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State Recommendations to Include Sexuality Education in Health Care Delivery

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Education and counseling have been shown to increase contraception use, allow youth to avoid unintended pregnancy, and increase knowledge regarding sexual health.[2] While medical screenings for youth enrolled in Medicaid are required to include health education and anticipatory guidance, states are allowed to define what is included in this health education. Unfortunately, in some states, medical screenings have not sufficiently included sexuality education. According to a recent nine-state survey by the Department of Health and Human Services' (HHS) Office of Inspector General, 60 percent of Medicaid-enrolled children and adolescents who received medical screenings did not receive a screening that included all necessary components. This includes the 20 percent of youth screened who did not receive any health education or anticipatory guidance, as required.[3] This issue brief outlines recommendations that advocates can use to encourage their states to include sexuality education in health care delivery.[4]

The Early and Periodic Screening, Diagnostic and Treatment Benefit Requirements

Most Medicaid-eligible children and adolescents under 21 years old are entitled to receive Early and Periodic Screening, Diagnostic and Treatment benefits (EPSDT).[5] 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.[6]

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[2] Inst. of Med., *Adolescent Health Services: Missing Opportunities* 158,160 (2009).
[3] 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 15-16 (May 2010).
[4] This brief is a companion to the NHeLP issue brief entitled *Sexuality Education in Health Care Delivery for Medicaid and CHIP-eligible Youth*, which provides in-depth legal analysis of Medicaid screening requirements, outlines the need to include sexuality education in health care delivery, and offers recommendations that the Centers for Medicare & Medicaid Services (CMS) could adopt to increase sexuality education delivery. This brief also compliments recent CMS stakeholder guides, *Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits* and *EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*.
[5] 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).
[6] *Id.* at § 1396d(r); *see also* CMS, STATE MEDICAID MANUAL § 5122.

CMS has issued controlling guidance to states in the *State Medicaid Manual* 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.[7]

States are to set the content and periodicity for these screens in consultation with child health organizations, such as the American Academy of Pediatrics.[8] The American Academy of Pediatrics' *Bright Futures*: *Guidelines for Child Health Supervision of Infants, Children, and Adolescents* recommends that medical screenings include "confidential, culturally sensitive and nonjudgmental" sexuality education and counseling to children, adolescents, and their caretakers.[9] *Bright Futures* guidelines include providing sexuality education throughout the youth's lifespan from birth through twenty-one years old.

Recommendations to States

As noted, many states are not currently providing adequate EPSDT screenings, and in screenings that are provided, health education is not being provided to all participants.[10] Further, among adolescents receiving care—both within the Medicaid program and outside of the Medicaid program—health education has not adequately included sexuality education. For instance, an observational study published last year noted that among adolescents between 12 and 17 years old, nearly one-third did not discuss sexual health with their patients.[11] State Medicaid program changes can help encourage the delivery of sexuality education. Recommendations that advocates can encourage states to adopt are listed here:

1. **Ensure Providers Have Clear Guidance on Sexuality Education Content**

As noted above, health education is a required component of the EPSDT medical screening. The federal guidance given for health education is broad to include benefits of a healthy lifestyle and encourage disease prevention; thus, states are largely able to decide the information that must be included in the health education component.[12] In general, most states do not give providers detailed guidance for EPSDT health education or anticipatory guidance.[13] Most states incorporate the *Bright Futures*

[7] CMS, STATE MEDICAID MANUAL § 5123.2(E).
[8] CMS, STATE MEDICAID MANUAL § 5123.1(A).
[9] AM. ACAD. OF PEDIATRICS, BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS 174 (2008).
[10] U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 3 at 15-16.
[11] Stewart Alexander, et. al., *Sexuality Talk During Adolescent Health Maintenance Visits,* 168(2) JAMA 163-64 (Fed. 2014).
[12] CMS, STATE MEDICAID MANUAL § 5123.2.
[13] Nat'l Alliance to Advance Adolescent Health, *Preliminary Thoughts on Restructuring Medicaid to Promote Adolescents Health* 3-4 (Jan. 2007); *see also* Inst. of Med., *Adolescent Health Services: Missing Opportunities* 278 (2009).

periodicity schedule, which indicates how often visits should occur, but the *Bright Futures* guidelines, which indicate what should be included in the substance of those visits, have been far less incorporated.[14] Fewer states require providers to deliver the components of the medical screening according to *Bright Futures* guidelines.

