BEFORE THE
ADMINISTRATIVE RULES COMMITTEE
OF THE
NORTH DAKOTA LEGISLATIVE COUNCIL

N.D. Admin. Code Chapter	**)**	**REPORT OF THE**
75-02-02, Medical Services	**)**	**DEPT. OF HUMAN SERVICES**
(Pages 157-206)	**)**	**September 13, 2012**

. . . . . .

For its report, the North Dakota Department of Human Services states:

1. The proposed amendments to N.D. Admin. Code chapter 75-02-02 are not related to statutory changes made by the Legislative Assembly.
2. These rules are related, in part, to changes resulting from the American Recovery and Reinvestment Act (ARRA), but most of the rules are not related to changes in federal statutes or regulations.
3. The Department of Human Services uses direct and electronic mail as the preferred ways of notifying interested persons of proposed rulemaking. The Department uses a basic mailing list for each rulemaking project that includes the county social service board directors, the regional human service centers, Legal Services offices in North Dakota, all persons who have asked to be on the basic list, and internal circulation within the Department. Additionally, the Department constructs relevant mailing lists for specific rulemaking. The Department also places public announcements in all county newspapers advising generally of the content of the rulemaking, of over 50 locations throughout the state where the proposed rulemaking documents may be reviewed, and stating the location, date, and time of the public hearing.

   The Department conducts public hearings on all substantive rule-making. Oral comments are recorded. Oral comments, as well as any written comments that have been received, are summarized

and presented to the Department's executive director, together with any response to the comments that may seem appropriate and a re-drafted rule incorporating any changes occasioned by the comments.

4. A public hearing on the proposed rules was held in Bismarck on April 23, 2012. The record was held open until 5:00 p.m. on May 3, 2012, to allow written comments to be submitted. Comments were received. The "Summary of Comments" is attached to this report.

5. The cost of giving public notice, holding a hearing, and the cost (not including staff time) of developing and adopting the rules was $2,309.88.

6. The proposed rules amend chapter 75-02-02 to provide needed updates to outdated language and to accommodate program practices. The following specific changes were made:

   Section 75-02-02-03.2. Section 75-02-02-03.2 is amended to clarify the definition of "certification of need," to define "licensed practitioner," to replace the definition of "residential treatment center for children" with "psychiatric residential treatment center," and to remove the definition of "secretary."

   Section 75-02-02-08. Section 75-02-02-08 is amended to clarify language, identify guidelines for inpatient prospective payment system hospitals who are reimbursed based on diagnostic-related groups, to clarify coverage of exercise and weight loss programs, fertility services, certain physician-administered drugs in outpatient settings, chiropractic treatment, and

pharmacy services. Additional amendments moved some language to other sections of chapter 75-02-02.

Section 75-02-02-09. Section 75-02-02-09 is amended to clarify eligibility for nursing facility level of care for patients on ventilators and patients with traumatic brain injury.

Section 75-02-02-09.1. Section 75-02-02-09.1 is amended to exclude Indians being served by Indian Health Services or referred for contract health services, and terminally ill patients receiving hospice from the copayment requirements; and to clarify copayments.

Section 75-02-02-09.3. Section 75-02-02-09.3 is amended to clarify payments for replacement dentures.

Section 75-02-02-09.4. Section 75-02-02-09.4 is amended to include language moved from section 75-02-02-08 dealing with determinations of medical necessity.

Section 75-02-02-09.5. Section 75-02-02-09.5 is amended to clarify provider limitations for providing certain personal care services, to add language regarding the maximum units that can be authorized for laundry, shopping, and housekeeping, and to require applicants to provide information needed to process an application.

Section 75-02-02-10. Section 75-02-02-10 is amended to clarify responsibilities of the independent review team.

Section 75-02-02-10.1. Section 75-02-02-10.1 is

amended to clarify language and identify when services are not payable.

Section 75-02-02-10.2. Section 75-02-02-10.2 is amended to clarify "ambulatory behavioral health care."

Section 75-02-02-11. Section 75-02-02-11 is amended to clarify the definition of "coordinated services provider," to clarify the process for assigning a coordinated services provider, and to clarify appeal rights of a person in the coordinated services provider program.

Section 75-02-02-12. Section 75-02-02-12 is amended to define "screening" and to clarify language.

Section 75-02-02-13. Section 75-02-02-13 is amended to define "out-of-state provider," to clarify the definition of "primary care provider," and to clarify terms and payments to out-of-state providers.

Section 75-02-02-13.1. Section 75-02-02-13.1 is amended to clarify who may be a transportation provider, who may be paid for transportation services, when travel expense is not paid, and limitations on payment of travel expenses.

