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North Dakota Department of Human Services Medicaid Access Monitoring Plan 2016

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Executive Summary: Review of recent updates to North Dakota Medicaid Access Monitoring Plan:

1. Public Comments:

The draft North Dakota Department of Human Services Medicaid Access Monitoring Plan 2016 was widely disseminated* for public comment on August 9, 2016, with comment period closing on September 9, 2016. No public comments were received. (*Note: public notice of the Access Plan was shared with the North Dakota Medicaid Medical Advisory Committee, with the North Dakota DHS/Tribal Consultation work group, all DHS staff, State legislators and County Social Service Directors. The draft Plan was posted on-line at both the DHS website and new CMS website, and notice was distributed to newspapers across the state).

2. Comments about data challenges:

a. Managing rural data in a small state such as North Dakota: Annually some data elements increase or decrease as a natural "churning" related to Medicaid beneficiary eligibility, and related to providers enrolling, increasing, or decreasing the available appointment openings they have available. Some of the provider numbers are small, so for example in one instance, the addition of just 2 providers resulted in a 200% increase for that provider type in one region. This "small number/large data change" dynamic lends to increased challenges in analyzing new data trends being monitored related to access to care.

b. Data related to counties with small Medicaid populations sometimes results in small data numbers, to the point that releasing the data risks disclosure of confidential information; every effort will be made to accomplish data transparency, but not at the risk of disclosures.

c. North Dakota implemented a new Medicaid Management Information System (MMIS) in October, 2015 (the Health Enterprise System), and a new eligibility system (SPACES) in February 2016. There is inevitable and often continuous improvement and system tweaking with large scale information technology transitions such as these. Medical Services Division staff has been primarily focused on efforts that directly affect beneficiaries and providers, and more recently, have been working on validating key data reports that paint a picture of access to care.

Data trend analysis has been affected by the new IT implementations. One example is Medicaid provider enrollment. By history, some providers were enrolled as group or facility enrollment but in the new MMIS all providers are enrolled as individual practitioners; also some providers chose not to

re-enroll. The effect is that related data elements have changed for underlying reasons having nothing to do with gains or losses related to beneficiary access.

As the new IT systems' operability capacities continue to be developed, DHS will add additional reporting methodologies but meanwhile, have now successfully generated and validated Medicaid specific reports that inform about access (see page 52 for discussion of data analysis and conclusions, and Appendix K at the end of this document to view data report details). In addition, the Medicaid Access Monitoring Plan incorporates substantial collateral data from an abundant number of state and national data sources that inform the access conclusions.

d. The nationwide implementation of the Affordable Care Act (ACA), and North Dakota's adoption of Medicaid Expansion on January 1, 2014, also has influenced the analysis of data trends. Some examples include: significant public campaigns and navigator assistance was available to facilitate beneficiary enrollments, and some previously uninsured individuals enrolled because of the individual mandate within the ACA. Enrollment "churning" occurred in the second half of SFH 2014 and throughout SFY 2015, as individuals and households began to sort out and in some instances change their enrollment choices. All of this impacts on the data trend lines. One example of impact was that while "services per 1000" data was relatively stable during SFY 2013 and SFY 2014 (with the second six-months impacted by ACA implementation), service volume does show declines in SFY 2015. DHS data analytics staff believes that in part, the SFY 2015 declines are related to the "woodwork effect". The woodwork effect was anticipated as a result of the ACA, including Medicaid expansion. It was expected that individuals would enroll for a number of the reasons described above, rather than the primary enrollment reasons prior to ACA, namely that the enrollee had health problems of concern driving their enrollment decision. The outcome is that healthier individuals enrolled in traditional Medicaid, as well as preventative care was available, which in combination, led to less health care acuity per 1,000 data, so the numbers decline in SFY 2015 in part is for this reason. An additional contributor was the workforce impacts related to the oil boom. It has been particularly challenging to maintain health care work force in western and some parts of central North Dakota. This occurred for many reasons. One example is that in Williston, ND housing costs became comparable to New York City and San Francisco.

e. Rurality impacts access to care in many areas of North Dakota, including that 36 of our 53 counties (68%) have frontier county designation, as well as our state has a significant number of health professional shortage areas and medically underserved areas and populations. On more positive notes, our state has providers who strongly value the quality of the care delivered, our Medicaid reimbursement rates remain strong compared to national trends, and some of the state-by-state rankings indicate that health care access in our state remains positive, despite the barriers. These

conclusions are further validated by the preliminary snapshot results associated with the Medicaid beneficiary survey, as discussed in the following bullet.

3. Medicaid Beneficiary Access Survey:

The CMS Access Rule highlights the importance of states seeking feedback from Medicaid beneficiaries in regard to their access to medical care. The reader is referred to page 43 for expanded narrative of the approach North Dakota has employed to accomplish beneficiary feedback related to access, as well as can view the beneficiary survey in Appendix F on pp 107.

After consultation and exploration of survey options, North Dakota elected to design a brief, access-specific survey that asked traditional Medicaid households questions directly associated with the 5 primary provider groups being targeted nationally for access analysis. Initially, draft surveys were administered to 7 adult traditional fee-for-service beneficiaries to test survey viability. Survey questions were generally aligned with accepted national survey format. An initial 12 month timeframe was modified to 6 months to improve alignment.

The beneficiary survey is being enclosed within a recipient newsletter sent to traditional fee-for-service Medicaid households, with the option of completing the survey on-line or via paper copy. An initial mailing of newsletters with surveys enclosed was disseminated to 2,061 Medicaid households in order to further test the survey methodology and to confirm beneficiary understanding of questions and that the access questions “get to” specific feedback regarding access to health care.

The preliminary analysis of the first 141 survey responses confirmed that the survey was operationalizing as intended. The final step in surveying is now being implemented, which involves dissemination of the recipient newsletter with Medicaid beneficiary survey enclosed, to 41,862 traditional Medicaid households across North Dakota.

Preliminary pilot results related to the first 141 surveys analyzed are limited and not generalizable to specific geographical locations, but rather present a snapshot of access as reported by 141 traditional Medicaid households across the state. Once we are able to incorporate the responses from the pending, substantial survey dissemination, we are confident that we will be able to categorize the data by specific geographical areas as well as provide cross-tabulation of specific provider groups and frontier county designations. The preliminary response rate from our state’s more rural counties is particularly encouraging.

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Preliminary data snapshots from pilot beneficiary access survey:

- Medicaid beneficiaries from eighty-one percent of North Dakota's 53 counties have submitted survey responses (all but 10 counties), including surveys from 69% of 36 counties with frontier designation. Twelve of the 141 surveys do not include a county designation, so are categorized as "Unknown County".
- **Regarding Primary Care Access:** One hundred and six beneficiaries responded about timely access to their primary care provider as soon as was needed, on a Likert scale of Never(2 responses)/Sometimes (6 responses)/Usually(30 responses)/Always(64 responses). **Ninety-two percent of initial responders reported they were usually or always seen by primary care in a timely manner.**
- **Regarding Medical Specialists Access:** Beneficiaries responded about timely access to specialist providers as soon as was needed, on a Likert scale of Never (2 responses)/Sometimes (7 responses)/Usually (24 responses)/Always (35 responses). **Eighty-seven percent of initial responders reported they were usually or always seen by specialists in a timely manner.**
- **Regarding Behavioral Health Provider Access:** Beneficiaries responded about timely access to behavioral health providers as soon as was needed, on a Likert scale of Never (2 responses)/Sometimes (4 response)/Usually (7 response)/Always (16 responses). **Seventy-nine percent of initial responders reported they were usually or always seen by behavioral health providers in a timely manner.**
- **It is encouraging that the highest volume of response for all 3 provider categories is that beneficiaries were ALWAYS able to meet with the identified provider when they needed to.**
- The response volume for Obstetrics services and Home Health services is too low to warrant initial assessment.

Beneficiaries were asked about variables that impacted access to services. Preliminary results are:

- We've had no problems accessing health care = 92 responders
- We've not seen any healthcare provider in the past 6 months = 20 responders
- Some providers are not accepting ANY new referrals = 6 responders
- Some providers are not accepting Medicaid referrals = 10 responders
- Some provider(s) offices are far from my home = 22 responders
- Appointments are not timely = 16 responders
- We've been hesitant to schedule because of copays or recipient liability = 10 responders
- Transportation is difficult = 20 responders
- Have used Telemedicine and found it helpful = 3 responders
- A provider we work with helped with referrals or coordination of care = 10 responders

The pilot data appears encouraging in regard to a preliminary access to health care snapshot, particularly regarding primary care, specialty care and behavioral health care, as well as the preliminary data indicates that a majority of Medicaid households (92) verbalize having experienced no recent problems with health care access. The North Dakota Medicaid Access Monitoring plan will be updated to incorporate the full results of this survey effort once remaining surveys are received and

data analysis has been completed. The results are anticipated to inform stakeholders about Medicaid beneficiary experiences related to access, and will further guide decision-makers about access-related dynamics. The preliminary results appear to validate some of the general data and Medicaid-specific data that is incorporated in this Medicaid access monitoring plan.

4. **Access Monitoring Plan: Data Analysis and Conclusions:**

Based on analysis of the presently available data, the Department of Human Services (DHS) has concluded that at this time, there are no specific access challenges identified that meet the Plan of Correction standards as defined in the CMS Final Rule on Access Monitoring. The Department endorses that access to health care is a critical concern, concludes that the known access challenges are complicated and will often require community-wide, region-wide and sometimes statewide partnerships to resolve. DHS administration is already at the table in many instances related to access barriers, and will continue to represent the concerns of all Medicaid beneficiaries, as well as maintain open and collaborative communication with the North Dakota Medicaid providers.

North Dakota is the fourth most rural state in the country, and rurality is a significantly complicating variable in our state's access-to-care equation. Access concerns became a particular focus of attention in 2010 and led to the Health Workforce Initiative (HWI). The "First Biennial Report" developed and published in 2010 by the University of North Dakota School of Medicine and Health Sciences Center for Rural Health was the beginning of a significant data monitoring effort specific to provider workforce and consumer access dynamics across North Dakota (see pp 17).

The HWI painted a strategic roadmap to address health care workforce challenges, has been implemented, and our state is starting to see some positive outcomes. The growing numbers and statewide distribution of Physicians Assistants and Nurse Practitioners is encouraging (increase of 19%/additional 162 enrolled Medicaid midlevel providers over SFY 2013), as are some of the outcomes of the health professional student loan repayment programs (see pp 38). Multiple stakeholder groups across North Dakota continue to dialogue to identify evolving concerns and brainstorm remedies.

The data informs that access in many parts of North Dakota often has complicating variables, and equally challenging solutions. Examples include the workforce shortages related to dental services and of licensed addiction counselors, certified nursing assistants, and other health care providers. Workforce challenges faced by our tribal nations complicate access, and have overlays from multiple federal agencies and the associated treaty obligations, federal policies and funding streams. Rural hospitals across the nation are facing growing financial concerns so the rural hospital pilot that is being implemented by three rural ND communities will be interesting to monitor for access outcomes (see pp 40). Still another example is the challenge of improving timely access to obstetric and behavioral health care for pregnant women who struggle with substance abuse. A number of DHS staff

participated in a taskforce that recently made recommendations to two legislative committees in preparation for the next legislative session.

Now that preliminary baseline data has been established, access monitoring can start to move forward by monitoring changes in access dynamics by geographical areas across North Dakota. Page 15 – 16 of this document describes the budget allotment rate modifications that were triggered by budget shortfalls associated with declining commodity prices, particularly oil. DHS will be monitoring access, including access to providers impacted by the budget modifications.

This Access Monitoring Plan as well as the references identified within, will inform in much greater detail as to the access landscape as well as the ongoing challenges being confronted by involved stakeholders across the state. Access monitoring and continued DHS involvement with stakeholders will be an ongoing effort supported by DHS administration.

north dakota department of human services

TABLE OF CONTENTS

north dakota department of human services

TABLE OF CONTENTS (cont.)

north dakota department of human services

Access Plan Introduction and North Dakota Medicaid Overview

Access Plan Introduction

- In accordance with 42 CFR 447.203, *North Dakota* developed this access monitoring plan for the following service categories provided under a fee-for-service (FFS) arrangement:

    - Primary care services
    - Physician specialist services
    - Behavioral health services
    - Pre- and post-natal obstetric services, including labor and delivery
    - Home health services

- This Medicaid Access Monitoring plan, per CMS final rule of November 2, 2015, limits the focus on access monitoring to traditional fee for services (FFS) Medicaid beneficiaries, including children who are Health Tracks (EPSDT) beneficiaries. The rule excludes Managed Care Programs (including Medicaid Expansion and Heathy Steps -CHIP), as well as waivered services and demonstration Medicaid programs [(2)]. As of March 31, 2016, **68,287** were eligible for traditional, fee-for-service Medicaid.

- Analysis of the data and information utilized to monitor access has the goal that Medicaid beneficiaries have access to healthcare that is comparable to that of the general population in North Dakota. The CMS Access Rule clarifies: Although states must demonstrate that beneficiaries have access to covered services at least comparable to others in the geographic area, comparable access does not necessarily require that beneficiaries obtain services from the same providers, or the same number of providers, as the other individuals in the geographic area.

- The Centers for Medicare and Medicaid Services (CMS) recognizes that some states have access barriers related to rurality, and to Health Professional Shortage Areas (HSPAs), or Medically Underserved Areas or Populations (MUAs, MUPs). Despite recent population increases, these ND indicators have not declined in volume or scope, and in some instances population trends and growth in numbers of Medicaid beneficiaries have exacerbated access challenges, for example implementation of Medicaid Expansion has improved health care coverage to more than 19,000 residents, but has placed more demand on health care providers to meet health care needs.

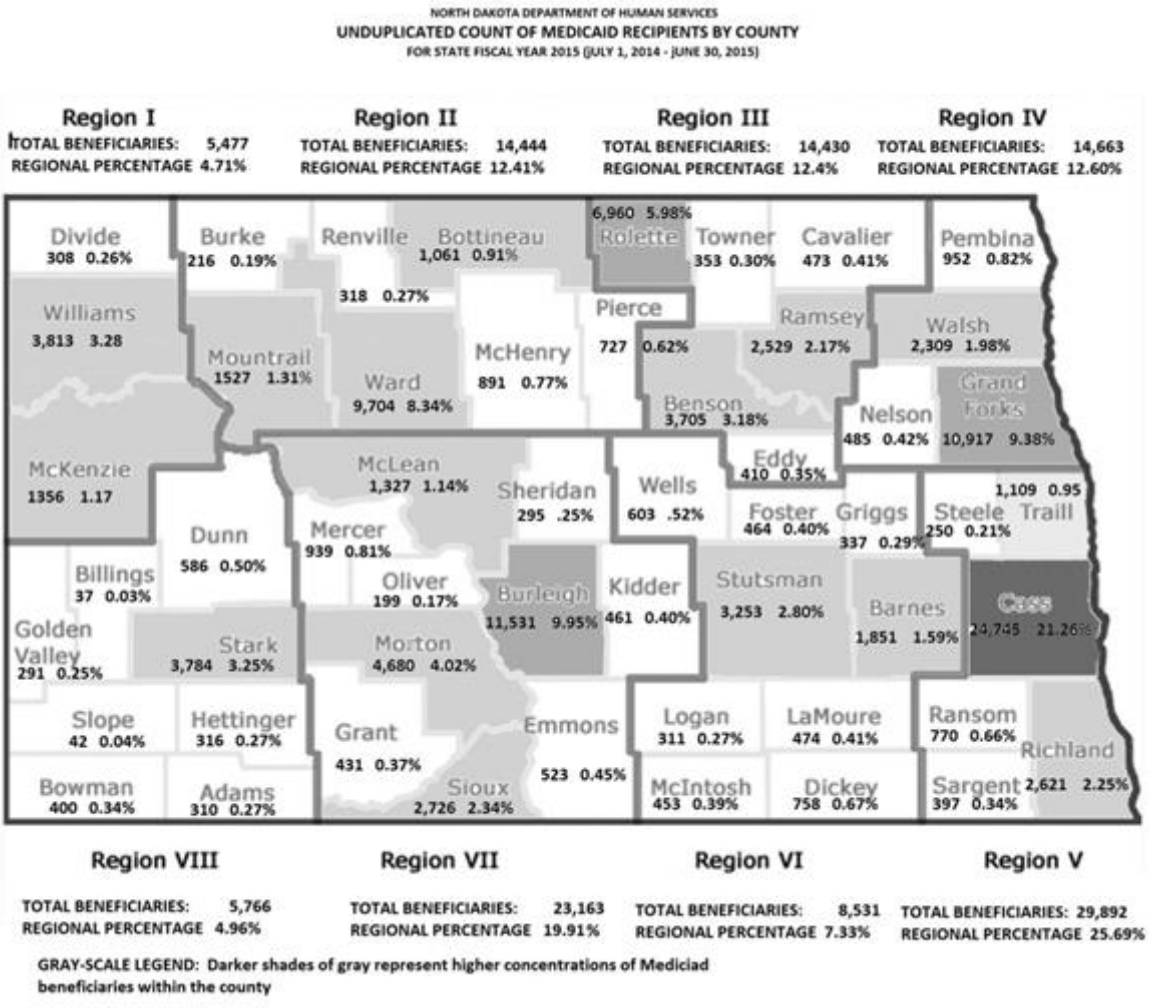
- This report will discuss in some detail the dynamics related to North Dakota's demographic changes, impact of rurality and provider availability geographically, and about North Dakota's efforts to improve health care access for all citizens. One implication is that some access concerns may be impacted by broader variables beyond those limited to health care access of Medicaid beneficiaries.

- The North Dakota Access Monitoring Plan has the primary objectives of:

    1. Identifying actionable data indicators that truly measure access;
    2. Beginning to strategize a coordinated approach between Access Monitoring and Quality Monitoring in relation to traditional fee for service Medicaid Beneficiaries in North Dakota;
    3. Capturing baseline access data for benchmark purposes;
    4. Monitoring the data indicators periodically to identify where access gains are occurring, as well as to identify access barriers;
    5. In those instances were Medicaid rates have been modified, this plan calls for three years of annual monitoring of provider service availability, to monitor impact on Medicaid beneficiary access.
    6. When barriers are identified, the data will be utilized to guide decision-makers in the analysis and problem-solving to resolve the access concerns.
    7. DHS will pursue continuous improvement of access-related data indicator analysis; the Department of Human Services Medical Services Division implemented a new Medicaid Management Information System (MMIS) in October 2015 and a new eligibility system (SPACES) in February 2016, so the learning curve related to data management is still evolving within these transitions. Additionally DHS Field Services is in process of configuring a new Electronic Health Record System for Field Services, to be operationalized in 2017 with the North Dakota State Hospital, and finalized in 2018 with expansion to the 8 Human Service Centers. In addition to learning from the approaches other states' have employed to monitor access, the new systems North Dakota is implementing is anticipated to be a rich source of data as new reports are configured and evaluated for reliability.

North Dakota Overview and Background

- The North Dakota Department of Human Services (DHS) is the single state agency that administers the Medicaid program. For State Fiscal Year (July 1, 2014 – June 30, 2015), the North Dakota Medicaid unduplicated count of all individuals eligible for Medicaid (including Medicaid expansion) was 116,366. Of this total, approximately 48% of enrollees were under 21 years of age, 44% were ages 21 to 44, and over 7% were 65 years of age or older. A point in time count of all Medicaid recipients from March 2016 tallied 89,116 recipients, which is 11.8% of North Dakota's total population. The 2015-2017 biennium appropriation for all Medicaid grants was $2.4 billion (see appendix A). **(The reader is referred to Appendix D – 1 through D – 8 for more graphs and narrative that further define the North Dakota Medicaid population.)**



- North Dakota Medicaid programs provide healthcare coverage for low-income individuals, including children, pregnant women, and individuals with disabilities, elderly, parents and other

low-income adults. North Dakota was one of the first states to implement Medicaid expansion on January 1, 2014. Medicaid expansion is operated as a managed care program and as of March 31, 2016, had 19,389 eligible adults.

- North Dakota is a large land state with a total population estimate of 756,927 (July 1, 2015 U.S. Census Bureau). This total population estimate is approximately 12.5% higher than the 2010 census. The increase in population is primarily due to the workforce needs related to the extraction of oil in the western part of North Dakota. The mining industry took off in 2010, and has been one of the primary drivers of income growth over the subsequent 5 years. During a time when many states were struggling with recession, in North Dakota personal income grew by 27.9%, with per capita personal income in 2015 reaching $54,448 (2nd highest in the nation, exceeded only by Connecticut). The North Dakota unemployment rate has been the lowest in the nation at 2.7%, and the percentage change in the labor force has been the highest in the nation at 9.5%. The Bureau of Labor Statistics lists the seasonally adjusted unemployment rate for North Dakota for March 2016 at 3.1%.(1)

- North Dakota is the 19th most extensive but the 4th least populous and the 4th least densely populated of the 50 United States; with an average of 9.7 people per square mile; only Alaska, Wyoming and Montana are more rural, while South Dakota falls within 5th place. Thirty six of North Dakota's 53 counties **(68%)** are classified as "frontier", and North Dakota qualifies as only one of six states eligible for the "frontier state" designation, which provides enhanced Medicare reimbursement rates under the frontier provisions of the Affordable Care Act (ACA). North Dakota has an older than average population, for example North Dakota is second only to Rhode Island in the percentage of its population that is 85 years of age or older (3 - pp viii ,4 & 5).

- As reported in the University of North Dakota Third Biennial Report, *there are fifty hospitals across North Dakota, comprised of six larger acute care (PPS or Prospective Payment System) hospitals located in the four largest cities, thirty-six critical access hospitals (each with 25 or fewer acute care beds), three psychiatric hospitals, two long-term acute-care hospitals, two Indian Health Service hospitals, and about 300 ambulatory care clinics. There are 43 trauma centers across the state, with each of the "Big Six" hospitals home to a Level II trauma center. Outpatient care is augmented by 57 federally certified rural health clinics, and five federally qualified health centers. Long-term care in the state is provided by 84 skilled nursing, 64 basic-care, and 73 assisted-living facilities* [**updated numbers are: 80 skilled nursing; 68 basic care; and 72 assisted living licensed facilities (18)**] (*see Long-Term Care Continuum at the end of this chapter for a comparison between assisted living and basic care**)**. *There are 28 independent local public health units and 31 facilities or programs statewide that provide mental health services*, and 57 licensed substance abuse

programs. The North Dakota DHS field services also delivers behavioral health and other services across the state through 8 regional human services centers, so in combination there are numerous options for Medicaid beneficiaries to receive healthcare (3-pp 5). As of July 2016, there were **16,799** enrolled Medicaid providers in North Dakota (includes both individual and group enrollments).

*The **Long-Term Care Continuum** is configured differently than most states, and one example is the structure and relationship that distinguishes a basic care facility vs. an assisted living facility. Low income individuals who are aged and/or disabled in North Dakota may be eligible to receive community-based residential care through the Medicaid state plan in two licensed settings: assisted living facility and basic care facility. Funding is also available to support services provided in assisted living to individuals who are not Medicaid-eligible through one of two state-funded programs, Service Payments for the Elderly and Disabled (SPED).

Some of the distinctions are:

Assisted Living Facility	Basic Care Facility
• Licensure requirements are comparatively less than basic care, and also less than assisted living licensure requirements in many other states.	• Licensure requirements are fairly comprehensive in terms of services, staffing, and other regulatory requirements and are similar to assisted living facility licensure requirements in other states
• Represents a privately-funded residential living option that is targeted to generally healthy and independent elderly individuals and couples who have minimal care needs and have available private funds to pay for their housing and care needs	• Provide a community residential living alternative to nursing facility care for privately paying and low-income individuals and their spouses who are eligible for Medicaid and/or other state programs and who have some level of physical and/or cognitive impairments that make continued independent living difficult
• staff must be available 24 hours/day but are not required to be on-site	• staff must be on-site and available 24 hours/day
• Most residents pay for services from their own private funds, with long term care insurance assisting in 25% of the cases.	• More than half (59%) of the residents living in basic care need assistance to pay for their care.

