NHeLP
NATIONAL HEALTH LAW PROGRAM

Sexuality Education in Health Care Delivery for Medicaid and CHIP-Eligible Youth

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Introduction

Medical screening is a necessary and required service for Medicaid- and some CHIP-eligible youth. This issue brief discusses the health education component of the medical screen, focusing on sexuality education. As discussed below, the medical screening that youth receive has not sufficiently included sexuality education. Yet, there are clear legal requirements for such screening, particularly for Medicaid-eligible youth under age 21. This issue brief includes recommendations to ensure that children and adolescents are provided a screen that includes age-appropriate sexuality education.

The Need for Sexuality Education

Age-appropriate sexuality education reduces the risk of unintended pregnancy and sexually transmitted diseases (STDs).[1] Education and counseling have been shown to increase contraception use, reduce the adolescent pregnancy rate and increase knowledge regarding sexual health.[2] This is important because nearly half of teens report having had sexual intercourse.[3] Those between 15 to 24 years old account for nearly half of new STDs each year. Individuals aged 13 to 24 years old account for nearly 20 percent of persons diagnosed with HIV/AIDS, with a disproportionate impact on young African-Americans, Latinos, gays, bisexuals, and men who have sex with men.[4] Further, 82 percent of teen pregnancies are unplanned.[5]

The Experts' Recommendations for Sexuality Education

The American Academy of Pediatrics' *Bright Futures*: *Guidelines for Child Health Supervision of Infants, Children, and Adolescents* (*Bright Futures*) recommends that physicians provide "confidential, culturally sensitive and nonjudgmental" sexuality education and counseling to children, adolescents, and their caretakers. *Bright Futures*

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[1] INST. OF MED., ADOLESCENT HEALTH SERVICES: MISSING OPPORTUNITIES 18 (2009).
[2] *Id.* at 158,160.
[3] Ctrs. for Disease Control & Prevention, *Youth Risk Behavior Surveillance—United States, 2013* 63(4) MORBIDITY & MORTALITY WKLY REP. 24 (June 13, 2014), *available at* http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf; *see also* JINA DHILLON & JANE PERKINS, NAT'L HEALTH LAW PROGRAM, ADDRESSING ADOLESCENT HEALTH: THE ROLE OF MEDICAID, CHIP AND ACA 2-3 (Nov. 5, 2012).
[4] Ctrs. for Disease Control & Prevention, Sexual Risk Behavior: HIV, STD, & Teen Pregnancy Prevention, http://www.cdc.gov/HealthyYouth/sexualbehaviors/ (last visited June 18, 2014); *see also* Dhillon & Perkins, *supra note* 3.
[5] Guttmacher Inst., Facts on American Teens Source of Information about Sex (Feb. 2012), http://www.guttmacher.org/pubs/FB-Teen-Sex-Ed.html.

recommends that the entire clinical environment create an atmosphere where the discussion of sexual health is comfortable, regardless of social status, gender, disability, religious beliefs, sexual orientation, ethnic background, or country of origin. *Bright Futures* also emphasizes that health care professionals should not assume the family's values are the patient's values.[6]

Table 1 summarizes the *Bright Futures* guidelines for age-appropriate sexuality education. *Bright Futures* gives recommendations on sexuality education in health care delivery from infancy until 21 years old. For example, during infancy and early childhood, *Bright Futures* recommends that providers teach parents common sexuality issues infants and young children experience, such as bathing and showering and masturbation. During the middle of childhood and adolescence, the recommendations include teaching youth about HIV, STDs, and pregnancy prevention, as well as counseling against abusive intimate relationships and drug and alcohol abuse.

The lack of sexuality education

Despite the recognized needs, most children and adolescents are not receiving sexuality education. A recent observational study of adolescents aged 12 to 17 years old found that nearly one-third of physicians did not discuss sexual health with their patients. Those physicians who did discuss sexual health spent, on average, 36 seconds doing so.[7] Moreover, when sexual health discussions do happen, they often address only a specific issue, such as counseling on perceived sexual risks and not the preventive education *Bright Futures* recommends.[8] Many physicians report a lack of confidence in discussing sex and sexuality. Nearly 90 percent of pediatricians who provide care to adolescents, in both public and commercial insurance, reported they desired additional instruction on health education, including sexuality education.[9] Providers were almost 60 percent more likely to initiate conversations on sexuality with African-American adolescents and nearly 90 percent less likely to initiate these conversations with Asian-American adolescents.[10] Even though providers were more likely to initiate sexuality education with some races and ethnicities, it is not known whether these discussions were culturally competent.[11]