State guidance to providers enrolled in the Medicaid program can be communicated through state provider manuals or state transmittals. Also, if state Medicaid enrollees receive care through managed care organizations (MCOs), contracts between the state and MCO can outline responsibilities and expectations for care delivery. MCOs, in turn, convey these requirements to providers in their plan networks.

> **RECOMMENDATION***:* The state Medicaid program should instruct providers treating youth enrolled in Medicaid and require MCOs to instruct providers that a complete screening must include sexuality education described in *Bright Futures Guidelines for Child Health Supervisions of Infants, Children, and Adolescents*.

2. Increase Providers' Payment to Account for Time to Treat Adolescents

Providers are more likely to sustain quality improvement interventions when they are being reimbursed for those services.[15] Lack of reimbursement for counseling services impedes providers' willingness and ability to provide the required health education.[16] This is particularly problematic for children and adolescents in need of sexuality education. If payment were not a factor, more than 85 percent of physicians not offering health education services expressed an interest in providing these services.[17]

Medicaid payments to providers are usually lower than the fees Medicare and private insurance pay. 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.[18] Providers are more likely to provide health care when they are being reimbursed for the services. States with lower reimbursement rates tend to have lower provider participation.[19]

Unlike the other EPSDT screening components, providers may not be reimbursed for health education provided separate from the screening components.[20] However, states

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[14] Nat'l Alliance to Advance Adolescents Health, *supra* note 12 at 2.
[15] Inst. of Med, *Child and Adolescent Health and Health Care Quality: Measuring What Matters* 10 (2009).
[16] Inst. of Med., *Adolescent Health Services: Missing Opportunities* 13, 143-147 (2009).
[17] Nat'l Alliance to Advance Adolescents Health, *Pediatricians Interest in Expanding Services and Making Practice Changes to Improve Care for Adolescents* 2 (2009).
[18] Am. Acad. of Pediatrics, *Medicaid Policy Statement*, 131 JOUR. OF THE AM. ACAD. OF PEDIATRICS 5 (May 2013).
[19] Am. Acad. of Pediatrics, *Implementation Principles and Strategies for the State Children's Health Insurance Program*, 107 JOUR. OF THE AM. ACAD. OF PEDIATRICS 5 (May 2001).
[20] Letter Number 92-12 from Thomas Wallner, Associate Regional Administrator, Dep't of Health & Hum. Servs. To Region X, Title XIX State Agency Subject: Clarifying Issues Related to Early and Periodic

can offer incentives for providers to deliver health education during a screening. *Paving the Road to Good Health* suggests that states align "reimbursement level to account for the time and complexity of adolescent well-care rates."[21]

> **RECOMMENDATION**: Provider payment fee schedule and MCO payments to network providers should be increased for Medicaid providers treating adolescents to account for the complex needs of adolescents and to encourage providers to deliver the comprehensive sexuality education as described in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*.

3. Ensure Preventive Visits Include Sexuality Education

CMS has set an annual 80 percent participation goal for the states, calculated based upon the number of eligible individuals who receive at least one periodic screening.[22] The Secretary of the Department of Health and Human Services uses the Annual EPSDT Participation Report Form CMS-416 to obtain information on states' EPSDT performance. States report the numbers and percentages of eligible children and youth by age grouping who received certain EPSDT services, including medical screens. [23] The instructions for completing Form 416 specify that states can only report complete medical screens, which means 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).[24] Among states where beneficiaries receive care through MCOs, states have adopted policies to ensure all MCOs deliver the required number of EPSDT screenings. For example, Tennessee requires MCOs that have a screening rate below 90 percent to conduct calls to all new members under 21 years old notifying them of the Medicaid services available.[25] In Georgia, MCOs are required monthly to supply providers with a list of Medicaid-eligible children and adolescents who have not met the EPSDT screening requirements or had a health visit within 120 days of enrolling into the

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Screening and Diagnosis and Treatment (EPSDT) Services (Dec. 10, 1991) (stating providers may still receive reimbursement when the medical screening components are delivered individually and different providers may deliver each component, except health education and anticipatory guidance cannot be delivered on its own); Letter from Director Medicaid Bureau to Regional Administrator Dallas, Subject: Clarifying Issues Related to the Early and Periodic Screening, Diagnostic and Treatment Program (1991) (stating "health education or anticipatory guidance is an essential component of every health care encounter, but not a separable service").

