NORTH DAKOTA DEPARTMENT of HEALTH

Special Health Services
Medical Advisory Council Meeting
Bismarck, North Dakota
May 5, 2018, 8:30 a.m. – 12:00 p.m.

Attendance:	
Appointed Medical Advisory Council Members	Jeffrey Nelson, MD; Blake Feil, DDS; Laura Schield, MD; Kari Casas, MD; Lori Sondrol, MD; Marc Ricks, MD; Sheila Ponzio, MD; and Justin Horner, MD
Special Health Services (SHS) Division Staff	Tamara Lelm, Division Director; Tammie Johnson, Program Administrator; Tina Feigitsch, Claims & Eligibility Administrator; Jaime Conmy, Medical Claims Service Specialist; Joyal Meyer, Newborn Screening Director; Amy Burke, Nurse Consultant; Peggy Masset, Administrative Assistant; DeNae Tokach, Administrative Assistant; and Kelsie Morris, Administrative Assistant
Other Continuous Representation	Joan Connell, MD, Medical Director; Mylynn Tufte, State Health Officer; Chris Jones, Department of Human Services (DHS) Executive Director; Dawn Mock, Medical Services Designee; Kodi Pinks, Department of Health (DoH) Epidemiology Staff Representative; Courtney Koebele, North Dakota Medical Association; Sarah Carlson, Family Advisory Council Designee; and Moe Schroeder, Family Advisory Council Designee
Welcome and Introductions	Tamara Lelm, SHS Division Director, provided a warm welcome and relayed appreciation for the time devoted for the annual Medical Advisory Council meeting and the commitment made by participants to assist the division in its work throughout the year. Introductions were made.
Opening Remarks	Mylynn Tufte, State Health Officer, provided introductory remarks on behalf of the DoH. Slides addressing purpose, values, and culture were shared in addition to the Governor's budget expectations, which include a 10% general fund reduction, a 3% contingency reduction, and a 5% FTE reduction. Chris Jones, DHS Executive Director, also provided introductory remarks on behalf of DHS. Five priority areas within the department include developmental disability payments, managed Medicaid, behavioral health, social service redesign (Senate Bill 2206), and culture change.

Special Health Services Update	Tamara Lelm provided an update for the SHS Division via a PowerPoint presentation. Highlights follow below. **Organizational Change:** Organizational changes within the DoH occurred 10/1/2017 that impacted the division. The Community Health Section, which was comprised of six divisions, was realigned into the Healthy and Safe Communities Section with five divisions and a Section Chief. Children Special Health Services (CSHS) evolved into Special Health Services (SHS) with inclusion of the Newborn Screening (NBS) Program and staff. Staff that worked with the State Systems Development Initiative and Autism Database were moved into to the Office of the State Epidemiologist. **Division Overview:** • Staff - SHS currently functions with 10 full-time staff and a part-time Medical Director. Dr. Joan Connell also has responsibilities within the DoH in an additional role as Field Medical Officer. • Current Budget - For the 2017-2019 biennium, the SHS division's budget appropriation is $3.8 million, $1.9 million in federal funding authority from the MCH Block Grant and $1.9 million in general fund authority. Historically, the division has requested a bit more spending authority than expected revenue, which provides flexibility to manage expenditures throughout the biennium. Generally, a year's grant award (with required match) is spent over a one-year period. By line item, approximately 39% of the budget is for salaries, 20% is for operating expenses, and 41% is for grants. • Programs - The SHS Division mission is to promote a system of care and services that improves the health and well-being of individuals with special health care needs and their families. Cross-cutting implementation strategies at the heart of all SHS programs include care coordination, collaboration, data-informed decisions, and information/education. The Division's four programs include: o Coordinated Services Program - Services and resources that support coordinated management of specific chronic health conditions. Services include Metabolic Food, Multidisciplinary Clinics, and Cardiac Care for Children. o Financial Coverage Program - Helps families pay for medical services for eligible children, youth, and young adults who require specialty care to diagnose and treat their chronic health conditions. Services include Diagnostic Testing and Evaluation, Treatment, and Russell Silver Syndrome. A large part of the meeting agenda focuses on advice for this program. Many years ago, the Legislature mandated financial

eligibility for treatment services at 185% of the federal poverty level, which equates to $46,435 annually for a family of four. Families can receive services above the 185% level but then share in a portion of the costs with SHS.