Section 75-02-02-13.2. Section 75-02-02-13.2 is amended to clarify payment of travel expenses for an institutionalized person and who may be paid those expenses.

Section 75-02-02-14. Section 75-02-02-14 is amended to clarify language.

Section 75-02-02-27. Section 75-02-02-27 is amended to identify what medications the department may not prior authorize.

Section 75-02-02-28. Section 75-02-02-28 is amended to remove duplicative language.

Section 75-02-02-29. Section 75-02-02-29 is created from language that was removed from section 75-02-02-08 dealing with primary care providers.

7. No written requests for regulatory analysis have been filed by the Governor or by any agency. The proposed amendments are not expected to have an impact on the regulated community in excess of $50,000. A regulatory analysis was prepared and is attached to this report.
8. A small entity regulatory analysis and small entity economic impact statement were prepared and are attached to this report.
9. These rules do have a fiscal impact on state revenues and expenditures, including on any funds controlled by the Department. The Department anticipates an increase in state general fund expenditures of approximately $12,506 per year.
10. A constitutional takings assessment was prepared and is attached to this report.
11. These rules were not adopted as emergency (interim final) rules.

Prepared by:

Julie Leer
Legal Advisory Unit
North Dakota Department of Human Services
September 13, 2012

SUMMARY OF COMMENTS RECEIVED
REGARDING PROPOSED AMENDMENTS TO
N.D. ADMIN. CODE CHAPTER 75-02-02
MEDICAL SERVICES

The North Dakota Department of Human Services (the Department) held a public hearing on April 23, 2012, in Bismarck, ND, concerning the proposed amendments to N.D. Administrative Code chapter 75-02-02, Medical Services.

Written comments on these proposed amendments could be offered through 5:00 p.m. on May 3, 2012.

One individual attended the public hearing. Three sets of written comments were received within the comment period. The commentors were:

1. June Herman, Regional VP, Advocacy, American Heart Association, 1005 12th Ave SE, Jamestown, ND
2. Scott Barry, North Dakota Academy of Physician Assistants, Fargo, ND
3. Amanda K. Ihmels, North Dakota Dietetic Association, Bismarck, ND
4. Constance Hofland, North Dakota Dietetic Association, Bismarck, ND

SUMMARY OF COMMENTS

Comment: The concern raised is within the first two weeks after the stroke, and being in the hospital, getting therapy twice a day so some concerns about the limitations that are within the document regarding physical therapy and speech therapy when it came to a stroke victim. At the initial onset, the family is so jumbled with what they are dealing with, and of course and what they trying to do within the first six months of a stroke is to reestablish a lot of the pathways so that the survivor can return to the best functioning as possible. So that leads me to section 4, the cost sharing. I am wondering if a potential solution in the future may be is, if it's a stroke victim within the first six months of their stroke if there is any consideration that could be done as far as imposing some of the co-payments. When the individual who had the stroke was the primary wage earner for the family, there could be some significant impact. When you look at, if you flip the page to the co-payment for physical therapy for each visit and for each speech therapy visit, it is really critical that they receive a lot of therapy right off the bat. When you start adding up the number of therapies you need for a stroke it does start to put a financial burden on the family. So that is one area for consideration.

Response: First of all, the Department certainly can check with the Centers for Medicare and Medicaid Services (CMS) to see if the Department can exclude individuals by disease state from cost sharing.

The response the Department received from CMS in follow-up is: "The comparability of service rules under 42 CFR 440.240 would apply, and thus a State could not exempt individuals arbitrarily based on illness or condition. While 1916A allows States to target cost

sharing to specific groups, it does not permit variations between people in the same cost sharing category unless comparability is met. So for instance if the State imposes cost sharing for an office visit for all groups and they want to exempt cost sharing if the person has a stroke diagnosis that could result, for example, in one individual in the parent/caretaker group having cost sharing and another in that same group not having cost sharing – and that type of deviation from comparability is not allowed."

Comment: Under section 6, where it starts with 75-02-02-09.4, b and c are the ones that provide a particular number of limitations on the visits. Within the first six months that doesn't give the stroke victim a lot of opportunity for some of the rehabilitative services. Is there any potential language that would allow for stroke patients or if you have to put some limitations on stroke patients within the first six months. I don't know the impact and burden on licensing on the department by noting this; I just wanted to point out the impact to the stroke family.

