Health Advocate

E-Newsletter of the National Health Law Program

Volume 30 October 2014

EPSDT Screening: Including Sexuality Education in Health Education

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Key Resources

NHeLP Issue Brief: Sexuality Education in Health Care Delivery for Medicaid and CHIP-eligible Youth, available here.

American University School of Law/Law Students for Reproductive Justice/NHeLP Webinar: Sexuality Education for Medicaid and CHIP-Youth, available here.

Toward a Healthy Future: Medicaid Early and Periodic Screening, Diagnostic and Treatment Services for Poor Children and Youth, available here.

CMS Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Child Visits, available here.

Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents: Promoting Health Sexual Development and Sexuality, available here.

Coming in November's Health Advocate:

Open Enrollment

Under Medicaid and some Children's Health Insurance Programs (CHIP), youth are eligible to receive the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which includes coverage for medical screening. Federal law requires each screen to include five required components. One component is age-appropriate health education, which should include sexuality education from infancy through age 20 (the age when EPSDT ends). This issue of the Health Advocate will focus on the content of the required medical screening and how these screens can and should include sexuality education.

Overview of EPSDT

EPSDT is a required health benefit for Medicaid-eligible individuals under age 21. For CHIP, states have more discretion in the program's design. States can establish CHIPs as separate programs, Medicaid expansions or a combination of those two options. EPSDT is a required benefit for CHIP-eligible youth when the state's CHIP program is a Medicaid expansion. However, when a state establishes CHIP as a separate program, it may choose whether to include the EPSDT benefit.

EPSDT is an acronym, which gives guidance for the delivery of services:

E- Screening services must begin **early** in the child's life.
P- Screening must be provided at pre-set, **periodic** intervals that meet reasonable standards of medical and dental practice, and must otherwise be provided when the need arises.
S- Vision, hearing, dental and medical **screenings** must be conducted to detect health problems.
D- **Diagnostic testing** must be conducted to follow up on problems or risks identified by a screen.
T- Illnesses or conditions discovered during the screening must receive **treatment**. State Medicaid programs must cover medically necessary services, defined broadly in EPSDT to include services necessary to "correct or ameliorate physical and mental illnesses and conditions."

The Required Content of the Medical Screen

Federal law requires each medical screen to include five components: a comprehensive health and developmental history; an unclothed physical examination; appropriate immunizations; laboratory tests; and health education and anticipatory guidance.