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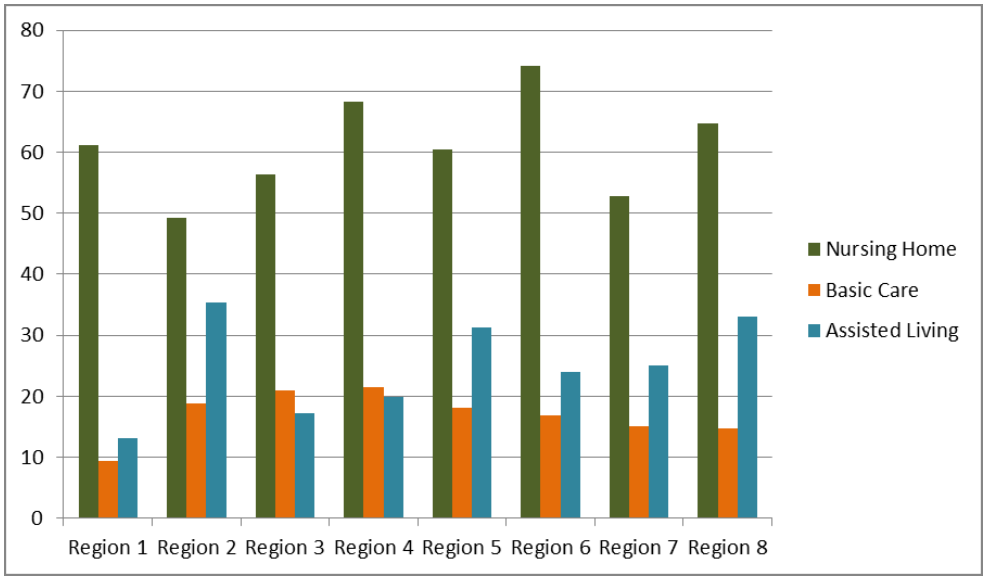
Long-term care beds per 1,000 residents 65+ in North Dakota



- North Dakota has made progress in reducing the numbers of uninsured. While 3 national ratings of 2014 percentile of uninsured are not in alignment, all reflect reductions to the number of uninsured in ND. The Center for Disease Control (CDC) National Center for Health Statistics released estimates from data based on the 2014 National Health Interview Survey (NHIS). The CDC findings rated ND as one of the states that achieved "significantly lower" uninsured percentile, at **6.0%** (all age groups) in comparison to the national average of 11.5% (6). In September 2014, the US Census Bureau released "*Health Insurance Coverage in the US – 2014*", with ND uninsured at **7.9%**, down 2.5% from the prior year, with the 2014 national average of 11.7% (7). Utilizing "Small Area Health Insurance Estimates (SAHIE), the US Census Bureau in another publication lists 2014 percent uninsured for ND as **9.3%** (8)**.** That the numbers from the various sources do not align points out one challenge to the ND Access Monitoring Plan; that data is not always consistent and poses some challenge in identifying "actionable data" that is accurate and reliable for decision-making purposes. The 9.3% ranking places North Dakota in 8th place nationally, with a Percentage Uninsured ranking range among states of 3.8% up to 21.4% for 2014.

- North Dakota State Law (Century Code Section 54-44.1-12) contains a provision for a budget allotment, should State revenue projections fall short of anticipated expenditures for the biennium. On Monday, February 1, 2016, the Office of Management Budget (OMB) released the revised revenue forecast. As a result of the revised revenue forecast, State agencies were required to submit an allotment plan to reduce general fund expenditures. In order to comply with State Law, including the Constitution, the amount of the necessary savings was 4.05%. For the Department of Human Services, this equated to a $53.95 million allotment. The Department's general fund

appropriation for the 2015-2017 biennium was $1.3 billion, of which Medical Assistance grants are sixty-seven percent (67%), or $880 million. (5).

2017-19 Budget Guidelines issued to State Agencies in May 2016 asked agencies to prepare 90% budgets. The Department of Human Services and the North Dakota Department of Corrections and Rehabilitation (NDDOCR) will not be strictly held to the 10 percent budget reduction because additional consideration must be given to services that impact public safety and the state's vulnerable citizens. In addition, the Governor's budget guidelines indicate that the state's traditional Medicaid program will not be subject to reductions beyond those implemented under the current budget's allotment process.

In July 2016 a new state budget forecast developed by Moody Analytics predicted continued revenue shortfalls for the remainder of the state's 2015 – 2017 biennium. The governor scheduled a special session of the North Dakota Legislature, which was held on August 2 – 4, 2016. The North Dakota Legislature adopted legislation, exempting the Department of Human Services from any further budget reductions for the 2015 – 2017 biennium.

North Dakota Medicaid Access Monitoring Plan Timeline

The Department of Human Services held Medical Advisory Committee meetings on May 24th and July 12, 2016 for the purpose of seeking input from stakeholders on the development of the Access Monitoring Plan, including finalizing decisions about the data elements that should be used, and discussion about the challenges of establishing thresholds that would indicate an actionable access gap. Threshold decisions are complicated by North Dakota's rurality, as well as that in some geographical areas; the numbers of enrolled providers are small, related to our state's significant Health Professional shortage and medically underserved population designations.

Below is a timeline of events up to the submission of the Access Monitoring Plan to CMS:

Date	Activity
February 19, 2016	Medicaid Medical Advisory Committee Meeting (budget allotment and request for input on stakeholders on access and monitoring)
May 24, 2016	Medicaid Medical Advisory Committee Meeting
July 12, 2016	Medicaid Medical Advisory Committee Meeting
August 9, 2016	Access Monitoring Plan posted for Public comment

August 11, 2016	Notice in newspapers of access plan public comment period
September 9, 2016	Comments Due on Access Monitoring Plan
October 1, 2016	Submission of Access Monitoring Plan to Centers for Medicare and Medicaid Services
October 1, 2019	Submit updated Access Monitoring Plan to CMS

State Demographic Variables Related to Access

- The **University of North Dakota School of Medicine and Health Sciences Third Biennial Report: Health Issues for the State of North Dakota 2015** is hereafter referred to as "*Third Biennial Report*", or within the narrative, referred to as "*the Report*". Direct quotes from the report are highlighted in italics (3) The *Third Biennial Report* (2015) provides the most updated data related to healthcare workforce concerns.

- The **first** of the biennial reports with recommendations was published in 2011 as a new requirement of the North Dakota Legislature, providing the first comprehensive analysis of the existing state of health in North Dakota, and its healthcare delivery enterprise. The report found that rural depopulation, out-migration of the young from the state, an increasingly older adult population, low population density and localized population growth in the major cities and in the Oil Patch would result in an increasing imbalance between the demand for healthcare and the supply of providers that would necessitate the need for more physicians and non-physician providers in North Dakota and better health care delivery systems. The Report concluded that North Dakota had a paradox regarding its healthcare workforce, characterized as shortages amid plenty. The size of the physician workforce in ND was found to be at or better than national norms for most specialties, including all the primary care disciplines. Despite this, there was a significant distribution problem, with the greatest number of providers located in the urban regions of the state and a shortage (especially primary care providers) in the rural areas. The first report went on to project health care challenges 15 years into the future, and concluded with a proposal for a multifaceted plan to address the health care needs of North Dakota, emphasizing necessary steps to reduce disease burden, increase the healthcare workforce through enhanced retention of graduates as well as expansion of class sizes, and improve the state's healthcare delivery system through more cooperation and coordination of the various health care delivery facilities.

- The **second** biennial report provided updates between 2011 and 2013, reanalyzed health of North Dakota's citizens and the status of our healthcare delivery systems, utilizing updated data and more refined projection tools. The report contained a more robust analysis of the healthcare challenges associated with the oil boom, and proposed approaches to ensure that adequate healthcare was available not only in the Red River Valley (Eastern ND) but particularly in the rapidly growing and challenging areas in the western part of the state that were most affected by the oil boom. The second report resulted in the ND legislature's full endorsement of the second phase of the Healthcare Workforce Initiative. Accordingly construction of a new medical school building was authorized, with medical student class size increased by 16 students per year, health sciences students by 30 students per year, and a variety of rural-focused residencies added.

- The **Third** Biennial Report provides a detailed analysis of North Dakota's health-related concerns, and offers the reader an update on the state's plans to address the issues, many of which have impact on access to health care, regardless of what health plan the beneficiary holds. Researched by staff of the Center for Rural Health, a division of the University of North Dakota School of Medicine and Health Sciences, the report informs the reader that *"unlike most of the rest of the country, North Dakota is directly addressing its healthcare challenges through its implementation of a well-vetted plan, the Healthcare Workforce Initiative (HWI)"*. Phase I of the HWI, which began by increasing medical and health sciences class sizes along with increasing residency slots, has already been fully implemented. Phase II is being implemented at present, and will be fully in effect by 2018. One aspect of the plan, the construction of the new School of Medicine and Health Sciences building is nearing completion, with staff starting to move in to the new facility on July 1, 2016. The reader is referred to the Third Biennial Report for more details on HWI, Phase II [3].

- Access to health care is one of the "deliverables" associated with the Biennial reports. "Comments on access to health care" from the Third Biennial Report:
  Access to care refers to the ability to gain entry into the health system. This can include the availability of health professionals and institutional access points such as hospitals, public health units, clinics, and services for emergency medical care, long-term care, behavioral and mental health, oral health, pharmacies, and others. Access is a fundamental issue because it directly addresses the ability of people to maintain or improve their health status. First, people need to be able to meet and talk with health and medical providers and have physical access to a clinic or hospital in order to be able to address any type of health episode. Limitations on access can lead to unmet health needs, delays in seeking appropriate care, unpreventable hospitalizations, and excessive utilization of higher-cost access points such as an emergency room. Limiting access exacerbates impaired health status and medical outcomes, and eventually adds to healthcare costs. A number of factors can restrict access to care, including an individual's ability to purchase health

services (e.g., level of income, insurance coverage, employer sponsored health insurance, and current health status); the supply of health professionals and the types of providers and medical specialties available; financial viability of health organizations and health systems; the location of health facilities; in North Dakota, natural barriers such as distance, weather, and road conditions; and ethnicity or race (e.g., American Indian access to care in North Dakota is hindered by income, employment, availability of services and providers, and location). All of these are important dynamics, factors to which North Dakota is not immune. Later chapters will address, in more detail, specific North Dakota access issues (i.e., healthcare organization and infrastructure). (Third biennial report, pp 24)

The Population of North Dakota in relation to Health Care Needs

Health care data as reported in the Maternal and Child Health Services Title V Block Grant -2015 (15), which indicates (italics):

North Dakota is the fastest growing state in the nation with an almost 10 percent population increase between the 2010 Census and the 2014 population estimate data, reaching a total of 739,482 residents. ***[Data Update 2015: 12.5% population increase, reaching a total of 756,927residents]*** *This has been primarily due to energy development activity, in addition to strong agricultural markets, and private sector growth.*

Contrary to the national population shift towards an aging population as the youngest of the baby boom generation enters their fifties, ND's population is becoming younger. The median age in ND is currently 36.9 years old, slightly younger than the national median of 37.2.

Health disparities and poverty disproportionately persist in the reservation areas of the state. AI's represent the largest minority population in ND (5.4%). ND has five federally recognized tribes and one Indian community; approximately 64 percent of AI's in ND live on reservations. The reader is referred to the website of the Indian Affairs Commission to learn more about the tribal nations in North Dakota http://indianaffairs.nd.gov/

ND's communities are becoming more racially diverse. The ND population of color (i.e., non-White) experienced a 24 percent increase from 2010 to 2013. During the same time period, when comparing racial/ethnic groups, the Black population experienced the fastest growth (59% increase), followed closely by the Hispanic population (54% increase).

The Maternal and Child Health Care Block Grant goes on to indicate:

Pregnant Women, Mothers and Infants up to Age 1

Women's/Maternal Health: ND is doing well ensuring that high-risk pregnant women are delivering at appropriate facilities. The proportion of low-birth weight infants being delivered at facilities for high-risk deliveries has steadily increased from 45 percent in 2008 to 75 percent in 2013. Several key challenges have been identified to improve the health of ND women and mothers. With only 37 percent

of ND women ages 18 through 44 being at a healthy weight, reducing overweight and obesity ranks high as a priority area for this population. The incidence of sexually transmitted infections in women ages 15-44 has steadily increased from 11.9 per 1,000 in 2008 to 17.4 per 1,000 in 2013 – a historical high. Smoking during pregnancy is another concern, with about 15 percent of pregnant women in the state smoking at any point during their pregnancy. Disparities exist in this population, especially in the AI population. In 2013, the mortality rate for all-causes for AI's birth through ages 44 was four times higher than the mortality rate for the White population. AI's overall have a higher prevalence of conditions such as diabetes, substance abuse, unintentional injuries, and smoking – especially those residing in reservations.

ND mandates newborn screening, and as a result, 100 percent of infants screened that receive a positive result receive timely definitive diagnosis and clinical management. ND's involvement with the Infant Mortality Collaborative for Improvement and Innovation (CoIIN) initiative has been successful in increasing partnerships and activities relating to safe sleep. While ND has been successful in decreasing neonatal mortality from a high of 4.2 per 1,000 live births to the current rate of 3.6 per 1,000 live births, AI infant mortality rates show significant disparities with an almost four-fold incidence of infant deaths as compared to that of the White infant population. ND CoIIN has formed a strong partnership with the American Indian Public Health Resource Center at the University of North Dakota to address infant mortality on AI reservations. Other concerns include the percent of ND Medicaid enrollees less than one year of age who receive at least one periodic screen. In 2011, 88 percent of ND Medicaid enrollees received a screen, however, this dropped to 71 percent in 2013. Enrollees of Healthy Steps, the state's Children Health Insurance Program receiving at least one periodic screen also steadily declined from a high of about 81 percent in 2009 to a low of approximately 72 percent in 2013. Infants still breastfeeding at six months in 2011 was 45 percent, a proportion significantly below the national average of 50 percent, thereby making this another priority area

An area of growing concern in North Dakota is the continued use of alcohol and other drugs while pregnant, including IV drug use of methamphetamine and narcotic analgesics. It is only at the point of delivery that this issue is identified in a concerning number of instances, and newborns are being delivered who are testing positive for substances. In 2015, Senate Bill 2367 created a task force on substance exposed newborns. The task force has provided a report with recommendations to the legislature's interim Judiciary and Tribal & State Relations Committees.

Children/Child Health:

Among children, ND has been successful in steadily decreasing the death rate from unintentional injuries attributable to motor vehicle crashes from a peak of 3.4 per 100,000 to no deaths per 100,000 in 2013. Non-fatal injuries in the same age group from motor vehicle crashes have also steadily decreased from 366 per 100,000 in 2010 to 316 per 100,000 in 2013. Challenges in this population include declining oral health care services utilization in Early Periodic Screening Diagnostic and Treatment (EPSDT) eligible children, with this proportion dropping from approximately 50 percent in 2010 to about 42 percent in 2013. Obesity and overweight in the childhood and adolescent populations ages 10 through 17 is another pertinent issue that needs addressing – with approximately 36 percent of

this population being overweight to obese. Bullying is also a concern for this population. According to the 2013 Your Risk Behavior Survey (YRBS), more than half (52%) of students in grades seven and eight had ever been bullied on school property. Cyber bullying is also becoming an issue, with more than a quarter (28%) of these same students reporting ever been electronically bullied, with a significant difference between females (39%) and males (17%).

Adolescent Health:

Among the ND adolescent population, there has been a continued decrease in teenage pregnancies among female youth ages 15 through 17, from a high of about 13 pregnancies per 1,000 in 2010, down to a rate of about 10 pregnancies per 1,000 in 2013. While the percentages are lower for high school students, bullying is also a concern for this population, with 25 percent of students in grades 9-12 reporting being bullied on school property during the past 12 months according to the 2013 YRBS. Motor vehicle crashes are the number one killer of teenagers, and young drivers are twice as likely as adult drivers to be in a fatal crash. In ND in the past three years, unintentional injuries among youth ages 15 through 24 due to motor vehicle crashes ranged from 19 to 27 per 100,000. Disparities persist in this age group, with 2013 AI suicide rates for youth ages 15 to 19 at much higher rates (21 suicides per 100,000) than the national rate (12 suicides per 100,000).

Children with Special Healthcare Needs:

In ND, approximately one in seven children (13.9%) has special health-care needs. Mandated services for certain conditions for CSHCN assists eligible families with medical costs and helps to provide gap filling services, such as state level care coordination and assisting with providing no cost medical food and low-protein modified food products for children with phenylketonuria (PKU) and maple syrup urine disease (MSUD). ND recognizes the importance of the medical home for all children, including CSHCN. In the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN), it was reported that 47.8 percent of children, ages 0 to 18, received coordinated, ongoing and comprehensive care within a medical home. While ND is doing better than the nation (43%), this percentage represents a decrease from 2005/06 (55%). Transition into adulthood is cited as a challenge by families in the NS-CSHCN, with only about 47 percent of families in 2009/10 reporting having adequate resources for successful transition, down from about 51 percent in 2005/06.

Oral Health:

ND has been successful in securing three oral health grants that have allowed the state ND Oral Health Program to function as the sustainable "backbone" organization in the state. These grants have strengthened the infrastructure and capacity to enable the Oral Health Program to carry out the core functions of public health. Despite this, challenges exist and the burden of oral disease is not uniformly distributed throughout ND. Access to oral health services is an ongoing concern and challenge. Vulnerable and underserved populations face a variety of barriers to oral health care including transportation issues; lack of insurance or ability to pay for care; inability to take time off work to go to the dentist or transport their children; limited availability of providers accepting Medicaid; and lack of understanding of the importance of good oral health and its impact on overall health. The limited oral public health infrastructure, particularly in rural counties and lower economically impacted state

regions, provides limited options for families in need. The existing oral health safety-net facilities are overburdened and cannot take on more patients without expanding their infrastructure. (15).

Dental care is a challenge in some geographical areas, with North Dakota having one-fourth fewer dentists per capita compared to national averages. North Dakota does not have a school of dentistry. There are a number of stakeholders and workforce initiatives striving to improve access, for example as recently as August 1, 2016 a Tribal Nation's North Dakota Oral Health Summit was held to discuss challenges and brainstorm solutions to dental access within our state's tribal communities.

The Health Policy Institute of the American Dental Association offers a research brief of a "Ten-Year, State-by-State Analysis of the Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services" **(24)**. The report categorizes North Dakota as one of the states that provides extensive adult Medicaid dental benefits as of August 2014. North Dakota rates were at 60.2 percent of commercial insurance charges (states ranged from 13.8% to 60.5%, with an average of 40.7%). The report further indicates that North Dakota was reimbursing pediatric dental Medicaid fee- for-service as a percentage of commercial dental insurance charges at 62.7%, which is a state by state ranking of 6th in the nation 2013. **(The reader is referred to Appendix B – 5 to view a current map of designated Dental shortage areas in North Dakota).**

<u>The population of North Dakota in relation to Healthcare needs (continued):</u>

The following excerpts (in *italics*) derive from the Third Biennial Report (2015) (3), describing the changing demographics that have been occurring in recent years, as well as offering some highlights related to health care variables. The biennial report is extensive, so the information that follows is limited to those variables that have access implications.

The Biennial report indicates: *North Dakota, like the rest of the country, is facing a major healthcare delivery challenge—how to meet a burgeoning need for healthcare services now and especially in the future with a supply of physicians and other providers that is not keeping pace with the growing demand. The problem is particularly acute in rural and western parts of North Dakota, where there has been a chronic shortage especially of primary care providers dating back for many decades. Part of the problem in North Dakota is an inadequate number of providers, but a larger portion of the problem is a maldistribution of providers who are disproportionately located in the larger urbanized areas of the state.*

About half (49%) of North Dakota's current population reside in metropolitan areas, with a little more than a quarter (27%) located in rural areas. This represents a dramatic change, since only a few decades ago, more than half of the state's population was located in rural areas. People in rural regions of North Dakota are older, poorer, and have less or no insurance coverage than people in non-rural areas, all of which are challenges to providing adequate healthcare. Rural regions continue to experience depopulation, except for significant population growth in those western regions associated with the oil boom; the cities continue to grow and prosper. Predictions for

population growth in the future are controversial and are tempered by the knowledge that another "boom-and-bust" cycle that has been seen before might occur again.

Age-related variables

The Third Biennial Report goes on to indicate: Older populations use dramatically more healthcare resources than do younger populations. North Dakota's population is among the oldest in the nation. This greatly influences the need for providers. Simply comparing the number of North Dakota physicians per 100,000 persons can be misleading unless the age of the populations being compared is taken into account. Rural North Dakotans are significantly older than their counterparts in micro- or metropolitan areas, and that disparity is increasing over time. The higher average age in rural North Dakota likely is the consequence of the continuing depopulation of the rural areas, with younger people moving elsewhere. This effect is evident in the agrarian sector, where the increase in average age has been particularly apparent in farmers.

There has been a significant increase in the number of the state's oldest citizens. People aged 85 and older constitute 2.5% of the state's population (North Dakota is second only to Rhode Island as the state with the highest percentage of older adults). Nationally, 1.8% of Americans are aged 85 and older. It is the state's second-fastest-growing cohort, with the most substantial growth being 28% for people 45 to 64 years old. (Third Biennial report, pp 11)

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Table 1. *Summary of demographics in North Dakota's population by metropolitan, micropolitan (large rural), and rural areas.*[11, 18, 20]

	Metropolitan		Micropolitan		Rural	
	N	%	*N*	%	*N*	%
Total	355,759	49%	171,786	24%	195,848	27%
Gender						
Male	179,849	51%	90,181	52.5%	99,971	51%
Female	175,910	49%	81,605	47.5%	95,877	49%
Age						
Under 20	91,481	26%	44,369	26%	50,034	26%
20–39	118,797	33%	53,575	31%	41,689	21%
40–64	103,313	29%	51,193	30%	66,127	34%
65–84	35,355	10%	18,430	11%	31,350	16%
85 and Older	6,813	2%	4,219	2%	6,648	3%
In Poverty						
Yes	39,163	11%	15,762	9%	25,798	13%
No	316,596	89%	156,024	91%	170,050	87%
Uninsured						
Yes	40,165	11%	19,046	11%	28,097	14%
No	256,326	72%	119,009	69%	132,996	68%
Unknown	59,268	17%	33,731	20%	34,755	18%

- Almost half the state's population (49%) lives in a metropolitan area, and almost 27% are in a rural area of less than 10,000.
- Gender distinctions are slight with males outnumbering females in all three population classifications.
- A slightly smaller percentage of rural residents are 20 years of age or younger in comparison with the other two population classifications.
- A much smaller percentage of rural residents are young adults (age 20–39) at 21% in comparison with micropolitan (31%) and metropolitan (33%).
- A higher percentage of rural residents are older adults (65–84) and the percentage of rural people who are 85 and older is almost two times that found in metropolitan areas.
- A higher percentage of rural residents live in poverty.
- A higher percentage of rural residents do not have health insurance.
- Nationally, rural residents tend to be poorer, older, and have less insurance coverage than those residing in non-rural regions. North Dakota data conform to that assessment because a higher percentage of rural North Dakotans are over 65 years of age and over 85 years of age, live in poverty, and are uninsured. Each of these factors is a detriment to achieving a higher level of health status.
- North Dakotans living in metropolitan areas tend to be younger in comparison with both micropolitan and rural areas, but the micropolitan areas have the lowest levels of poverty and have a lower percentage without health insurance.

Third Biennial report, pp 9

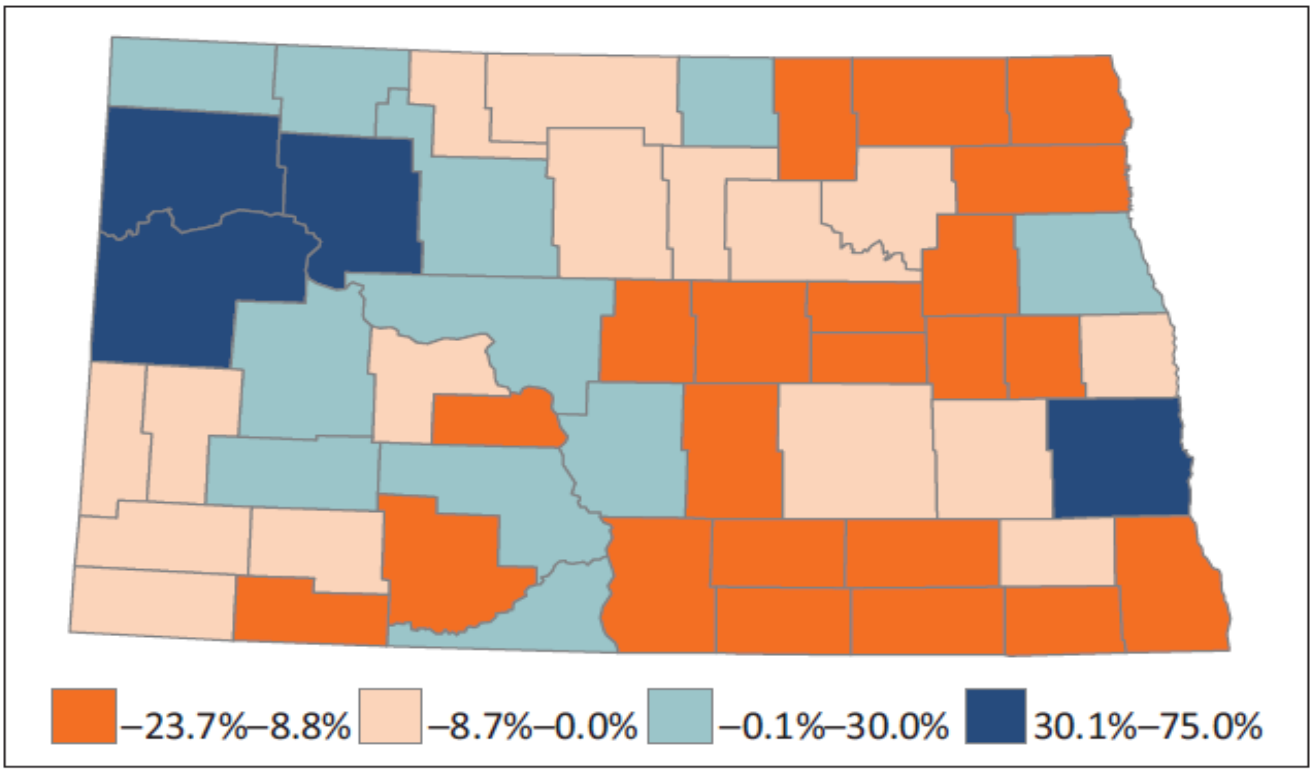

Figure 10. Percentage change in county population from 2000 to 2013.[5, 6]

- Nine counties have increased their population by an average of 10% or more from 2000 to 2013.
- Six counties had population gains of less than 10%. From 2000 to 2013 28 counties have lost population. The largest gains seen from 2000 to 2013 were Cass, Williams, McKenzie, and Mountrail.