Response: The Department doesn't have separate cost sharing for services while someone is inpatient. When a patient is discharged and is receiving the services outpatient, copayments would kick in. Unless the patient fits into one of Medicaid's excluded categories, i.e., pregnant women, children, etc. With regard to the limitations on the number of services per year, where the rules allow 15 visits per year of physical therapy and 30 visits per year of speech therapy, those are service limits that the department put in place back in '04 and some of them in '05 in response to some budget situations where the Legislative Assembly asked the Department to look at its services and implement some limitations. With all of these, the provider who is delivering the service may request permission from the department to exceed those limits. If there is medical documentation to support the necessity of that, the Department will approve those. There is the ability for a patient to receive the services above these limits.

Comment: The follow up I have: is there a delay in approval for the additional therapies, because that was the other point that was raised is not to have a gap. If there is an approval process by which the department needs to get word back out, do they then have the hold on the physical and speech therapy not knowing if they are going to be reimbursed.

Response: Nearly all of the time, with the exception of an unanticipated staff absence of the staff person who does those approvals, they are done very timely. The only delay would be if the provider waited until the last visit was used to request future visits and the next future visit is tomorrow. Then there could be some delay, but if the provider anticipates that the patient is using two visits per week and only has two left so by the end of next week the patient is going to be out and submits that request for additional therapy, there shouldn't be a gap in service. It's just the coordination of all that and the anticipation of when that's going to end.

Comment: On the very last page where it lists the different services that could be covered under home and community based services; what qualifies under home and community based services? Are we talking about physical therapy, speech therapy? A new community

based service that we are looking at developing in our state is community paramedicine. It may be too soon for these particular rules, but if that did fit in home and community based services, that would be a potential good thing for the state because we are trying to get find a way to get health care delivery out in to some rural areas through the concept of community paramedicine.

Response: The section you Are referring to, for the record, is 75-02-02-30, and is specifically related to the primary care provider rules. That particular section, Item 5 and, then L, Home and Community Based Services, is saying those services in that list under Item 5 do not need to have a referral from a primary care provider. If somebody is required to have a primary care provider and their primary care provider determines they need to see a neurologist, they need a referral to go to the neurologist, but if they need home and community based services they do not need a referral for home and community based services.

In response to the question: what are those home and community based services? They are primarily personal care services, the emergency response system, they are not specifically the therapy type services because those do need that whole care plan where the physician or the primary care provider is aware of it and makes the referral to the physical therapist.

Comment: 75-02-02-08 (1)(a)(1): "Should say 'under the direction of a physician, physician assistant or dentist ...' since PAs provide inpatient hospital services and issue orders relative to care and treatment."

Response: According to 42 CFR 440.10: Inpatient hospital services means those items and services ordinarily furnished by the hospital for the care and treatment of inpatients provided under the direction of a physician or dentist . . .

The Department cannot add physician assistants to this provision through rulemaking. No change is made to the rules based on this comment.

Comment: 75-02-02-08 (1)(b): "Should say, '... under the direction of a physician, physician assistant or dentist ...' since PAs provide outpatient hospital services including preventive, diagnostic, therapeutic, rehabilitative, or palliative items and services."

Response: According to 42 CFR 440.20: Outpatient hospital services means preventative, diagnostic, therapeutic, rehabilitative or palliative services that-
(1) are furnished to outpatients;
(2) are furnished by or under the direction of a physician or dentist; and
(3) are furnished by an institution that- . . .

The Department cannot add physician assistants to this provision through rulemaking. No change is made to the rules based on this comment.

Comment: 75-02-02-08 (1)(g): "Physician services, whether furnished in the office, the patient's home, a hospital, nursing facility or elsewhere. Physician services whether furnished in the office ... means those services provided, within the scope of practice of the physician's profession or physician assistant's scope of practice as defined by state law, by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy."

Response: According to 42 CFR 440.50: Physician services, whether furnished in the office, the recipients home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician:

(1) within their scope of practice of medicine or osteopathy as defined by State law; and
(2) by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy; or
(3) are furnished by a doctor of dental medicine or dental surgery who is authorized to furnish those services in the State in which he or she furnished the services.....

The Department cannot add physician assistants to this provision through rulemaking. No change is made to the rules based on this comment.

Comment: 75-02-02-08 (1)(h): "... physician services furnished by licensed practitioners within the scope of their practice."

Response: According to 42 CFR 440.60: Medical care and any other type of remedial care other than physician services provided by licensed practitioner means any medical or remedial care or services, other than physicians services, provided by licensed practitioners within the scope of practice under State law.....

The Department cannot add physician assistants to this provision through rulemaking. No change is made to the rules based on this comment.