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[6] AM. ACAD. OF PEDIATRICS, BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS 174 (2008).
[7] Stewart Alexander et al., *Sexuality Talk During Adolescent Health Maintenance Visits,* 168(2) JAMA 163, 164 (Feb. 2014).
[8] INST. OF MED., *supra* note 1 at 172-73.
[9] NAT'L ALLIANCE TO ADVANCE ADOLESCENTS HEALTH, PEDIATRICIANS INTEREST IN EXPANDING SERVICES AND MAKING PRACTICE CHANGES TO IMPROVE CARE FOR ADOLESCENTS 6 (2009).
[10] Alexander et al., *supra* note 7 at 167.
[11] *See Id*.

Table I: Bright Futures Guidelines for Age-Appropriate Sexuality Education

Infancy- Birth to 11 Months	Early Childhood- 1 to 4 years	Middle Childhood- 5 to 10 years	Adolescence- 11 to 21 years
✓ Discuss with parents how to behave toward infants as they become aware of genitalia ✓ Encourage parents to practice proper naming of their infant's genitalia during diapering and bathing	✓ Most common sexuality issues to discuss include bathing, showering, toileting, modesty, privacy, masturbation and sexual play ✓ Provide reassurance about normal activities, such as masturbation and sexual play ✓ Distinguish normal activities from sexual abuse and distressing sexual behavior ✓ Encourage family discussions regarding sex education ✓ Discuss with parents ways to distinguish appropriate and inappropriate behavior	✓ Begin to provide information to children and give them opportunities to ask questions ✓ Perform a sexual maturity rating ✓ Address upcoming stages of sexual development ✓ Teach the differences between male and female genitalia, including the function of each body part ✓ Teach about HIV and STDs, including the viruses and bacteria that cause the diseases, as well as the modes of transmission ✓ Teach children to express intimacy in appropriate ways and avoid manipulative relationships ✓ Teach children their right to not have someone inappropriately touching their body ✓ Teach children responsibilities related to their body, including privacy and hygiene ✓ Suggest books and other tools parents can use to discuss sexuality with their child	✓ State the advantages of delaying sexual involvement ✓ Suggest skills for refusing sexual advances ✓ Provide information about drug and alcohol risks ✓ Counsel against coercive and abusive intimate relationships ✓ Provide information about contraceptives, including emergency contraceptives, to adolescents who are sexually active and those who plan to become sexually active ✓ Provide a safe and confidential environment for adolescents to discuss same-sex attractions ✓ Provide personalized anticipatory guidance to adolescents with special health care needs ✓ Provide advice to adolescents to avoid risky sexual behavior

AM. ACAD. OF PEDIATRICS, BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS 169-75 (2008).

Legal Requirements for eligibility and services

This section provides background on Medicaid and CHIP eligibility for children, as well as 19 to 20 year olds covered under the Affordable Care Act's Medicaid expansion. The legal requirements for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are presented, including the requirement for all medical screenings to include age-appropriate health education.

Medicaid

Medicaid Eligibility

The Medicaid Act requires participating states (all states participate) to cover certain low-income children and youth. Medicaid covers all youth up through 18 years old whose family incomes are below 133 percent of the federal poverty level (FPL).[12]

States are also required to cover various populations of children and adolescents. In most states this includes recipients of SSI because of blindness or disability.[13] States must also cover certain youth who are involved with the federal foster care system under title IV-E of the Social Security Act, including youth who receive federal adoption assistance payments or for whom an adoption assistance agreement is in effect.[14] The ACA requires states to provide continued Medicaid coverage to youth up to age 26 within their state who were in foster care on their 18th birthday or older.[15]

States have the option to provide Medicaid coverage to additional groups of children and adolescents including pregnant adolescents in families with incomes between 133 to 185 percent of the FPL;[16] "medically needy" youth under 21 years old, who except for excess income levels, would qualify as categorically needy;[17] youth under 18 who have disabilities but do not qualify for SSI due to income or resources deemed to them from parents;[18] or youth with tuberculosis who meet the income and resources test for individuals with disabilities.[19] Also, pursuant to the ACA, states may provide Medicaid coverage to youth up to age 26 who were in foster care on their 18th birthday in another state.[20]

