



Children's Special Health Services (CSHS) Medical Advisory Council Meeting

Comfort Suites – Meeting Room F
Saturday – May 1, 2010
8:30 a.m. to 12:00 noon CDT

Present from the ND Department of Health (DoH): Terry Dwelle, MD, State Health Officer and John Baird, MD, Special Populations Section Chief, North Dakota Department of Health.

Present from the Children's Special Health Services Division (CSHS): Tamara Gallup-Millner, Division Director; Joan Connell, MD, Medical Director; Devaiah Muccatira, SSDI Program Coordinator; Sue Burns, Program Administrator; Tricia Kiefer, Program Administrator; Melissa Evans, Eligibility & Claims Administrator; Denise Kirsch, Office Assistant; Diane Bruley, Administrative Assistant; and Alicia Phillips, Administrative Assistant.

Present as Appointed Medical Advisory Council Members: Thomas D. Carver, MD, Heidi Goldstein, MD, Marcus Fiechtner, MD, Wendy Fix for John Warford Jr., DDS, Robert Kemp, MD, Myra Quanrud, MD, John Martsof, MD, William Klava, MD, Jacqueline Quisno, MD, and Ellen Feldman, MD.

Present from the ND Department of Human Services: Maggie Anderson, Director, Medical Services Division, North Dakota Department of Human Services, Gary Betting, MD, Medical Services Division Medical Consultant and Joanne Luger, DDS, Medical Services Division Dental Consultant.

Present as Family Advisory Council Designee: Evelyn Klimpel.

Absent: Bruce Levi, North Dakota Medical Association Executive Director.

WELCOME AND INTRODUCTIONS

Tamara Gallup-Millner gave a warm welcome and thanked the Medical Advisory Council members for their assistance during the past year. Introductions were made and the agenda reviewed.

OPENING REMARKS

Terry Dwelle, MD, State Health Officer and John Baird, MD, Special Populations Section Chief, thanked Children's Special Health Services staff for the leadership provided on behalf of the children with special health-care needs population and relayed appreciation to all members for attending the meeting.

Dr. Dwelle highlighted priority areas for the MCH population that had been identified through a recent needs assessment process for the Title V MCH Block Grant. He also relayed that health care reform creates an opportunity to deal with a variety of health issues including access to care, prevention and wellness, home visiting programs, childhood obesity, immunization, oral health, school health centers, medical home, health disparities, and data.

CSHS DIVISION OVERVIEW AND UPDATE

Tamara Gallup-Millner relayed that 2010 is the 75th anniversary of Title V of the Social Security Act. It's a year to recognize and celebrate the progress made in maternal and child health and the evolution of CSHS from the original Crippled Children's Program in 1935, to the present, where the Division's mission to improve the health of children has expanded to include the development of community-based systems of services for children with special health care needs and their families. CSHS functions with eight full-time staff and the part-time services of Dr. Joan Connell, the CSHS Medical Director. In addition to state staff, CSHS also utilizes social work professionals located in each of the 53 county social service offices to help with eligibility and care coordination activities. The major funding source for maternal and child health programs is the Title V MCH Block Grant which has been flat funded for several years at about \$1.8 million per year. CSHS administers the portion of Title V MCH Block Grant funds devoted to children with special health care needs. This federal grant funding is shared with three other divisions in the Health Department. The CSHS Division's budget for the 2009-2011 biennium, which is a combination of federal and state matching funds, is about \$2.7 million. With current funding, CSHS has the ability to make small adjustments but not implement changes that have a major budgetary impact.

Tammy shared some programmatic highlights and reviewed reports and other handouts that were included in the meeting packet. The main focus of the Medical Advisory Council meeting is to obtain advice for the **Specialty Care Diagnostic and Treatment Program**. This program helps families pay for medical services for eligible children. The Legislature has mandated financial eligibility for the CSHS Treatment Program at 185% of the Federal Poverty Level. That equates to \$40,793 for a family of four. The only deduction allowed is annual health insurance premiums that are paid out-of-pocket. Families with incomes above the 185% level can receive treatment services but then share in a portion of the costs with CSHS.