Comment: 75-02-02-08 (1)(i): "Physicians must certify and sign the plan of care for home health for Medicare – this is a function that many PAs are trained and experienced in performing. Medicare does authorize PAs to provide care plan oversight, which these rules could at least permit, if not the certification/ordering and signing of plan of care. Therefore, it should read: "Home health care services ... based on certification of need and a written plan of care by a licensed physician or physician assistant to a patient in the patient's place of residence..."

Response: According to 42 CFR 440.70: Home health services means the services in paragraph (b) of this section that are provided to a recipient— (1) At his place of residence, as specified in paragraph (c) of this section; and (2) On his or her physician's orders as part of a written plan of care that the physician reviews every 60 days, except as specified in paragraph (b)(3) of this section...

On July 12, 2011, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule: "Medicaid Program: Face to Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health". The rule clarifies provisions enacted in Section 6407(d) of the Affordable Care Act (ACA).

Section 6407(d) of the ACA makes it clear that physician's orders for home health must be based on a face-to-face encounter. In addition, this section provides that specific nonphysician practitioners (NPP) may perform the face-to-face encounter; however, the rule still indicates the order/certification must be from the physician.

This proposed rule has not been issued as final. According to CMS, a final rule is expected in the fall of 2012. Until the federal rule is final, it would not be prudent to make any changes to ND Administrative Code based on the proposed federal rule. No change is made to the rules based on this comment.

Comment: 75-02-02-08 (1)(i)(3): "Medical supplies, equipment, and appliances ordered or prescribed by the physician or physician assistant as required I the care of the patient and suitable for use in the home;"

Response: According to 42 CFR 440.70: Home health services means the services in paragraph (b) of this section that are provided to a recipient— (1) At his place of residence, as specified in paragraph (c) of this section; and (2) On his or her physician's orders as part of a written plan of care that the physician reviews every 60 days, except as specified in paragraph (b)(3) of this section...

Home health services include the following services and items. Those listed in paragraphs (b)(1), (2) and (3) of this section are required services; those in paragraph (b)(4) of this section are optional.

> (1) Nursing service, as defined in the State Nurse Practice Act, that is provided on a part-time or intermittent basis by a home health agency as defined in paragraph (d) of this section, or if there is no agency in the area, a registered nurse who— (i) Is currently licensed to practice in the State; (ii) Receives written orders from the patient's physician; (iii) Documents the care and services provided; and (iv) Has had orientation to acceptable clinical and administrative recordkeeping from a health department nurse.
> (2) Home health aide service provided by a home health agency,
> (3) Medical supplies, equipment, and appliances suitable for use in the home.

On July 12, 2011, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule: "Medicaid Program: Face to Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health". The rule clarifies provisions enacted in Section 6407(d) of the Affordable Care Act (ACA).

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This proposed rule has not been issued as final. According to CMS, a final rule is expected in the fall of 2012. Until the federal rule is final, it would not be prudent to make any changes to ND Administrative Code based on the proposed federal rule. No change is made to the rules based on this comment.

Comment: 75-02-02-08 (1)(i)(4): "with the plan of treatment outlined for the patient by the attending physician or physician assistant and in collaboration with the home health agency."

Response: According to 42 CFR 440.70: Home health services means the services in paragraph (b) of this section that are provided to a recipient— (1) At his place of residence, as specified in paragraph (c) of this section; and (2) On his or her physician's orders as part of a written plan of care that the physician reviews every 60 days, except as specified in paragraph (b)(3) of this section...

On July 12, 2011, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule: "Medicaid Program: Face to Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health". The rule clarifies provisions enacted in Section 6407(d) of the Affordable Care Act (ACA).

Section 6407(d) of the ACA makes it clear that physician's orders for home health must be based on a face-to-face encounter. In addition, this section provides that specific nonphysician practitioners (NPP) may perform the face-to-face encounter; however, the rule still indicates the order/certification must be from the physician.

This proposed rule has not been issued as final. According to CMS, a final rule is expected in the fall of 2012. Until the federal rule is final, it would not be prudent to make any changes to ND Administrative Code based on the proposed federal rule. No change is made to the rules based on this comment.

Comment: 75-02-02-08 (1) (j): "Law includes physicians and nurses, but excludes PAs. We would like PAs included in this law."

Response: Hospice care means the following items and services provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan (for providing such care to such individual) established and periodically reviewed by the individual's attending physician and by the medical director (and by the interdisciplinary group described in paragraph (2)(B)) of the program:
(1)nursing care provided by or under the supervision of a registered professional nurse,
(2)physical or occupational therapy, or speech-language pathology services,

(3)medical social services under the direction of a physician.....

This referenced citation is taken from 42 U.S.C 1395x(dd)(1). The Department cannot add physician assistants to this provision through rulemaking. No change is made to the rules based on this comment.