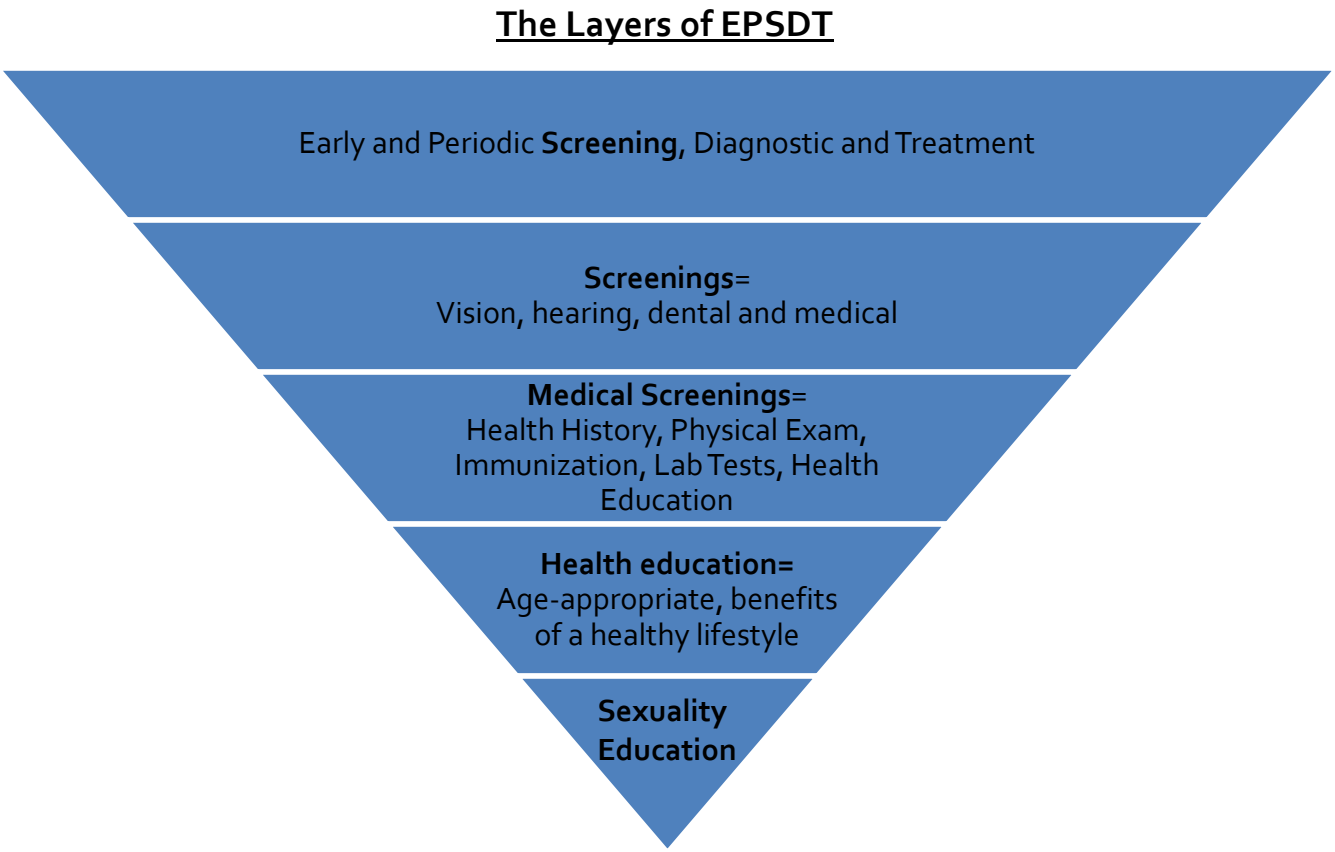
The Health Education Component

Health education and anticipatory guidance are key components of the medical screen. The physical examination should inform the health education to be provided; however, this education must also be preventive, and anticipatory guidance is envisioned to be forward-looking toward the health issues that typically arise for similarly aged youth. Federal guidance, through the State Medicaid Manual, also directs that this health education should cover benefits of a healthy lifestyle and encourage disease prevention.

States are given flexibility to further define the health education component. However, courts have recognized that states must define the EPSDT screening contents (in its instructions to providers) with enough specificity to ensure children and adolescents actually receive the required benefits.

The Need for Sexuality Education

Sexuality education is often not included in health discussions, even though a healthy understanding of sex and sexuality has proven beneficial for youth. Education and counseling have been shown to increase contraception use, reduce adolescent pregnancy rate and reduce STI and HIV contraction. This is consistent with federal requirements that health education must encourage disease prevention and benefits of a healthy lifestyle.



Sexuality education must also be age-appropriate. The American Academy of Pediatrics' *Bright Futures: Guidelines for Child Health Supervision of Infants, Children and Adolescents* recommends that sexuality education be provided to the family and child throughout childhood, beginning at infancy and continuing through adolescence. The idea is that these conversations should not start in adolescence, when studies show most youth are already beginning to have sex; rather, the foundation for healthy sexuality should have been laid since infancy.

Excerpt from *Bright Futures* Guidelines for Age-Appropriate Sexuality Education:

Infancy- Birth to 11 Months: Encourage caretakers to practice proper naming of genitalia.

Early Childhood- 1 to 4 years: Discuss common issues, such as bathing, privacy, toileting, masturbation and sexual play.

Middle Childhood- 5 to 10 years: Teach youth the differences between male and female genitalia, the causes of HIV and STDs, and appropriate forms of intimacy.

Adolescence- 11 to 21 years: Provide the adolescent with information about contraceptives, and counsel against coercive and abusive relationships.

Challenges in Ensuring Provision of Sexuality Education

Too many children and adolescents are, unfortunately, not receiving sexuality education during the EPSDT medical screen. First, the majority of children and adolescents eligible for the EPSDT benefit are reportedly not receiving the required medical screening *at all*, and over half of those who are screened are not receiving complete screenings that include all five components. Specific to health education, over 20 percent of youth are not receiving any health education during their medical screen. Second, youth enrolled in both public and private insurance are not receiving sexuality education during their health maintenance visits. Nearly one-third of physicians observed in a recent study did not discuss sexual health, and when these conversations did occur, the average discussion lasted 36 seconds. There are at least three challenges that impede adequate sexuality education in health care delivery:

1) **Lack of Guidance**:

As noted, health education is largely within states' discretion to define. A recent Centers for Medicare & Medicaid Services (CMS) report, *Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits*, recommends states align their EPSDT policies with *Bright Futures* recommendations. However, detailed guidance on the content of health education, including sexuality education, should be directed from CMS to states and from states to providers.

2) **Lack of Accountability**:

States are required to report to the Secretary of Health and Human Services (HHS) on the number and percentage of eligible youth, by age group, who received medical screens. States must report this information on the Annual EPSDT Participation Report Form CMS 416 (Form 416), and the Form's instructions require that states only report complete medical screens that include all five components. However, Form 416 does not include cells for reporting each component. Furthermore, 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). Currently, there are no measures associated with health education.

3) Low Provider Payments:

Health education is a required component of the medical screen, so Medicaid providers are not reimbursed separately for providing health education. Moreover, child health providers voice persistent concerns that Medicaid reimbursement of medical screening is insufficient. In 2011, payment for evaluation and management services (which would include preventive health visits) was 64 percent behind Medicare rates and even further behind private insurance rates. Research suggests that if payment were not a factor, more than 85 percent of physicians not offering health promotion and health education services would be more interested in providing these services.

Conclusion

EPSDT presents an opportunity for children and adolescents enrolled in Medicaid and some CHIPs to receive periodic comprehensive screenings that include sexuality education. However, the opportunity for providing this education is all too often missed. The problem can be addressed through improved federal guidance, improved state efforts to ensure accountability and increased provider payments that recognize the cost and time associated with providing effective, age-appropriate health education as part of a comprehensive medical screen.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

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