reimbursement schedule for physicians providing EPSDT services. See Okla. Chapter of Am. Acad. of Pediatrics v. Fogarty, 472 F.3d 1208, 1210–11 (10th Cir. 2007); see also Clark v. Kizer, 758 F. Supp. 572, 578 (E.D. Cal. 1990) (finding that California failed to keep a sufficient physician participation

purchasing power to accelerate changes to SUD coverage and benefits,³⁸³ including the raising of payment rates.³⁸⁴ For example, in 2017 New Jersey proposed “a \$74 million increase in Medicaid rates for SUD services with the stated purpose of increasing access to [SUD] treatment.”³⁸⁵ Although states will have to spend more when they raise reimbursement rates, they will continue to get a federal match at the same percentage, meaning more funding will come from the federal government for those services as well.³⁸⁶ If states raise Medicaid reimbursement rates, they can incentivize providers to make the necessary treatment services available in geographical areas that have historically lacked them.

CONCLUSION

As the federal government has recognized, the opioid crisis is a national emergency. Lives are being lost, families are being torn apart through incarceration and foster care entry, and the economy is suffering in many ways, including workforce costs and lost tax revenue.³⁸⁷ Existing responses are lacking something important: a prevention perspective that does not just seek to slow the flow of pain pills on the market, but one that addresses and attacks the root causes of addiction.

The public health response must be national in scope and leverage existing legal and regulatory infrastructures to the fullest extent possible. It is easy enough to claim that people who take prescription pain relievers should be responsible enough to avoid addiction or else pay the consequences. However, this approach ignores the fact that, as LCHD theory demonstrates, there are biological and environmental factors that put children, many of whom have been victimized themselves, at high risk for addiction.

ratio or level of reimbursement rate to ensure equal access to dental care across the state), *aff'd in part, vacated in part sub nom.* Clark v. Coye, 967 F.2d 585 (9th Cir. 1992).

383. BACHRACH ET AL., *supra* note 172, at 3.

384. *Id.*

385. *Id.*

386. FMAP rates are generally determined annually and are not affected by states changing reimbursement rates. See ALISON MITCHELL, CONG. RESEARCH SERV., R43847, MEDICAID'S FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) 2 (2018). Federal assistance takes into account a three-year average of per capita income in the state. *Id.* Exceptions to matching can be legislated; for instance, the Health Homes exception provides that a state “receive[s] [a] 90% federal reimbursement for these services for the first eight quarters” it is available in a state. See *id.* at 10.

387. See *supra* Part I.

In an era where Medicaid is under threat,³⁸⁸ the opioid crisis teaches us that children's Medicaid is worth protecting; indeed, it is worth implementing fully, in the ways that all three branches of government have instructed, in order to address health conditions as early in life as possible. It is that promise of positive impact on lifelong health that prompted Congress to create and maintain children's Medicaid as a more robust and aggressive package of health benefits than that afforded to adults. The current political climate has involved efforts by Republican lawmakers and executive branch agencies at the state and federal levels to restrict Medicaid eligibility through work requirements and time limits and to roll back the Affordable Care Act, including its Medicaid expansion provision.³⁸⁹ These threats to the Medicaid program, which could eventually include changes that move the program from an entitlement to block grant or per capita funding, could ultimately result in the gutting of EPSDT as well.³⁹⁰ If the U.S. is to keep its children healthy and maintain an infrastructure that allows us to respond to health epidemics like the opioid crisis, Medicaid and its EPSDT components must remain intact and robust. It is critical that all three branches of the federal government restore their full support for the EPSDT initiative and not take any steps that would weaken the benefits that the program provides to keep children healthy physically and mentally.

This nation is fortunate to have in Medicaid EPSDT a far-reaching existing health law system—indeed, the largest provider of children's health coverage in the country³⁹¹—that is already structured to provide

388. *CMS Announces New Policy Guidance for States to Test Community Engagement for Able-bodied Adults*, CMS.GOV: NEWSROOM (Jan. 11, 2018), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-01-11.html> [<https://perma.cc/3L9Q-5MKC>] (noting how CMS announced policy in January 2018 to support work requirements by states as a condition for Medicaid eligibility).

389. See Holly Michels, *As Montana Legislature Starts, Expect a Fight Over Medicaid*, MISSOULIAN (Nov. 18, 2018), http://missoulian.com/news/government-and-politics/as-montana-legislature-starts-expect-a-fight-over-medicaid/article_aedc0562-8587-57f7-9e40-55aec94f6031.html [<https://perma.cc/4Q76-JQCJ>] (reporting that Republicans in Montana have called for work requirements, asset testing, or drug testing in order for Medicaid to permanently expand); Andy Schneider, *Surprise! CMS Approves Kentucky Work Requirement Waiver Again*, GEO. U. HEALTH POL'Y INST.: SAY AHHH! BLOG (Nov. 21, 2018), <https://ccf.georgetown.edu/2018/11/21/surprise-cms-approves-kentucky-work-requirements-waiver-again/> [<https://perma.cc/9TMS-FLY7>].