Tammy provided an overview of the other programs within CSHS.

- Most of the children are served by CSHS through **Multidisciplinary Clinics** and/or specialty programs. Some of these clinics are administered through the division while others are contracted out to partner agencies and organizations.
- CSHS provides formula and low protein modified food products through the **Metabolic Food** program for children who are diagnosed with PKU or MSUD.
- The **Russell-Silver Syndrome** program is a special program that the legislature added a couple of sessions ago. This program provides growth hormone treatment and medical food for children with Russell-Silver syndrome.
- CSHS provides services through a **Care Coordination** program. Children with complex health conditions often need care from a variety of providers and service delivery systems (e.g., medical care, family support, and other community-based services). Efforts are made to link families to the services and resources they need.
- CSHS also provides **Information and Referral Services**. A wide variety of information is provided to families upon their request.
- The **State Systems Development Initiative** focuses on data-related activities on behalf of the MCH population. Two reports were showcased. The first report titled *Children with Special Health-Care Needs in North Dakota* was prepared by the Data Resource Center for Child and Adolescent Health using data from the National Survey of Children with Special Health-Care Needs. The second report titled, *North Dakota Birth Defects Monitoring System Summary Report 2001-2005*, was prepared by the ND State Data Center. The data compiled in this report

includes children born with congenital anomalies or birth defects data in ND. Both reports are available on the CSHS website at www.ndhealth.gov/cshs/.

- Staff also work on projects and activities to improve the **Service System for Children with Special Health Care Needs** including monitoring how the system is working for children and their families.

Tammy reviewed the reports that were generated for the meeting. CSHS serves around 2,000 children per year. Last year, ninety-one percent of them had a source of health care coverage. The majority were privately insured while one-fourth were covered by public programs such as Medicaid or the Children's Health Insurance Program. CSHS fills in some of the gaps for an underinsured population. The top conditions identified in children served through CSHS included heart conditions, cleft lip and/or palate, and asthma. With payment of claims, the conditions for which CSHS paid out the most were asthma, cleft lip and/or palate, diabetes mellitus, and handicapping malocclusion. This is not surprising since CSHS sponsors clinics or programs to help with the management of those conditions. CSHS also helps children with some significant dental conditions as many families don't have dental insurance. It was asked if CSHS has a similar rate of privately insured children when compared to other states. Overall, ND has a pretty highly insured child population. Nationally, children with special health care needs tend to be covered more through the public coverage sources such as Medicaid. This isn't unexpected since Medicaid offers waiver programs and other wrap around services to meet the needs of individuals with disabilities and other special populations.

Tammy shared information from the Title V needs assessment and planning process for the Maternal and Child Health (MCH) population, an activity which is required every five years. This was a data driven process with input solicited from a wide range of stakeholders and partners from across the state. A planning retreat was held in February 2010 where ten priorities were identified that will direct efforts over the next five years to improve the health of mothers and children, including those with special health care needs.

Tammy shared some thoughts regarding the potential short and long-term implications for the CSHS division with health care reform. The division's gap-filling role for the underinsured may be impacted. Much will depend on the essential benefit package, once it has been defined. The insurance department has developed a website that contains updates regarding the health care reform in ND. For more information, advisory members can go to www.nd.gov/ndins/consumer/reform/.

Terry Dwelle provided information on Public Health Emergency Response (PHER) grants that are available for a statewide call-in nurse program. The program will likely have protocol driven messages (e.g., a protocol to assess mental health concerns over the phone). The grant will provide funding to get the program started. They are looking for an agency to apply and then commit to sustaining the program.

MEDICAL SERVICES UPDATE

Tammy welcomed Maggie Anderson, Director of the Medical Services Division within the North Dakota Department of Human Services who graciously agreed to provide an update for council members.