Comment: 75-02-02-08 (1)(m): "PAs order physical therapy, occupational therapy, and speech, language and hearing therapy for Medicare patients; should be authorized to prescribe these services for Medicaid patients."

Response: According to 42 CFR 440.110: *Physical therapy* means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified physical therapist.

The Department will make a change to the proposed rules so the language is consistent with Federal Medicaid Regulations. The language will read as follows:

m. Physical Therapy. "Physical therapy" means those services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided to a patient by or under the supervision of a qualified physical therapist.

Comment: 75-02-02-08 (1)(n): "PAs order physical therapy, occupational therapy, and speech, language and hearing therapy for Medicare patients; should be authorized to prescribe these services for Medicaid patients."

Response: According to 42 CFR 440.110*: Occupational therapy.* (1) *Occupational therapy* means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified occupational therapist.

The Department will make a change to the proposed rules so the language is consistent with Federal Medicaid Regulations. The language will read as follows:

n. Occupational Therapy. "Occupational therapy" means those services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided to a patient and given by or under the supervision of a qualified occupational therapist.

Comment: 75-02-02-08 (1)(s): "These rules exclude PAs. Should be amended to add and the services of a physician assistant practicing within the scope of his/her professional practice as defined by state law."

Response: According to 42 CFR 440.160: Inpatient psychiatric services for individuals under age 21 means services that are provided under the direction of a physician and are provided by a psychiatric hospital.....

The Department cannot add physician assistants to this provision through rulemaking. No change is made to the rules based on this comment.

Comment: 75-02-02-08(1)(v)(2): "Amend to read '.... A physician or physician assistant practicing within the scope of his/her professional practice as defined by state law.' "

Response: The Department will be making the following change to 75-02-02-08(1)(v)(2):

(2) Family planning services, including drugs, supplies, and devices, when such services are under the medical direction of a physician or licensed practitioner of the healing arts within their scope of practice as defined by state law. There must be freedom from coercion or pressure of mind and conscience and freedom of choice of method, so that individuals may choose in accordance with the dictates of their consciences.

Comment: 75-02-02-08 (2)(g): "Should be amended to acknowledge that PAs may perform physician services and prescribe drugs to patients in a home setting."

Response: This section is solely citing which services would be excluded from a cost comparison calculation. It is not referencing actual services being delivered and does not address scope of work areas.

No change is made to the rules based on this comment.

Comment: 75-02-02-08 (3)(6)(a)(1): "Should read, '... a primary care provider who may be a physician or PA practicing within the scope of his/her professional practice as defined by state law.' "

Response: North Dakota Century Code section 50-24.1-32 does not authorize physician assistants to provide primary care case management services to Medicaid recipients. 2009 Senate Bill No. 2168 authorized nurse practitioners to serve as primary care providers; however, this legislation did not include similar language relative to physician assistants. No change is made to the rules based on this comment.

Comment: 75-02-02-08 (3)(6)(b): "Should also read, '..... a primary care provider who may be a physician or PA practicing within the scope of his/her professional practice as defined by state law.' "

Response: North Dakota Century Code section 50-24.1-32 does not authorize physician assistants to provide primary care case management services to Medicaid recipients. 2009 Senate Bill No. 2168 authorized nurse practitioners to serve as primary care providers;

however, this legislation did not include similar language relative to physician assistants. No change is made to the rules based on this comment.

Comment: 75-02-02-08 (3)(6)(c): "List of physician specialties which you wouldn't expect to find PAs necessarily, except that PAs are not identified as primary care provided or as providing medically necessary services anywhere else which are services that commonly provide and should therefore be paid for by insurance, public and private."

Response: North Dakota Century Code section 50-24.1-32 does not authorize physician assistants to provide primary care case management services to Medicaid recipients. 2009 Senate Bill No. 2168 authorized Nurse practitioners to serve as primary care providers; however, this legislation did not include similar language relative to physician assistants. No change is made to the rules based on this comment.

Comment: 75-02-02-08 (3)(e): "§ PAs are excluded from this list,. but should not be."

Response: North Dakota Century Code section 50-24.1-32 does not authorize physician assistants to provide primary care case management services to Medicaid recipients. 2009 Senate Bill No. 2168 authorized nurse practitioners to serve as primary care providers; however, this legislation did not include similar language relative to physician assistants. No change is made to the rules based on this comment.

Comment: 75-02-02-09.1(2)(c): "Should say, 'each physician doctor of medicine or osteopathy visit or PA practicing within the scope of his/her professional practice as defined by state law.'"