[21] CMS, PAVING THE ROAD TO GOOD HEALTH: INCREASING MEDICAID ADOLESCENT WELL-CARE VISITS 11 (Feb. 2014).

[22] CMS, STATE MEDICAID MANUAL § 5360(B).

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

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

[25] *See* Contract Risk Agreement between the State of Tennessee, d.b.a. TennCare and Amerigroup Tennessee, Inc. 2.7.6.2.2.1, *available at* http://www.sec.gov/Archives/edgar/data/1064863/000095012309057587/w76069exv10w4.htm. *See also* Nat'l Academy for State Health Policy, Initiatives to Improve Access (Dec. 10, 2013), http://www.nashp.org/improve-access/.

program. The MCO or provider must then contact the youth's family to schedule a screening.[26]

> **RECOMMENDATION**: State Medicaid programs should require MCOs to conduct additional outreach to Medicaid-eligible youth under 21 years old if the MCOs participation rate does not meet the required 80 percenter threshold.

For all states where Medicaid enrollees receive care through an MCO or prepaid inpatient health plan (PIHP), the state must conduct independent external quality review (EQR) to monitor quality, timeliness, and accessibility in the delivery of care.[27] 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).[28] States choose PIPs topics and set applicable quality measures to be monitored.[29] These have included projects and measures related to the adolescent well-care visit; however, recent CMS findings note only two states use performance measures and PIPs that expressly monitor the delivery of EPSDT medical screens.[30]

> **RECOMMENDATION**: Medicaid programs should engage in external quality review activities aimed at monitoring the delivery of health education and anticipatory guidance that includes age-appropriate sexuality education as described in *Bright Futures*: *Guidelines for Health Supervision of Infants, Children, and Adolescents*.

4. Encourage Adolescents to Attend Visits with Enhanced Confidentiality and Incentives

Adolescents are most likely to attend care visits when they are able to see a provider privately, and the adolescents are ensured that discussions with their providers will be kept in confidence. This is particularly true when an adolescent is seeking reproductive health services and discussing sexual health and history with his or her provider.

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[26] *See* Amended and Restated Contract between the Georgia Department of Community Health and Management Organization for Provision of Services to Georgia Families 4.7.2.4, *available at* https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/site_page/CMO_DCH%20Contract.pdf; *see also* Nat'l Academy for State Health Policy, *supra* note 25.

[27] 42 C.F.R. § 438.364(a)(2); *see also* David Machledt, Nat'l Health Law Program, *External Quality Review: An Overview* 3 (June 16, 2014). At this writing, CMS has issued a proposed regulation to require pre-paid ambulatory health plans (PAHPs) to also conduct external quality reviews. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability, 80 Fed. Reg. 31,149 (to be codified at 42 CFR Parts 431, 433, 438, 440, 457, & 495).

[28] 42 C.F.R. § 438.358.

[29] 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 27 at 2.

[30] 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 29.

Seventy percent of adolescents who sought family planning services stated they would not seek those services if their parents would be notified.[31] Further, in a national survey of adolescents between the ages of 12 to 17, the most commonly cited barrier to STI testing was concern that "their parents will find out they are having sex."[32]

There are some federal protections governing confidentiality, but they are not absolute. The Health Insurance Portability and Accountability Act (HIPAA) privacy rule generally allows a parent or guardian who is legally considered to have authority to act on behalf of a minor to access his or her minor dependent's medical records, unless an additional or stricter state law prohibits this access or the health care is provided at the direction of the court.[33] Parents and guardians are able to assent to confidentiality between a provider and the adolescents; and if the parent does assent to such an agreement, then the provider must uphold this agreement.[34] HIPAA prohibits parents or guardians from accessing minor's health records when a minor can solely consent to care for a particular service.[35]