- Newborn Screening and Follow-up Program - The goal of this program is to identify conditions at an early age when treatment and intervention can prevent health problems, support early development, and save lives. Newborn screening consists of three simple tests: Blood Spot, Hearing, and Critical Congenital Heart Disease. Shortly after birth, newborns are screened for more than 50 disorders.

- Children with Special Heath Care Needs (CSHCN) System Enhancement Program - Improves health outcomes of children with special health care needs by advancing a quality, comprehensive system of care that promotes the healthy development and well-being of children and their families. Six core outcomes that describe the system of services for CSHCN include: Family Professional Partnership, Medical Home, Adequate Health Insurance, Early and Continuous Screening and Surveillance, Easy to Use Services and Supports, and Transition to Adult Health Care.

Data from the 2016 National Survey of Children's Health:

The National Survey of Children's Health is an important data source used to track health status and outcomes of the pediatric population. For the CSHCN population in ND 0 to 18 years of age, some of the indicators being monitored include: the prevalence of children with special health care needs, receipt of care within a medical home, receipt of services to make transition to adult health care, children who are adequately insured, and CSHCN receiving care in a well-functioning system.

SHS Statistical Reports for SSY 2017:

- Program Data Report - SHS served over 1,900 children in FFY 2017.
- Health Care Coverage Report - 93% of children served by SHS had a source of health care coverage, almost two-thirds of which was through private insurance and one-third through Medicaid. SHS is usually a secondary payer that fills gaps for what other payers do not cover for an "underinsured" or "inadequately insured" population.
- Claims Payment Report – This year claims payment is at an expected amount of around $200,000 as staff have resumed timely prechecking and processing with use of the ND Health Enterprise Medicaid Management Information System (MMIS) and have resolved some of the issues with provider claims submissions. Other select highlights follow:

Conditions with the highest number of children receiving claims payment in FFY 2017	
Heart Conditions	37
Diabetes	16
Cleft Lip/Palate	14
Handicapping Malocclusion	10
Hearing Loss	9
Asthma	7
Syndromes	5
Seizure Disorders	5

Conditions for which SHS paid the most in FFY 2017	
Handicapping Malocclusion	$16,829
Cleft Lip/Palate	$12,698
Growth Hormone Deficiency	$11,255
Diabetes	$ 9,127
Hydrocephalus	$ 7,166
Cancer	$ 5,396
Asthma	$ 5,098
Heart Conditions	$ 5,092

Budget Update:
The final federal funding award for the MCH Services Block Grant has not yet been received for the period 10/1/2017 – 9/30/2018. The award for the previous federal fiscal year was $1,725,639, one-third of which was allocated for CSHCN. Guidance for the 2019-2021 state biennial budget was provided from the Governor in April 2018. It required reductions in general funds and FTE's at the department level. A strategic review for the Health Department is scheduled for May 2018 with submission of the department's budget likely in August 2018.

Highlights from Select Interim Legislative Committees:
The interim Health Services Committee conducted a study of the early intervention system for infants and toddlers with developmental disabilities. Advocates included "Friends of ND Part C Early Intervention group". The interim Human Services Committee conducted a study of public human services, including the ND Social