Typically, Medicaid only covers services that are provided through the Medicaid State Plan. The only services that can be provided outside of the Medicaid State Plan are those that are made available through a waiver. A waiver is developed to serve specific populations that may have a need for

services that are not available through the state plan. By meeting established criteria for the waiver, the family's income can be waived. At this time, ND Medicaid has five waivers:

- Developmental Disabilities Waiver
- Self Directed Supports
- Home and Community Based Services (Aged and Disabled)
- Technology Dependent (must have nursing home level of care, be on a vent for more than 20 hours a day, and have family support)
- Medically Fragile

All waivers must be cost neutral, which means the services provided through the waiver will not cost more than care provided through an institution. The Medically Fragile Waiver was implemented several years ago and was born out of the same legislation as the Russell Silver Syndrome program. The Medically Fragile Waiver can cover up to 15 children. Recently, eligibility criteria were reduced. Originally families needed to score 40 or more points within the level of need and meet the level of care in order to be considered. The level of care is a federal requirement of Medicaid waivers. Level of need points have recently been reduced from 40 to 30. The level of need score is completed by the child's physician and is accompanied by a narrative written by the family that describes the child's special needs and the impact on their family. There are currently three families being served under the Medically Fragile Waiver with two other children going through the screening and eligibility process.

Two new waivers were funded during the 2009 legislative session, the Children's Hospice Waiver and the Autism Waiver. The Children's Hospice Waiver became a priority since a once a family elects hospice, Medicaid and/or Medicare require curative care to end. From that point on, the child can only receive palliative care. When on the Children's Hospice Waiver, a child with a life threatening illness can receive the services available through the Medicaid State Plan along with case management, home health, hospice and nursing services in addition to the palliative care that they may need. The waiver was submitted the end of March. The federal government is expected to give approval with an effective date of July 1, 2010.

The Autism waiver was created to provide additional services to those families whose children birth to age 5, have an Autism Spectrum Disorder. This service will be a self directed program. To be eligible, the child must meet the Intermediate Care Facility for the Mentally Retarded (ICFMR) level of care and have a confirmed diagnosis of an Autism Spectrum Disorder. Waiver services include program coordination, in-home supports, environmental modifications, equipment and supplies. This waiver will hopefully be effective July 1, 2010 but has yet to be submitted and approved.

Maggie provided an update on Healthy Steps (SCHIP), which was reauthorized in early 2009. Some of the federal changes included the following:

- Orthodontia was included as a dental service benefit. Since orthodontia was not previously included under dental services in ND, Medical Services is working with Blue Cross/Blue Shield and the Centers for Medicaid and Medicare Services (CMS) to figure out how to include the service when it wasn't funded in this biennium's budget.
- Mental health parity was also added as a requirement. The parity was to be effective on any benefit plan that started after October 2009. ND's current benefit plan started in July 2009 and will not be renewed until July 2011. ND Medicaid is working with CMS to determine when the change can be implemented.
- There were changes in how Rural Health Clinics and Federally Qualified Health Centers are paid, which won't be a negative.

- Quality improvement strategies will be monitored on a yearly basis by an outside vendor.
- Outreach dollars were received to encourage more families to apply. Special items were designed for people living in Native American communities.
- Effective July 1, 2009, the income eligibility level increased to 160% of net income.

An update was provided on the Medicaid Management Information Systems (MMIS). The current system that is being used was implemented in 1978. During the 2005 legislative session, funds were authorized to develop a new system. It was hoped that the new system would be ready April 2011 but that target date is likely not achievable.

Maggie provided an update on health care reform. One of the cornerstones will be Medicaid expansion. It's being tagged as the largest expansion to Medicaid since the beginning of the program in 1965. The expansion states that anybody in the US who is a legal citizen and who earns 133% of poverty or less using modified adjustment gross income will be eligible for the Medicaid program. The effective date for this expansion is set for January 1, 2014. Additional guidance from the federal government is expected.