Third biennial report, pp 10

Poverty Rates

North Dakota currently ranks 9th in the nation for poverty (13). The third biennial report adds additional detail: *Poverty rates vary based on age, race, geography, and household composition. Poverty is higher in rural than urban North Dakota (about 14% compared to 12%).*

About 17% of North Dakota's children (less than 18 years of age) are in poverty, which compares to about 8% of people in the state who are 65 years and older (nationally the rates are 27% and 13%, respectively).

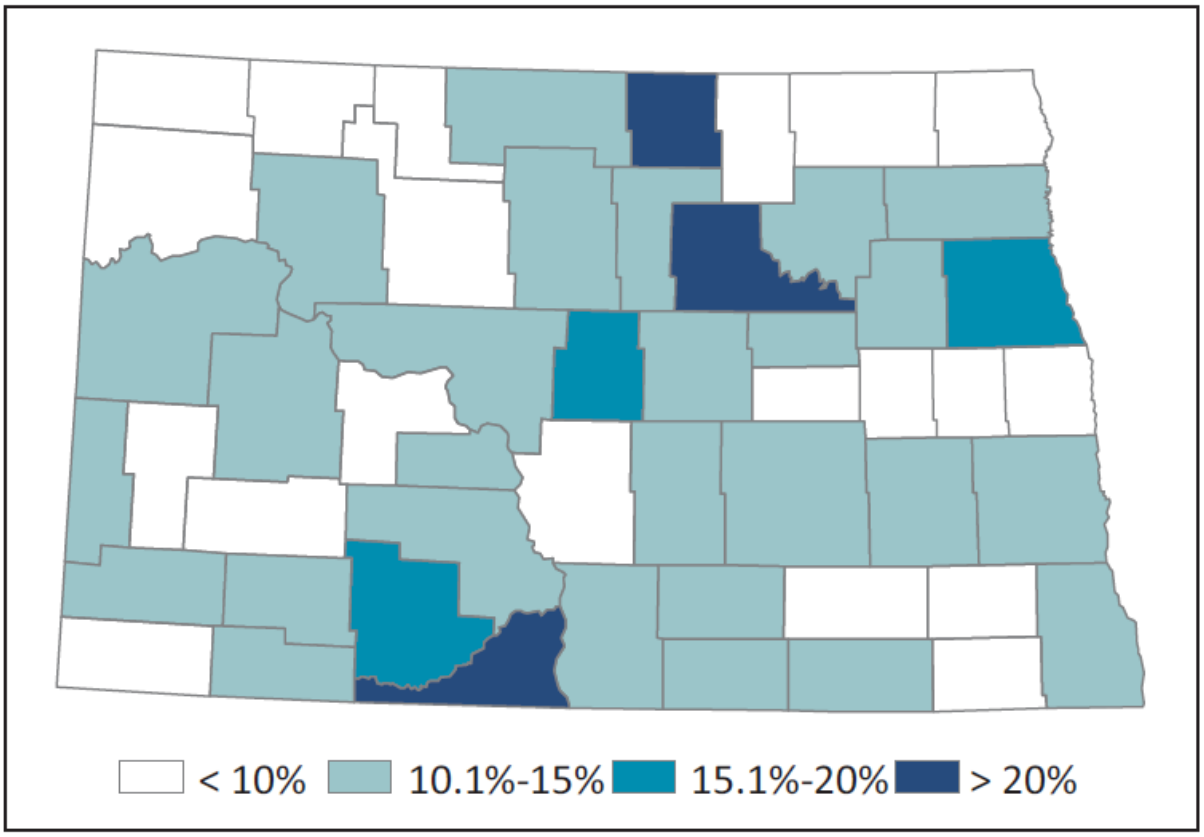

Figure 6. Poverty in North Dakota by counties.[18]

- Poverty in North Dakota counties has ranged from 6.7% to 41.4% from 2000 to 2012.

Oil Patch Impact

Counties by oil Production: The current oil boom has propelled North Dakota to being the second-largest oil-producing state; it was in ninth place in 2006. This boom has produced an economic impact of over $13 billion and has produced roughly 30,000 jobs with expectations of adding 7,000 to 10,000 a year for about five years. All of the oil production is focused in the western half of the state, especially the far west counties *(Third Biennial report pp 15)*

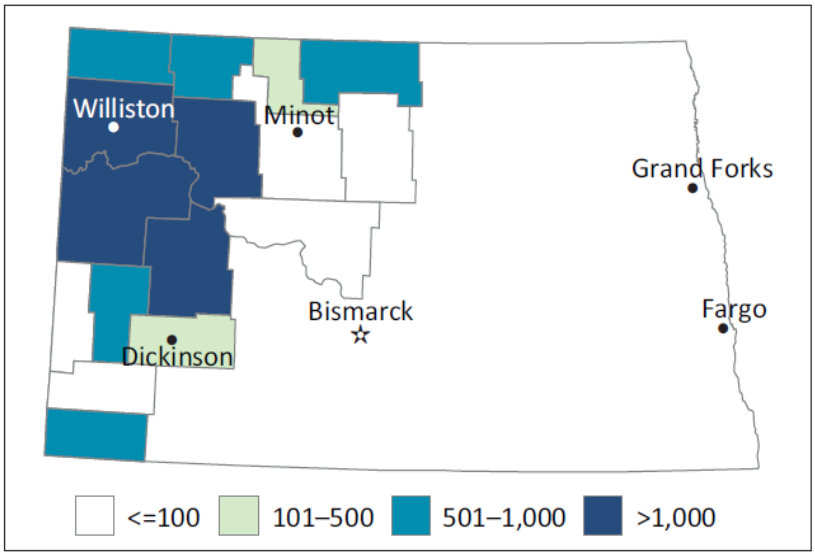

Figure 21. Oil Patch counties by number of active rigs.[33]

- Seventeen counties in North Dakota are considered active in oil production by the North Dakota Department of Mineral Resources. These counties have had oil well production in 2012. The highest producing counties are McKenzie and Williams with a combined 38% of statewide production of oil.

The hub of the oil impact is centered in Williams County North Dakota. It is noteworthy that as of June 2016 there are currently no oil rigs drilling in Williams County, which helps tell the story about the decline in oil tax revenue in North Dakota, until such time as the price per barrel of oil returns to the point that companies can achieve positive revenue generation associated with the high costs of deep well fracking.

The Health of North Dakota:

The Third Biennial Report next considers the health of North Dakotans, which in comparison with the rest of the United States is generally good. North Dakotans have a slightly lower problem with diabetes than the rest of the United States, and are less likely to report fair or poor health. However, North Dakotans tend to have a higher risk of cancer and a mortality rate that exceeds the national average. Across North Dakota, behavioral risks tend to increase as population density decreases; thus rural areas have the worst behavioral risk, with an increased frequency of obesity, smoking, and drinking, especially in males.

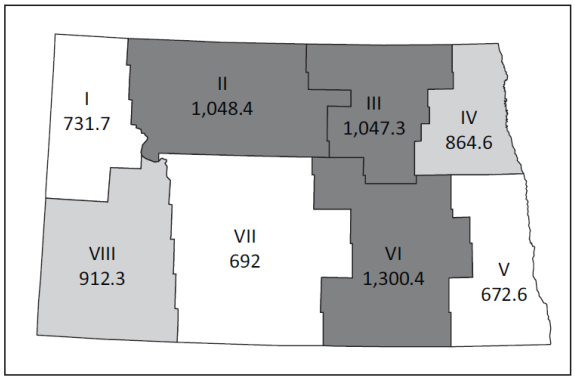

Figure 40. Mortality rate in North Dakota regions after adjusting for age.[26, 31]

- Regions II, III and VI have the highest mortality rates.
- Regions I, V and VII have the lowest mortality rates.

The Report then analyzes the quality of healthcare delivered in North Dakota, and found in general that it is as good as or better than much of the United States, but there appears to have been a decline in several measures in the past few years, particularly in the delivery of acute-care services. North Dakota (along with other upper Midwest states) generally provides high-quality care at relatively lower cost than other states in the United States; North Dakota ranked ninth in the country in one recent assessment undertaken by the Commonwealth Fund.

Physician work force:

The physician workforce is considered next in the Report, which finds that North Dakota has somewhat fewer physicians per population than the United States as a whole or the Midwest comparison group, although the gap has narrowed over the past three decades. Our physicians are older, less likely to be in a hospital-based practice, and more likely to be male than elsewhere in the United States. About one-fourth of the physician workforce is made up of international medical graduates, about the same as the rest of the country. The University of North Dakota (UND) is an important source of physicians for the

state, accounting for 45% of the more than 1,000 physicians practicing in North Dakota who graduated from a U.S. medical school. Of all the physicians in the state, about 40% received some or all of their medical training (medical school or residency or both) in-state. As is the rule for the rest of the United States, there is a striking gradient of patients per physician depending on geographic region; micropolitan areas (large rural) have about twice as many patients per physician as metropolitan areas, while rural areas have about five times as many. Predictions of inadequate physician supply leading to further increases in the number of patients per provider, especially in rural areas, have helped buttress support for the HWI that is intended to address those concerns. Absent the effects of the HWI, current estimates indicate a shortage of some 260 to 360 physicians by 2025, primarily the consequence of the heightened need for healthcare services as the Baby Boom generation ages but also from retirements in the similarly aging physician workforce (one-third of the physicians in North Dakota are 55 years of age or older). Even more physicians will be needed if the population grows as recently predicted. If the population of North Dakota increases to 800,000 people, around 500 additional physicians will be needed. And if the population grows to 1 million (as some have predicted), the state would need about 1,000 more physicians.

Primary care

The state's primary care physicians (family medicine, general internal medicine, and general Pediatrics) are considered next in the (3rd Biennial) Report. Compared with the rest of the country and the Midwest, North Dakota has more primary care physicians when normalized to the population size. Their density is significantly higher than either comparison groups in both metropolitan and micropolitan regions; it is only in rural areas that North Dakota lags the Midwest comparison group, and only by a small percentage (2%). Primary care physicians in North Dakota are more likely to practice in rural areas compared with specialist physicians, but they still are twice as likely to be found in urban regions rather than rural areas after correcting for population. Residency training in North Dakota is an especially important conduit of primary care physicians, since nearly half (45%) of them have completed a residency within the state; more than half went to medical school at UND or completed a residency or did both in the state. (Biennial Report pp IX & X)

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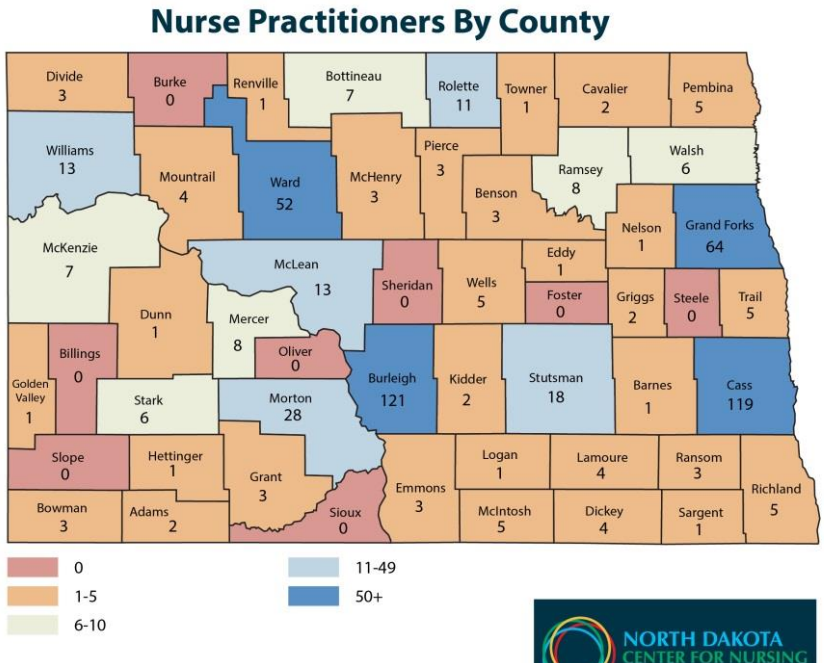
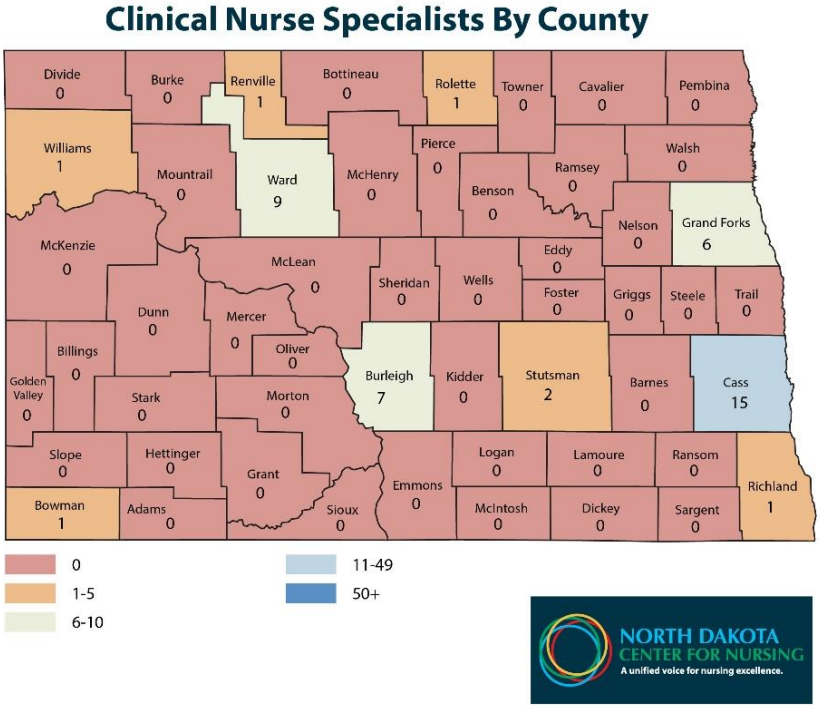
Maps of Physician Assistant and Nurse Practitioner practices across North Dakota

(17)

In 2015, North Dakota had a total of 706 Nurse Practitioners as compared to 407 in 2010 (NDBON Annual Report 2011-2012, NDBON 2015 Licensure Data). In 2015, 9 counties had 0 Nurse Practitioners compared to 11 counties in 2010 (Moulton, Johnson & Lang, 2010). (Note: This map includes NP primary work county. Additional counties where NPs work are not reflected in this map).



In 2015, there were 55 Clinical Nurse Specialists (NDBON Licensure Data 2015). Forty-four counties have zero Clinical Nurse Specialists. The greatest numbers of Clinical Nurse Specialists are located in Cass County.



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Specialists Workforce

The Third Biennial Report indicates that North Dakota has relatively fewer specialists than the Midwest or the rest of the United States in certain specialties, including obstetrics/gynecology. We have more psychiatrists than other Midwest states, although two-thirds of them work in the eastern part of the state, leaving the western parts of North Dakota with a shortage. Similar trends are found with other nonphysician providers. While nurse practitioners (NPs) and physician assistants (PAs) are much more likely to be female than their physician counterparts, they too are distributed more in the metropolitan than rural areas in a proportion similar to primary care physicians. This is particularly true for NPs; PAs are the most evenly distributed across North Dakota of any healthcare provider group. Compared with U.S. figures, North Dakota has about 7% fewer NPs but 37% more PAs. North Dakota has many more nurses (95%) and pharmacists (51%) than the national average, and they too are particularly distributed in the metropolitan areas. In the case of pharmacists, their relative scarcity in rural areas is balanced by a greater supply of pharmacy techs and by a robust telepharmacy program spearheaded by North Dakota State University. North Dakota has one fourth fewer dentists than the United States as a whole, but almost one-fourth (22%) more physical therapists. When looking at the entire North Dakota healthcare provider workforce, there is a consistent finding of a relative shortage of providers especially in rural and micropolitan (large rural) areas compared with metropolitan regions, but with important variations across the state depending on the particular provider type.

The North Dakota Hospital Workforce Study looked at a wide spectrum of 25 different categories of healthcare workers (from nurses to lab technicians to dieticians to business personnel) and found, perhaps somewhat surprisingly, that hospitals are reporting Significant worker shortages in only three of the 25 categories (12%), and even in those areas, the vacancy rates are not much above national norms. (Biennial report, pp IX)

The cost of care is another influence on individual health. North Dakota has been described as a low-cost, high-quality state in which the cost of care, relative to other states, is lower; importantly, the quality of care delivered is considered high. It thus is a higher-performing state. Even in a relatively low-cost state like North Dakota, cost has been and remains a dominant concern within public policy discussions, particularly within the framework of healthcare reform. For example, the Community Heath Needs Assessments (CHNA) that are required of all nonprofit hospitals under the Affordable Care Act, found that the high costs of healthcare to consumers was the fifth-most common health need identified by community members out of a list of 21 items. The finding was based on data from 39 of the 41 hospitals in the state; thus this is strong evidence of concern. The number one health issue was healthcare workforce shortages (addressed in more detail in the following chapters). In general, healthcare costs in the United States are high in comparison to other countries, accounting for 17.7% of gross domestic product (GDP), which is a common and accepted measure of economic production and activity. (Biennial report pp 24)

Comparison with national benchmarks

The Third Biennial report comments: Part of the explanation for the relative good health and health outcomes in North Dakota may relate in part to more healthful lifestyles. For eight of 10 general health measures, North Dakotans are relatively healthier when compared to the country as a whole (e.g., fair/poor health, high cholesterol, high blood pressure, diabetes, cholesterol screen, influenza immunization, asthma, and sigmoidoscopy/ colonoscopy). However, in North Dakota, the number of people who are overweight and obese is higher, (62.2% vs. 60%), and the state has a lower pneumonia immunization rate (24.9% vs. 25.4%). In the Second Biennial Report, it was reported that North Dakota scored slightly better on overweight/obesity by having 62% of the population so classified versus a national rate of about 64%. Thus the North Dakota rate has stayed constant, but for the country, this has improved. This will be an issue for North Dakotans to monitor. In a similar manner, the percentage of North Dakotans viewing themselves as having only fair or poor health is roughly the same as was reported two years ago; however, the U.S. rate has worsened (18% versus 14.9% in 2012.) **(Biennial report pp 27)**

There are a growing number of state healthcare rankings, and since organizations utilize differing metrics and data indicators, some of the state ranking information is not easily aligned. Still there is value in considering the rankings as point in time snapshots that help paint the picture of North Dakota health status. Some examples include: The United Health Foundation, in their 2015 ranking of overall citizens health lists ND as being in 12th place nationally based on analysis of 34 health indicators (9). In contrast, the Commonwealth Fund Health System Data Center ranks North Dakota in 26th place nationally, 2015 (10). **The reader is referred to Appendix I for a more detailed breakdown of health indicators as measured by entities that rank states.**

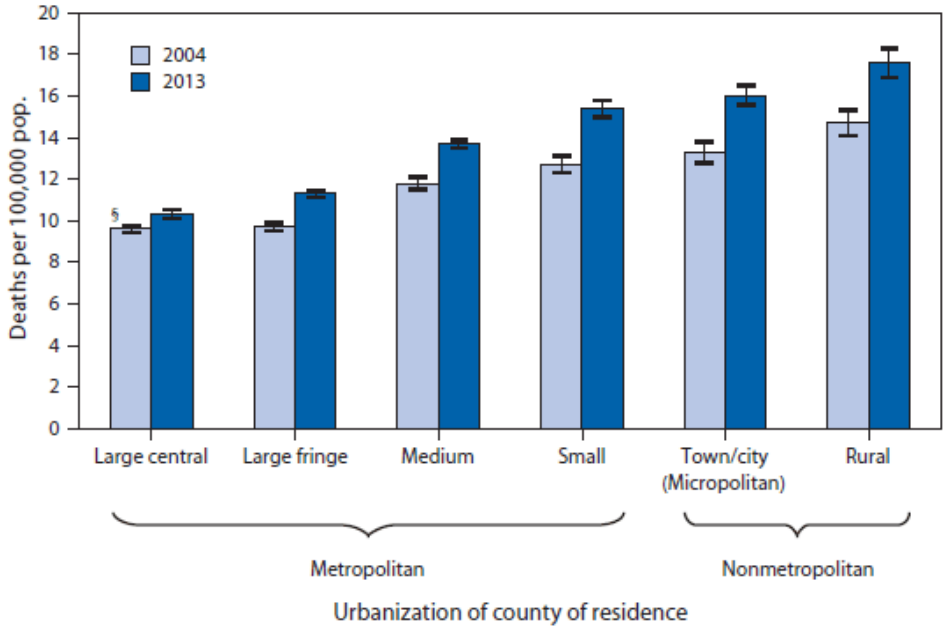
The Center for Disease Control (CDC) maintains annual data on incidence of specific health indicators, and it is likely that the CDC will be a helpful data resource when monitoring/analyzing specific access related dynamics of our state's Medicaid enrolled provider's outcomes for indicators within the functional scope of provider services (8). A good example is the CDC's informative data about suicide rates and dynamics.

CDC data about suicide completion rates:

Suicide is a complex health indicator. One variable that has impact is rurality. The CDC indicates:

***QuickStats:* Age-Adjusted Rates for Suicide,* by Urbanization of County of Residence† — United States, 2004 and 2013**

April 17, 2015 / 64(14);401



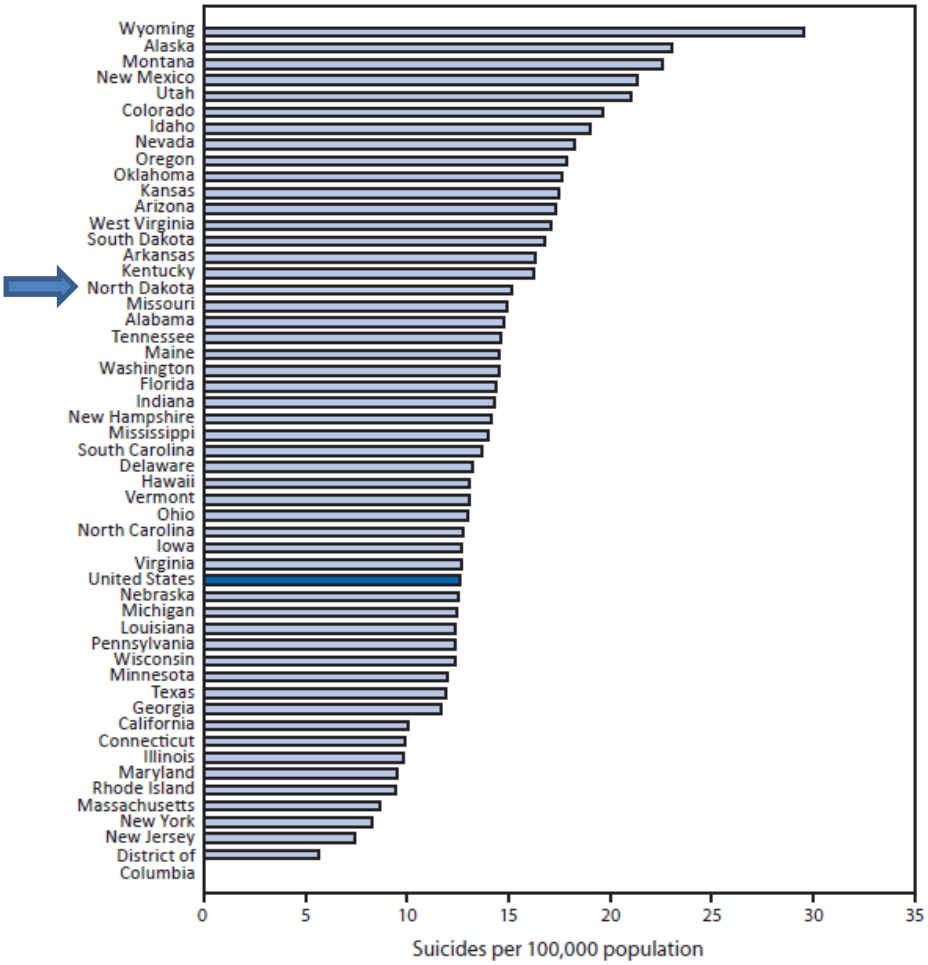
* Age-adjusted rates per 100,000, based on the 2000 U.S. standard population. Suicides are coded as *U03, X60–X84, and Y87.0 in the *International Classification of Diseases, 10th Revision*.