	Services Redesign Project. The committee also spent time reviewing results of the North Dakota Behavioral Health System Study. The Health Care Reform Review Committee studied impacts of the Affordable Care Act and Medicaid managed care.
Medical Services Update	**Medical Services Update:** Dawn Mock was in attendance on behalf of Medical Services in the DHS and answered questions that arose. She relayed that slots for the medically fragile waiver will increase to 25 in June. Dawn provided connections to the following staff based on their content expertise: 1) Autism Waiver - Kathy Barchenger and 2) Insulin Pumps - Tammy Zachmeier and Tammy Holm.
Business/Minutes	**Dr. Joan Connell:** A motion to approve the May 2017 minutes was made by Courtney Koebele and seconded by Marc Ricks. The minutes were approved with the following correction – the addition of Myra Quanrud, MD and Courtney Koebele as attendees at the 2017 meeting.
Provider Qualifications, Certification, and Enrollment	**Provider Qualifications:** Jaime reported that there were 319 providers that were due to recertify based on information in the SHS database. Of those, 296 (93%) recertified and 23 (7%) did not. This includes two pediatricians, one internist, two family practice physicians, two occupational therapists, one rheumatologist, two speech pathologists, one general surgeon, and 12 physical therapists. Of the 23 that did not recertify, six are no longer practicing in ND. SHS is no longer able to verify physical therapist's qualifications without a charge of $20.00 per verification so staff are calling to request a copy of their licensure. Future efforts include quality improvement activities to update the SHS Specialist List and potential collaboration with Medicaid regarding provider enrollment. SHS staff stated that they utilize CertiFACTS to verify provider board certification. They also review provider licensure and ND Medicaid enrollment. Dawn Mock reported that ND Medicaid requires providers to complete a provider enrollment application which is revalidated every five years. She stated that they rely on the facilities/providers to address board certification as they do not require it or verify it in MMIS. Council members relayed that CME's are required for licensure and that there are financial implications and testing required with board certification. A motion was made and approved to explore collaborative efforts between SHS and Medicaid that would reduce redundancy with provider enrollment and verification of board certification status.

Financial Eligibility, SHS Covered Services, and Reimbursement Issues	**High-Cost Clients:** A three-year analysis shows a trend of two clients each year with an average paid between $5,000 to $8,000 per client except for one client in 2015 that reached $17,000. For 2018 SHS is monitoring two brothers that have been diagnosed with hypopituitarism for which one has had claims and is at $5,000. A claim was received for another child that was denied for system reasons, but if/when the claim does come in and is payable, it will pay the full $20,000. It is not an issue now; however, they are monitored closely so that we are aware of any higher payments that might arise. • Claims processing - MMIS is currently set up to cover the child, where SHS policy is condition specific. Due to the setup of MMIS, SHS is not able to allow the system to do a lot of the work for us. We need to still do a lot of manual work before a claim can be paid. • SHS Cost Share is different than recipient liability that is used in DHS. SHS uses the patient responsibility amount that is indicated by the primary insurance, where DHS looks at the allowed amount for the service. • Tina, Jaime & Dawn will work together to try and streamline payment services. **Diabetic Pumps and Supplies:** Most diabetic supplies are purchased through mail order from Medtronic. Sanford Healthcare Accessories is currently the only Durable Medical Equipment (DME) supplier located in-state that stocks some of the pumps and is enrolled with ND Medicaid. DME suppliers do not need to be located within the state but must be enrolled with ND Medicaid to facilitate payment. Therefore, families that wish to utilize other pumps which are not carried by ND Medicaid enrolled providers are not payable through SHS. **Continuous Glucose Monitors:** Dr. Connell led a discussion on continuous glucose monitors. • Dr. Sondrol suggested that SHS continue to cover continuous glucose monitors on a case-by-case basis (transmitters & sensors), as the yearly cost would be less than $4,000 per year for a patient. This would potentially lead to more controlled diabetes. • The group discussed the new Libre system. This is not a closed-loop system, costs approximately $200 for monitor, and is not FDA approved for clients less than 18 years old. • SHS should continue to cover continuous glucose monitoring on a case-by-case basis if determined medical necessary (e.g. hypoglycemic unawareness). **ND Medicaid diabetic supply list changes:** SHS covers items per SHS policy that ND Medicaid does not. However, since SHS utilizes the ND Health Enterprise MMIS for payment, this presents challenges due to the separate benefit plans. The ND Medicaid

preferred diabetic supply list for test strips and meters has been reduced, which has been impacting SHS payment as well. SHS is continuing to work with clients and providers to resolve these payment issues.