Response: North Dakota Century Code section 50-24.1-32 does not authorize physician assistants to provide primary care case management services to Medicaid recipients. 2009 Senate Bill No. 2168 authorized nurse practitioners to serve as primary care providers; however, this legislation did not include similar language relative to physician assistants. No change is made to the rules based on this comment.

Comment: 75-02-02-10(1)(3)(a):

- Be composed of individuals who have no business or personal relationship with the inpatient psychiatric facility or program requesting a certification of need;
- Include a physician;
- Have competence in diagnosis and treatment of mental illness; and
- Have adequate knowledge of the situation of the individual for whom the certification of need is requested.
- § Should say, include a physician or PA practicing within the scope of his/her professional practice as defined by state law."

Response: According to 42 CFR 441.153 (Team certifying need for services):

Certification under §441.152 must be made by terms specified as follows: (a) For an individual who is a recipient when admitted to a facility or program, certification must be made by an independent team that—(1) Includes a physician; (2) Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and (3) Has knowledge of the individual's situation.

(b) For an individual who applies for Medicaid while in the facility of program, the certification must be— (1) Made by the team responsible for the plan of care as specified in §441.156; and (2) Cover any period before application for which claims are made.

(c) For emergency admissions, the certification must be made by the team responsible for the plan of care (§441.156) within 14 days after admission.

The Department cannot add physician assistants to this provision through rulemaking. No change is made to the rules based on this comment.

Comment: 75-02-02-11(1)(b): "Should say physician, nurse practitioner, physician assistant, or Indian health services provider."

Response: North Dakota Century Code section 50-24.1-32 does not authorize physician assistants to provide primary care case management services to Medicaid recipients. 2009 Senate Bill No. 2168 authorized nurse practitioners to serve as primary care providers; however, this legislation did not include similar language relative to physician assistants. No change is made to the rules based on this comment.

Comment: 75-02-02-12(2)(d): "Should say, personal physician, one substituting for that physician, primary care provider, or PA practicing within the scope of his/her professional practice as defined by state law."

Response: North Dakota Century Code section 50-24.1-32 does not authorize physician assistants to provide primary care case management services to Medicaid recipients. 2009 Senate Bill No. 2168 authorized nurse practitioners to serve as primary care providers; however, this legislation did not include similar language relative to physician assistants. No change is made to the rules based on this comment.

Comment: 75-02-02-12(3)(4)(b): "Should say, '... authorized by physician, nurse practitioner or physician assistant ...' "

Response: North Dakota Century Code section 50-24.1-32 does not authorize physician assistants to provide primary care case management services to Medicaid recipients. 2009 Senate Bill No. 2168 authorized nurse practitioners to serve as primary care providers;

however, this legislation did not include similar language relative to physician assistants. No change is made to the rules based on this comment.

Comment: 75-02-02-30(1)(a): "To be clear this should say, a primary care provider whom may be a physician assistant practicing within the scope of his/her professional practice as defined by state law."

Response: North Dakota Century Code section 50-24.1-32 does not authorize physician assistants to provide primary care case management services to Medicaid recipients. 2009 Senate Bill No. 2168 authorized nurse practitioners to serve as primary care providers; however, this legislation did not include similar language relative to physician assistants. No change is made to the rules based on this comment.

Comment: 75-02-02-30(3): "Should say, 'A physician, a physician assistant or nurse practitioner...' ".

Response: North Dakota Century Code section 50-24.1-32 does not authorize physician assistants to provide primary care case management services to Medicaid recipients. 2009 Senate Bill No. 2168 authorized nurse practitioners to serve as primary care providers; however, this legislation did not include similar language relative to physician assistants. No change is made to the rules based on this comment.

Comment: This proposed rule change does not change any current Medicaid reimbursement, correct?

Response: That is correct. No change is made to the rules based on this comment.

Comment: As the rule change currently is it does not provided reimbursement for weight management programs, even if taught by a licensed registered dietitian?

Response: Weight management programs are not a covered service, regardless of who the provider is. Medical Nutrition Therapy, which ND Medicaid does cover, is described in the Medicaid Coding Guideline which can be found at:
http://www.nd.gov/dhs/services/medicalserv/medicaid/cpt.html

No change is made to the rules based on this comment.

Comment: Section 75-02-02-08 r. (2) does not specify or exclude registered dietitians. If we are looking to be considered as a preventative services practitioner do we need to have RDs included?

Response: Licensed registered dietitians can enroll in ND Medicaid to provide Medical Nutrition Therapy. The rule in 75-02-02-08 h. includes "Medical care and any other type of remedial care recognized under state law and furnished by licensed practitioners within the

scope of their practice as defined by state law." Licensed registered dietitians would fall under this definition and do not need to be separately identified. No change is made to the rules based on this comment.