There is no change for the Children's Health Insurance Program. Currently in ND, children are checked for Medicaid eligibility and then CHIP eligibility. If the child is not eligible for either program, then their name is then passed on to Blue Cross/Blue Shield for the Caring for Children Program.

A new eligibility system is needed to assure it connects with the Health Insurance Exchange, a web based system.

There will be a new eligibility group - "Childless Adults" - who would be eligible up to 133% of poverty. This group includes the people who do not have children and are not otherwise disabled. The first three years of implementation, the Federal Government will provide a 100% match for this population. The start of year four it drops to 95% and will continue to drop until the year 2020 where it will stay at 90%. This group will only have benchmark coverage, which is not as comprehensive as Medicaid.

Other items mentioned included drug rebates, coverage of children in Foster Care until age 26, which will be effective 1/2014, and payment for primary care at the Medicare rate. Optional items included medical home, chronic disease management, family planning up to 185%, and cost sharing for preventive services.

BUSINESS

Minutes

Dr. Connell asked if there were any comments or questions regarding the 2009 minutes. Dr. Martsolf moved to approve the 2009 meeting minutes. Dr. Quanrud seconded the motion and all were in favor. The minutes were approved.

CSHS Medical Eligibility

Dr. Connell reported the addition of Leukodystrophy to the CSHS Eligible condition list and the removal of Metachromatic Leukodystrophy which took effect on April 1, 2010.

Autism

An update was given on the Autism Spectrum Disorder task force. A CSHS staff member participates on the task force as a representative for the ND Department of Health. Sub-committees have been formed to address specific areas such as evidence-based services, training and education for families and service providers, infrastructure, and funding. Meetings have been held periodically in order to create a final report that will be presented to the Governor in July. An autism survey is also being conducted.

CSHS provides clinic and informational support for children with autism. A Resource Booklet for children with Autism Spectrum Disorders was developed, which is on the CSHS website. CSHS also funds the Great Plains Inter-Disciplinary Clinics (GPIC). These are primarily diagnostic clinics which are held in Minot and Jamestown for children who may have autism. Two children per clinic are seen using an arena style approach with various providers. Dr. Quanrud stated that these clinics have been very helpful and provide good learning opportunities.

Short Bowel Syndrome

Dr. Connell reviewed the policy drafts for short bowel syndrome and inflammatory bowel disease. It was decided to have short bowel syndrome placed on its own rather than under syndromes because it doesn't have a genetic association. Coverage was confirmed for enteral feeds and transplants up to the \$20,000 limit as well as the need to have procedures done by a pediatric surgeon unless there is an emergency situation. Dr. Quanrud moved to approve this policy and Dr. Klava seconded the motion. All were in favor.

Inflammatory Bowel Disease

The draft policy for inflammatory bowel disease was reviewed. Crohn's disease will be removed as a separate diagnosis but it will be referenced with the more general category of inflammatory bowel disease along with ulcerative colitis. Members advised that diagnostic criteria be simplified to reflect that the diagnosis be confirmed with a biopsy, which could be conducted by a gastroenterologist or surgeon and that enteral feeds be covered. Dr. Kemp moved to approve this policy and Dr. Quanrud seconded this motion. All were in favor.

Metabolic Screening and Medical Food

CSHS has had a legislative council inquiry regarding expansion of the metabolic food program. Families have also enquired about formula and food coverage for OTC, a urea cycle disorder. The formula and low-protein food needed for treatment is comparable in cost to what children with PKU require. OTC is currently not screened through the newborn heel stick screening and is not included on the list of medically eligible conditions for CSHS. Other members of the Health Department have been meeting to discuss potential expansion of the metabolic food program for comparable conditions to PKU and MSUD such as OTC, but not limiting the discussion to just OTC.

Barb Schweitzer, a staff member from the Family Health Division, gave a brief overview of metabolic screening in ND, which initially started in the 1960's to identify babies with PKU. She relayed that OTC has not been recommended nationally to be added to the newborn screening test. Dr. Carver stated that most screenings are done for conditions that are treatable and OTC doesn't have a good outcome.