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[12] ACA § 2001(a)(5)(B)(codified at 42 U.S.C. § 1396a)(replacing 133 percent of the FPL with 100 percent of the FPL in the Social Security Act § 2001), 42 U.S.C. § 1396a(l)(2)(C) (requiring the state to have an minimum income eligibility of 133 percent of the FPL beginning January 1, 2014), *Id*. § 1396a(l)(1)(D)(stating this change in income eligibility applies to those born after September 30, 1983 who are between 6 to 18 years old); *See also Id*. §§ 1396a(a)(10)(A)(i)(IV), (VI); *Id.* §§ 1396a(l)(1)(B)-(C), 2(A),(B) (requiring coverage of individuals under 6 years old); One hundred and thirty-three percent of the federal poverty level is approximately $15,521 a year for an individual and $26, 748 a year for a family of three. CMS, 2014 POVERTY GUIDELINES, *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Downloads/2014-Federal-Poverty-level-charts.pdf.

[13] 42 C.F.R. § 435.120(B).

[14] 42 U.S.C. §§ 672(h), 673(b); 42 C.F.R. § 435.145.

[15] 42 U.S.C. § 1396a(a)(10)(A)(i)(IX)(cc).

[16] *Id*. §§ 1396a(a)(10)(A)(ii)(IX), 1396a(l)(1)(A).

[17] *Id*. § 1396d(a)(i); 42 C.F.R. §§ 435.301(b)(2)(i), 435.308.

[18] 42 U.S.C. § 1396a(e)(3).

[19] *Id*. § 1396a(a)(10)(A)(ii)(XII).

[20] *Id*. §§ 1396a(a)(10)(A)(ii)(XVII), 1396d(w).

Medicaid EPSDT Services

Most Medicaid-eligible children and adolescents under 21 years old are entitled to receive Early and Periodic Screening, Diagnostic and Treatment services (EPSDT).[21] EPSDT includes four separate screens: vision, hearing, dental, and medical. The medical screen has five mandatory components: a comprehensive health and developmental history, an unclothed physical examination, appropriate immunization, laboratory tests, and health education, including anticipatory guidance.[22] Medical screens must be provided at pre-set periodic intervals, according to periodicity schedules, and otherwise as needed by the child. States are to set the content and periodicity for these screens in consultation with child health organizations, such as the American Academy of Pediatrics.[23]

The federal Medicaid agency, the Centers for Medicare & Medicaid Services (CMS), has issued controlling guidance to states in the *State Medicaid Manual*. This guidance informs states that the health education component of the medical screen should cover the benefits of a healthy lifestyle and encourage disease prevention. Anticipatory guidance should be forward-looking, age-appropriate, and directed at both the child and the caregiver. The goal of anticipatory guidance is to instruct families and youth on the physical and mental developments that should be anticipated to occur at various ages.[24] Thus, health education and anticipatory guidance must be age-appropriate, explain the benefits of a healthy life-style, and discuss disease prevention. These requirements mean that sexuality education is a necessary part of the health education screen.

Unfortunately, EPSDT all too often falls short of its promise. A recent nine state survey conducted by the Office of Inspector General within the Department of Health and Human Services (HHS) concluded that 76 percent of children did not receive all EPSDT required medical, vision and hearing screenings, and 60 percent of the children who were screened did not receive a complete medical screen (that is, at least one of the five mandatory components of the medical screen was missed).[25] Notably, over 20 percent of children receiving an EPSDT screen did not receive any health education or anticipatory guidance.[26]

A Note on 19 and 20 year olds

The ACA expanded coverage to non-disabled childless adults under age 65 with incomes below roughly 133 percent of the Federal Poverty Level (FPL).[27] A United States Supreme Court ruling effectively made that expansion a state option.[28] In those