Comment: Is there any other reason for adding the definitions in subsections (1)(w) and (x) for "exercise program" and "weight loss program" other than to use these terms rather than "diet remedies" in subsection (2)(a) to exclude "exercise programs" and "weight loss programs?"

Response: No there is no other reason for adding the definitions noted. The reason the two definitions are added is because the two terms are used later in the chapter. No change is made to the rules based on this comment.

Comment: What is the reason for listing some services specifically in the new Section 75-02-02-30? Is it because these are the services listed in 42 USC 1396u-2 and these would not otherwise be covered by the rule in 75-02-02-08 (h) or is there some other reason for listing out some services specifically?

Response: 75-02-02-30 is the primary care provider section and the services listed in subsection (5) are those services that do not require a referral from a primary care provider. This section was previously located in 75-02-02-08; it was revised and moved as part of this rulemaking. No change is made to the rules based on this comment.

Prepared by:

Julie Leer

Julie Leer, Director
Legal Advisory Unit
N.D. Dept. of Human Services

In Consultation with: Maggie Anderson, Medical Services

July 20, 2012

Cc: Maggie Anderson, Medical Services
Cindy Sheldon, Medical Services

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Jack Dalrymple, Governor
Carol K. Olson, Executive Director

MEMO

TO: Julie Leer, Director, Legal Advisory Unit

FROM: Maggie Anderson and Cindy Sheldon, Medical Services Division

RE: Regulatory Analysis of Proposed North Dakota Administrative Code chapter 75-02-02, Medical Services

DATE: January 25, 2012

The purpose of this regulatory analysis is to fulfill the requirements of N.D.C.C. § 28-32-08. This analysis pertains to proposed North Dakota Administrative Code Article 75-02-02. These amendments are not anticipated to have a fiscal impact on the regulated community in excess of $50,000.

Purpose

The purpose of this regulatory analysis is to fulfill the requirements of N.D.C.C. § 28-32-08.1. This impact statement pertains to proposed amendments to N.D. Admin. Code chapter 75-02-02. Federal law does not mandate the proposed rules.

Classes of Persons Who Will be Affected

The classes of persons who will most likely be affected by these rules are:

- Recipients that receive services through the Medicaid program
- Personal Attendant Care providers
- Medical providers

These groups will be affected by:

- Copayments will be eliminated for certain categories of Medicaid eligible individuals (i.e. Indians who receive services through Indian Health

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Services or through contract health, or recipients who are terminally ill and receiving hospice).

- Copayments will decrease from three to six dollars for each nonemergency service provided in a hospital emergency room.
- By expanding the provider types that can serve Medicaid recipients in the Primary Care Case Management program, the rules will ensure consistency with North Dakota Century Code, which also allows Nurse Practitioners to serve as Primary Care Providers.

Probable Impact

The proposed amendments may impact the regulated community as follows:

- Copayment eliminations will benefit the provider's administrative processes by eliminating the need to collect copayments from recipients.
- A broader pool of providers will benefit from Medicaid case management reimbursement because they will be able to provide services to Medicaid recipients who are on the Primary Care Case Management program.
- Medicaid recipients will benefit by having no copayment if: an Indian who receives services from Indian Health Services providers or through referral by Contract Health Services or is terminally ill and is receiving hospice.

Probable Cost of Implementation

The fiscal impact projection for implementing the proposed rule is $12,505.84 in state general funds per year.

Consideration of Alternative Methods

A review of Medicaid policies, federal and state laws, which lead to the proposed amendments, was undertaken to determine the best approach to changes. The review included a discussion of current policy, possible alternatives, and recommendations to the Department. The amendments provide the least impact to Medicaid recipients, Medical Service providers and fiscally.

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ıck Dalrymple, Governor
arol K. Olson, Executive Director

MEMORANDUM

TO: Julie Leer, Director, Legal Advisory Unit

FROM: Maggie Anderson and Cindy Sheldon, Medical Services Division

DATE: January 25, 2012

SUBJECT: Small Entity Regulatory Analysis Regarding Proposed Amendments to N.D. Admin. Code chapter 75-02-02.

The purpose of this small entity regulatory analysis is to fulfill the requirements of N.D.C.C. § 28-32-08.1. This regulatory analysis pertains to proposed amendments to N.D. Admin. Code chapter 75-02-02. Federal law does not mandate the proposed rules.

