NAPNAP 20 Brace Road, Suite 200, Cherry Hill, NJ 08034-2634 856-857-9700 F. 856-857-1600 www.napnap.org

Testimony to the Medicaid Commission
U.S. Department of Health and Human Services

August 17, 2005

Governor Sundquist, Governor King, Medicaid Commissioners –

Thank you for the opportunity to testify before the Medicaid Commission today. My name is Amy Demske and I am the Washington Representative for the National Association of Pediatric Nurse Practitioners (NAPNAP).[1]

NAPNAP represents approximately 7,000 members, as the professional association for pediatric nurse practitioners and other advanced practice nurses who care for children. Pediatric nurse practitioners are registered nurses with advanced education and clinical experience and provide primary, acute, and specialty care services to children from birth to 21 years of age.

We come before you today because we are concerned that the National Governors Association (NGA) proposal on cost-sharing and benefit package flexibility – if adopted – would negatively alter the framework of the Medicaid program, specifically with regard to pregnant women and children. According to the NGA proposal[2], "*…states (would) have broad discretion to establish any form of premium, deductible, or co-pay for all populations, for all services, and could make them enforceable.*"

Medicaid law has always prohibited states from imposing cost-sharing requirements on services provided to eligible children. Eligible pregnant women are provided with the same protections for health care related to a pregnancy. In addition to these protections, current law also prohibits Medicaid cost-sharing requirements for all emergency and family planning services. NAPNAP is concerned that if the NGA proposal is adopted, fewer Medicaid-eligible children, adolescents and pregnant women will seek preventative and primary care services – health care that is critical during the developmental stages of life.

The NGA proposal recommends that states be given greater flexibility to decide who gets what Medicaid benefits. According to the NGA[3], "*Medicaid reform should include the ability to offer a different level of benefits, using S-CHIP as a model, to certain Medicaid beneficiaries, such as those for whom Medicaid serves as a traditional health insurance program.*" If Congress adopts the NGA proposal, states may opt to make these changes strictly for budgetary reasons. These changes could signal the end of many vital services for children – such as Early and Periodic

---

[1] The President of NAPNAP is Jo Ann Serota, MSN, RN and the Health Policy Chair is Karen Duderstadt, MS, CPNP.

[2] Medicaid Reform: A Preliminary Report from the National Governors Association, June 15, 2005, pages 5-6.

[3] Medicaid Reform: A Preliminary Report from the National Governors Association, June 15, 2005, page 6.

Screening, Diagnosis, and Treatment (EPSDT) services provided to children under the age of 21. EPSDT was established as a mandatory service in 1967 and provides preventative services and treatment to children enrolled in Medicaid. Under EPSDT, children receive screening, vision, dental and hearing services.

NAPNAP urges the Medicaid Commission not to look to the State Children's Health Insurance Program (SCHIP) as a guidepost for Medicaid benefit and coverage decisions, as suggested in the NGA proposal. SCHIP participants have higher incomes than Medicaid beneficiaries, and unlike SCHIP, the federal government has long considered Medicaid an entitlement for mandatory low-income populations. Since 1997, states have modeled their SCHIP benefit packages on a variety of models – no one is alike. Some closely mirror their state's Medicaid package, and others more closely resemble a commercial health insurance or state employee plan health plan. Like Medicaid, SCHIP does not impose co-payments for preventative health care services. If States were able to impose co-payments on Medicaid children, it would unfairly expose a lower-income population to payments not currently required by the SCHIP program.

If the NGA proposal is adopted, Medicaid beneficiaries could be exposed to cost-sharing expenses of up to 5 percent of the family's income (for families with incomes *below* 150 percent of the poverty line) and 7.5 percent of income for families above 150 percent of the poverty line. This means that a family of three with a family income of $16,000[4], could be required to pay $800 in co-payments, premiums, and deductibles over a year's time.

States currently have a number of methods for managing the care they provide to Medicaid beneficiaries. Many states are using managed care to coordinate and deliver care. States are also enjoying increased flexibility to "waive" federal Medicaid rules through the use of Section 1115 demonstration projects.

We hope the Medicaid Commission will protect Medicaid's long-standing commitment to low-income pregnant women and children and maintain the federal protections that provide vulnerable populations with access to primary and preventative care services.

[4] Federal Poverty Levels: Federal Register, Volume 70, Number 33, February 18, 2005, pages 8373-8375.