Areas of discussion and recommendations from advisory members included the following:

- Add OTC and possibly other metabolic conditions that require formula to the list of CSHS eligible conditions so the formula needed for treatment could be provided to families that meet family financial requirements established for the Specialty Care Treatment Program. Consider categorizing these types of conditions broadly under a heading such as “orphan diseases”.
- Have a subcommittee review the issue more thoroughly and come up with recommendations regarding expansion of the Metabolic Food program that could be forwarded on to DoH leadership and possibly the Governor’s office to determine if more funding is possible as part of the state’s budgeting process.
- Include medical food as a line item in the CSHS budget.
- Find a legislative champion to address the issue of metabolic disorders requiring expensive formula and food.
- Consider coverage for mitochondrial cocktail supplements in addition to formula and low-protein food.

Dr. Connell stated a subcommittee will be formed and asked those interested in joining to let her know.

Genetic Testing for Cystic Fibrosis

Dr. Connell reviewed a scenario that had been brought up in CSHS for administrative review. A child who had a positive newborn screening for Cystic Fibrosis went through genetic testing and the parents wanted to screen the siblings as well. For one of the siblings, the actual sweat chloride test was within normal range, but was higher than the child diagnosed with Cystic Fibrosis. The child who came back with a positive screening for Cystic Fibrosis had a sweat chloride screening come back within normal limits; however, he did have the genetic mutation present. Dr. Connell referred advisory members to a handout with CSHS policy guidelines for genetic testing and counseling. Discussion ensued following a review of the policy:

- How can you do counseling if you cannot test the parent?
- BCBS pays for first degree relatives (parents and siblings).
- Care should be restricted to patients with a positive screen.
- With the results that were mentioned in this particular case, coverage is a grey area.

Dr. Kemp motioned to deny genetic testing of other members of the family and cover only the child who screened positive for Cystic Fibrosis. Other family members who screen positive at a later time could apply for diagnostic services if a CSHS-eligible condition like Cystic Fibrosis is suspected. Dr. Quanrud seconded this motion. All were in favor.

Guillain-Barre

Children's Special Health Services has received a request to cover a child who has Guillain-Barre but currently doesn't require a tracheotomy or ventilation. For this condition, CSHS requires that the child have a tracheotomy and/or a ventilator to be eligible for CSHS. Dr. Quanrud motioned to keep the criteria for Guillain-Barre as it is currently listed. Dr. Kemp seconded the motion. All were in favor.

Financial Eligibility, Covered Services, and Reimbursement Issues

Financial Eligibility

Melissa gave a brief overview of children in recent years who have met the \$20,000 financial eligibility limit. In the last five years there have been only four children who reached the limit. This year another child will either meet the limit or come very close. This particular child has no other

source of coverage and has had many out-of-state hospital charges for outpatient testing along with some inpatient stays for a nerve injury.

Dr. Connell stated that the recommendation from last year on the eligibility level for CSHS was to increase the percent of federal poverty from 185% to 200%. The advisory council recommended this change be pursued within the Health Department for inclusion in the Governor's budget so it could be addressed during the upcoming Legislative Session.

Covered Services and Reimbursement Issues

Sue Burns relayed that CSHS currently covers several dental conditions including cleft lip and palate, congenital dental disorders, ectodermal dysplasia and handicapping malocclusion. Orthodontic services are covered for cleft lip and palate, ectodermal dysplasia and handicapping malocclusion; however, orthodontia has not been covered for congenital dental disorders. Dr. Lugar made a motion to cover orthodontia for congenital dental disorders on a case-by-case basis. Each situation needs to be assessed individually to make sure there are functional rather than cosmetic implications. Dr Fiechtner seconded the motion. All were in favor.