390. See ELIZABETH WRIGHT BURAK, GEORGETOWN UNIV. HEALTH POLICY INST., *HOW RESTRUCTURING MEDICAID COULD AFFECT CHILDREN 3–4* (2017), <https://ccf.georgetown.edu/wp-content/uploads/2017/02/Medicaid-funding-caps.pdf> [<https://perma.cc/GZ35-9N5N>].

391. See MURRIN, *supra* note 175 (noting that every state is required to offer the EPSDT benefit). More recent data does not disaggregate Medicaid enrollment from CHIP enrollment; nearly 35.6 million children are enrolled in CHIP or the Medicaid program in the forty-eight states that reported child enrollment data for October 2018. *October 2018 Medicaid & CHIP Enrollment Data Highlights*, *supra* note 17.

care to a population that is disproportionately affected by the opioid epidemic. The barriers to EPSDT utilization generally, barriers to comprehensive screening of children in the doctor's office for mental health and substance abuse and barriers to provision of all medically necessary behavioral health treatment, must be removed so that children who are at risk for opioid abuse can get the help they need to avoid addiction and to thrive. There must be a national conversation about how to leverage Medicaid and EPSDT specifically, along with other approaches, to attack the opioid crisis upstream before the largest national public health crisis of our time³⁹² claims Luke, Melanie, and the rest of their generation.

The Heckman Equation and the body of research supporting the LCHD model indicate that this investment in our children's health and mental health is a sound one, and will have payoffs beyond the opioid epidemic.³⁹³ Healthier children can become better educated adults who engage productively in the workforce and can parent effectively. The payoffs will last generations. Research shows that trauma can be inter-generational,³⁹⁴ this nation must stop the opioid crisis from claiming a next generation too.

LCHD theory in fact provides a model for conceptualizing policy responses to health crises beyond the opioid crisis. Many health crises, such as alcoholism, diabetes, and obesity, are correlated with risk factors and burgeoning health conditions in childhood.³⁹⁵ For example, scholars and policymakers are increasingly looking to the adverse childhood experiences literature to connect childhood trauma with a host of poor

392. See Robert Redfield, *Opinion: Opioids Are Public Health Crisis of Our Time*, *AJG* (June 10, 2018), <https://www.ajc.com/news/opinion/opinion-opioids-are-public-health-crisis-our-time/6h1l1hLamJDXE0VFKv22H/> [<https://perma.cc/S4KJ-349U>]; see also *Understanding the Epidemic*, CDC, <https://www.cdc.gov/drugoverdose/epidemic/index.html> [<https://perma.cc/ZB6V-3MDD>] (last updated Dec. 19, 2018) (“On average, 130 Americans die every day from an opioid overdose.”).

393. See Conti & Heckman, *supra* note 120, at 392 (according to Heckman, the earlier the investment in a child's life, the larger the return); *supra* Part II.

394. See, e.g., Amy Bombay et al., *Intergenerational Trauma: Convergence of Multiple Processes Among First Nations Peoples in Canada*, 5 *J. ABORIGINAL HEALTH* at 6, Nov. 2009 (“Traumatic events exact an enormous psychological and physical toll on survivors, and often have ramifications that must be endured for decades.”).

395. See, e.g., Alderman et al., *supra* note 7, at 93–95 (calling for regulations to reduce sugary beverages and food consumption to reduce obesity epidemic); Felitti et al., *supra* note 12 (“Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt”); Wiley, *supra* note 87, at 208–11 (calling for regulations to reduce sugary beverages and food consumption by children to lower diabetes prevalence).

health outcomes, including all three of those health conditions.³⁹⁶ Science is increasingly recognizing that trauma affects not just mental health, but physical health, and in fact correlates not only with greater risk of alcoholism,³⁹⁷ diabetes,³⁹⁸ and obesity,³⁹⁹ but also with greater risk of cancer and heart disease when that trauma leads to toxic stress for a child.⁴⁰⁰ In applying LCHD theory to leverage children's Medicaid to address the opioid epidemic early and preventively, this Article takes the first step in providing a blueprint for the ways in which the LCHD model can be applied to address other health crises by focusing on critical and sensitive periods of early life. This upstream approach adds an important dimension to the "new public health" scholarship to provide a pathway for health policy to facilitate detection and treatment of the needs of at-risk children as a means for improving lifelong health. For this nation to be healthy, the kids have to be alright.

396. See, e.g., Felitti et al., *supra* note 12, at 245; Jack P. Shonkoff et al., *Technical Report: The Lifelong Effects of Early Childhood Adversity and Toxic Stress*, 129 PEDIATRICS e232, e236–37 (2012); see also Trauma-Informed Care for Children and Families Act of 2017, S. 774, 115th Cong. (amending the Public Health Service Act, the Elementary and Secondary Education Act of 1965, Medicaid, and other laws to revise or establish provisions related to trauma, including provisions regarding the National Child Traumatic Stress Initiative, Performance Partnership Pilots, health professional shortage areas, and training of school personnel, court personnel, and health care providers); Trauma-Informed Care for Children and Families Act of 2017, H.R. 1757, 115th Cong. (same).

397. Felitti et al., *supra* note 12, at 253 tbl.5.

398. *Id.* at 254 tbl.7.

399. *Id.* at 252 tbl.4.

400. *Id.* at 254 tbl.7; Shonkoff et al., *supra* note 396, at e238.