† Counties were classified into urbanization levels based on a classification scheme that considers metropolitan/nonmetropolitan status, population, and other factors.

§ 95% confidence interval **(22)**.

The CDC goes on to rank completion rates:

***QuickStats:* Age-Adjusted* Suicide† Rates, by State§ — United States, 2012**
November 14, 2014 / 63(45);1041-1041



* Age-adjusted rates per 100,000 based on the 2000 U.S. standard population. Populations used for computing death rates are postcensal estimates based on the 2010 census estimated as of July 1, 2012.
† Intentional self-harm (suicide) as the underlying cause of death includes codes for by discharge of firearms (X72–X74), and Intentional self-harm (suicide) by other and unspecified means and their sequelae (U03,X60–X71,X75–X84,Y87.0), in the *International Classification of Diseases, 10th Revision*. § U.S. residents only.
In 2012, the overall age-adjusted suicide rate in the United States was 12.6 per 100,000 population. Among states, Wyoming had the highest suicide rate (29.6), followed by Alaska (23.0), Montana (22.6), New Mexico (21.3), and Utah (21.0). The District of Columbia had the lowest suicide rate (5.7), followed by New Jersey (7.4), New York (8.3), Massachusetts (8.7), and Rhode Island (9.5). For 34 states, suicide rates were higher than the overall U.S. rate. In 2012, a total of 40,600 suicides were reported in the United States.
Source: National Vital Statistics System. Mortality public use data files, 2012. Available at http://www.cdc.gov/nchs/data_access/vitalstatsonline.htm.

The reader will note in the National Alliance on Mental Illness comments later in this chapter that North Dakota has passed a number of recent legislative bills to strengthen the state's suicide responses, and to support training on Mental Health First Aid. The eight Human Service Centers also

manage 24/7 crisis line systems, each with the capacity to facilitate after hours face-to face assessments when indicated. The majority of HSC emergency responders have now been trained in Applied Suicide Interventions Skills (ASIST).

In a June 2016 news release, the Director of Suicide Prevention with the ND Department of Health announces awards of $588,870 for evidenced-based suicide prevention projects in schools and communities across North Dakota. The grants are a part of $1.2 million dollars appropriated during the most recent legislative session. The news release indicates that: "Suicide impacts people of all ages but suicide is the second leading cause of death for youth, ages 15 to 24 in North Dakota." Initial grants were awarded to educational associations to provide gatekeeper training programs like SafeTALK as well as to assist participating schools in implementing the Sources of Strength program. FirstLINK was supported in continuing their 24/7 service of the National Suicide Lifeline, as well as their evidenced based "Call-back program", and PATH, Inc. received funds to provide ASIST and "Zero Suicide" training to their therapeutic foster homes, therapists and staff. Awards were also granted to community clinics and Family Planning clinics across ND to provide depression screenings and referrals. Visit http://www.ndhealth.gov/suicideprevention/ for information about suicide and suicide prevention. (23)

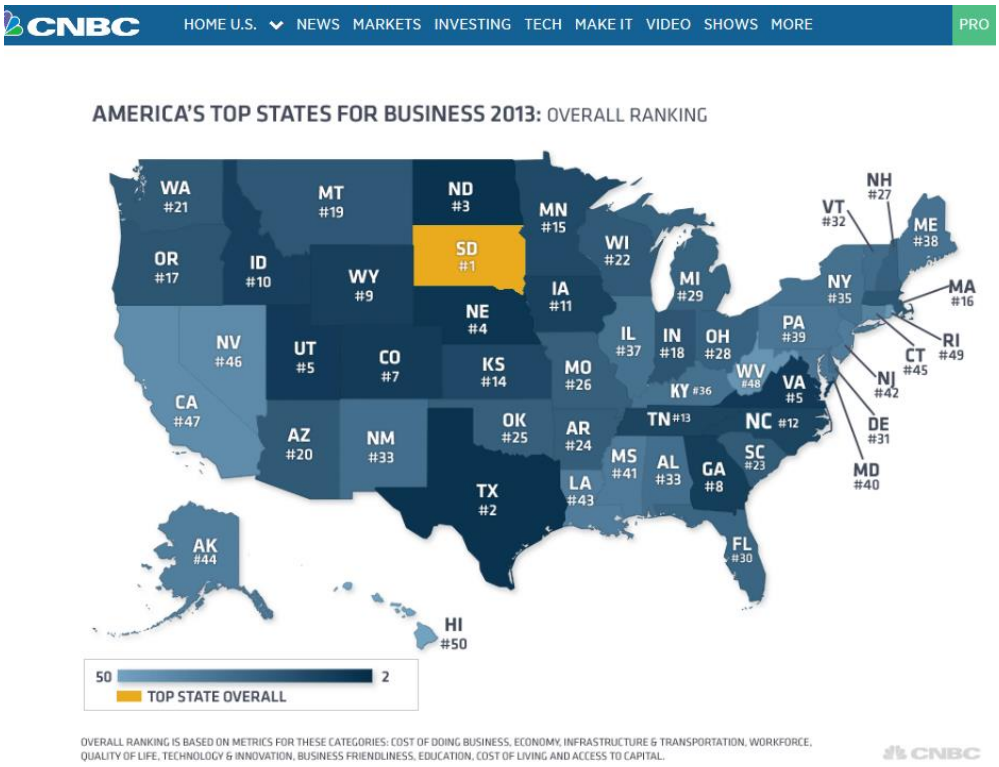
Comparison with national benchmarks (continued)

Also new to some ranking organizations is analysis of quality of life/sense of well-being. Interestingly, several organizations conclude that the sense of well-being of North Dakota residents has recently improved, despite budget impacts associated with the slowdown in oil productivity, stagnant commodity prices, and challenging revenue forecasts.

The Organization for Economic Co-operation and Development (OECD) (18) is an intergovernmental economic organization of 35 countries, founded in 1961. The OECD divided the United States into 51 regions based on states. It found that the top five U.S. states ranked by well-being in their 2016 report were:

1. New Hampshire (77.6)
2. Minnesota (76.2)
3. Vermont (74.8)
4. Iowa (72.9)
5. **North Dakota (72.4)**

In a CNBC article, another ranking organization rated North Dakota in 5rd place nationally in the area of Quality of Life for 2013 (20), as well as ranked in 3rd place as America's top states for Business 2013.



Cass County is by far our state's most populous county, and has 24,745 Medicaid recipients, which is 21.3% of all beneficiaries in North Dakota. The county seat, Fargo fared well in a July 2016 ranking of the 25 healthiest cities in America, with a national ranking of 15th place. The article goes on to indicate: Employment is important to personal health for a variety of reasons, including providing regular income and often, health insurance. Only 2.4% of the workforce in Fargo is out of a job, the lowest unemployment rate of any U.S. metropolitan area. With low unemployment, Fargo residents are more likely to have health insurance and less likely to live in poverty than most Americans. Adults in Fargo report an average of only 2.7 mentally unhealthy days and 2.7 physically unhealthy days per month, each among the least in the country.

North Dakota also ranks well in regard to percentage of population receiving disability benefits. We are ranked 5th in the nation for low disability numbers (3.4% of the North Dakota population being disabled); our May 2016 unemployment rate was at 3.2% (tied – 6th lowest), and our labor force participation rate is 70.4% (2nd highest) (21).

There are several organizations that rate states in regard to behavioral health services. The ranking reports from Mental Health America (MHA) – 2015 (12) indicate: "States with the lowest prevalence of mental illness and highest rates of access to care include: Massachusetts, Vermont, Maine, **North**

Dakota, and Delaware. States with the lowest prevalence of mental illness and highest rates of access to care for youth include: Vermont, **North Dakota**, Wisconsin, Iowa and Maine.

However, MHA ranks North Dakota less well in the following indicators:

- 43rd in the country for mental health workforce availability
- 39th for state hospital 180 day readmissions
- 43rd for youth who attempted suicide
- 46th in ranking of adults with dependence or abuse of illicit drugs or alcohol.

The MHA 2015 report goes on to rate the states on overall vs. adult vs youth vs. access rankings as follows:

Overall Ranking	**Adult Ranking**	**Youth Ranking**	**Access Ranking**
1 Massachusetts	1 Massachusetts	1 Vermont	1 Vermont
2 Vermont	2 New Jersey	**2 North Dakota**	2 Massachusetts
3 Maine	3 Hawaii	3 Wisconsin	3 Maine
4 North Dakota	4 Maryland	4 Iowa	4 Delaware
5 Delaware	5 Connecticut	5 Maine	5 Iowa
6 Minnesota	6 Minnesota	6 Massachusetts	**6 North Dakota**
7 Maryland	7 Delaware	7 South Dakota	7 Pennsylvania
8 New Jersey	8 Illinois	8 Kansas	8 Minnesota
9 South Dakota	**9 North Dakota**	9 West Virginia	9 South Dakota
10 Nebraska	10 Nebraska	10 Ohio	10 District of Columbia

- Additionally, MHA ranks North Dakota in first place for providing mental health services to youth who need them and is rated 3rd in the country for adults reporting access to mental health services when they need them. The 2015 report was the first time MHA reported a state ranking.

The National Alliance on Mental Illness Mentally Ill (NAMI) also ranks states on their performance **(19)**. For example, NAMI reports:

- With passage of 2015 Senate Bill 2048, North Dakota requires teachers to have mental health training as a component of licensure;
- 2015 Senate Bill 2209 requires school districts to provide annual suicide prevention training to all middle school and high school instructional staff, teachers and administrators;
- 2015 House Bill 1049 which creates and enacts a new section of the ND Century Code related to loans for certain behavioral health professionals and duties of the board of addiction counseling examiners. Requires the board to evaluate licensure coursework requirements and clinical training requirements.
- 2015 House Bill 1048 provides for behavioral health boards to plan, in collaboration with the other boards, for the administration and implementation of licensing and reciprocity standards for licensees;
- 2015 House Bill 1040 that authorizes advanced practice nurse practitioners and physician's assistants to participate in involuntary commitment proceedings and continuing treatment petitions.

- 2015 House Bill 1106 provide for a study related to criminal defendants who are veterans or serving in the armed forces, including whether additional treatment and sentencing options should be considered if PTSD or other behavioral health conditions are suspected.

Health Professional Shortage Areas (HSPA)/Medically Underserved Areas (MUA) of North Dakota:

North Dakota remains one of the most rural states in the United States. Thirty six of North Dakota's 53 counties are designated as "frontier", meaning that there are less than 6 persons per square mile within the county. Recent analysis of 2015 population data by the UND Office of Primary Care (16) demonstrates that none of the counties have changed from their frontier designation status despite population increases since 2010, as well as concludes that HSPA designations also have remained stable. Funding priorities for thirty four (34) federal programs rely on HSPA/MUA designations.

Nation-wide, rurality generally adds to health care access challenges, and the HSPA/MUA designated areas experience recruitment and retention challenges. Within North Dakota this rural provider shortage trend is also evident, given the preponderance of health care providers practicing in the more urban areas of our state.

On the positive side, the National Health Service Corp (NHSC) prioritizes loan repayment program eligibility to practitioners of the healing arts who work within an identified North Dakota Mental Health Professional Shortage Area. For example, one of the regions comprised of six counties and two tribal nations has the highest HSPA score in North Dakota, yet that designation allows for generous student loan repayment, and resulted in seven (7) professional staff from the human service center (HSC) in that region (11% of total HSC staff) receiving NHSCs student loan repayments during 2015. Loan forgiveness has been a strong asset for recruitment and retention. However, this same agency had been recruiting for a psychiatrist for more than a year during this same timeframe, and did not receive an inquiry from a single applicant, resulting in an eventual decision to reclassify the position to a mid-level provider.

During the last legislative session, a new state loan forgiveness program was authorized that utilizes state dollars to create an additional loan repayment alternative. Although the repayment amounts are lower, eligibility was expanded, for example, to include hard to recruit licensed addiction counselors.

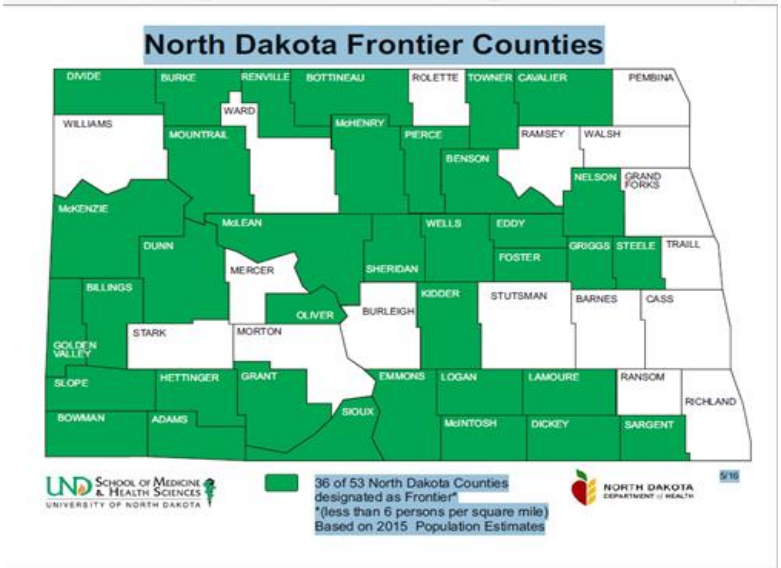
The Office of Primary Care coordinates the state loan forgiveness program, and also manages the Rural Opportunities in Medical Education program (ROME). ROME is a 24-28 week interdisciplinary experience in a rural primary care setting, open to third-year students at the University of North Dakota School of Medicine and Health Sciences. Students live and train in non-metropolitan communities under the supervision of physician preceptors. ROME students experience health care

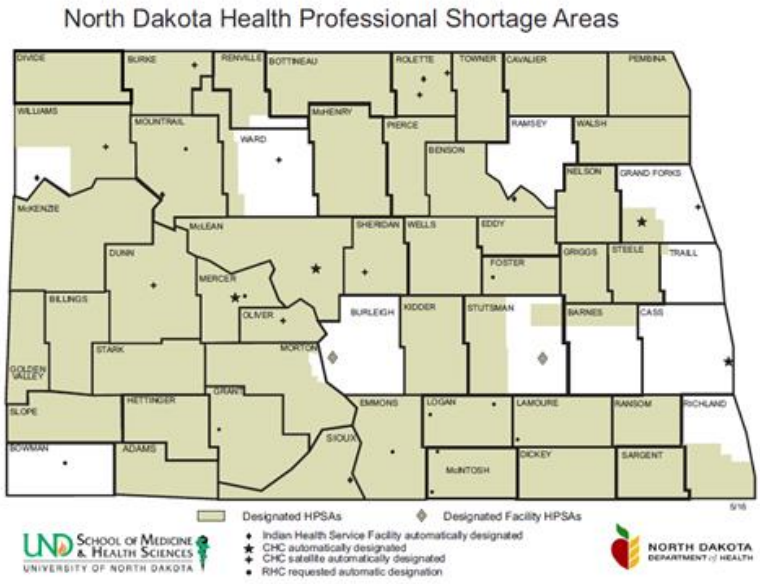
delivery in rural areas throughout the state of North Dakota, where providing access to health care is sometimes challenging.

Through ROME, students learn about problems commonly encountered in primary care, from routine health maintenance to medical emergencies and rare and unusual diagnosis. Each primary preceptor is board-certified in family medicine, but students also will work with board-certified surgeons, internists, pediatricians, and other specialists available in the community (16)

On balance, living in a rural county, and living in a medically underserved or health professional shortage designated area, will result in an increase in health care access challenges for the general population of that catchment area, including Medicaid beneficiaries. When access concerns are identified, an individualized analysis is indicated to determine whether frontier county/HPSA/MUA designations contribute to the access concern, or add to the challenge in resolving the concern. Across North Dakota, these designations are more extensive than most states, so this definitely presents complicating variables in relation to monitoring Medicaid access.

There are a series of related statewide maps in Appendix B that describe the designations discussed in this section, including HSPA maps for dentists and for mental health professionals. Following are maps of frontier status and of general HPSA designated areas:





On August 4, 2016 the Centers for Medicare and Medicaid announced a Frontier Community Health Integration Project Demonstration, which aims to develop and test new models of integrated, coordinated health care in the most sparsely-populated rural counties with the goal of improving health outcomes and reducing Medicare expenditures.

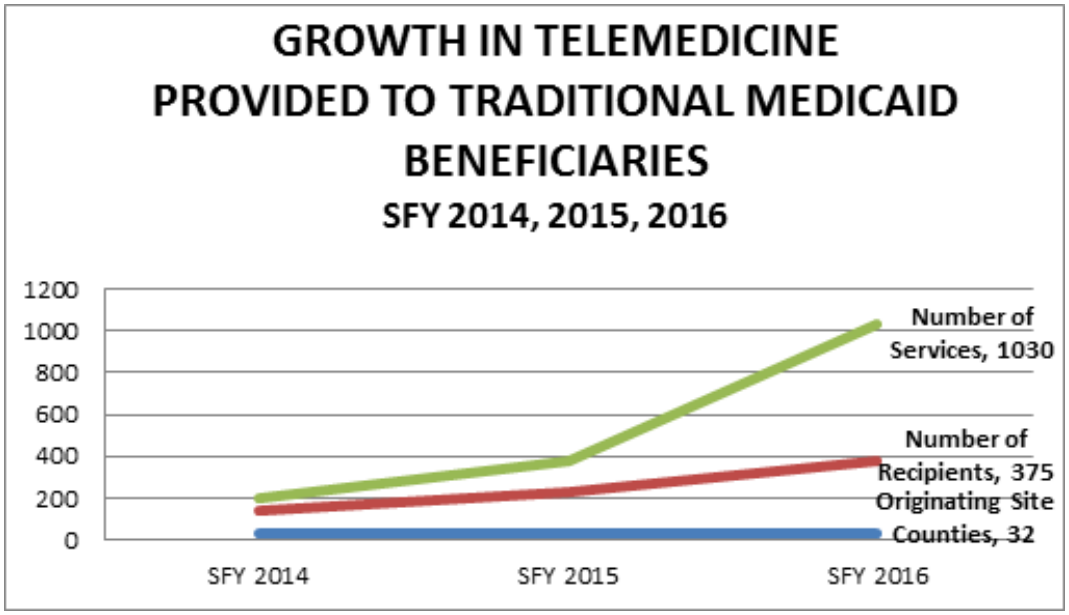
The news release indicates: "Critical Access Hospitals (CAHs) serve as the hubs for healthcare activities in frontier areas, but they often serve few inpatients. In this Demonstration, CMS expects CAHs to increase access to services that are often unavailable in frontier communities with the goal of avoiding expensive transfers to hospitals in larger communities. CMS will evaluate whether providing these services in frontier communities can improve the quality of care received by Medicare beneficiaries, increase patient satisfaction, and reduce Medicare expenditures."

Of the 10 facilities identified nationally to participate in the three year demonstration, three facilities from western North Dakota are included: McKenzie County Health Care Systems in Watford City, Jacobson Memorial Hospital Care Center in Elgin, and Southwest Health Care, Inc. in Bowman. Montana and Nevada also have participating sites **(25)**.

Telemedicine

Telemedicine is the use of telecommunication and information technologies to provide clinical health care at a distance. It helps to eliminate distance barriers and can improve access to medical service that would often not be consistently available in distant rural communities.

Tele behavioral health services are services authorized under the North Dakota Medicaid telemedicine policy, including: psychiatric evaluations and medication monitoring, substance use disorder evaluations, and some therapy services. Telepharmacy is the practice of delivering pharmacy services via telecommunications to patients in locations where they may not have in-person access to a pharmacist. The originating site is the location where the consumer is, and the distant site is the location of the provider. **(The reader is referred to Appendix G to view the N.D. Medicaid Telemedicine Policy).**



*	data excludes Medicaid waivered service and managed care recipients, excludes state hospital telepharmacy services, and excludes all who do not have traditional Medicaid
**	data was pulled based on services paid, so SFY 2016 likely is under-reported
***	originating site is location where the consumer receives services from the distant site provider

The line graph above derives from claims paid to Medicaid enrolled providers for telemedicine services delivered to traditional fee-for-service Medicaid beneficiaries for SFY 2014, 2015 & 2016. The graph excludes recipients who are enrolled in Medicaid managed care programs, and excludes telemedicine

recipients who are not enrolled in North Dakota Medicaid. The graph paints the picture of telemedicine to traditional Medicaid recipients, and demonstrates that telemedicine to this population has been growing.

During SFY 2016, 375 recipients of traditional Medicaid received 1,030 telemedicine services. These services were initiated from originating sites in 32 different ND counties. Within these numbers, the Human Service Centers served 215 beneficiaries of traditional Medicaid who received 451 behavioral health telemedicine services originating from 21 counties across North Dakota. This amounts to 57% of all telemedicine recipients, 44% of all telemedicine services received, delivered to 66% of all originating site counties during SFY 2016.

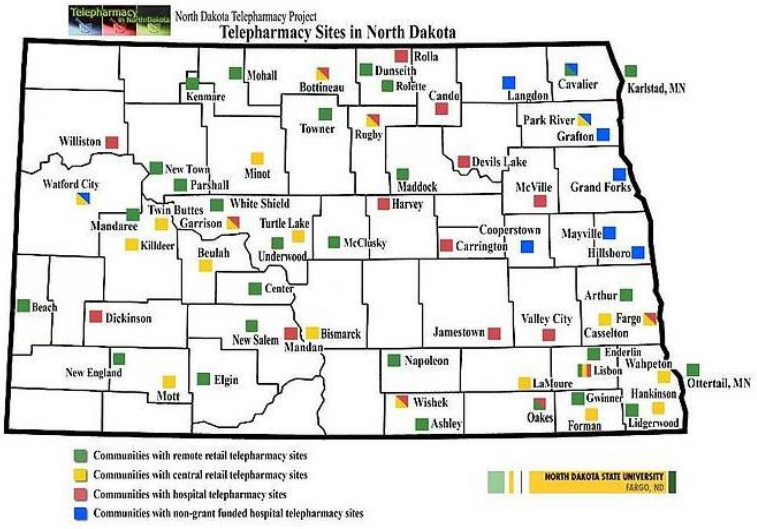
Telepharmacy:

There are 254 pharmacies across ND and 62 tele pharmacies. Five counties have no pharmacy and ten counties do not have a telepharmacy. The North Dakota state hospital offers telepharmacy services to some consumers receiving outpatient services from the human service centers.

In regard to pharmacy workforce initiatives, North Dakota is implementing a second Pharmacy Technician program in the state, with classes starting in August 2016. The Pharmacy Technician Certificate Program is sanctioned and funded by the North Dakota Board of Higher Education as a collaborative effort of the North Dakota State College of Science and the North Dakota State University College of Pharmacy. The program receives input and support from the North Dakota Board of Pharmacy, North Dakota Pharmaceutical Association, North Dakota Society of Health-System

Pharmacists and the Northland Association of Pharmacy Technicians.

Telepharmacy Map



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Enhancing Beneficiary Communication and Feedback

CMS emphasizes that beneficiary feedback about access is a priority. The Department's Medical Services Division will be implementing three new communication and feedback pathways for Medicaid beneficiaries:

- Beneficiary Survey: A recipient newsletter has been developed that will have an access-related survey enclosed. The newsletter is being disseminated to approximately 43,900 traditional, fee-for-service Medicaid recipient households, and specifically asks for feedback regarding access across the 5 primary provider categories, and asks about variables that improve or present as barriers to access. For beneficiary convenience, an on-line version of the survey is also being created to allow electronic completion. **The reader is referred to Appendix J to view the Beneficiary survey**. The on-line survey can be found at: https://eforms.nd.gov/lfserver/SFN61091BeneficiarySurvey

- Email: A new DHS Medical Services Division email address has been created for beneficiaries to provide narrative feedback about access (ndmedicaid@nd.gov)

- Beneficiary Web Page: An informational webpage has been developed for Medicaid recipients which will allow for the sharing of access-related information, and in the future will be responsive to frequently asked questions about how to locate a health care provider, and similar. www.nd.gov/dhs/services/medicalserv/ and click on "Medicaid".