CSHS received a request a few years ago requesting coverage of a PTT or INR monitoring system for the home; however, at that time it was not FDA approved for home use so the request was denied. Recently the monitoring system has become FDA approved. Pediatric cardiologists have been recommending these devices for home use. Advisory members had several questions and requested that more information be provided before the policy was implemented as written. Information requested included the following:

- What reasons are there for doing it in the home (e.g., rural access issues)?
- What is the cost of the device?
- Are rental units available?

In the interim until further information is provided, Dr. Quanrud motioned that cases could be reviewed individually to determine whether the PTT or INR monitoring system should be covered for in-home use. Dr. Klava seconded the motion. All were in favor.

Sue Burns referred to the draft policy on Auditory Trainers. CSHS has received a request to cover an Auditory Trainer for a child with hearing loss. The device augments hearing aids and is often used in the school setting. Insurance and Medicaid will not pay for these devices. Advisory council members recommended the device not be covered at this point in time as additional information was needed. Members questioned whether the device was medically necessary or mainly used for educational purposes. Dr. Carver motioned to bring this topic back next year with more input from families and audiologists on use outside the school setting for children with various conditions such as hearing loss, central processing disorders, etc. Dr. Quanrud seconded the motion. All were in favor.

The fact sheet on reuse and recycling of medical equipment was reviewed. Dr. Klava mentioned that families often cannot get funding to adjust seating if a wheelchair was not paid for by Medicaid. Tammy relayed this issue could be brought up to Mary Helmers, the staff person that deals with DME within the Medical Services Division of the DHS.

Programmatic Updates

Family Advisory Council

Tammy acknowledged Evelyn Klimpel, a CSHS Family Advisory Council member, and thanked her for her attendance.

System of Care for Children with Special Health Care Needs

Medical Home

Dr. Carver and Dr. Quanrud were invited to give an update regarding their Medical Home pilot practices. Medical home in the model being used for kids with special health care needs is a process of care that recognizes that the families or parents are the experts of their child and the system is set up to provide individualized, comprehensive, coordinated care that involves the entire family. Cultural and religious beliefs are respected and resources are sought out for the family as needed. An individual care plan is constructed that accompanies the child wherever they go. There are eight sites across the state that are piloting this model of care. Sites vary in their progress toward becoming a medical home with some further along than others.

Dr. Quanrud currently has many families involved in her site who have a care plan which is created for children who score a four or higher by doing an intensity of need screening. Medical home teams are comprised of a primary care provider, two family members and a care coordinator. Currently there are 10 physicians working with the Medical Home system. The family members on the team have been a valuable resource. Dr. Carver stated that the Adult Medical home model through BCBS is more focused on chronic disease management so they are able to see more patients in a day. In the pediatric Medical Home model, fewer patients are seen per day as more interaction is required with the family and various community partners such as the child's school. Having a care coordinator for a child with special health care needs is important because they call the family a day before the child's visit to go through the goals of the appointment. CSHS provides a care coordination grant to help fund care coordinators at participating sites.

Tricia provided information about a new Care Coordination Training Curriculum that was funded through the ND State Council on Developmental Disabilities. There are several modules in the curriculum including fundamentals of care coordination, state and local resources, and health benefits counseling. Once it's complete, the curriculum will initially be made available to care coordinators in the Medical Home pilot sites. Eventually other case management staff will be able to access it on-line.

Transition

To support healthy youth transitions, CSHS has created age specific information packets that include handouts to help prepare families and youth for transition to adulthood. Information in the packets targets three different age groups: 14 to 15 year olds, 16 to 17 year olds and individuals 18 or older.

