SENATE HUMAN SERVICES COMMITTEE

HB 1044

Testimony of Jay Metzger, PA-C

North Dakota Academy of Physician Assistants

February 20, 2023

Chairman Lee, Senate Human Services Committee members, the North Dakota Academy of PAs is asking for a DO NOT PASS recommendation on HB 1044.

HB 1044, submitted by the ND Department of Health and Human Services (NDDHHS), will remove section 50-24.1-32 of the NDCC, a law that explicitly codifies that PAs and NPs are recognized as primary care providers in the Medicaid program. NDDHHS testimony to the House Human Services committee conveyed that PAs and NPs were aware of the bill and issues surrounding the intent, but we were not. Our opposition is not simply because we were not informed; it is because this law ensures that PAs and NPs are recognized as primary care providers for our Medicaid patients.

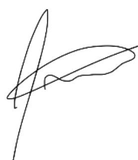
In discussions with the NDDHHS following the House HSC hearing, the intent as to why this piece of the NDCC needs to be removed does not make sense to us. The NDDHHS desires to discontinue the Primary Care Case Management program (PCCM), and to do so, they feel that removing this section from the NDCC is the only way. Title 75-02-02-29 of the ND Admin Code, which has section 50-24.1-32

as a law implemented, covers many other providers and aspects of care for Medicaid patients, not just PAs and NPs (see excerpt from Title 75 below). The authority for Title 75-02-02-29 comes from NDCC 50-24.1-04, which gives the NDDHHS the authority to adopt rules and regulations as necessary to qualify for any federal funds available to the Medicaid program.

The NDAPA opposes HB 1044 because there is no reason why this section of the NDCC must be removed to achieve the end goal that the NDDHHS and those that want to end the PCCM program desire. The NDDHHS has the authority to change through the Admin Code process, and the NDAPA believes that is how this it should be done. Removing the law that recognizes PAs and NPs as primary care providers for Medicaid patients puts our members at risk of being denied that ability in the future without going through the legislative process.

Chairman Lee and members of the Senate Human Services Committee, the members of the NDAPA ask for a DO NOT PASS on HB 1044.

Thank you for your time.



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advantage in terms of safety, effectiveness, or clinical outcome over other available drugs used for the same therapeutic indication.

5. Drug use review board meeting procedures.

   a. Any interested party may address the drug use review board at its regular meetings if the presentation is directly related to an agenda item.

   b. The drug use review board may establish time limits for presentations.

   c. The department shall post on its web site the proposed date, time, location, and agenda of any meeting of the drug use review board at least thirty days before the meeting.

6. Within thirty days of the date the drug use review board's recommendation is received by the department, the department shall review the recommendations and make the final determination as to whether a drug requires prior authorization and, if so, when the requirement for prior authorization will begin. If the department's final determination is different from the recommendation of the drug use review board, the department shall present, in writing, to the drug use review board at its next meeting the basis for the final determination.

7. The department shall post on its web site the list of drugs subject to prior authorization and the date on which each drug became subject to prior authorization.

8. A recipient may appeal the department's denial, suspension, reduction, or termination of a covered drug based upon application of this section as authorized under North Dakota Century Code chapter 28-32.

History: Effective September 1, 2003; amended effective October 1, 2012; April 1, 2020.
General Authority: NDCC 50-24.6-10
Law Implemented: NDCC 50-24.6; 42 USC 1396r-8

75-02-02-29. Primary care provider.

1. Payment may not be made for services that require a referral from a recipient's primary care provider for recipients, with the exception of recipients who are notified by the department and are required within fourteen days from the date of that notice, but who have not yet selected, or have not yet been auto-assigned a primary care provider.

2. A primary care provider must be selected by or on behalf of the members in the following Medicaid units:

   a. The parents or caretaker relatives and their spouses of a deprived child under the age of eighteen years, but through the month of the child's eighteenth birthday, up to fifty-four percent of the federal poverty level.

   b. For up to twelve months, the parents or caretaker relatives, along with their spouses and dependent children, of a deprived child under the age of eighteen years, but through the month of the child's eighteenth birthday, who were eligible under the parents and caretaker relatives and their spouses category in at least three of the six months immediately preceding the month in which the parents or caretakers lose coverage under the parents and caretaker relatives and their spouses category due to increased earned income or hours of employment.

   c. For up to four months, the parents or caretaker relatives, along with their spouses and dependent children, of a deprived child under the age of eighteen years, but through the month of the child's eighteenth birthday, who were eligible under the parents and caretaker relative and their spouses category in at least three of the six months

immediately preceding the month in which the parents or caretaker relatives lose coverage under the parents and caretaker relatives and their spouses category due to increased alimony or spousal support.