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[21] *Id*. §§§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B).
[22] *Id*. § 1396d(r); *see also* CMS, STATE MEDICAID MANUAL § 5122.
[23] CMS, STATE MEDICAID MANUAL § 5123.1(A).
[24] CMS, STATE MEDICAID MANUAL § 5123.2(E).
[25] U.S. DEP'T OF HEALTH & HUM. SERVS.,OFF. OF INSPECTOR GEN., OEI-05-08-00520, MOST MEDICAID CHILDREN IN NINE STATES ARE NOT RECEIVING ALL REQUIRED PREVENTIVE SCREENING SERVICES 12,14 (May 2010).
[26] *Id*. at 15-16.
[27] ACA § 2001(a)(1)(codified at 42 U.S.C. § 1396a).
[28] *Nat'l Fed. of Indep. Bus. v. Sebelius*, 132 S.Ct. 2566, 2607-9 (2012).

states expanding Medicaid (currently 27 states), 19 and 20 year olds are among the expansion population. These individuals are eligible for EPSDT.

CHIP

CHIP Eligibility

States have the option to implement a Children's Health Insurance Program (CHIP), and all states have done so.[29] Under CHIP, states have significant discretion in determining the eligibility limits. A state may cover youth with family incomes above the eligibility-threshold for Medicaid. Forty-six states and the District of Columbia cover children with family incomes 200% of the FPL or higher.[30]

CHIP Services

States can establish CHIPs as a separate program, as an expansion of Medicaid, or as a combination of those two options.[31] Twelve states and the District of Columbia operate CHIP as an expansion of Medicaid; 18 states, as a separate program; 20 states, as a combination of the two approaches.[32]

CHIPs must include well-child care. When the state's CHIP is a Medicaid expansion, enrolled children are entitled to EPSDT.[33] States with separate or combination CHIPs can choose coverage that is tied to commercial insurance available in the state (called benchmark coverage in the Social Security Act) or HHS Secretary-approved coverage.[34] In addition, states can also choose whether to include the ESPDT benefit in its separate program's design.

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[29] 42 U.S.C. § 1396d(u)(2). Arizona has begun to phase out its CHIP program by freezing enrollment and cutting eligibility. *See* TRICIA BROOKS ET AL., GEORGETOWN U. HEALTH POL'Y INST., CTR. FOR CHILDREN & FAMILIES, DISMANTLING CHIP IN ARIZONA (May 2014).

[30] GEORGETOWN UNIV. HEALTH POL'Y INST., CTR. FOR CHILDREN & FAMILIES, MEDICAID AND CHIP PROGRAMS, http://ccf.georgetown.edu/facts-statistics/medicaid-chip-programs/ (last visited June 19, 2014). Specifically, the total number of 46 states and the District of Columbia is composed of: 20 states that provide coverage up to 200 percent of the FPL; eight states that provide coverage up to 250 percent of the FPL; 17 states, including the District of Columbia, that covers youth up to 300 percent of the FPL; one state that covers youth up to 350; and one state that covers youth up to 400 percent of the FPL. The remaining four states provide coverage at least up to 150 percent of the FPL. GEORGETOWN UNIV. HEALTH POLICY INST., CTR. FOR CHILDREN & FAMILIES, ELIGIBILITY LEVELS IN MEDICAID & CHIP FOR CHILDREN, PREGNANT WOMEN, PARENTS, AND CHILDLESS ADULTS (July 23, 2013), *available at* http://ccf.georgetown.edu/wp-content/uploads/2012/04/Eligibility-Levels-in-Medicaid-CHIP-for-Children-Pregnant-Women-Parents-and-Childless-Adults3.pdf; Two-hundred percent of the FPL is approximately $23,340 a year for an individual and $39,580 a year for a family of three, according to the 2014 Poverty Guidelines. CMS, *supra* note 12.

[31] 42 C.F.R. § 457.70(a).

[32] ANITA CARDWELL ET AL., NAT' ACAD. FOR STATE HEALTH POL'Y & JOE TOUSCHNER ET AL., GEORGETOWN U. HEALTH POL'Y INST., CTR. FOR CHILDREN & FAMILIES, BENEFITS AND COST SHARING IN SEPARATE CHIP PROGRAMS 3 (May 2014).

[33] 42 C.F.R. § 457.70(c).

[34] §§ 457.410(a).