Early Hearing Detection and Intervention

Sue gave an update on Early Hearing Detection and Intervention (EDHI). In 2000, the North Dakota Center for Persons with Disabilities (NDCPD) through Minot State University received a grant to start universal newborn hearing screening and over the years the federal grant has expanded to early hearing detection and intervention (EHDI). Currently, hospitals are screening on a volunteer basis since there is no state mandate. The goals of the program are to have all babies screened for hearing loss by one month of age, diagnosed by three months of age and into intervention by six months of age. In 2009, 98% of infants born in ND hospitals received a newborn hearing screening and of those 9% were referred for a second screen. Overall in 2009, ten ND children were diagnosed with a hearing loss. ND

EHDI works with Right Track and Early Intervention to help screen children who have not followed up with a second screening. Dr. Kemp suggested making it a priority that families are referred to Right Track for follow-up screening as hospitals may be too busy to re-screen. Dr. Carver relayed that his clinic is trying to get the screening equipment in his office so at the well-child check-up appointments, the child can be re-screened. Some concerns have arisen with the program: 1) when a facility's screening equipment breaks down, how do they pay for new equipment and 2) some facilities only wanting to report on "their" babies and not the other ones who may come in later. During the last legislative session, The Health Department received \$50,000 for EHDI, which will be used to develop a method to notify primary care providers of hearing screening results so they can provide better follow-up. One idea being considered is having hearing screening information added to the ND immunization information system so it's readily available to the family's primary care provider. Sue extended an invite to the upcoming EHDI Summit which will be held on June 22, 2010 and referred to the "Communicate with Your Child" pamphlet along with the ND specific resources handout.

Provider Qualifications

Recertification Report for Physicians

Melissa reviewed the recertification report for physicians on the CSHS specialist list and relayed that out of the 120 to 130 letters sent to physicians only about 80 recertification's were received back. Board certification information used to be available on the Pediatrics and Internal Medicine's websites; however, the Board of Internal Medicine is the only website that CSHS can currently access. The American Board of Medical Examiners site will only provide whether a physician is certified or not, but does not show the date certified or the date certification expired. To address this issue, CSHS is considering subscribing to the American Board of Medical Specialties (ABMS) website, which would provide the certification eligibility dates needed for the CSHS specialist list. The annual cost to subscribe to this website is around \$1,200. Medical Advisory members advised that CSHS should continue to use board certified physicians who have expertise to take care of children with complex, chronic health conditions.

Physician Provider Qualifications

Dr Connell indicated that advice was needed on the expertise required to take care of kids with special health care needs. Over all, consensus has been that physicians providing care for our special needs kids are board certified. Current CSHS policy states that physicians must be licensed to practice medicine in ND and must meet one of the following requirements at the time of enrollment:

1. Be a diplomat of the American or Canadian Board of their specialty.
2. Have been admitted for final exam by the American or Canadian Board of their specialty.
3. Have completed the formal education and training qualifications that would make them eligible to take the final exam of the American or Canadian Board of the specialty upon completion of their required period of practice.

If authorized under the 2nd or 3rd requirements the authorization is temporary until the Physician becomes a diplomat. If they cannot meet these requirements within 5 years, they become ineligible to provide care under CSHS.

Various scenarios for children with asthma, diabetes, and cardiac conditions were discussed with general comments summarized below:

- Kids served through CSHS are probably more severe.

- Family Practitioners provide ongoing management for kids with special needs because there is a lack of access to pediatric specialty providers, especially in rural areas of the state.
- There may be instances where it wouldn't be acceptable or comfortable for a family practitioner or pediatrician to manage care.
- Primary care physicians refer to specialists or ask for help when needed.

General consensus was that board certified primary care providers can use their judgment in providing care for all the diagnoses on the CSHS list.

Nurse Practitioners and Physician Assistants Provider Qualifications

Dr. Connell shared the CSHS policy for registered nurses. They must be licensed to practice nursing in ND. A Bachelor's degree in nursing and nursing certification are preferred. Registered nurses practicing as nurse practitioners must be licensed to practice in ND with authority to provide services as a family nurse practitioner, pediatric nurse practitioner or school nurse practitioner. A Master's degree in nursing and nursing certification are preferred. At this time CSHS does pay for care that is provided by the nurse practitioner when it is done with consultation with the specialist (e.g., monitoring PTT, blood pressure, flu shot, etc.). CSHS does not pay physician's assistants directly as they bill under their supervising physician.