Other federal privacy protections include the Family Educational Rights and Privacy Act (FERPA), which governs the privacy of health information in school records. FERPA allows parents or "eligible" students (students over 18 years old) to access health information, and parents and eligible students must consent to most disclosures.[36] Generally, FERPA, instead of HIPAA's privacy rule, will apply to school-based health centers operated in elementary, secondary, and post-secondary schools.[37] FERPA applies to "education records" in covered education agencies or institutions. Education records are broadly defined to include records the school maintains.[38] At post-secondary institutions, records that are maintained and shared solely for treatment purposes are considered treatment records, and are not subject to FERPA, but are subject to the HIPAA privacy rule.[39] An educational agency or institution is considered

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[31] Abigail English, et. al., Guttmacher Inst., *Confidentiality for Individuals Insured as Dependents: A Review of State Laws and Policies* 3 (July 2012).
[32] Kaiser Fam. Found., SexSmarts Survey: Teens and Sexual Health Communication, http://kff.org/womens-health-policy/poll-finding/sexsmarts-survey-teens-and-sexual-health-communication/ (last visited July 10, 2015); English, *supra* note 31.
[33] 45 C.F.R. § 161.101-552; 45 C.F.R. §§ 164.102-106; 45 C.F.R. §§ 164.500-534.
[34] 45 C.F.R. § 164.502.
[35] 45 C.F.R. § 164.502; *See also* Nat'l Institute for Health Care Management, Protecting Confidential Health Services for Adolescents & Young Adults; Strategies & Considerations for Health Plans (May 2011).
[36] *See* 20 U.S.C. § 1232g; 34 C.F.R. Prt. 99 (FERPA applies to all educational institutions receiving federal education funding). *See also* Jane Hyatt Thorpe & Sara Rosenbaum, *Understanding the Interaction between EPSDT and Federal Health Information Privacy and Confidentiality Laws* 3 (Sept. 2013).
[37] U.S. DEP'T OF HEALTH & HUM. SERVS. & U.S. DEP'T OF EDUCATION, JOINT GUIDANCE ON THE APPLICATION OF FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA) AND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) TO STUDENT HEALTH RECORDS 3-4, 6-7 (2008), *available at* http://www2.ed.gov/policy/gen/guid/fpco/doc/ferpa-hipaa-guidance.pdf.
[38] 34 C.F.R. § 99.3.
[39] *Id.* It is worth noting that if a school that meets the definition of a HIPAA covered entity uses a student's health information for purposes other than treatment, such as to bill Medicaid, the transaction is subject to HIPAA transaction requirements. However, for privacy concerns, the school is subject to FERPA

covered under FERPA if it receives federal education funding. The school-based health center must also be acting under the direction of the school—*i.e*. the health center has an agreement with the school to follow the school's directions. Otherwise, HIPAA's privacy rule will apply to the individual's health records.[40]

The level of confidentiality afforded a minor will largely depend on state law, including states statutes, regulations, and court cases to the extent they allow a minor to consent to their own care without parental notice or consent. A minor's ability to consent to care will depend on the minor's status (emancipated or married minors are often able to consent to their own care), and will vary by state depending on the service. For instance, every state and the District of Columbia allows minors to consent to STI screenings and treatment, though five of these states restrict this permission to individuals over 14 years old. Twenty-six states and the District of Columbia permit youth to consent to contraceptive services and supplies. Thirty-two states and the District of Columbia allow all individuals under the age of 18 years old to consent to prenatal care, and most states permit minors with children to consent to services for his or her own children. Only two states and the District of Columbia allow youth to consent to an abortion without parental notice or consent.[41]

For adolescents receiving Medicaid coverage through a MCO, the insurance contracts and policies will also affect confidentiality. Confidentiality issues can develop when states or MCOs issue explanations of benefits (EOBs) and denial of claims. EOBs explain the services a patient has received following his or her provider visit. A recent survey found that most state Medicaid agencies do not require an EOB to be sent home after each visit, although it still remains a widespread practice among insurers.[42] MCOs are required to send denial of claim notices to inform Medicaid beneficiaries the reason the program is not covering a sought service.[43] Such notices are important consumer protection requirements to afford adequate due process. However, a denial notice that lists the services received has the potential to inadvertently share information that adolescents do not want shared.