Table 2 summarizes states coverage of services in their CHIPs. The table notes the 12 states and the District of Columbia with Medicaid-expansion CHIPs that must provide EPSDT. According to a recent report published by the Center for Children and Families at Georgetown University Health Policy Institute, 26 states with separate or combination CHIPs provide all or some children with benefits that were the same or similar to Medicaid benefits. The remaining 12 states provide benchmark or Secretary-approved coverage that does not include Medicaid-based benefits.[35]

In sum, child health experts recommend that youth under age 21 receive periodic health education that includes sexuality education. Medicaid-eligible youth are entitled to EPSDT, which has health education as a mandatory component of the medical screen. States' coverage of medical screening for CHIP-enrolled children is more flexible. As discussed above, however, youth are not receiving adequate medical screening and sexuality education. To address the gaps, we recommend the following.

[35] CARDWELL, *supra* note 32 at 13-14.

Table 2: Medicaid Benefits in CHIPs

State	Program Design		
	Medicaid Expansion, including EPSDT	**Separate CHIP program with EPSDT or similar benefits***	**Separate CHIP, does not provide EPSDT or similar benefits**
State Totals	12 states and D.C.	26 states	12 states
Alabama			✓
Alaska	✓		
Arizona		✓	
Arkansas			✓
California	✓		
Colorado			✓
Connecticut			✓
Delaware		✓	
District of Columbia	✓		
Florida		✓	
Georgia			✓
Hawaii	✓		
Idaho		✓	
Illinois		✓	
Indiana		✓	
Iowa		✓	
Kansas		✓	
Kentucky		✓	
Louisiana		✓	
Maine		✓	
Maryland	✓		
Massachusetts		✓	
Michigan		✓	
Minnesota	✓		
Mississippi			✓
Missouri		✓	
Montana		✓	
Nebraska	✓		
Nevada		✓	
New Hampshire	✓		
New Jersey		✓	
New Mexico	✓		
New York		✓	
North Carolina		✓	
North Dakota			✓
Ohio	✓		
Oklahoma	✓		
Oregon		✓	
Pennsylvania			✓
Rhode Island	✓		
South Carolina	✓		
South Dakota		✓	
Tennessee		✓	
Texas			✓
Utah			✓
Vermont		✓	
Virginia		✓	
Washington		✓	
West Virginia			✓
Wisconsin		✓	
Wyoming			✓

ANITA CARDWELL ET AL., NAT'L ACAD. FOR STATE HEALTH POL'Y & JOE TOUSCHNER ET AL., GEORGETOWN U. HEALTH POL'Y INST., CTR. FOR CHILDREN & FAMILIES, BENEFITS AND COST SHARING IN SEPARATE CHIP PROGRAMS 12-13 (May 2014).

*Note: In some states, benefits provided may depend on age or income. States operating combination CHIPs may place some children in a program where Medicaid benefits are provided, while others will be placed in a CHIP that does not provide Medicaid benefit.

Recommendations:

I. CMS should provide ongoing, clear instruction and encouragement for states to implement the *Bright Future*s sexuality education recommendations under EPSDT

Over the years, states have failed to implement Medicaid's EPSDT requirements, including the requirements for medical screens. Courts have ordered states to take specific steps to address this problem.[36] For instance, in *Bond v. Stanton*, the court noted that "Indiana…by requiring only a general physical examination (even with tests for vision, hearing, and dental or mental problems) leaves it to the provider to decide what services to perform."[37] The court ordered the State to define the EPSDT screen content and procedures with enough specificity to ensure children and adolescents actually receive the required benefits.[38]

A recent CMS report, *Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits,* provides recommendations for improving EPSDT screening. The report recommends that states align their policies with the *Bright Futures* recommendations. This extends to addressing payment policies, managed care contracts, and enrollee and provider guidance materials.[39] Notably, a survey published by the National Alliance to Advance Adolescent Health found that most states do not point participating providers to the *Bright Futures'* guidelines.[40]

> **RECOMMENDATION**: CMS should provide additional guidance to state Medicaid programs for instructing managed care entities and Medicaid-participating providers that the periodic medical screen must include health education and anticipatory guidance and that this includes age-appropriate sexuality education as described in *Bright Futures: Guidelines for Child Health Supervisions of Infants, Children, and Adolescents*.