Claims processing and payment update:

Last year it was reported that MMIS had been quite challenging since go live of 10/5/15. However, this year things are going well. Issues have been resolved regarding cost share, and the claims are now processing through the system correctly.

- A quality improvement (QI) project was initiated around the following components for claims:
  - Obtaining the medical records required for payment.
  - Clean claims submitted without duplication (missing or incorrect provider taxonomy numbers, incorrect member ID numbers, etc.).
- A PowerPoint presentation showing the SHS policy/procedure guidelines and the claim requirements for providers and billing departments was created as an educational piece on how to submit claims correctly.

Cardiac Care for Children Program Coverage of cardiac transition visits:

Children born with a congenital heart defect are typically followed by a pediatric cardiologist. The pediatric cardiologist will continue to see clients into adulthood if the adult cardiologists do not have specific training regarding congenital heart defects. Some facilities are implementing a cardiac transition visit, where the pediatric and adult cardiologists would meet, along with the patient, to determine who would be the best fit to continue to treat the patient's cardiology needs. SHS is only able to pay the adult cardiologist at the time of the transition visit if the pediatric cardiologist is in attendance, according to SHS policy.

Denials & Miscellaneous Calls Update

Miscellaneous Calls:

- In review of the documented contact sheets, SHS received 34 calls from families that did not become SHS clients. These calls were summarized as:
  - Questions regarding the application for the SHS Financial Coverage Program.
  - Needs for other referrals (e.g., ND Medical Assistance (Medicaid), Early Intervention, Family Voices, Developmental Disabilities, etc.
  - Transportation assistance requests from families, many of whom were enrolled with ND Medicaid.
    - Transportation is not a covered service through SHS, but is through ND Medicaid.

Denials:

- 5 applications were denied as follows:
  - 4 were denied due to incomplete applications or missing information.

	○ 1 was denied due to a non-eligible condition of abdominal pain, but eventually resulted in an open case for Diagnostic Testing and Evaluation services for the eligible condition of Immunodeficiency States.
SHS Medical Eligibility, Potential New Conditions, and Coordination with Other DHS Services	**Orthodontist feedback regarding SHS eligibility for handicapping malocclusion:** Dr. Feil brought forth the discussion of coverage of handicapping malocclusion and suggested that SHS look at this as a covered service if accompanied along with an SHS eligible condition. Tammy Lelm explained that the point system in scoring was developed in collaboration with the dental community. Dr. Feil reported that the orthodontists score patients based upon a variety of issues such as overbite, and that the scoring should be tighter. Dr. Connell reviews all medical information including orthodontic pictures and x-rays. Dr. Feil stated that he would be willing to review the case information as well to approve or deny based on the point system to decrease any misuse that could be caused. Dr. Feil, made a motion that a covered special medical condition (e.g., craniofacial, congenital disorders, cleft lip and palate, ectodermal dysplasia, and other disorders) be a requirement to receive orthodontia through Special Health Services, rather than using a points system. Dr. Ricks seconded. SHS staff will work with Dr. Feil and other orthodontists on this work effort. **Unidentified syndrome coverage through SHS:** Symptoms will continue to be reviewed for possible qualification under syndromes, based on established criteria. **Expansion into behavioral health by SHS:** Behavioral health is currently not covered by SHS due to a limited budget. Options to further this initiative were discussed, which could include applying for an Optional Budget Request. Other considerations would likely require legislation. No motion resulted, but a request was made to further discuss this issue. **DHS Autism Waiver Update:** The new Autism Waiver changes went into effect on December 6, 2017. This expanded the age criteria/slots and allowed other portions of the waiver to be reviewed/changed by Centers for Medicare and Medicaid Services (CMS). As a result, to qualify for the autism waiver, the child must be a diagnosed by a clinical psychologist or a psychiatrist. They may also be diagnosed by a multidisciplinary team, but a clinical psychologist or psychiatrist must be a member of that team. DHS accepts a school psychologist or medical psychologist and do not look at master's verses doctoral levels of education. A pediatrician or primary care provider is not able to diagnose autism to qualify for the Autism Waiver program. However, a medical diagnosis of autism by a pediatrician would be acceptable for other services (e.g., Applied Behavior Analysis (ABA) therapy under the Medicaid state plan). For ABA, the physician's diagnosis is to determine medically necessity and state whether the child meets this

	based on their diagnosis.
	