States have adopted various methods to protect the confidentiality of health services. Nebraska specifies that the recipient could be the insured, the beneficiary, the legal

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and not HIPAA privacy rule. U.S. DEP'T OF HEALTH & HUM. SERVS. & U.S. DEP'T OF EDUCATION, *supra* note 37 at 4.

[40] 20 U.S.C. § 1232g(a)(4); *See* Thorpe & Rosenbaum, *supra* note 36 at 15.

[41] Guttmacher Inst., *State Policies in Brief: An Overview of Minors' Consent Law* 2 (April 1, 2015). In some states, a provider is permitted or is required to contact a minor's parent for certain services, even if the minor is able to consent to services. *E.g.* CAL. FAM. CODE § 6928.

[42] Kathleen Tebb, et. al., University of California-San Francisco, ICF International & Mount Sinai Adolescent Health Center, *Protecting Adolescent Confidentiality Under Health Care Reform: The Special Case Regarding Explanation of Benefits* 3 (June 2014); *See also* Harriet Fox & Stephanie Limb, Nat'l Alliance to Advance Adolescent Health, State Policies Affecting the Assurance of Confidential Care for Adolescents 3 (April 2008) (stating three of the 42 states included in the survey required Medicaid MCOs to send EOBs home).

[43] 42 C.F.R. § 438.210(c); CMS, Notice and Forms, CMS.gov, https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices.html.

representative, or an immediate family member.[44] When the adolescent is able to consent to a service, Washington prohibits the state from mailing appointment notices, calling the home to confirm appointment, or mailing a bill or explanation of benefits without the adolescent's permission.[45]

> **RECOMMENDATION**: States should develop policies that allow adolescents to protect their privacy when they are solely able to consent to reproductive health services. Such policies should include asking the adolescent how information regarding the care received should be delivered.

In addition to enhancing confidential services, states can adopt other measures to encourage adolescents to get health education. CMS permits Medicaid managed care plans to use administrative funds from their capitation payments to offer incentives for adolescents to attend preventive health visits. In *Paving the Road to Good Health*, CMS suggests that incentives could include non-cash incentives, such as free movie tickets, gift cards, or raffle tickets for larger prizes.[46] Note, however, that states offering service under a fee for service system are not able to receive federal financial participation for incentives offered to beneficiaries. The Community Health Network of Connecticut, a non-profit federally qualified health center, offered free movie tickets to patients for both scheduling and keeping appointments. In one year in Connecticut, adolescent preventive visits participation rate increased 12 percent, and 19 to 20 years olds participation rates increased over 22 percent.[47]

> **RECOMMENDATION**: Medicaid MCOs should offer adolescents non-cash incentives to schedule and keep annual preventive care visits.

5. Increase Adolescents' Access to Preventive Care Through School-Based Health Centers

School-based health centers offer a convenient venue for adolescents to receive a range of preventive services, including reproductive health education. School-based health centers can provide a complete range of health services and most often are located on school campuses, but they are often operated in partnership with community health centers, hospitals, or local health departments. There are nearly 2,000 school-based health centers operating in the United States; however, the majority of these clinics are located in the Northeast.[48] These centers usually focus on prevention and counseling students to form healthy habits.[49] School-based health centers

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[44] Abigail English, et. al., Guttmacher Inst., *Confidentiality for Individuals Insured as Dependents: A Review of State Law and Policies* 16 (July 2012).
[45] WASH. REV. CODE § 284-04-515(3)(6).
[46] CMS, *supra* note 6 at 12.
[47] Community Health Network of Connecticut, http://www.chnct.org/ (last visited July 10, 2015).
[48] School-based Health Alliance, *2010-11 Census Report of School-based Health Centers*, *available at* http://www.sbh4all.org/atf/cf/%7BB241D183-DA6F-443F-9588-3230D027D8DB%7D/2010-11%20Census%20Report%20Final.pdf.
[49] U.S. Dep't of Health & Hum. Servs., Health Resources & Servs. Administration, School-based Health Centers, http://www.hrsa.gov/ourstories/schoolhealthcenters/ (last visited May 28, 2015).