North Dakota Medicaid Rates: Comparison analysis of Medicaid payment rates to Medicare and other payers

The North Dakota Legislature has been able to grant inflationary increases to providers over the past decade, generally with those increases exceeding Consumer Price Index (CPI) and Medicare Economic Index (MEI), as well as comparable or in excess of the CPI Medical Care inflation index. In addition, during this period nursing facility rate limits have been rebased in 2006, 2009 and 2013 and wage pass-through increases were granted in 2009 and 2013; and the state provided additional general fund-only dollars through "oil-impact" legislation that helped providers in oil impact areas address staff recruitment and retention.

	ND Legislative Inflationary Increases for Providers	Overall CPI (CY)	MEI (CY)	CPI Medical Care
July 1, 2015	3%		.8%	2.6%
July 1, 2014	4%	2.0%	.8%	2.4%
July 1, 2013	4%	2.0%	.8%	2.5%
July 1, 2012*	3%	1.7%	.6%	2.7%
July 1, 2011*	3%	3.6%	.4%	3.0%
July 1, 2010	6%	1.2%	1.2%	3.4%
July 1, 2009^	6%	-2.1%	1.6%	3.2%
July 1, 2008	5%	5.6%	1.8%	3.7%
July 1, 2007	4%	2.4%	2.1%	4.4%
July 1, 2006	2.65%	4.1%	2.8%	4.0%
July 1, 2005	2.65%	3.2%	3.1%	4.2%

* For the 2011 – 2013 biennium, providers reimbursed from the professional fee schedule did not receive an inflationary increase.
^ For State Fiscal Year 2010, some providers, who receive other non-inflationary increases, did not receive the annual inflationary increase.

Additional fee comparison:

Commercial fee schedules are proprietary so are not available for fee comparison purposes. It is well known however, that nationally, the Medicaid fee schedules are lower than those used by private insurance companies.

The Medicaid-to-Medicare Fee Index below was developed by the Kaiser Family Foundation indexing 2014 rates. Even with the July 1, 2016 rate change to the North Dakota professional fee schedule, North Dakota will remain a top tier state in relation to other states' Medicaid reimbursement [17]. (see comparison table on following page).

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Medicaid-to-Medicare Fee Index

Timeframe: 2014

Location	All Services
United States	**0.66**
Alaska	1.29
Montana	1.04
North Dakota	**1.00** → As of 07/01/2016
Delaware	0.98
Wyoming	0.96
Maryland	0.92
New Mexico	0.91
Connecticut	0.90
Nebraska	0.90
Mississippi	0.89
Oklahoma	0.89
Idaho	0.88
Oregon	0.83
Iowa	0.82
Arizona	0.81
Nevada	0.81
Arkansas	0.80
District of Columbia	0.80
South Carolina	0.80
South Dakota	0.80
Vermont	0.80
Massachusetts	0.79
North Carolina	0.79
Virginia	0.79
West Virginia	0.79
Kansas	0.78
Kentucky	0.77
Alabama	0.76
Georgia	0.75
Utah	0.74
Washington	0.74
Colorado	0.72
Louisiana	0.71
Wisconsin	0.71
Minnesota	0.69
Pennsylvania	0.67
Texas	0.65
Maine	0.64
Hawaii	0.62
Illinois	0.62
Indiana	0.61
Ohio	0.61
Missouri	0.60
New Hampshire	0.58
New York	0.57
Florida	0.56
Michigan	0.54
California	0.52
New Jersey	0.45
Rhode Island	0.38
Tennessee	N/A

Source: Kaiser Family Foundation
http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index

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Data Assessment/Monitoring Process

Specific data indicators have been identified for monitoring Medicaid beneficiary- to- provider access. Additional data has been compiled from numerous national and state-level information sources (see "References" for data source details). Efforts have been made to capture the most recent data available, and in some instances data trends are charted for SFY 2013, 2014 and 2015. State fiscal year 2015 is the primary data baseline year.

The University of North Dakota (UND) School of Medicine and Health Sciences staff, in particular the Center for Rural Health, and the Office of Primary Care, have long-standing research efforts regarding the state's health care demographics and workforce challenges. Their research adds an understanding of North Dakota's health care system that is critical to consider in analyzing access monitoring data.

UND staff is also a primary point of contact on the status of the North Dakota Health Care Workforce Initiative (HWI). Now entering Phase 2, HWI implements a statewide strategy to address identified health care provider shortages and service gaps, including those that pose broad challenges to our state's residents' access to provider services within specific identified geographical areas across North Dakota.

The Center for Rural Health in partnership with local hospitals and public health units, conducts detailed Community Health Needs Assessments, ranging from 15 to 17 community assessments annually. These reports prioritize a community's health care needs, as well as identify specific health care service gaps, so will be useful points of reference in those instances where a health care access concern is identified for a specific geographical location. If the reader would like to view a community assessment, go to the following site; you will find that most hospitals identify a link to their most recent community survey: https://ruralhealth.und.edu/projects/flex/hospitals

Initial Access Monitoring Plan deliverables are to establish baseline data benchmarks that provide a snapshot of access. The data acquired will also form the basis to begin access monitoring.
If data trend analysis suggests that an access problem may exist, attempts will be made to "drill down" to better analyze the specifics and define the scope of the access concern. One example: A review of one identified provider group across SFY 2013, 2014 and 2015 reveals that the numbers of this provider group declined from 50 providers in 2013 down to 42 providers in 2015, a decline of 16%.

However, the number of Medicaid patients seen for the provider service increased by 16%; the number of total patient visits grew by 32% and the volume of billing grew by 39% during this same timeframe.

As in the example above, it is anticipated that some data analysis will need to be multi-faceted, taking in to consideration rural-related variables, such as workforce challenges related to HWI gap analysis, as well as overlays of North Dakota's extensive Health Professional Shortage Area designations, and Medically Underserved geographic area or underserved population designations.

If analysis concludes that an access concern is primarily limited to Medicaid beneficiaries in an identified geographic area, and has reached an actionable threshold, North Dakota Medicaid staff will utilize available data to work with providers and other stakeholders to formulate possible available solutions to address the identified access gap. Data will continue to be captured at least annually for a period of three years after budget allotment changes, to continue to monitor any identified concern and to determine if the access gap is resolving.

Access issues more often than not are anticipated to be complex, such that a cookie cutter approach to resolution is not likely to be helpful. Rather, North Dakota's implementation of a plan to monitor identified access concerns will involve transparency, employ a collaborative approach, and will be individualized based on the systemic analysis of the variable(s) surrounding the access barrier.

The Department will collaborate and consult with the Centers for Medicare and Medicaid Services regarding identified access concerns that impact North Dakota Medicaid beneficiaries. Access concerns are anticipated to fall along a continuum, some of which may be specific to Medicaid, and some that have broader access-related impacts to a wider array of residents in a geographic location.

Review of 15 possible access-related data Indicators:

Based on recommendations made by the North Dakota Medicaid Medical Advisory Committee from the May 24th and July 12th meetings, the following data indicators received support out of a pool of 15 possible data elements:

1. Monitor Changes in Service Volume

2. Monitor Changes in Provider Enrollment Volume (Consider modifying to a disenrollment report, and consider a no billing activity report for currently enrolled providers.)

3. Rate and Fee Schedule Comparisons with surrounding states

4. Utilize Surveys of Enrolled Providers

5. Survey Child Welfare agencies

6. Measure impact on quality of patient care (Keep as discretionary question-not a direct measure of access but quality of care is an important indicator to ND providers and would be good to know if we are losing ground)

7. Monitor the number of individuals enrolling for Medicaid coverage

8. Monitor provider group categories for access trends based on volume of services, of provider billing, numbers of patients seen, number of service events. Consider formatting service and events data into "per 1000" data reports so we have a standardized metric for future comparison purposes.

(The reader is referred to Appendix H for a more detailed commentary of the original 15 data indicators under consideration, and the Medicaid Medical Advisory Committee's response and recommendations to each)

Behavioral Health Services

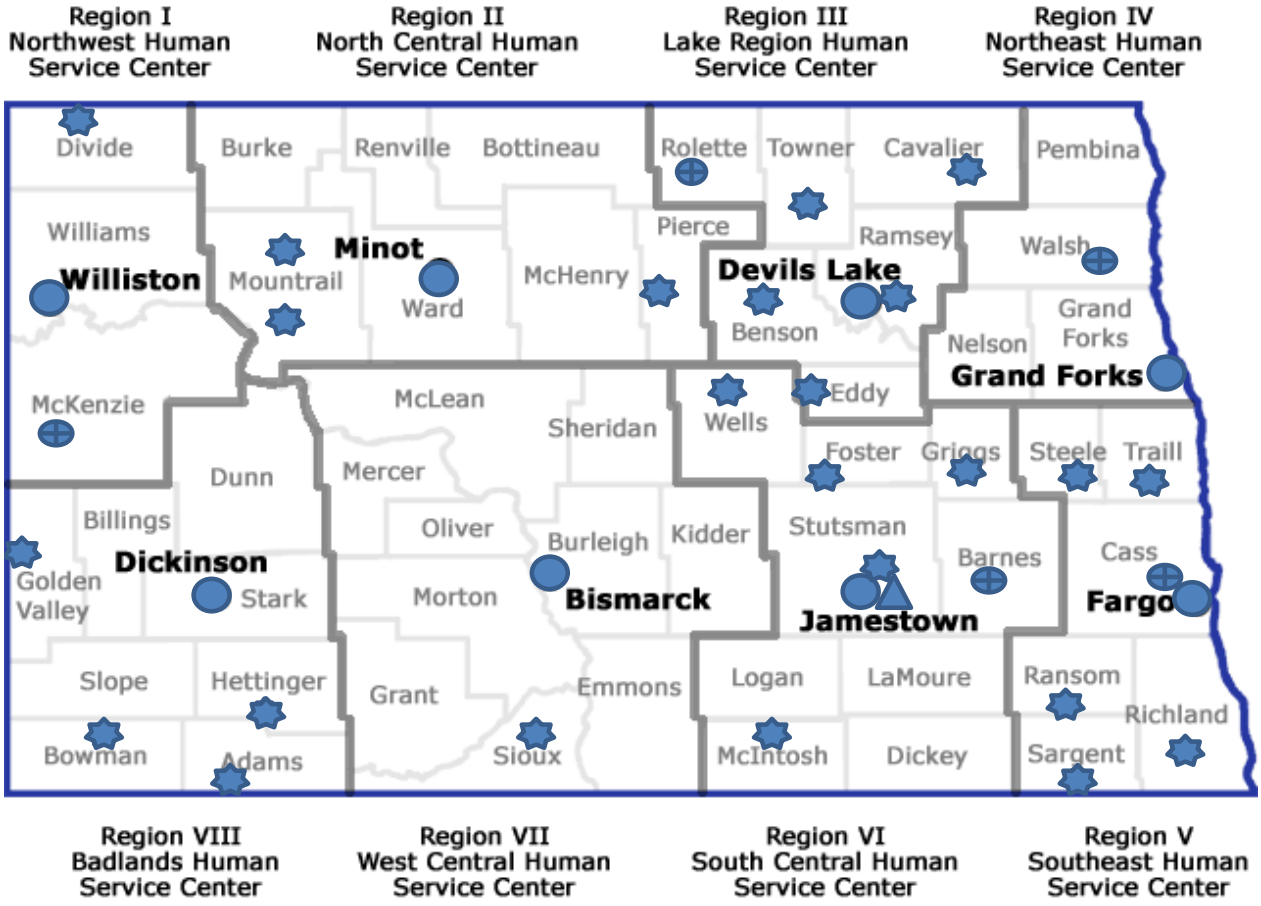
Mental Health and Substance Abuse services in North Dakota are provided by public, private and tribal/IHS agencies across an array of levels of care. In general, facilities with larger numbers of staff are more likely to enroll as Medicaid behavioral health providers compared to sole proprietor or smaller staffed agencies **(see Appendix E – 2, listing licensed substance abuse programs across N.D.)**. The two Divisions within the Department of Human Services that most directly interface with the behavioral health provider systems across North Dakota are the Behavioral Health Division and the Field Services Division.

The Division of Behavioral Health provides leadership for the planning, development, and oversight of a system of care for children, adults, and families with severe emotional disorders, mental illness, and/or substance use disorders. This division works with all licensed behavioral health providers across North Dakota.

The Department of Human Services Field Service Division is a significant direct service provider of behavioral health services across North Dakota. In the early 1970s, North Dakota participated in a federal demonstration project that lead to the creation of the first HSC. The Lake Region Human Service Center was chosen as the rural site nationally to pilot a behavioral health service delivery concept of "one stop shopping within one administrative umbrella" to residents in need of behavioral health services. In North Dakota, the model essentially combined area social service centers and community mental health centers, and co-located with additional services. The pilot was successful such that in the mid-1970s the three smaller HSCs adopted this model, and in the early 1980s, the remaining five regions were converted to the human service center model.

The Regional Human Service Centers are part of the North Dakota Department of Human Services Division of Field Services. Divided into 8 regions, the HSCs deliver mental health and substance abuse services across North Dakota, including to Medicaid beneficiaries, and to the uninsured. Each HSC

provides emergency and crisis services on a 24-hour basis, and screen all admissions to the North Dakota State Hospital to assure "least restrictive setting necessary" criteria, and rule out community-based options for treatment. South East Human Service Center in Fargo also contracts for a mobile crisis unit. Additionally the HSCs deliver developmental disability services, vocational rehabilitation services, aging services, and provide program supervision and consultation to the counties and tribes related to child welfare service delivery. Case managers from the HSCs often meet with individuals in their homes and in local community settings, in addition to the outreach sites described in the statewide map that follows.



Legend:

- **Regional Human Service Center primary office location**
- **Human Service Center Outreach office locations**
- **HSC full-time or multi-staffed satellite office**
- **North Dakota State Hospital (Jamestown, ND)**

(See Appendix E – 1 for additional narrative discussion of outreach site locations.)

While wait time monitoring was deemed to be an undue burden on Medicaid enrolled provider agencies, the newly developed beneficiary survey does have a format that considers timeliness in

access to services, so we are trying to "get at this data" from a recipient feedback perspective rather than measuring timely access at a provider level. Consistent with this approach, the HSCs have periodically asked consumers about satisfaction with wait time for behavioral health services. The HSCs have also been implementing methodologies to further improve timely access. The satisfaction survey numbers that follow allow analysis of feedback on a statewide level but unfortunately are not generalizable to the regional level.

Table 1: Are you satisfied with the time you had to wait between your initial call to the center and the time of your first appointment?

	Adult		Youth*	
	2012	2014	2012	2014
	n=1,201	n=264	n=126	n=22
SATISFIED	93.1%	89.6%	96.7%	86.4%
NOT SATISFIED	6.9%	10.4%	3.3%	13.6%

*the question was asked only of those youth who had been receiving services for less than 6 months.

Additional access-related questions were also asked:

Table 2: How long did you wait from your initial contact with the human service center until your first appointment?

	Adult		Youth	
	2012	2014*	2012*	2014*
	n=1,179			
LESS THAN 5 DAYS	52.6%			
6 TO 10 DAYS	26.9%			
11 TO 20 DAYS	9.5%			
MORE THAN 20 DAYS	11.0%			

*This question was omitted from both the 2014 Adult and Parent/Guardian surveys and on the 2012 Parent/Guardian survey

Table 3: What distance do you have to travel to get to the human service center?

	Adult		Youth*	
	2012	2014	2012	2014
	n=1,249	n=267		
FEWER THAN 5 MILES	67.1%	64.8%		
6-20 MILES	19.9%	16.1%		
21-50 MILES	8.1%	6.4%		
51-100 MILES	4.2%	10.1%		
OVER 100 MILES	0.8%	2.6%		

This question was omitted from the 2012 and 2014 Parent/Guardian survey

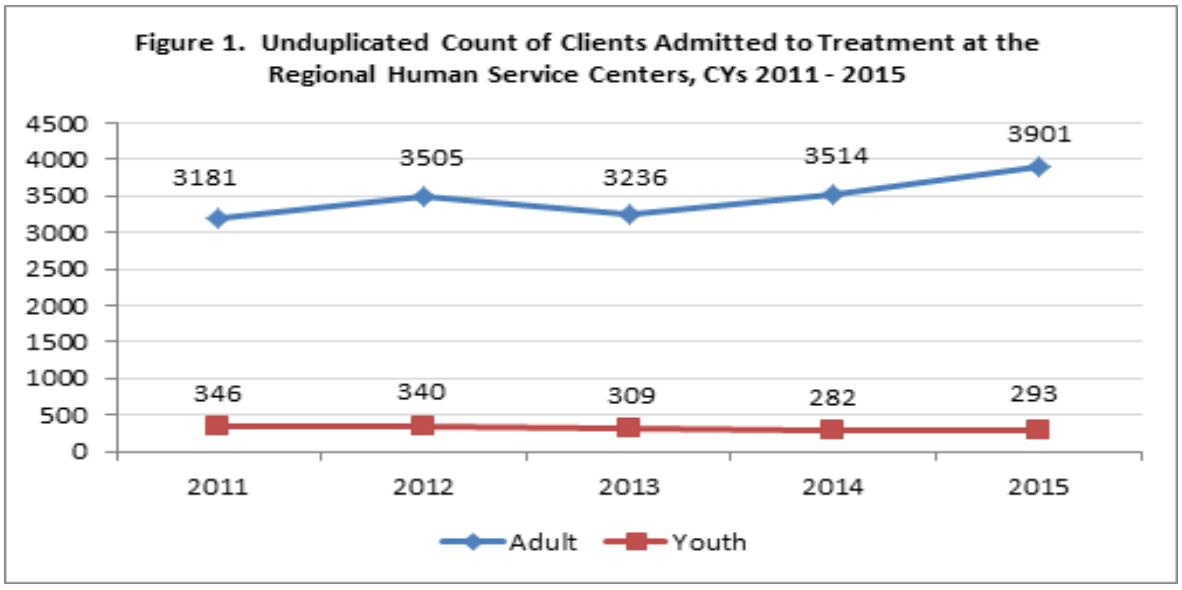
Table 4. The location of services is convenient.

	Adult		Youth	
	2012	2014	2012	2014
	n=1,123	n=223	n=330	n=106
AGREED	93.1%	95.5%	98.5%	94.3%
DISAGREED	6.9%	4.5%	1.5%	5.7%

The percentages are calculated on only those respondents who agreed or disagreed

Two other access-related developments have also been playing out at the HSCs:
1. **Walk-in Clinics for substance use disorder evaluations** was piloted by one of the HSCs beginning in 2012 and was rolled out statewide among all 8 HSCs over the past two years. Essentially this was a NIATx Process Improvement Initiative that resulted in "no appointment necessary; if interested in an evaluation for a substance use disorder, just come in during identified times on identified days of the week and HSC a licensed addition counselor will provide the evaluation". No show rates were subsequently reduced significantly, efficiency improved, and access-related wait time further reduced.

The following graph describes all consumers admitted to substance use disorder treatment services to the HSC's during identified calendar years. The volume of individuals served increased by 19%, with adults increasing by 23% and youth declining by 15% from calendar year 2011 to 2015.



2. The more recent access-related development at the HSCs is the **transition to "Open Access"** for mental health and substance use disorder presentations that is currently being implemented. Conceptually similar to walk-in clinics, currently 4 of the HSCs have or are in progress toward transitioning to open access for both mental health and substance abuse initial presentations.

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Services provided by the human service centers to Medicaid beneficiaries SFY 2013, 2014 & 2015:

	SFY 2013	SFY 2014	SFY 2015
Unduplicated Medicaid recipients *	3,957	4,362	5,137
Unduplicated Service Events	237,468	252,757	276,518
Ratio of service events per recipient/yr.	60:1	58:1	54:1

*The data excludes the Medicaid Expansion population

The reader is referred to Appendix E for additional information related to behavioral health services in North Dakota, including reference to E – 2 that lists the licensed substance abuse programs, with those who are Medicaid enrolled providers highlighted, and to E – 3 which adds regional level detail about the HSC services to Medicaid recipients (SFY 2013 to 2015).

Data Analysis and Conclusions regarding Access by provider group:

The CMS Access rule targets 5 provider groups, as described below. Additionally the CMS Access Rule indicates that in any situation where provider reimbursement rates are modified, states are to monitor possible access impacts that may result. DHS has incorporated additional baseline data reports related to the allotment, setting the stage for this monitoring. See provider group # 6 below for discuss of that piece.

The access monitoring data and conclusions are documented as follows:

1. Primary care services (provided by a physician, nurse practitioner, physician assistant, federally-qualified health center, clinic, or dental provider)

- North Dakota primary care providers as a group fare well in regard to access, based on the preliminary statewide snapshot provided by 141 traditional Medicaid beneficiary households. **Ninety-two percent of initial responding households reported they were usually or always seen by primary care in a timely manner.**
- As noted in the aggregate data section of report # 3, this provider group increased 8% in numbers of participating providers in SFY 2015 over SFY 2013, and has high numbers of enrolled providers. While reports # 1 & # 2 are attached to this monitoring plan to offer a wider context more so than being specific to the core provider populations targeted by CMS for Access Monitoring, the data specific to changes in the numbers of midlevel practitioners is encouraging. Physician Assistants and Nurse Practitioners who submitted claims increased by

162 providers in SFY 2015 over SFY 2013. SFY 2016 data may show an increase in enrollment of Physician Assistants as, with implementation of the ND MMIS, this group can now be a primary care provider for ND Medicaid clients. The Physician Assistant provider group also has a statewide dispersion that is strong, including having practices in some of the more rural areas of North Dakota.

- In contrast, dental providers in North Dakota are 25% fewer compared to national per capita averages, and as discussed in considerable detail within this access monitoring plan, we have dental workforce challenges that affect access, with multiple entities continuing to try to identify solutions. Medical Services Division is actively involved in many of these conversations. Medicaid reimbursement of dental services are among the highest rates in the nation, and the scope of services authorized in relation to traditional Medicaid recipients is also strong. The dental landscape is a complex challenge that exceeds the ability of Medical Services to resolve independently, and does not trigger a Plan of Correction per CMS Access Rule guidelines.

2. Physician specialty services (cardiology, urology, and radiology)

- Specialist providers also fare well in the preliminary beneficiary survey results related to access. **Eighty-seven percent of initial responders who saw a medical specialist over the most recent 6 month period reported they were usually or always seen by specialists in a timely manner.**
- **Medical specialists in aggregate have largely maintained stable Medicaid participation numbers from SFY 2013 through SFY 2015, as demonstrated in the data in report # 3 (see Attachment K). Over the same timeframe office visits per 1000 also remained fairly stable.** The decrease in the average number of visits from SFY 2013 as compared to SFY 2014 is the difference of .006 visits per person and the increase in the average number of visits from SFY 2014 to SFY 2015 is the difference of .03, neither of which are material, nor appear to indicate any issues related to access. The differences are more just a fluctuation in the need for specialty services.
- At this point, data does not warrant a Plan of Correction regarding Medical Specialists.

3. Behavioral health services (mental health and substance abuse)

- Generally speaking, a number of data indicators reflect positively on North Dakota's overall access to behavioral health providers. Medicaid Data Report # 3 demonstrates some statewide enrolled provider fluctuation between SFY 2013, 2014, and 2015, with respective statewide aggregate provider numbers***** of 82, 83, and **91 Medicaid providers for SFY 2015**. All regions saw a growth in the number of Medicaid providers, with the exception of Region 8 (Dickinson) with 15 providers during SFY 2015, a decline of 3 providers since SFY 2013. (* Note: statewide tally of aggregate provider numbers is different from the total providers for each region because some providers serve multiple regions; in this report the data count is "where the beneficiary is", rather than the provider.)
- The dispersion of behavioral health outreach offices around North Dakota, in combination with community-based case manager outreach is a likely contributor to consumer satisfaction with access, and the growth of telemedicine and telepharmacy likely also are positive contributors.
- Overall positive access to behavioral health is also noted in the state-by-state rankings as indicated by Mental Health America – 2015, and validated at a preliminary level by the

beneficiary survey feedback in which 79% of responders endorsing being seen by behavioral health providers "usually or always" as soon as they needed the appointment. Human Service Centers are in the process of simplifying their case opening protocols and implementing "Open Access" so responsiveness to access should improve further as a result.