	Developmental Disabilities (DD) Waiver Update:
	The DD Traditional Medicaid Home and Community Based Services waiver will be expiring March 31, 2019. DHS will be hosting public meetings to gather input on what people like about the waiver, and suggestions on ways to improve the waiver.
	
	Medically Fragile Waiver:
	The Medically Fragile Waiver administered by DHS is currently full. However, an increase in 5 slots was approved to start June 1, 2018.
	• Of the extra slots:
	  ○ 4 from the current wait list have been fully approved.
	  ○ 1 child is pending.
	
	Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT):
	Moe Schroeder and Chris Jones will meet as a subcommittee to discuss EPSTD coverage for medical services.

Newborn Screening, Follow-up and Metabolic Food	**Newborn Screening and Follow-Up Program:** Detail was not discussed due to time constraints. **Expansion of Metabolic Food Options:** A request has been made by a parent to approve metabolic foods with Glycomacropeptide (GMP) for consumption for a 1-year old child with Phenylketonuria (PKU). SHS does not provide formulas with GMP. WIC-eligible children are approved to receive GMP formulas. The group discussed the addition of medical foods, as well as potential costs. Information was reviewed from accounting regarding cost projections. and SHS reported that we currently provide metabolic formula to 26 individuals. The group discussed the medical necessity and that staff and medical director reviewed current medical information and research available on medical foods with GMP. SHS also provided an informal survey of several states that participate in the NewSTEPs community. Eight states responded. Results from this survey, including ND are as follows: • 6 states proved formula with GMP, 3 do not. • 5 states have a metabolic food program, 4 do not. • 6 states Medicaid provides Metabolic food (formula) 3 states do not. • 2 states receive partial NBS funds, 6 receive none, and 1 is unsure.

	Dr. Nelson motioned to provide current formulas only (Not GMP), seconded by Dr. Ricks and Dr. Casas.

Technology Advances	**Telehealth:**
	Amy Burke and Dr. Joan Connell led a discussion regarding telehealth nursing possibilities for use in ND. These currently include asthma and school nursing However, considerations should include:
	• Medicaid policy
	  ○ Misinformation must be clarified for pediatric specialists.
	• Telehealth requirements
	  ○ Medicare requires a population per city of 30,000 (e.g., Bismarck, Grand Forks, Minot and Dickinson)
	Medicaid asked for public comment regarding their policy on Telemedicine Services (NDMP 2012-0007). Select DOH staff provided feedback on specific changes/modifications that they felt would be beneficial going forward. Some examples are:
	• Changing certain words to be more inclusive of a variety of providers for a variety of services (e.g., include school nursing).
	  ○ Sanford has expressed interest in telehealth.

System Enhancement	**Medical Home:** Not discussed, directed to handout **Transition:** The Transition Tool Kit was disseminated to the group.
Epidemiology Update	**Autism Database:** Kodi Pinks reported that the new Autism Database report form will be available June 1, 2018 • Current statistics are stating that 1 in 59 births are diagnosed with autism.
Closing Remarks/Wrap-Up	Five council members had terms that expired this year. They included: Dr. Carver, Dr. Quisno, Dr. Sondrol, Dr. Feil and Dr. Casas. Responses for remaining on the council were as follows: • Dr. Carver-Yes via email to Dr. Connell. • Dr. Quisno-Yes via email to Dr. Connell. • Dr. Sondrol-Yes. • Dr. Feil-Yes. • Dr. Casas-Yes. Dr. Connell closed the meeting after giving a warm thank you to the council for all their challenging work and support.