predominately deliver care to students in grades 6 to 12, and given that nearly half of adolescents report being sexually active, this is a key time to deliver sexuality education.[50] The services provided are decided on a local level, and the range of reproductive health services varies. Sixty-five percent of centers offer contraceptive counseling, 72 percent offer sexual orientation counseling, 82 percent offer abstinence counseling, and 77 percent discuss relationship violence.[51] The centers can also contribute to reducing racial and ethnic health disparities. The majority of students receiving care are students of color and low-income. Around 80 percent of school-based health centers are located in public schools, and over half are located in urban areas. [52]

In December 2014, CMS issued a Dear State Medicaid Director letter to clarify that states can receive federal financial participation for qualifying services delivered at a school-based health center, even if the service is generally offered without cost.[53] This guidance reverses previous CMS policy that Medicaid generally would not pay for services that were available without cost to recipients.[54] This guidance also clarifies that CMS does not consider schools legally liable third parties that must be billed before seeking payment from Medicaid. The Medicaid statute requires providers to bill legally liable third parties before billing Medicaid. The letter notes that states are not foreclosed from requiring schools under state law to pay for services when other payers are available.[55]

School-based health centers must meet general Medicaid requirements to receive reimbursement for services. The service must be a covered service listed under the Social Security Act § 1905(a) or available under the EPSDT benefit, the delivering provider must be a Medicaid-participating provider, and the individual must be a Medicaid beneficiary.[56] Medicaid billing does not have a particular code for school-

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[50] Heather Boonstra, Guttmacher Inst., *Meeting the Sexual and Reproductive Health Needs of Adolescents in School-based health Centers* 2-3 (2015); *See also* 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.

[51] Heather Boonstra, *supra* note 50 at 4.

[52] *Id.* at 2; School-Based Health Alliance, *supra* note 48.

[53] CMS, *Dear State Medicaid Director Letter* (Dec. 15, 2014) (regarding Medicaid payment for services provided without charge).

[54] *See* CMS, MEDICAID AND SCHOOL HEALTH: A TECHNICAL ASSISTANCE GUIDE (AUGUST 1997); *See also* MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING GUIDE (2003). This new guidance comes after the policy against Medicaid not covering services offered to the public for free was challenged in 2004. HHS Departmental Appeals Board concluded that this policy was not an interpretation of the Medicaid statute or subsequent, regulations. HHS DEPARTMENTAL APPEALS BOARD, DEC. NO. 1924 (2004), reconsidered in Ruling 2005-1 (2005).

[55] CMS, *Dear State Medicaid Director Letter* 3 (Dec. 15, 2014) (regarding Medicaid payment for services provided without charge); *See* 42 U.S.C. § 1396a(a)(25) (stating the State or local agency administering the Medicaid program must take reasonable measures to seek payment from all third parties legally liable for payment of care or services), *But see* 42 U.S.C. § 1396b(c) (stating Medicaid is the primary payer for Medicaid-covered services for children with disabilities provided under an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) under the Individuals with Disabilities Education Act (IDEA) though payment should still be sought from third-party insurers).

[56] 42 U.S.C. § 1396a(a).

based health centers. A state codes for services provided in the school-based health centers in terms of the specific service that will be provided.

> **RECOMMENDATION***:* State Medicaid programs can partner with educational institutions to increase the number of school-based health centers throughout the United States and in turn, increase access to reproductive health care. If the state determines that it needs to submit a state plan amendment to implement the CMS December 2014 free care policy, it should do so immediately.

Conclusion

Adolescents are not receiving the necessary and required medical screening. When adolescents are receiving these screenings, they often do not adequately include sexuality education. The provider's office is an opportunity to provide personalized, confidential counseling, and guidance to adolescents based on their individual needs. States and MCOs play an important role in ensuring that adolescents enrolled in Medicaid receive a complete Medicaid screening. State advocates can use the recommendations outlined in this issue brief as a starting point to encourage delivery of sexuality education.