d. A pregnant woman up to one hundred fifty-seven percent of the federal poverty level.

e. An eligible woman who applied for and was eligible for Medicaid during pregnancy continues to be eligible for sixty days, beginning on the last day of pregnancy, and for the remaining days of the month in which the sixtieth day falls.

f. A child born to an eligible pregnant woman who applied for and was found eligible for Medicaid on or before the day of the child's birth, for twelve months, beginning on the day of the child's birth and for the remaining days of the month in which the twelfth month falls.

g. A child, not including a child in foster care, from birth through five years of age up to one hundred forty-seven percent of the federal poverty level.

h. A child, not including a child in foster care, from six through eighteen years of age, up to one hundred thirty-three percent of the federal poverty level.

i. A child, not including a child in foster care, from six through eighteen years of age who becomes Medicaid eligible due to an increase in the Medicaid income levels used to determine eligibility.

j. An individual who is not otherwise eligible for Medicaid and who was in title IV-E funded, state-funded, or tribal foster care in this state under in the month the individual reaches eighteen years of age, through the month in which the individual reaches twenty-six years of age.

k. A pregnant woman who requires medical services and qualifies for Medicaid on the basis of financial eligibility resulting in a recipient liability under section 75-02-02.1-41.1 and whose income is above one hundred fifty-seven percent of the federal poverty level.

l. A child less than nineteen years of age who requires medical services and qualifies for Medicaid on the basis of financial eligibility resulting in a recipient liability under section 75-02-02.1- 41.1 and whose income is above one hundred seventy percent of the federal poverty level.

m. The parents and caretaker relatives and their spouses of a deprived child who require medical services and qualify for Medicaid on the basis of financial eligibility resulting in a recipient liability under section 75-02-02.1-41.1 and whose income is above one hundred thirty-three percent of the federal poverty level.

n. A child, not including a child in foster care, less than nineteen years of age with income up to one hundred seventy percent of the federal poverty level.

o. An individual age nineteen or twenty eligible under Medicaid expansion, as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152], and implementing regulations.

3. A physician, advanced practice registered nurse with the role of nurse practitioner, physician assistant, or certified nurse midwife practicing in the following specialties or the following entities may be selected as a primary care provider:

a. Family practice;

b. Internal medicine;

c. Obstetrics;

d. Pediatrics;

e. General practice;

f. Adult health;

g. A rural health clinic;

h. A federally qualified health center; or

i. An Indian health services clinic or tribal health facility clinic.

4. A recipient need not select, or have selected on the recipient's behalf, a primary care provider if:

   a. The recipient is aged, blind, or disabled;

   b. The period for which benefits are sought is prior to the date of application;

   c. The recipient is receiving foster care or subsidized adoption benefits;

   d. The recipient is receiving home and community-based services; or

   e. The recipient has been determined medically frail under section 75-02-02.1-14.1.

5. Payment may be made for the following medically necessary covered services whether or not provided by, or upon referral from, a primary care provider:

   a. Early and periodic screening, diagnosis, and treatment of recipients under age twenty-one;

   b. Family planning services;

   c. Certified nurse midwife services;

   d. Optometric services;

   e. Chiropractic services;

   f. Dental services;

   g. Orthodontic services provided as the result of a referral through the early and periodic screening, diagnosis, and treatment program;

   h. Services provided by an intermediate care facility for individuals with intellectual disabilities;

   i. Emergency services;

   j. Transportation services;

   k. Targeted case management services;

   l. Home and community-based services;

   m. Nursing facility services;

n. Prescribed drugs except as otherwise specified in section 75-02-02-27;

o. Psychiatric services;

p. Ophthalmic services;

q. Obstetrical services;

r. Behavioral health services;

s. Services for treatment of addiction;

t. Partial hospitalization for psychiatric services;

u. Ambulance services;

v. Immunizations;

w. Independent laboratory and radiology services;

x. Public health unit services; and

y. Personal care services.

6. Except as provided in subsection 4, or unless the department exempts the recipient, a primary care provider must be selected for each recipient.

7. The department may not limit a recipient's disenrollment from a primary care provider. A primary care provider may be changed at any time upon request by the recipient.

History: Effective October 1, 2012; amended effective July 1, 2014; April 1, 2016; January 1, 2017; April 1, 2018; April 1, 2020; January 1, 2022.
General Authority: NDCC 50-24.1-04, 50-24.1-41
Law Implemented: NDCC 50-24.1-32, 50-24.1-41; 42 USC 1396u-2