- Medicaid Data report # 4 tells somewhat of a different story, and needs some clarification. The report speaks to "visits per 1000" recipients (visits measures discrete appointments) and "services per 1000" (services measures units of service, so for example, one appointment might be 4 units of service). Visits per 1000 for the purpose of access monitoring, is likely the more useful number to attend to. Both visits and services have declined statewide; however Medical Services Analytics staff believe that the "per 1000" overlay and subsequent data changes is related to evolving Medicaid beneficiary enrollment more so than an indication that fewer beneficiaries are receiving needed services. The pertinent variables include: North Dakota is becoming younger; the Affordable Care Act health insurance mandate requires more individuals to seek coverage, and the public education related to ACA, as well as navigator assistance in enrollment we believe has resulted in more young and healthier enrollees. Since this data is "per 1000", an increase in healthier beneficiaries will lower the overall numbers of visits per 1000, and in that sense, is a positive outcome. While continued analysis of the "per 1000" data is warranted, there is not presently evidence to conclude that the majority of the change is related to beneficiaries being less able to access services, so much as the beneficiary group as cohort population is needing fewer services. Data elsewhere in this Medicaid Access Monitoring Plan seems to support this contention, for example the sense of wellbeing of North Dakotans has been improving, mental health concerns are believed to be lower than national averages, and similar.
- While the preliminary conclusion related to access to behavioral health care is that the data does not result in triggering a plan of correction under CMS Access Rule guidelines, this conclusion is not intended to suggest that all is well within the behavioral health delivery system. We know there are concerns about the workforce numbers of licensed addiction counselors and their dispersion around the state, and that Medication Assisted Treatment (MAC) is still in its infancy in North Dakota. We additionally recognize that stakeholder groups around the state identify areas where expansion of the scope of behavioral health services for some populations is being recommended. These are important conversations to continue, and while related, are not within the primary scope of the Medicaid Access Monitoring Plan.

4. Pre and post-natal childbirth services (pregnancy, child birth, and post-delivery care)

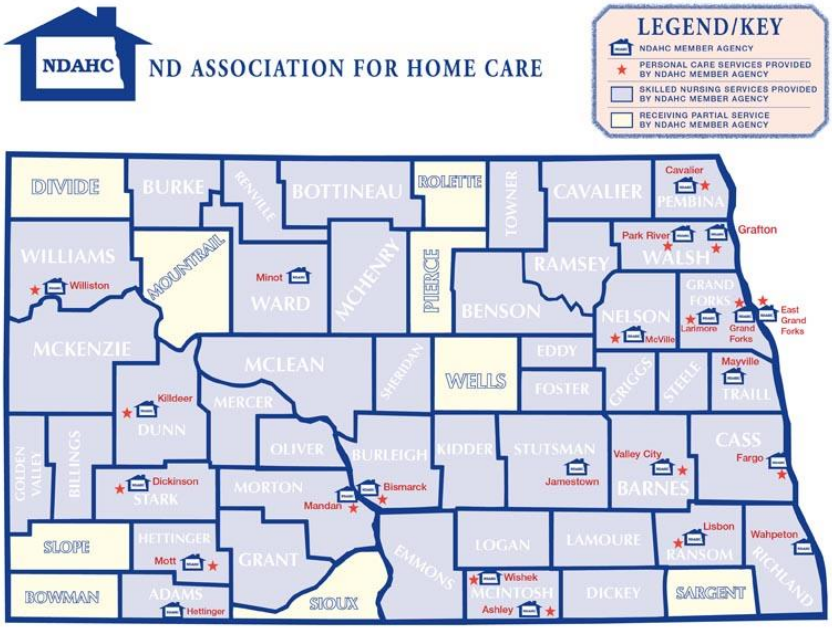
- There are 350 in-state obstetric care practitioners currently enrolled as providers of North Dakota Medicaid, and an additional 16 out-of-state providers enrolled.
- In reviewing the initial 141 beneficiary survey responses related to access, there were not enough responders in this survey category to analyze the data. However an additional 24 surveys were subsequently analyzed, 9 beneficiaries responded within the 165 surveys, with the following cumulative results:
  Beneficiaries responded about timely access to obstetric providers as soon as was needed, on a Likert scale of Never (0 responses)/Sometimes (0 responses)/Usually (2 responses)/Always (7

responses). **One hundred percent of the initial 9 survey responders reported they were usually or always seen by Obstetrics Providers in a timely manner.**

- The high fence post area of concern related to pregnancy, child birth and post-delivery care in North Dakota is pregnant women with substance abuse problems choosing not to seek help with either the pregnancy or the substance usage, early in the pregnancy. Too many are presenting at the point of delivery, resulting in newborns testing positive for substances and the very concerning sequela that follows for many of these children and families. The state legislature designated a task force to study this concern, and conclusions and recommendations have been submitted to two legislative committees for action in the upcoming legislative session.

5. Home health services (transition services from a hospital to a home setting)

- Home health service is an important but overall limited component in the North Dakota continuum of care of community-based services for those managing or recovering from illness. In regard to the initial 141 beneficiary survey responders regarding timely access, only one individual endorsed receipt of home health, but did not answer the timeliness question.
- Medicaid data reports #3 and #4 address home health data. Report #3 addresses regional and statewide aggregate of the provider participation during SFY 2013, 2014 & 2015. North Dakota Medicaid requires home health agencies to be Medicare certified in order to be enrolled to provide home health services. As with any provider group, there is inevitable "churning" of provider numbers for an array of reasons, and in this instance the provider numbers are small so change analysis must be approached with some caution. Statewide aggregate denotes 24 providers delivering services during SFY 2013, and 20 providers delivering services in 2014 and 2015; a decline of 16.6% of home health providers.
- Home health provider agencies in general cover broad catchment areas that are often not limited to regional boundaries. The Map below describes the ND home health coverage landscape, and can be viewed in Appendix F in larger format. Hospital acuity, based on the "per 1000" visits for SFY 2015 has declined so one data indicator to continue to monitor is whether the dynamic of enrollment of overall healthier individuals among a younger enrollment population continues.



6. Monitoring Access to Care subsequent to rate reductions in 2016:

The North Dakota Constitution and State Law require a balanced budget, which in 2016 resulted in a budget allotment for North Dakota state agencies including DHS (see page 15 and 16 for details). The outcome was a required savings of state dollars that had been previously authorized. Medicaid comprises sixty-eight percent of the DHS budget, so Medicaid-funded services had to be considered for the saving plan. Through the public input process offered by the Department, providers offered public comments. By far, the highest volume issue identified was the concern that quality of care to Medicaid beneficiaries would be negatively impacted, including as a dynamic of managing provider budgets to maintain staff in an environment where recruitment and retention of staff was already challenging for many.

DHS has developed preliminary data reports pertinent to provider types impacted by rate reductions, which at this point form baseline data that depicts provider snapshots of access that existed prior to rate change implementations. As is true of the overall access plan, SFY 2015 is the core baseline year, although trends are also considered for SFY 2013 and 2014. Hereafter, this Medicaid Access Monitoring Plan will update data to monitor, analyze, and inform. The legislative assembly will reconvene in early January 2017 and DHS anticipates that interest in preliminary report updates, and additional baseline reporting may be requested.

Pertinent to the allotment, the Medicaid data reports in Appendix K include:

- Professional Service Providers report # 8;
- Speech, Physical, and Occupational Therapy reports # 6 & 9;
- Ambulance Services reports # 7 & 10;
- Additional baseline reports are being constructed specific to Medicaid and by recipient age. DHS also will develop baseline data specific to the long-term care facilities.

The allotment specific baseline data has been shared with CMS and incorporated into State Plan Amendments submitted for the allotment rate reductions. Thereafter, within the context of this Access Monitoring Plan, DHS will update and analyze allotment related data to monitor for possible impacts to beneficiary access.

Specifically, the allotment impacted rates for Ambulance Services, Physical, Occupational and Speech Therapy, and services reimbursed from the professional fee schedule.

Ambulance:

Data demonstrating the number of providers enrolled and the number of providers participating is included as Report # 7. The enrollment and participating provider data for SFY 2013 through 2015 shows a slight increase in enrolled providers and a fairly steady number of participating providers. The Department would not expect large fluctuations in these two measures for this provider type, as the number of ambulance providers tends to be stable and they are emergency responders who do not ask for payment source when they are dispatched to an emergency situation.

Please reference Report # 10 for information on utilization volume for Ambulance services. Attachment G shows both visits per 1,000 and services per 1,000; however, the Department has determined that visits per 1,000 is the most appropriate data to compare. Visits for 2013 and 2014 were stable, with the numbers dropping slightly for 2015. With the implementation of the Affordable Care Act (including Medicaid expansion in North Dakota), there was more than normal enrollment "churning" in the second half of SFY 2014 and into SFY 2015. One example of impact was that while "services per 1000" data was relatively stable during SFY 2013 and SFY 2014 (with only six months of ACA impact), service volume does show declines in SFY 2015. DHS data analytics staff believes that in part, the declines are related to the "woodwork effect". It is reasonable to believe that individuals within this population are lower utilizers of health care services as they had not sought Medicaid coverage until the ACA outreach and individual mandate. The outcome is that healthier individuals enrolled in traditional Medicaid, which the Department believes led to less health care acuity per 1,000 data.

The decrease in visits from SFY 2013 as compared to SFY 2015 is the difference of .017 visits per person, which does not appear to indicate any issues related to access and is more just a fluctuation in the need for this type of service.

Because of the rate reductions, enrollment and utilization information for ambulance services will be monitored to ensure continued access to services for Medicaid recipients.

Additional area to be monitored for ambulance service access:

Because a portion of ambulance transport does involve specialty transport (between a hospital discharge and nursing home), the Department will survey ambulance providers as part of its Access Monitoring Plan to determine if ambulance service providers are limiting this type of transport.

Physical, Occupational and Speech Therapy

Data demonstrating the number of providers enrolled and the number of providers participating is included as Report # 6. The enrollment and participating provider data for SFY 2013 through SFY 2015 shows notable increases in both enrolled and participating providers for all three provider groups impacted by this amendment. As the Department monitors access as a result of the rate reductions, the enrollment and participating data will be reviewed in combination with utilization information to track availability of these services for Medicaid clients.

Report # 9 shows both visits per 1,000 and services per 1,000; however, the Department has determined that visits per 1,000 is the most appropriate data to compare. A comparison of visits between 2013 and 2014 shows an increase, with the numbers dropping some for SFY 2015. With the implementation of the Affordable Care Act (including Medicaid expansion in North Dakota), there was more than normal enrollment "churning" in the second half of SFY 2014 and into SFY 2015. One example of impact was that while "services per 1000" increased between SFY 2013 and SFY 2014 (with only six months of ACA impact), service volume does show declines in SFY 2015. DHS data analytics staff believes that in part, the declines are related to the "woodwork effect". It is reasonable to believe that individuals within this population are lower utilizers of health care services as they had not sought Medicaid coverage until the ACA outreach and individual mandate. The outcome is that healthier individuals enrolled in traditional Medicaid, which the Department believes led to less health care acuity per 1,000 data.

The decrease in the average number of visits from SFY 2013 as compared to SFY 2015 is the difference of .061 visits per person, which does not appear to indicate any issues related to access and is more just a fluctuation in the need for this type of service.

Because of the rate reductions, enrollment and utilization information for physical, occupational and speech therapy services will be monitored to ensure continued access to services for Medicaid recipients.

Services reimbursed from the Professional Fee Schedule:

Data demonstrating the number of providers enrolled and the number of providers participating is included in Report # 8. Providers who render services reimbursed from the Medicare RVU pricing methodology are within this list of providers. Overall the number of enrolled providers is increasing. Also, as part of the implementation of the Medicaid Management Information System in October 2015, all providers needed to re-enroll. The enrollment process started toward the end of SFY 2013. By history, some providers were enrolled as group or facility enrollment but in the new MMIS all providers are enrolled as individual practitioners; also some providers chose not to re-enroll. The effect is that related data elements have changed for underlying reasons having nothing to do with gains or losses related to beneficiary access.

As the Department monitors access as a result of the rate reductions, the enrollment and participating data will be reviewed in combination with utilization information to track availability of these services for Medicaid clients.

Please reference Report # 8 for information on utilization volume of services reimbursed from the professional fee schedule. Report # 8 shows both visits per 1,000 and services per 1,000; however, the Department has determined that visits per 1,000 is the most appropriate data to compare. A comparison of visits between 2013 and 2015 shows a decrease. With the implementation of the Affordable Care Act (including Medicaid expansion in North Dakota), there was more than normal enrollment "churning" in the second half of SFY 2014 and into SFY 2015. Services per 1,000 decreased between SFY 2013 and SFY 2015. DHS data analytics staff believes that in part, the declines are related to the "woodwork effect". It is reasonable to believe that individuals within this population are lower utilizers of health care services as they had not sought Medicaid coverage until the ACA outreach and individual mandate. The outcome is that healthier individuals enrolled in traditional Medicaid, which the Department believes led to less health care acuity per 1,000 data.

The decrease in the average number of visits from SFY 2013 as compared to SFY 2015 is the difference of 1.25 visits per person, which does not appear to indicate any issues related to access and is more just a fluctuation in the need for the combination of services reimbursed from the professional fee schedule.

Because of the rate reductions, enrollment and utilization information for services reimbursed from the professional fee schedule will be monitored to ensure continued access to services for Medicaid recipients.

Additional area to be monitored for access for services reimbursed from the professional fee schedule:

DHS will monitor feedback from families and advocacy agencies whether services are being maintained at levels appropriate to each individual's needs to be successfully maintained in community-based settings.

DHS will consult with child welfare agencies as to possible impacts on access and will consider monitoring if more beneficiaries are being forced back on to public assistance programs, or increased trends of admissions into the North Dakota State Hospital.

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APPENDIX

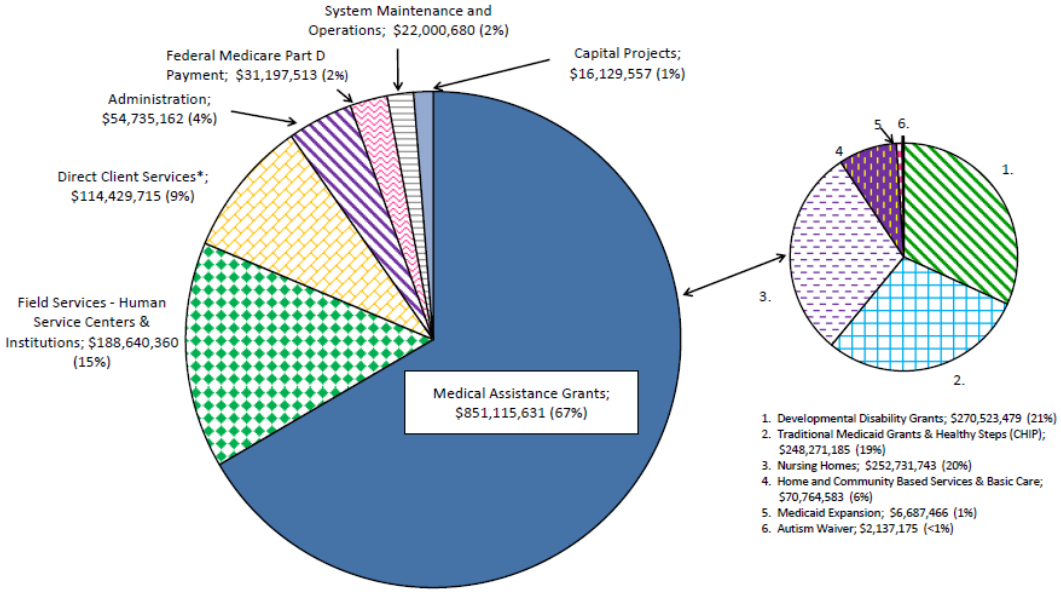
Appendix A

North Dakota Department of Human Services

2015 - 2017 Legislatively Approved SB 2012, Other Passed Bills, and February 2016 Allotment

Where Does the Money Go?

Department-Wide Total General Fund $1,278,248,618 (includes $53,954,215 Budget Allotment)



* Includes Temporary Assistance for Needy Families (TANF), Job Opportunity Basic Skills, (JOBS) Child Care, Supplemental Nutritional Assistance Program (SNAP), Low Income Home Energy Assistance Program (LIHEAP), IV-D Judicial, Regional Child Support Units, Child Welfare, Aging, Mental Health, Substance Abuse, Vocational Rehabilitation, Autism Voucher Program, and Non-Medical Developmental Disability grants and services.

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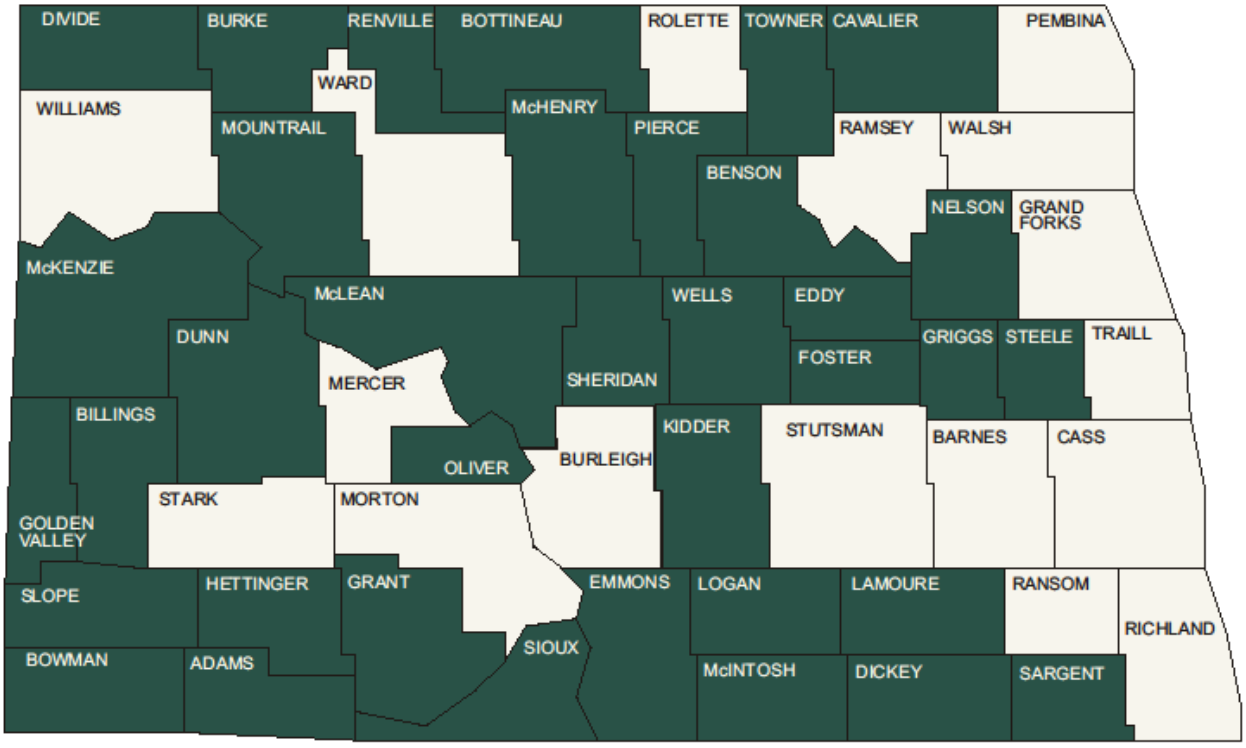
Appendix B: HPSA/MUA MAPS

B-1

North Dakota Frontier Counties



UND School of Medicine & Health Sciences
University of North Dakota

36 of 53 North Dakota Counties designated as Frontier*
(less than 6 persons per square mile) Based on 2012 Estimates

North Dakota Department of Health

*Department of Health and Human Services Definition of Frontier – (http://frontierus.org/defining.php)

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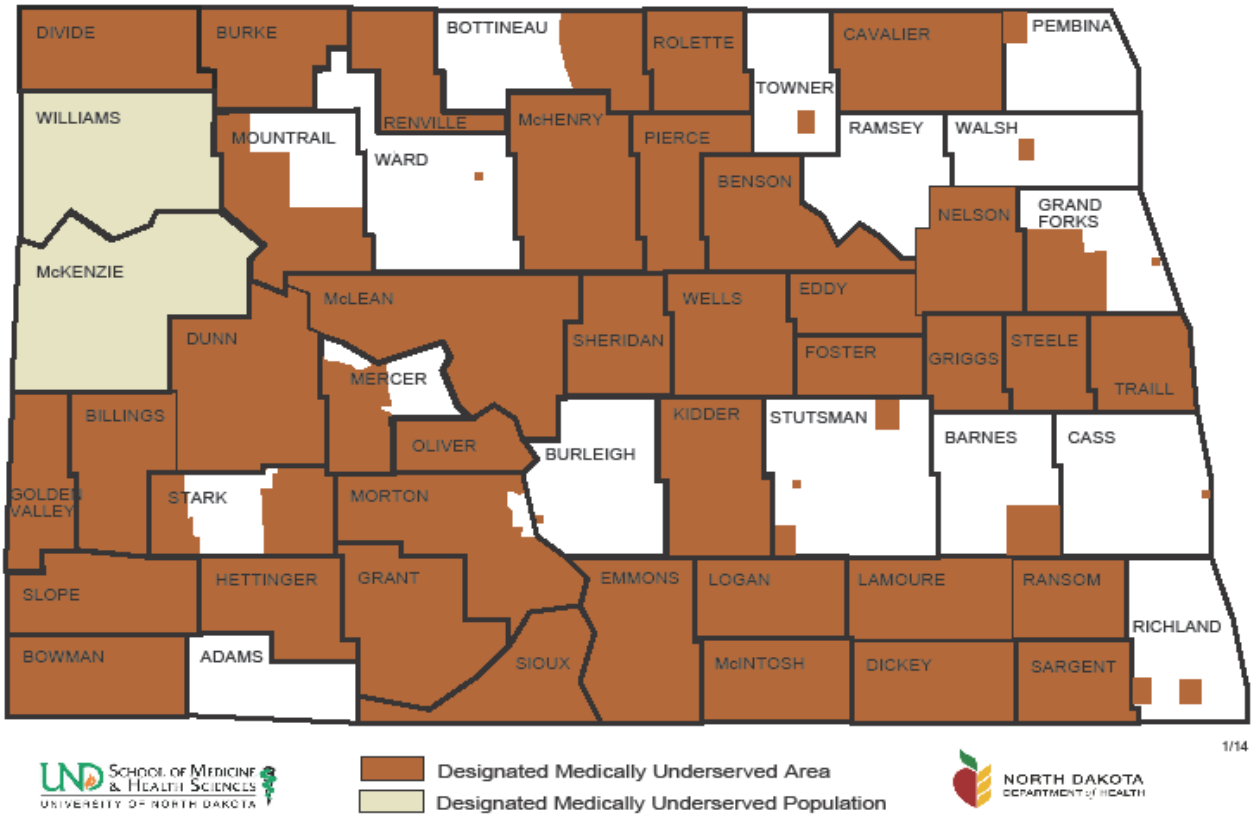
B - 2

North Dakota Medically Underserved Areas/Populations (MUAs/MUPs)