The question for discussion was what care provided by nurse practitioners and physician assistants should CSHS cover and pay for?

Various scenarios for children were addressed and lengthy discussion ensued with general comments summarized below:

- Since most present were under the board of medical examiners rather than the Board of Nursing, members could be biased. Representation of a nurse practitioner is needed as they are providing pediatric care in the state and this is a controversial issue. Information on the role of the Board of Nursing would also be helpful.
- Should nurse practitioners and physician assistants who meet certain criteria be advertized as specialists for kids with special health care needs and be added to the CSHS specialist list?
- Nurse practitioners and physician assistants have been involved in things like ordering labs that have recommended by a specialist.
- Nurse Practitioners do not require a supervising physician but a Physicians Assistant does. CSHS guidelines do not address the issue.
- Addressing this on a case-by-case basis was suggested but it would likely be cumbersome and political.
- What does Medicaid do? They require licensure but not certification.
- CSHS could require that enrolled practitioners have references from others to attest to their qualifications and competence for patient care on a case-by-case basis.
- Concerns were voiced that provider qualification issues are often retrospective in nature and CSHS does not always know ahead who the child will be seeing. Sometimes referrals are made to providers who are not on the CSHS specialist list and the family is left with the bill. CSHS is usually payer of last resort.
- Care needs to be accessible but it also needs to be of good quality.
- Two different levels could be considered, one of nurse practitioners and one for specialists.
- Some offices try and find out who the individual's insurance will cover and direct care accordingly. Access to care can be timelier with mid-levels.

- Some excellent Physician Assistants are providing diabetic care that is supervised by physicians without any special training in pediatric diabetes.
- If a supervising physician is not approved by CSHS, than the Physician Assistant should not provide services that will be paid for by CSHS.
- If a physician is an approved CSHS provider, even though the Physician Assistant has superior abilities in certain types of management (e.g., diabetes), its ok for that physician to be the Physician Assistant's supervisor. Some members questioned whether that physician knew his or her own limits in this instance.
- Having an unqualified physician being paid as the specialist provider by CSHS could be a concern except in emergency situations.
- Prospectively CSHS could screen for pre-qualifications. Retrospectively CSHS needs to rely on licensure.

General consensus was that more information was needed regarding nurse practitioners before a decision can be made. It was recommended that in order for CSHS to approve care by the physician's assistant, the supervising physician must meet the CSHS provider qualifications.

Occupational Therapist Provider Qualifications

CSHS is recommending a change in the occupational therapist qualifications since membership in the American Occupational Therapy Association is not restricted to occupational therapists. The ND licensing board requires certification by the National Board of Certification in Occupational Therapy, Inc. as part of ND licensing criteria. Dr. Kemp made a motion to proceed with the recommended change that occupational therapists be licensed to provide services in ND. Dr. Carver seconded the motion. All were in favor.

Provider Qualifications for Children with ADD/ADHD

At this time ADD and ADHD have not been added to the CSHS eligible condition list. In an effort to prepare for this addition, discussion would be helpful regarding who should be approved to provide services. It was recommended that providers that are diagnosing the condition (physicians and nurse practitioners) and psychologists (that do testing and behavior modifications) are the providers that CSHS should be paying to diagnosis and treat children with ADD and ADHD.

CLOSING REMARKS/WRAP-UP

Council membership - Five physicians have terms that will be expiring this year. They include: Drs. Carver, Goldstein, Quisno, Kemp and Martsolf. All have agreed to another term.

There is currently a spot open on the CSHS Medical Advisory Council. CSHS may look at a nurse practitioner for this open spot. Sue Hafner, a Pediatric Nurse Practitioner, was recommended or someone who is not one working within a big practice who could give a better perspective on some of the issues in rural areas.

Dr. Connell closed the meeting after giving a warm thank you to the committee for all their hard work and support.