The National Association of Pediatric Nurse Practitioners (NAPNAP) Comment on Medicaid and CHIP Program Legislative Changes to Provide Quality of Care to Children

RE: CMS-2480-NC

Thank you for the opportunity to provide comment for your consideration in developing Secretary Sebelius' recommendations for legislative changes to improve the quality of care provided to children under Medicaid (Title XIX) and the Children's Health Insurance Program (Title XXI) of the Social Security Act. As the President of NAPNAP, I am writing to you on behalf of the more than 7,500 pediatric nurse practitioners (PNPs) who provide primary care, acute care, care coordination, and pediatric specialty care to children enrolled in Medicaid and CHIP programs. Overall, NAPNAP is very supportive of the comprehensive list of evidence-based, core child health quality measures developed as part of this legislation as well as the emphasis that has been given to identifying and eliminating racial and ethnic disparities in child health. NAPNAP also strongly supports provisions in the law that call for obesity prevention programs and funding for obesity prevention demonstration projects. As an organization, NAPNAP believes that the childhood obesity epidemic and its related current and future co-morbidities present significant strain and financial threat to our nation's well-being.

Specifically, with regard to recommendations for legislative changes to improve the quality of child health under Titles XIX and XXI of the Social Security Act, NAPNAP believes that it is essential to:

1) Continue to improve processes that encourage enrollment, renewal, and retention of Medicaid or CHIP coverage for children and youth;
2) Ensure that expanded Medicaid or CHIP coverage translates into actual improved access to safe, high-quality, pediatric health and dental care for children including those with special health care needs;
3) Use provider-inclusive language in all Medicaid and CHIP statutes, rules, and regulations to make certain enrollees have access to the health care provider of their choice; and
4) Provide survey and results-reporting mechanisms that are inclusive of nurse practitioner provided care as well as physician care.

Improvement in Processes That Encourage Enrollment, Renewal, and Retention

NAPNAP members applaud improvements in processes for enrollment, renewal and retention of coverage for children noted in Sections 211, 401(a) and 402 of the Children's Health Insurance Program Reauthorization Act of 2009. The emphasis on a 12-month duration of care coverage for children is especially welcome. As PNPs have witnessed first hand, care disruptions, delays in timely treatments, and sometimes unnecessary duplication of services or shuffling between various managed care assigned providers occur when children's eligibility

status is continually interrupted by parents' precarious, off-and-on employment patterns and difficult to navigate eligibility waiting periods. Assuring a 12-month coverage period is important to children receiving continuous, safe, quality care.

Section 402 describes reporting requirements for the states as to their processes for enrollment, renewal, and retention of Medicaid and CHIP coverage for children. We believe that tracking increases in enrollment and reasons for denial of coverage, as well as requiring standardization of reporting procedures at the state level will provide important data that will be useful in establishing best practices for expanding and expediting coverage.

Ensuring that Medicaid or CHIP Coverage Translates into Children's Improved Access to Care

NAPNAP members are concerned about statutory and regulatory barriers that often prevent children and their families from being able to access highly skilled, high-quality primary care services provided by pediatric nurse practitioners (PNPs). For example, current reimbursement language in the Patient Protection and Affordable Care Act (PPACA) allows for 100% reimbursement for Medicaid and CHIP-covered primary care services when delivered by a primary care physician but calls for a reduction to 85% for the same services rendered by a nurse practitioner. This statutory change in reimbursement has caused some NPs to lose their jobs because clinics cannot afford the 15% reduction in reimbursement for NP services. PNPs practice advanced practice nursing—a science and set of skills that is focused on health and wellbeing, primary prevention and health promotion. In addition to courses in physical assessment, advanced pathophysiology, pharmacology, and pharmacotherpeutics, PNPs are educated in child growth and development, nutrition, behavioral management, child safety, coordination of care across care continuums, and parent-child relationship, making PNPs particularly well-suited to provide comprehensive primary care services for children and their families, as well as management and care coordination for children with special health care needs. NAPNAP believes reimbursement should be based on quality services rendered, not the professional designation of the person providing the services. At a time when our nation is threatened by serious shortages of primary care providers it seems counterproductive to provide health care organizations with financial disincentives for hiring and utilizing NPs.

Section 401(a) also allows for demonstration projects for new models of care, such as health care/medical home models of comprehensive, coordinated care for children with special health care needs. NAPNAP is very concerned that language in the PPACA requires physician involvement in health care/medical home models of care. This type of exclusionary language rules out the ability of an advanced practice nurse managed clinic from being able to provide a health care/medical home model of care for its patients. Many nurse-managed clinics in the U.S. serve diverse Medicaid and CHIP populations. We believe that all children enrolled in Medicaid and CHIP should have access to health care/medical home models of care, regardless of whether the care is delivered by NPs or physicians.

Section 402 provides for a GAO study and report regarding access of children to primary and specialty services. We strongly support this provision. NAPNAP is concerned about the geographic variability in pediatric provider access, especially for children with special health care needs who live in rural or impoverished urban areas. Equally concerning is the difficulty in

finding dental providers willing to serve children enrolled in Medicaid and CHIP. In particular, there is a scarcity of dental providers skilled in or willing to serve children with special health care needs who may require extensive dental work under general anesthesia. Given dental problems such as toothaches and dental abscesses are a top reason for school absence in the United States, improving access to dental care should be a priority for Medicaid and CHIP programs.

Use of Provider-Inclusive Statutory and Regulatory Language

NAPNAP is pleased to see scattered examples of provider-inclusive language in Section 402(a) such as *pediatric health providers* and *pediatric health professionals.* However, NAPNAP strongly encourages consistent use of provider-inclusive language throughout the legislative language. It is also important that provider-inclusive language be used as CMS and states draft regulatory language for implementing Medicaid and CHIP at the state level. In particular, NAPNAP supports language explicitly including NPs and nurse-managed clinics as designated providers of primary care as well as new, demonstration models of care such as health care/medical homes.

Inclusion of Nurse Practitioner Care in Survey/Results Reporting

While NAPNAP strongly supports measuring and reporting child health outcomes on a state by state basis, NAPNAP's members are very concerned the HEDIS CAHPS 4.0 has been recommended as the instrument for surveying family experience of care for children and children with special health care needs. In its current iteration, the HEDIS CAHPS 4.0 asks questions excluding nurse practitioner delivered care. For example, there is a doctor-specific heading for a number of questions relating to "How well doctors communicate". All of the questions in this section refer to how the "doctor" communicated, provided important information to help the family make a health care decision, or returned a phone call. Using a physician-centric instrument will exclude nurse practitioner care outcomes from being measured and reported. NAPNAP strongly advocates for either using a more provider-inclusive survey instrument or revising the HEDIS CAHPS 4.0 instrument so questions are asked about "your pediatric health provider" or "your doctor or nurse practitioner" versus "the doctor". NAPNAP strongly encourages use of provider-inclusive surveys for measuring all health outcomes including family experience with care. Additionally, NAPNAP believes that there should be a strong legislative mandate that states collect outcome measures for child health care provided by nurse practitioners as well as physicians.

Sincerely,

Jean Martin, PhD, RN, CPNP
President, NAPNAP