Consistent with public health, safety, and welfare, the Department has considered using regulatory methods that will accomplish the objectives of applicable statutes while minimizing adverse impact on small entities. For this analysis, the Department has considered the following methods for reducing the rules' impact on small entities:

1. Establishment of Less Stringent Compliance or Reporting Requirements

The only small entities affected by these proposed amendments are small medical providers. The impact will not be a negative one, but more importantly a helpful one. By expanding the provider types that can serve Medicaid recipients in the Primary Care Case Management program, the rules will ensure consistency with North Dakota Century Code, which also allows Nurse Practitioners to serve as Primary Care Providers.

The proposed amendments are as least stringent as possible to incorporate Federal and state law, program integrity and program changes. The reporting requirements have not changed.

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2. Establishment of Less Stringent Schedules or Deadlines for Compliance or Reporting Requirements for Small Entities

The proposed amendments will not alter in any material way any required schedules or deadlines for compliance or reporting requirement of providers; however, if they are not an enrolled provider, they will be required to enroll as a provider with Medical Services.

3. Consolidation or Simplification of Compliance or Reporting Requirements for Small Entities

The proposed amendments will not alter in any material way any required compliance or reporting requirements of providers. For this reason, the establishment of less stringent schedules or deadlines for compliance or reporting requirements for these small entities was not considered.

4. Establishment of Performance Standards for Small Entities to Replace Design or Operational Standards Required in the Proposed Rules

The design and operational standards required in the proposed rules will not change for providers.

5. Exemption of Small Entities From All or Any Part of the Requirements Contained in the Proposed Rules

The requirements of the proposed amendments are imposed on all recipients and providers receiving or rendering services for Medicaid; there are no exceptions.

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Carol K. Olson, Executive Director

MEMORANDUM

TO: Julie Leer, Director, Legal Advisory Unit

FROM: Maggie Anderson, Director, Medical Services

DATE: January 25, 2012

SUBJECT: Small Entity Economic Impact Statement Regarding Proposed Amendments to N.D. Admin. Code chapter 75-02-02.

The purpose of this small entity economic impact statement is to fulfill the requirements of N.D.C.C. § 28-32-08.1. This impact statement pertains to proposed amendments to N.D Administrative Code chapter 75-02-02.

1. Small Entities Subject to the Proposed Rules

The small entities that are subject to the proposed amended rules are Medicaid recipients and providers.

2. Costs For Compliance

There are no expected administrative and other costs required for compliance with the proposed rules.

3. Costs and Benefits

There are no expected probable costs to private persons and consumers who are affected by the proposed rules.

The probable benefit to private persons and consumers who are affected by the proposed rule: there will be benefits to Medicaid recipients for the decrease or

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elimination of copayments and because of the expansion of the provider types (to include Nurse Practitioners) that can serve as a Primary Care Provider.

4. Probable Effect on State Revenue

The probable effect of the proposed rules on state revenues is an estimated increase in state general funds of $12,505.84 per year.

5. Alternative Methods

The Department considered whether there are any less intrusive or less costly alternative methods of achieving the purpose of the proposed rules. Because small entities will not experience administrative costs or other costs, exploring alternative methods was not necessary.

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Carol K. Olson, Executive Director

TAKINGS ASSESSMENT

concerning proposed amendment to N.D. Admin. Code chapter 75-02-02.

This document constitutes the written assessment of the constitutional takings implications of this proposed rulemaking as required by N.D.C.C. § 28-32-09.

1. This proposed rulemaking does not appear to cause a taking of private real property by government action which requires compensation to the owner of that property by the Fifth or Fourteenth Amendment to the Constitution of the United States or N.D. Const. art. I, § 16. This proposed rulemaking does not appear to reduce the value of any real property by more than fifty percent and is thus not a "regulatory taking" as that term is used in N.D.C.C. § 28-32-09. The likelihood that the proposed rules may result in a taking or regulatory taking is nil.

2. The purpose of this proposed rule is clearly and specifically identified in the public notice of proposed rulemaking which is by reference incorporated in this assessment.

3. The reasons this proposed rule is necessary to substantially advance that purpose are described in the regulatory analysis which is by reference incorporated in this assessment.

4. The potential cost to the government if a court determines that this proposed rulemaking constitutes a taking or regulatory taking cannot be reliably estimated to be greater than $0. The agency is unable to identify any application of the proposed rulemaking that could conceivably constitute a taking or a regulatory taking. Until an adversely impacted landowner identifies the land allegedly impacted, no basis exists for an estimate of potential compensation costs greater than $0.

5. There is no fund identified in the agency's current appropriation as a source of payment for any compensation that may be ordered.

6. I certify that the benefits of the proposed rulemaking exceed the estimated compensation costs.

Dated this 25th day of January, 2012.

by: Julie Lee
N.D. Dept. of Human Services