II. CMS should include sexuality education as an aspect of quality monitoring and reporting

A. EPSDT Reporting

The Secretary uses the Annual EPSDT Participation Report Form CMS-416, commonly known as Form 416, to obtain information on states' EPSDT performance. On the form, states report the numbers and percentages of eligible children and youth by age grouping who received certain EPSDT services, including medical screens. [41]

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[36] *See generally* JANE PERKINS, NHELP FACT SHEET: MEDICAID EPSDT CASE TRENDS AND DOCKET (March 2014).
[37] *Bond v. Stanton*, 655 F.2d 766, 769-70 (7th Cir. 1981).
[38] *Id*. at 770.
[39] CMS, PAVING THE ROAD TO GOOD HEALTH: STRATEGIES FOR INCREASING MEDICAID ADOLESCENT WELL-CARE VISITS 8-28 (Feb. 2014).
[40] NAT'L ALLIANCE TO ADVANCE ADOLESCENT HEALTH, STATE EPSDT POLICIES FOR ADOLESCENT PREVENTIVE CARE 2 (Sept. 2011).
[41] *See* CMS, STATE MEDICAID MANUAL § 5320. 2(C) (instructing states of the required reporting requirements and describing Form 416 contents); *See also* CMS, Form CMS-416: Annual EPSDT

The instructions for completing Form 416 provide that states can only report complete medical screens, which means that a state should not report a screen that did not include all five of the mandatory medical screening components (one of which is health education and anticipatory guidance).[42] Notably, however, Form 416 itself does not include cells for reporting each component.[43] CMS does instruct that the provider "must agree to keep records necessary to disclose the extent of services furnished."[44]

Specific to health education, the court in *Memisovski v. Maram* noted that the Illinois Medicaid agency had not evaluated the level or quality of health education being provided.[45] Illinois did not conduct reviews to ensure all EPSDT services were provided and did not collect quality data to assess EPSDT services delivered. Rather, the State relied solely on provider invoices to determine the extent of care provided. The court ordered the State to address the problem and, following negotiations the parties agreed the state would report quarterly on the specific services provided.[46] In *Bond v. Stanton*, the court similarly concluded that Indiana's Medicaid agency could not "assure that it provides a screen sufficiently comprehensive" because the State did not receive adequate reports about the nature and extent of screening.[47] For example, Indiana asked only if an examination was performed—not if a complete EPSDT screen was delivered.[48] The state was required to amend its plan for EPSDT delivery.[49]

There are different options for tracking the delivery of EPSDT screens. The CMS *State Medicaid Manual* lists examples that include an itemized provider claim demonstrating each service provided.[50] Some states issue standardized forms for providers to use during office visits that track whether each of the five medical screening components were provided. These forms sometimes include cues for age-appropriate health education.[51] NHeLP has previously called for the use of standardized age-appropriate medical reporting forms that include specific reporting and cuing on developmental assessment and health education/anticipatory guidance.[52] We do so again here.

> **RECOMMENDATION**: CMS should issue policy guidance that requires states to use standardized, age-appropriate screening that includes specific reporting and cuing on the EPSDT five components of the medical screen, including health education/anticipatory guidance.

Participation Report Instructions, *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/CMS-416-instructions.pdf.

[42] CMS, STATE MEDICAID MANUAL § 5360(D).

[43] *See* CMS, *supra* note 41.

[44] CMS, STATE MEDICAID MANUAL § 5310(A).

[45] *Memisovski ex. Rel Memisovski v. Maram*, No. 92 C 1982, 2004 WL 1878332, at 40-41 (Ill. N.E. 2d 2004).

[46] *Memiosovski v. Maram,* No. 92 C 1982, 2007 WL 4232716, at 1 (Ill. N.E. 2d 2007); *See also* Notice of Motion at 15-29, Memiosovski v. Maram No. 92 C 1982, 2004 WL 1878332 (Ill. N.E. 2d

[47] *Bond v. Stanton,* 655 F.2d 766, 770 (7th Cir. 1981).

[48] *Id*.

[49] *Id.* at 772.

[50] CMS, STATE MEDICAID MANUAL § 5320.2(B).

[51] U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 25 at 19.

[52] JANE PERKINS, NAT'L HEALTH LAW PROGRAM, LIST OF EXECUTIVE ACTIONS REGARDING EPSDT PROGRAM 2 (Dec. 2008).