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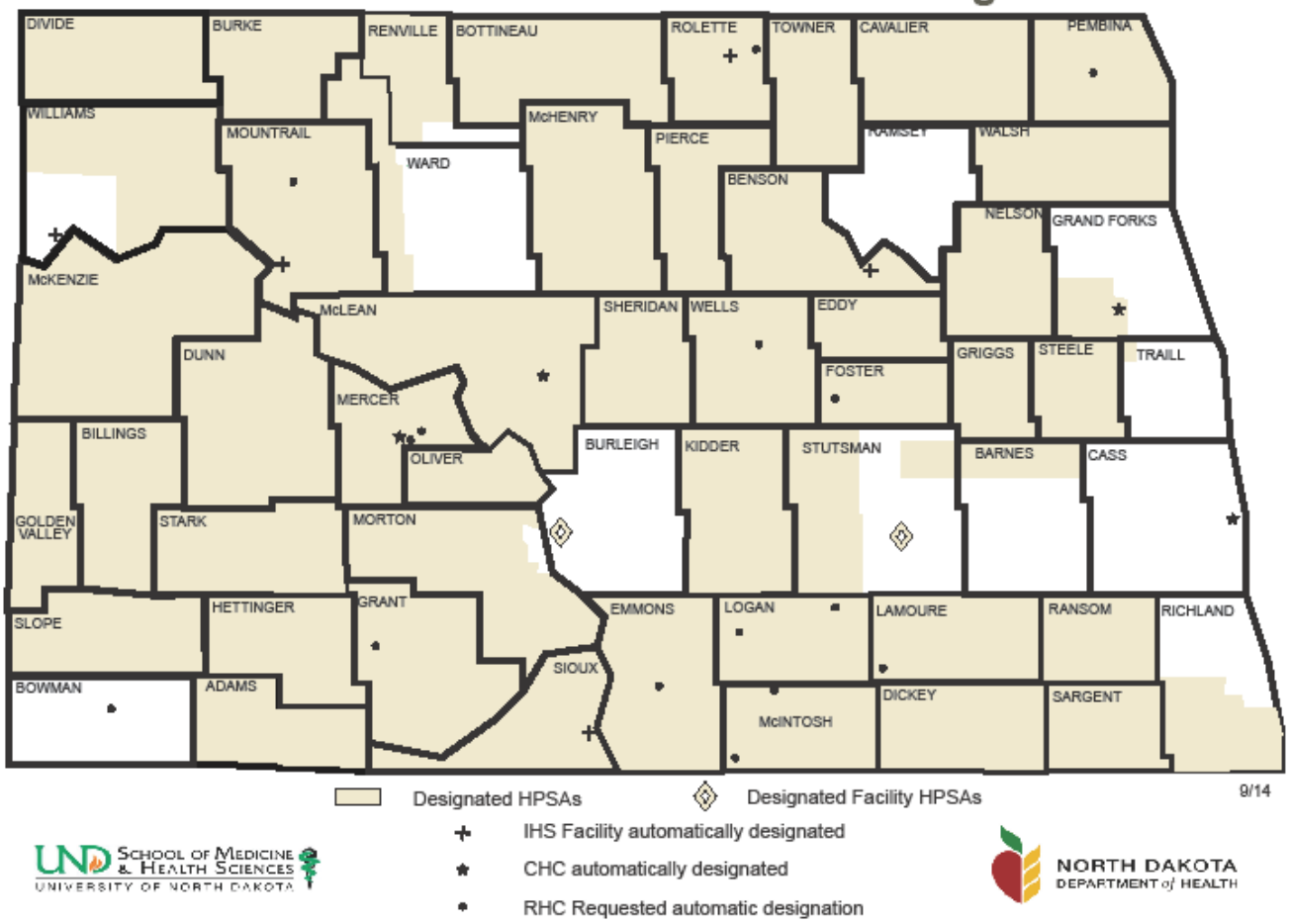
B - 3

North Dakota Health Professional Shortage Areas



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North Dakota Department of Health

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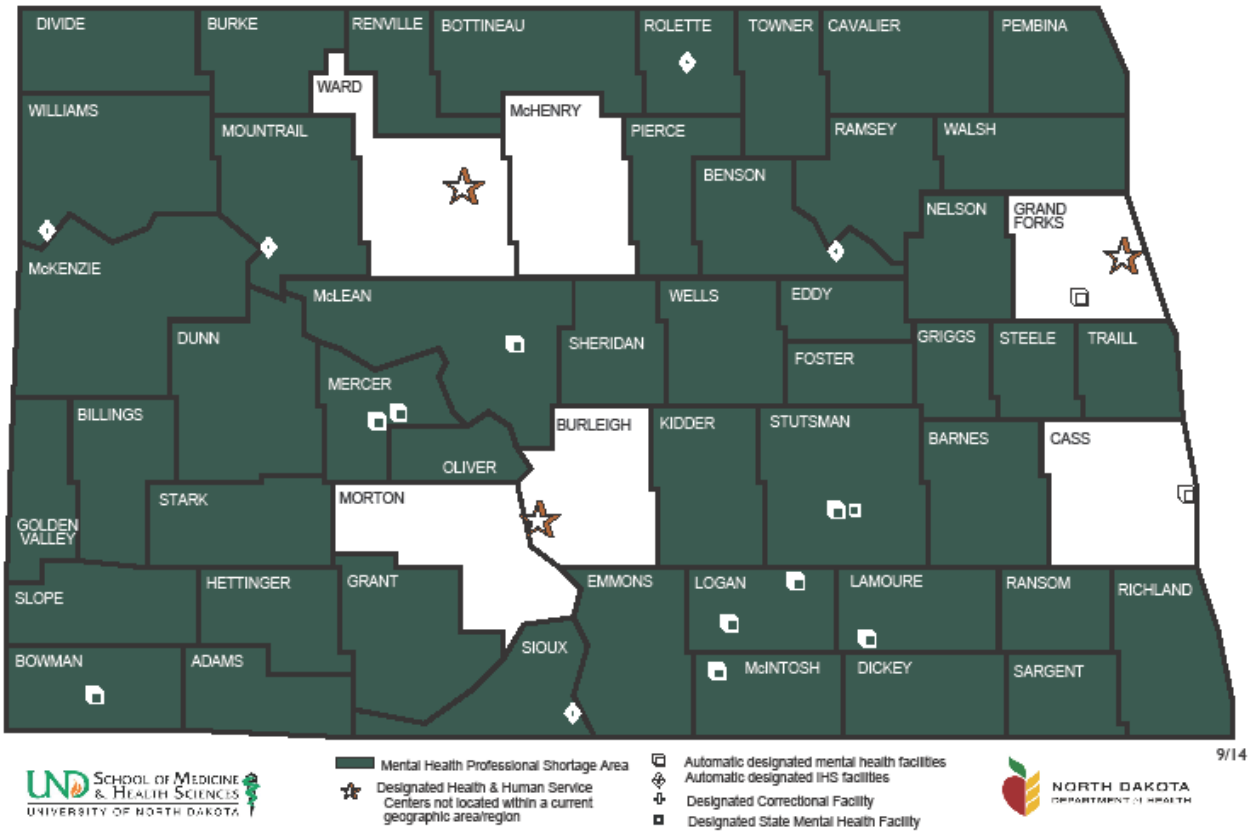
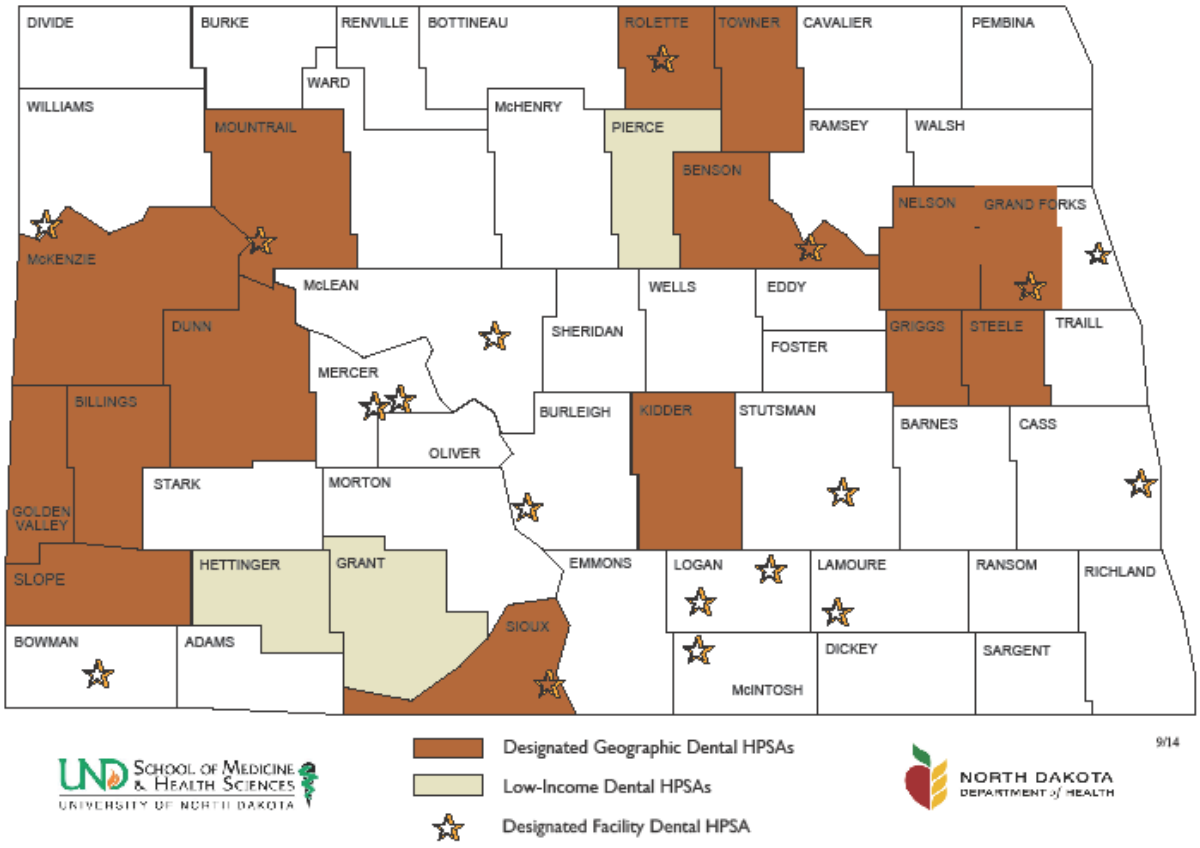
B - 4

North Dakota Mental Health Professional Shortage Areas



North Dakota Dental Health Professional Shortage Areas



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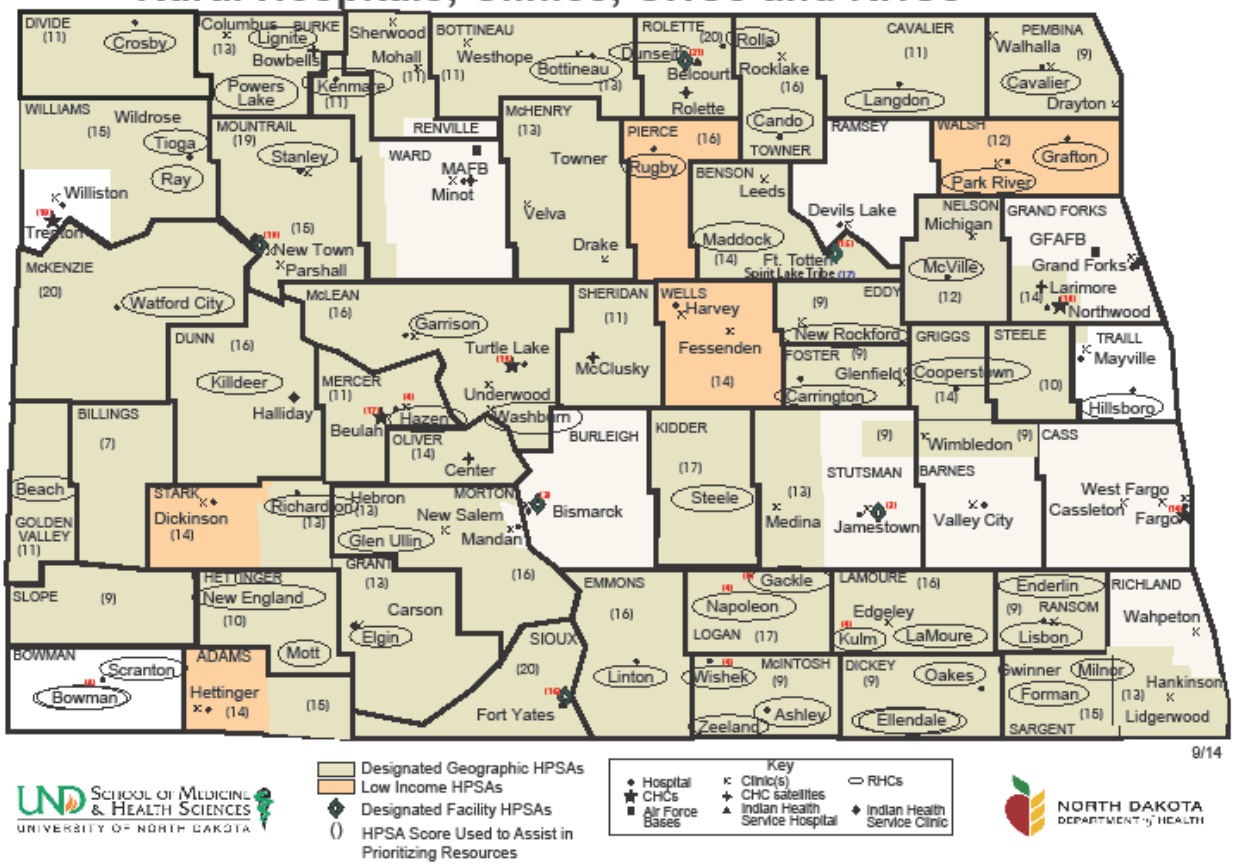
B - 6

North Dakota Health Professional Shortage Areas
Rural Hospitals, Clinics, CHCs and RHCs



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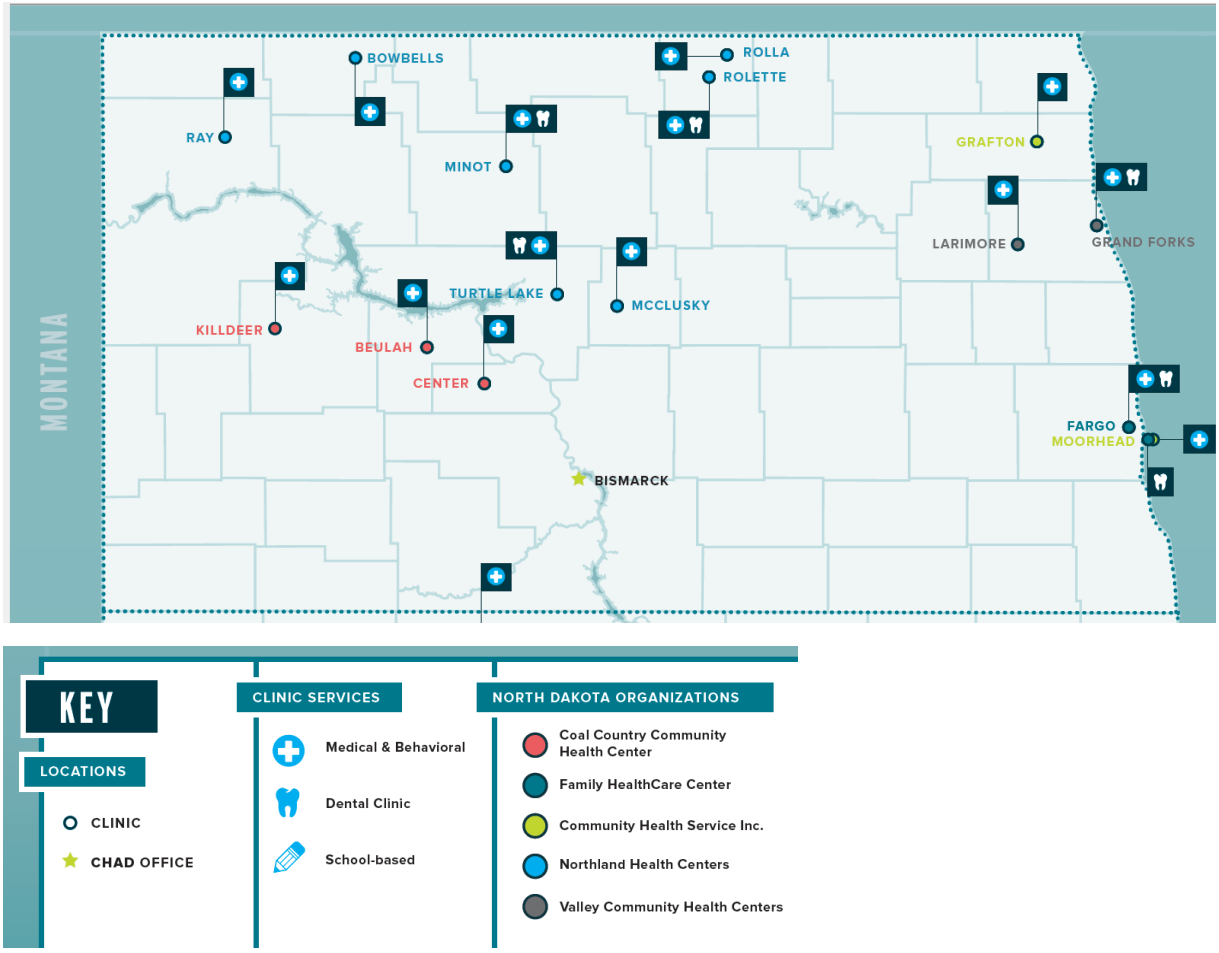
Appendix C:

C - 1

Appendix C: Community HealthCare Networks of the Dakotas



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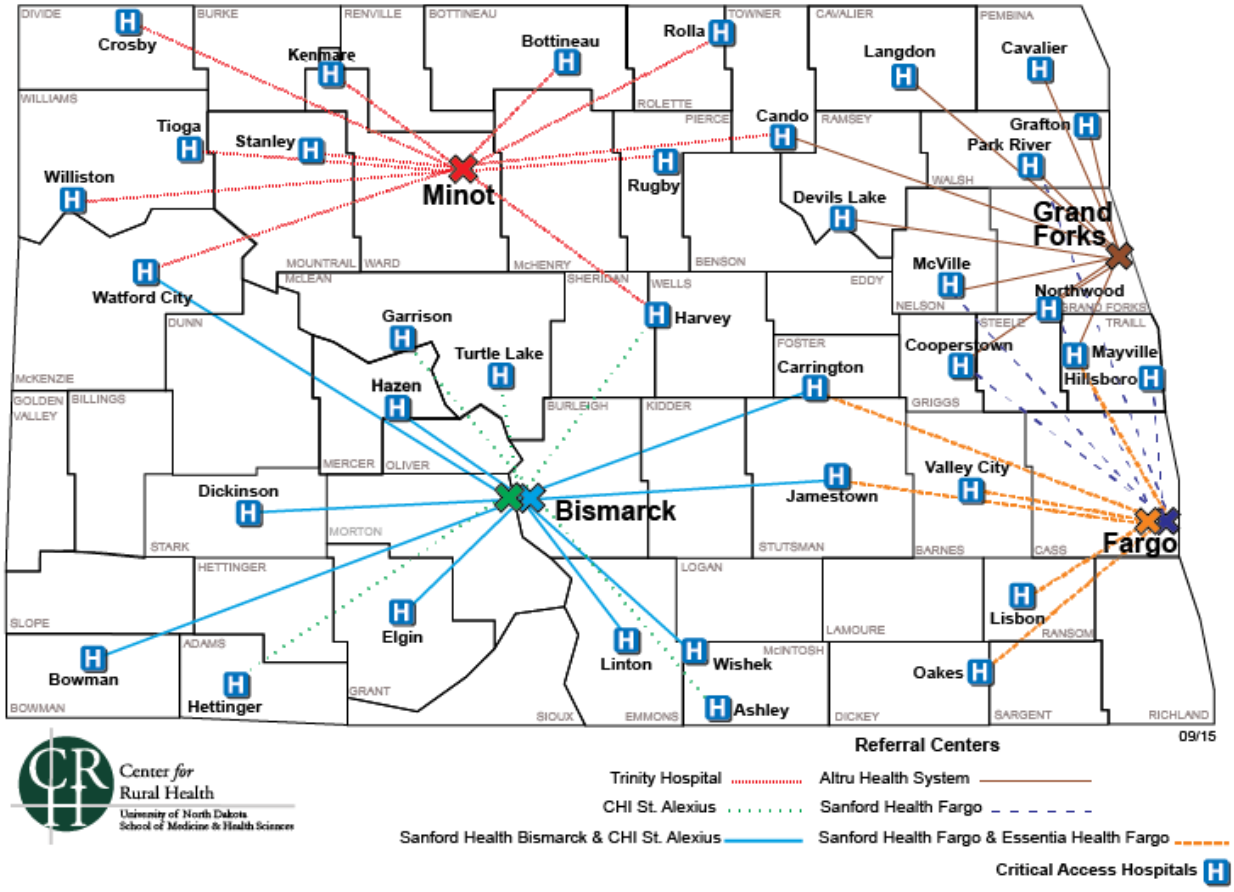
C - 2

North Dakota Critical Access Hospitals & Referral Centers



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Appendix D: North Dakota Medicaid trends (SFY 2013, 2014 & 2015)

D - 1

Pie Chart Analysis (SFY 2013, 2014, 2015):

See D 2 for statewide map of Medicaid beneficiary distribution across North Dakota, and see D – 3 through D – 8 for pie chart age and regional distribution of recipients. All Medicaid recipients are included in this data.

Regarding Recipients by Age Group, SFY 2013, 2014 & 2015

- **Ages + 65:** The population age 65+ has remained stable, with an increase of 44 recipients in 2014, but then a decrease of 92 recipients in 2015. This is less than a 1% variation across this time span.
- **Ages 0 – 20:** This population has declined 9% in relation to all age cohorts (likely attributable to growth of Medicaid expansion) but has increased in cohort numbers with most of the increase occurring in 2015; SFY 2014 = increase of 522 recipients; SFY 2015 = increase of 3343 recipients In total, we added 3865 recipients over the SFY 2013 baseline; an increase of 7%.
- **Age 21 – 64:** This recipient population grew by 8% in SFY2014, and another 3% in SFY 2015; adding 21,167 beneficiaries between 2013 – 2015; It is likely that approximately 78% of this increase is attributable to Medicaid expansion.

In total from SFY 2013 to 2015, recipient numbers increased by 24,984. Approximately 19,389 (78%) were recipients of Medicaid Expansion, and 3865 (15%) were youth; the remaining 1739 (7%) of recipients were in the Age 21 – 64 cohort.

Nationally the Medicaid population grew by 7.7% from 2014 to 2015 [(14)]; in North Dakota the growth was 9.1%, largely due to ND being an early adopter of Medicaid Expansion in 2014.

Regarding Recipients by Region:

- All 8 HSC regions increased in number of Medicaid beneficiaries from 2013 to 2015; SE and WC regions had the largest increases, followed by NC and then NE

Region	NW	NC	LR	NE	SE	SC	WC	BL
Growth	+1410	+3861	+1950	+3162	+6698	+1513	+4800	+1590
Total 2015	5477	14,444	14,430	14,663	29,892	8531	23,163	5766

- Seventy-one percent of beneficiaries (82,168) live in a region served by the 4 urban towns are located, and where the "big six" hospitals are located, & 26% live in Fargo region, so this likely helps with access. The Lake Region is a high health care disparity catchment area where another 14,430 beneficiaries reside.
- The Willison (NW), Jamestown (SC), and Dickinson (BL) regions in total have 19,774 recipients, which is 11.9% of all 2015 Medicaid beneficiaries.