B. Performance Measures

Beginning in 2013, the Children's Health Insurance Program Reauthorization Act (CHIPRA) began to require the Agency for Healthcare Research and Quality (AHRQ) to annually assess child and adolescent quality measures, known as the Children's Core Set of Health Care Quality Measures for Medicaid and CHIP (Child Core Set).[53] Use of the measures by state Medicaid and CHIPs is voluntary. However, the federal government compiles information on the states' experiences.[54] Currently, there are no measures associated with health education.[55]

> **RECOMMENDATION**: CMS should promote the development of a federal quality measure that state Medicaid programs can use to assess whether health care providers treating adolescents conduct health education, particularly sexuality education, as described in *Bright Futures: Guidelines for Child Health Supervisions of Infants, Children, and Adolescents*.

C. External Quality Review

For all states where Medicaid and CHIP enrollees receive care through managed care organizations (MCO) or prepaid inpatient health plans (PIHP), the state must conduct independent external quality review (EQR) to monitor quality, timeliness, and accessibility in the delivery of care.[56] The EQR must at a minimum include three activities: compliance with quality and access standards, validation of performance measures, and MCO/PIHP ongoing performance improvement projects (PIPs).[57]

States choose PIPs topics and set applicable quality measures to be monitored.[58] These have included projects and measures related to the adolescent well-care visit; however, recent CMS findings note only two states using performance measures and PIPs that expressly monitored the delivery of EPSDT medical screens.[59]

> **RECOMMENDATION**: CMS should issue guidance to state Medicaid programs that encourages them to engage in external quality review activities aimed at

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[53] 42 U.S.C. § 1320b-9a (CHIPRA § 401, adds § 1139A(a)(6) of the Social Security Act).
[54] *See* 42 U.S.C. § 1320b-9a(e)(6) (HHS is required to assess and report to Congress every three years the status of efforts to improve child health quality); *See also* KATHLEEN SEBELIUS, REPORT OF THE SECRETARY FOR THE U.S. DEP'T OF HEALTH & HUMAN SERVS., 2013 ANNUAL REPORT ON THE QUALITY OF CARE FOR CHILDREN IN MEDICAID AND CHIP (Sept. 2013).
[55] *See* CMS, 2014 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Dec. 2013).
[56] 42 C.F.R. § 438.364(a)(2); *see also* DAVID MACHLEDT, EXTERNAL QUALITY REVIEW: AN OVERVIEW 3 (June 16, 2014).
[57] 42 C.F.R. § 438.358.
[58] CMS, FINDINGS FROM EXTERNAL QUALITY REVIEW (EQR) TECHNICAL REPORTS FOR THE 2012-2013 REPORTING CYCLE FOR 33 STATES, BY GENERAL TOPIC, FIGURE EQR 2. PERFORMANCE IMPROVEMENT PROJECTS TARGETING CHILDREN OR PREGNANT WOMEN (2013); *see also* MACHLEDT, *supra* note 56 at 2.
[59] CMS, FINDINGS FROM EXTERNAL QUALITY REVIEW (EQR) TECHNICAL REPORTS, 2012-2013 REPORTING CYCLE, TABLE EQR. 5 PERFORMANCE MEASURES FOR MEDICAID AND CHIP MANAGED CARE PLANS THAT EVALUATE CARE PROVIDED TO CHILDREN AND PREGNANT WOMEN (2013); CMS, FIGURE EQR 2 *supra* note 58.

monitoring the delivery of health education and anticipatory guidance that includes age-appropriate sexuality education as described in *Bright Futures*: *Guidelines for Child Health Supervisions of Infants, Children, and Adolescents*.

Conclusion

The health care visit is an obvious but underused place for confidential sexuality education to occur. Health education is a legally required component of the medical screening for all youth eligible for the EPSDT benefit. The American Academy of Pediatrics has announced specific recommendations for age-appropriate health education, including sexuality education, as described in *Bright Futures*. State Medicaid and CHIP programs should adopt these standards to help ensure that low-income children and youth receive the services they need. Advocates should encourage the recommendations found in this issue brief. Sexuality education provided during health care delivery presents the opportunity for personalized counseling and education to meet each individual's needs throughout early childhood and adolescence—but changes must be made to ensure delivery.