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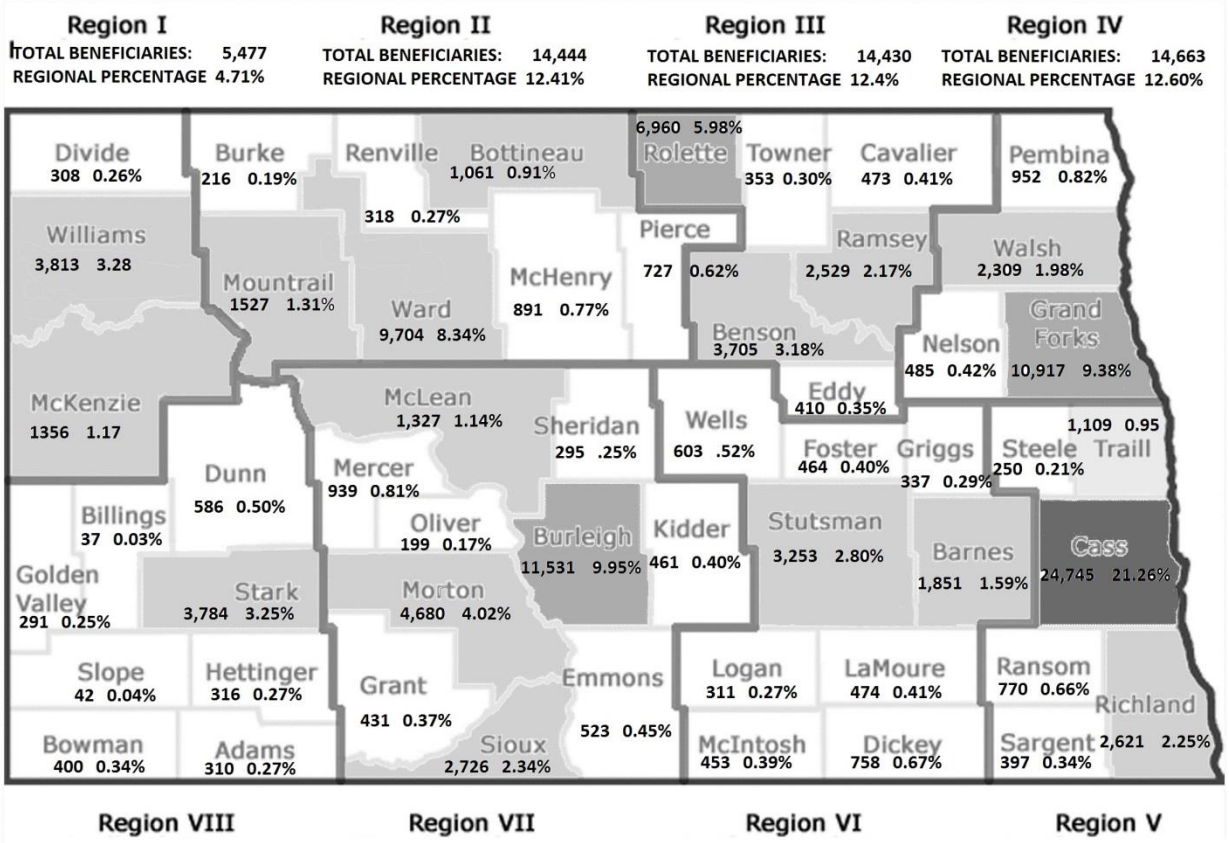
D - 2

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

UNDUPLICATED COUNT OF MEDICAID RECIPIENTS BY COUNTY

FOR STATE FISCAL YEAR 2015 (JULY 1, 2014 - JUNE 30, 2015)



GRAY-SCALE LEGEND: Darker shades of gray represent higher concentrations of Mediciad beneficiaries within the county

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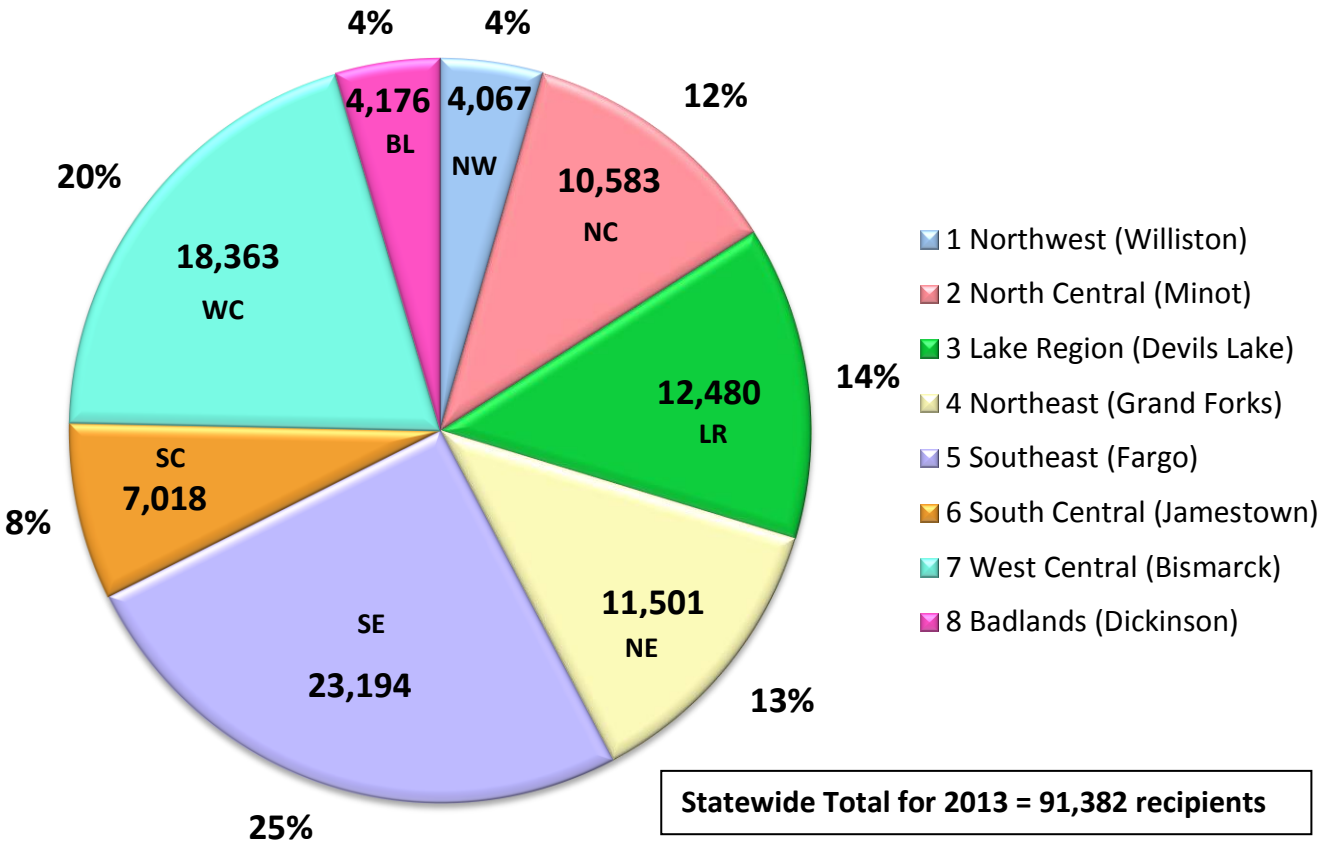
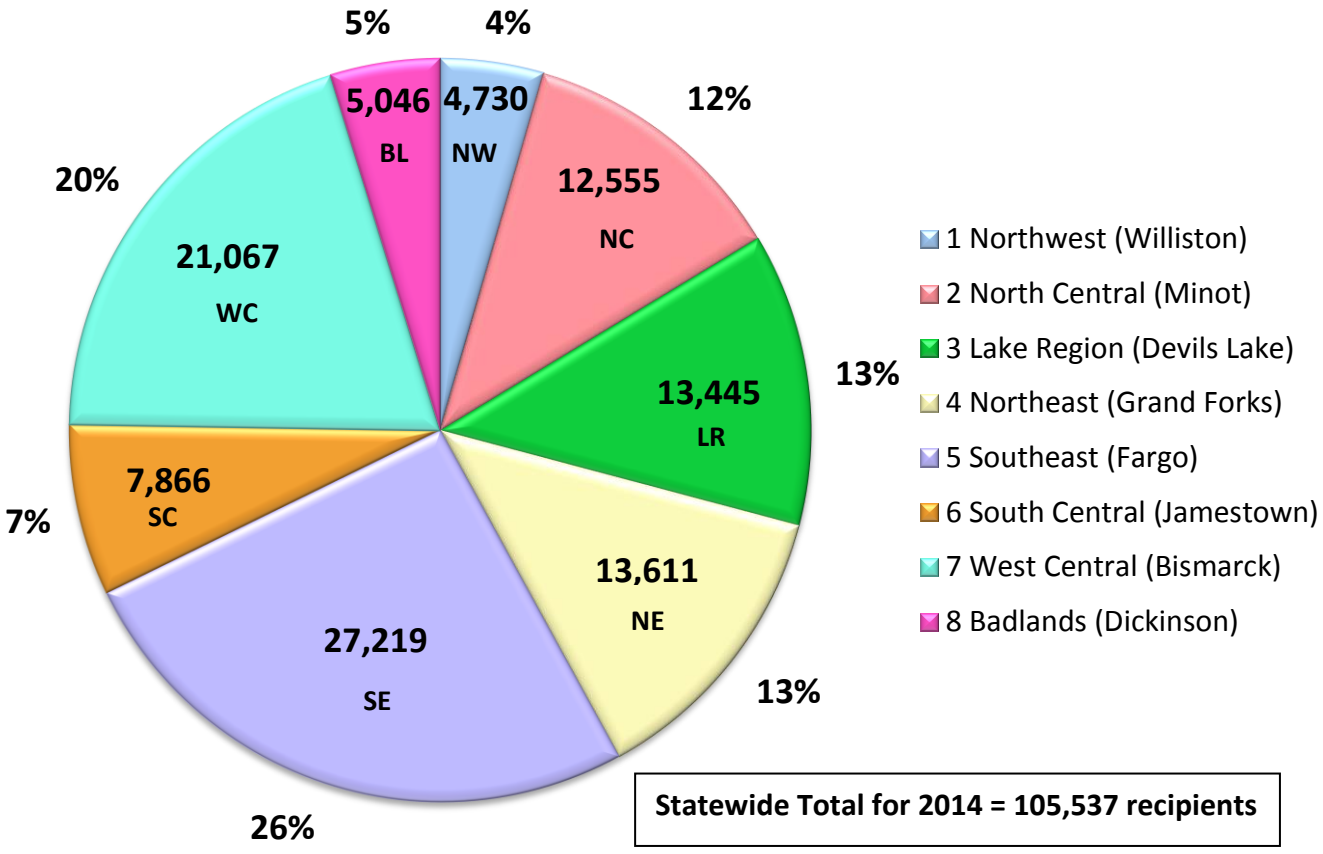
D - 3

UNDUPLICATED COUNT OF MEDICAID RECIPIENTS BY REGION FOR STATE FISCAL YEAR 2013



Statewide Total for 2013 = 91,382 recipients

UNDUPLICATED COUNT OF MEDICAID RECIPIENTS BY REGION FOR STATE FISCAL YEAR 2014



Statewide Total for 2014 = 105,537 recipients

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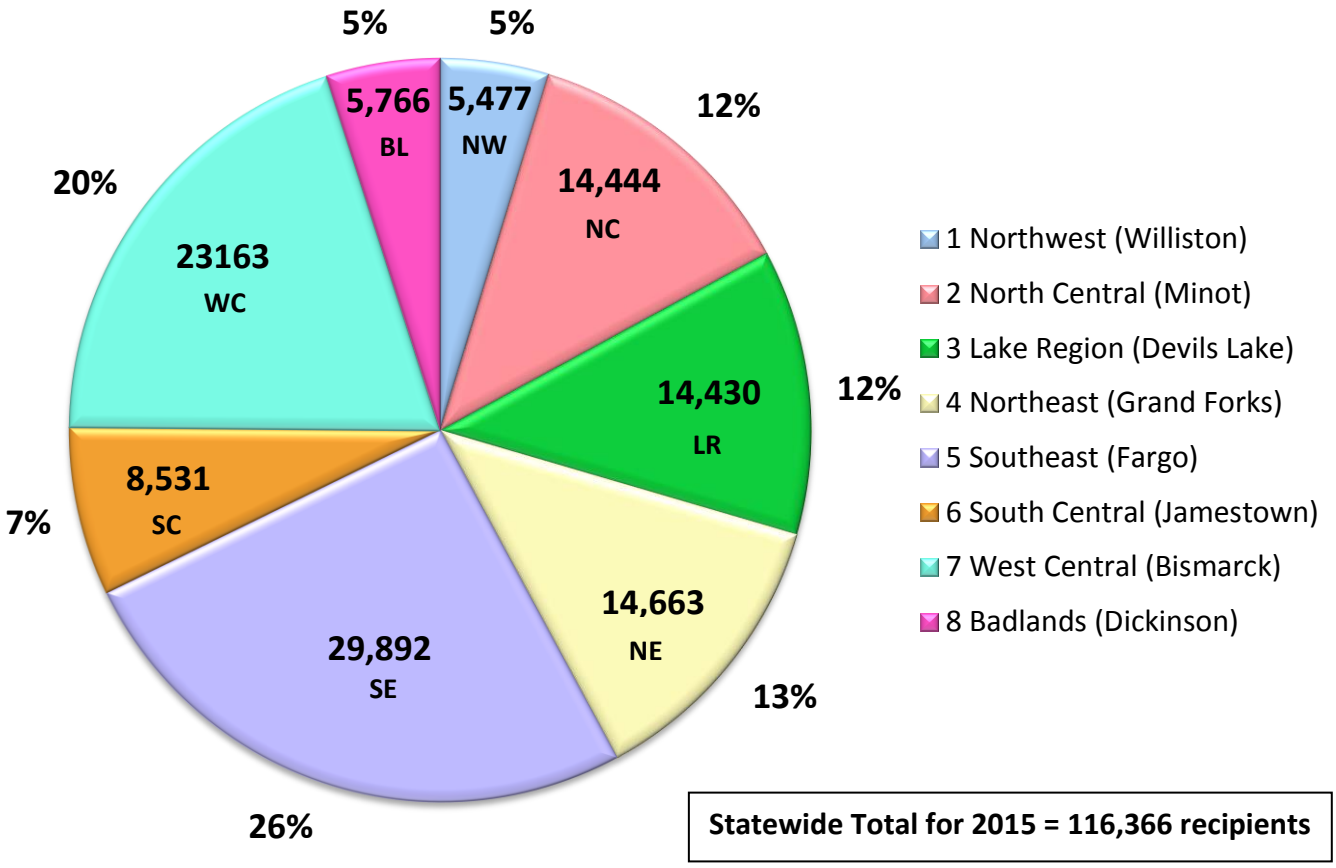
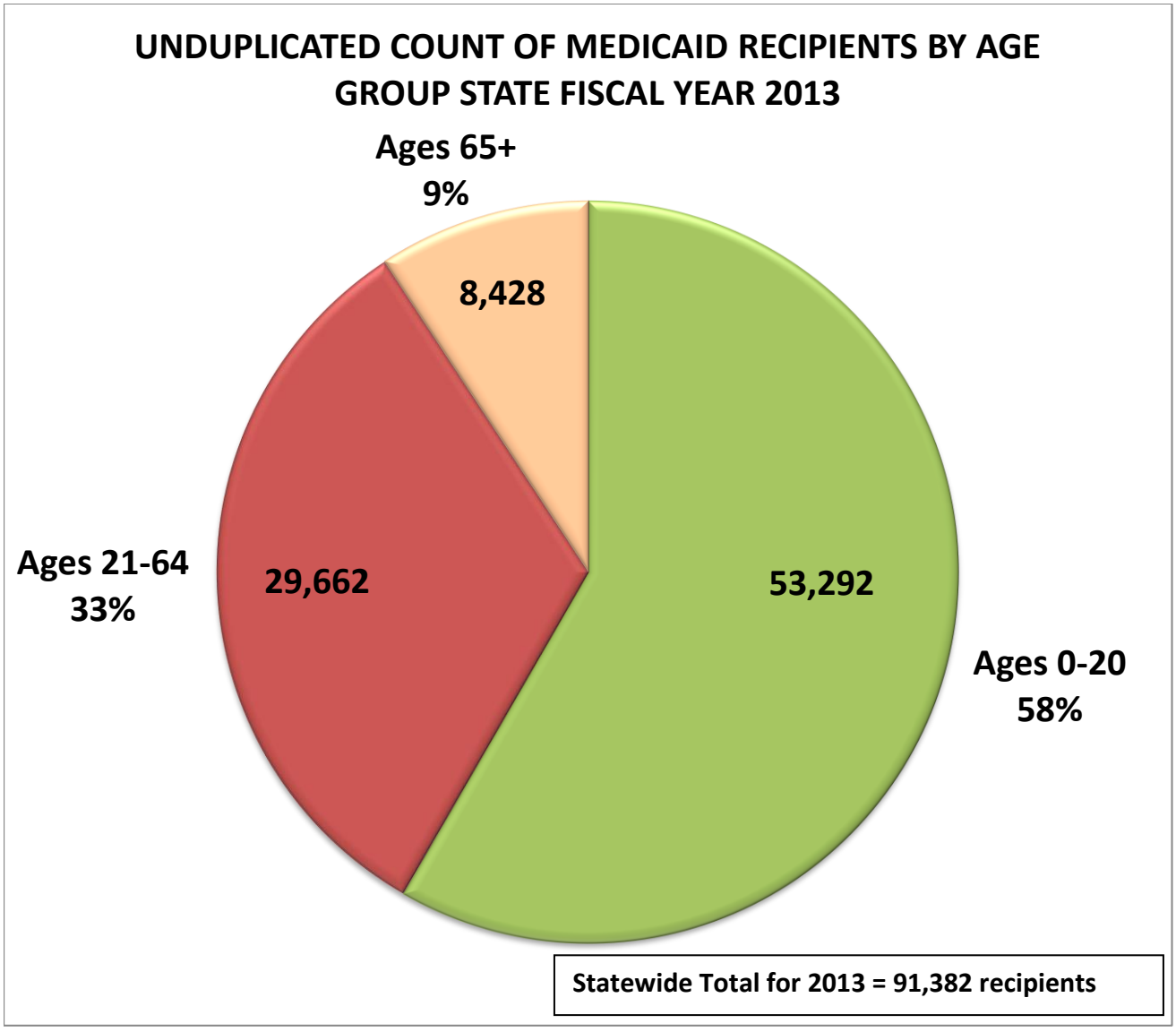
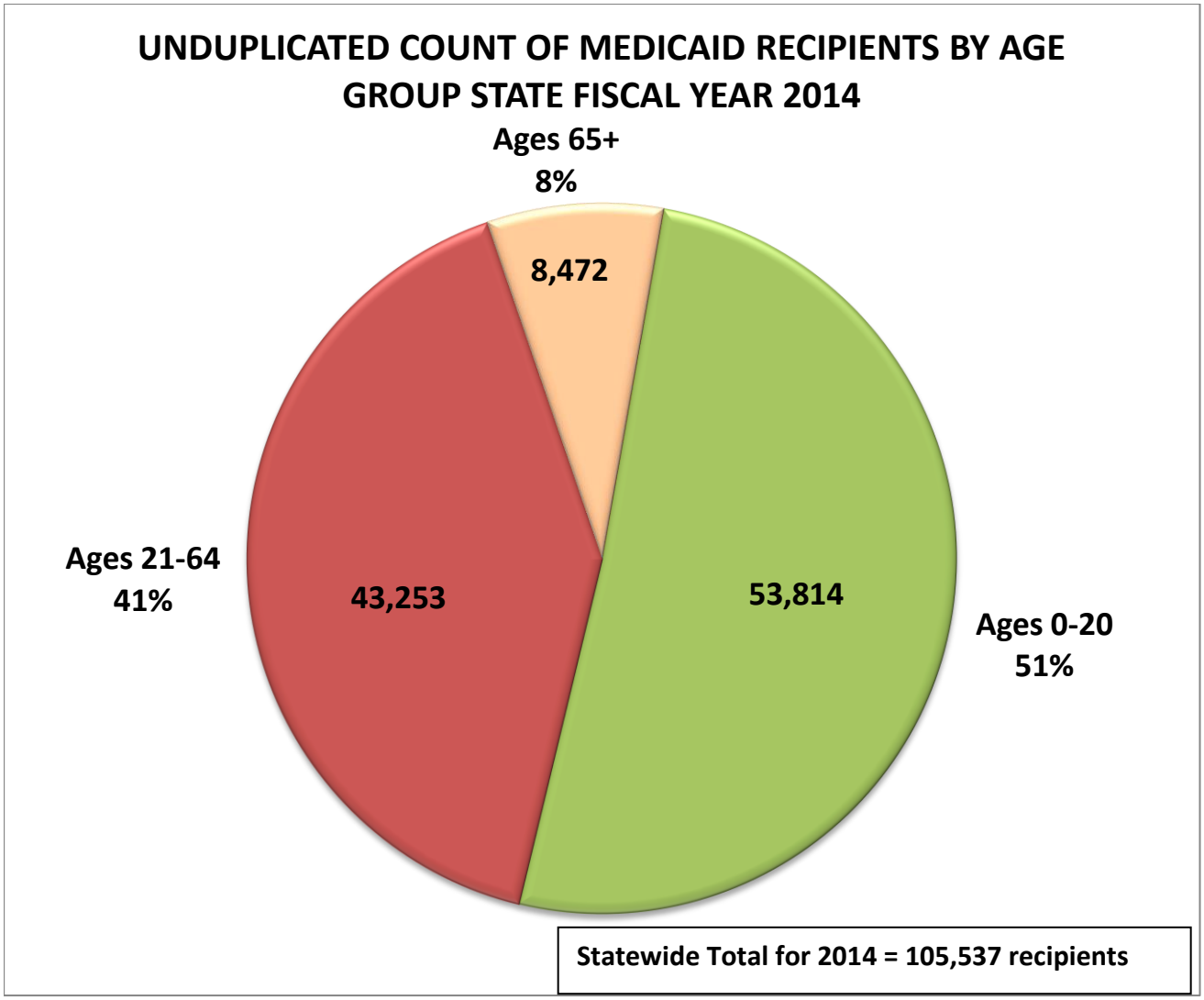
D - 5

UNDUPLICATED COUNT OF MEDICAID RECIPIENTS BY REGION FOR STATE FISCAL YEAR 2015



Statewide Total for 2015 = 116,366 recipients


UNDUPLICATED COUNT OF MEDICAID RECIPIENTS BY AGE GROUP STATE FISCAL YEAR 2013
Ages 65+
9%
8,428
Ages 21-64
33%
29,662
53,292
Ages 0-20
58%
Statewide Total for 2013 = 91,382 recipients


UNDUPLICATED COUNT OF MEDICAID RECIPIENTS BY AGE GROUP STATE FISCAL YEAR 2014
Ages 65+
8%
8,472
Ages 21-64
41%
43,253
53,814
Ages 0-20
51%
Statewide Total for 2014 = 105,537 recipients

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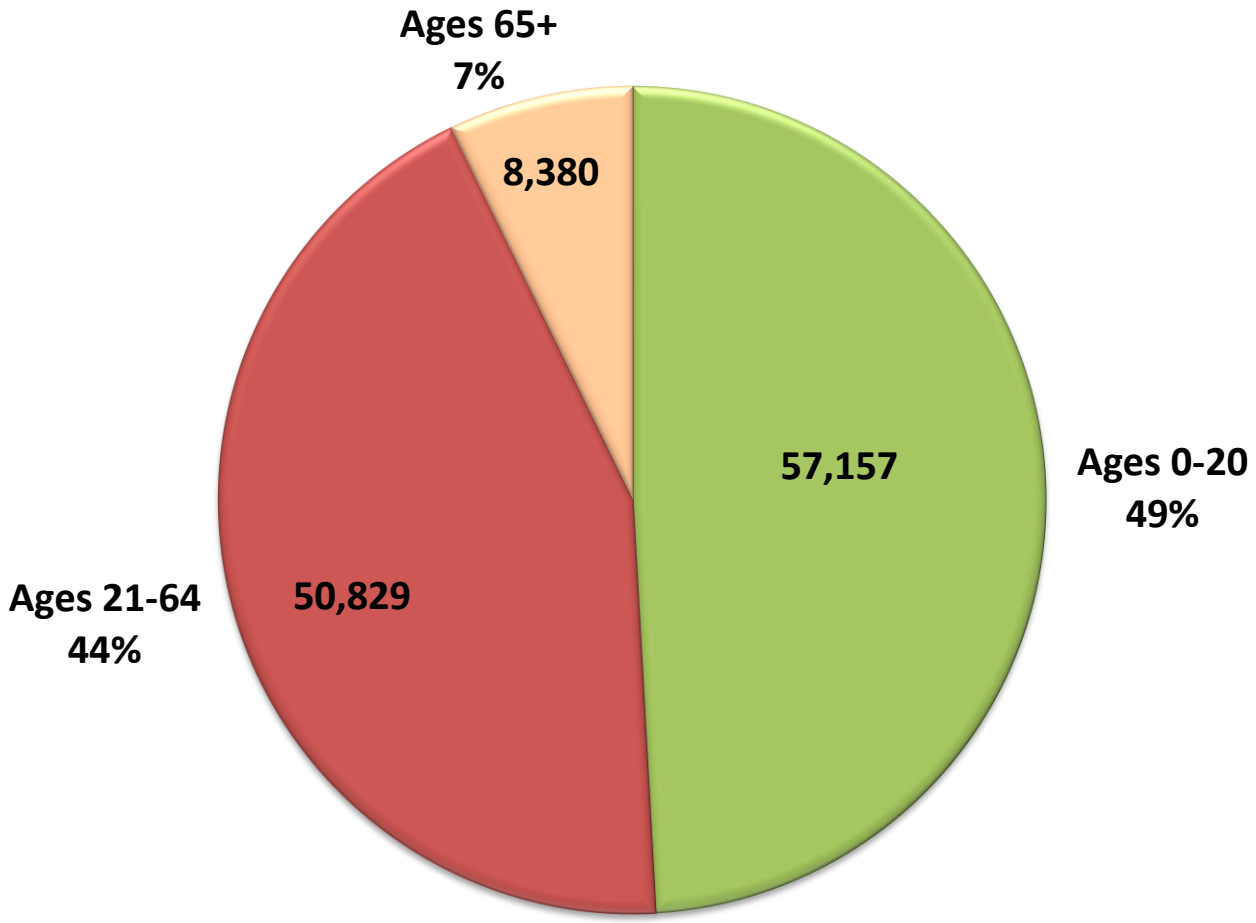
D - 8

UNDUPLICATED COUNT OF MEDICAID RECIPIENTS BY AGE GROUP STATE FISCAL YEAR 2015



Statewide Total for 2015 = 116,366 recipients

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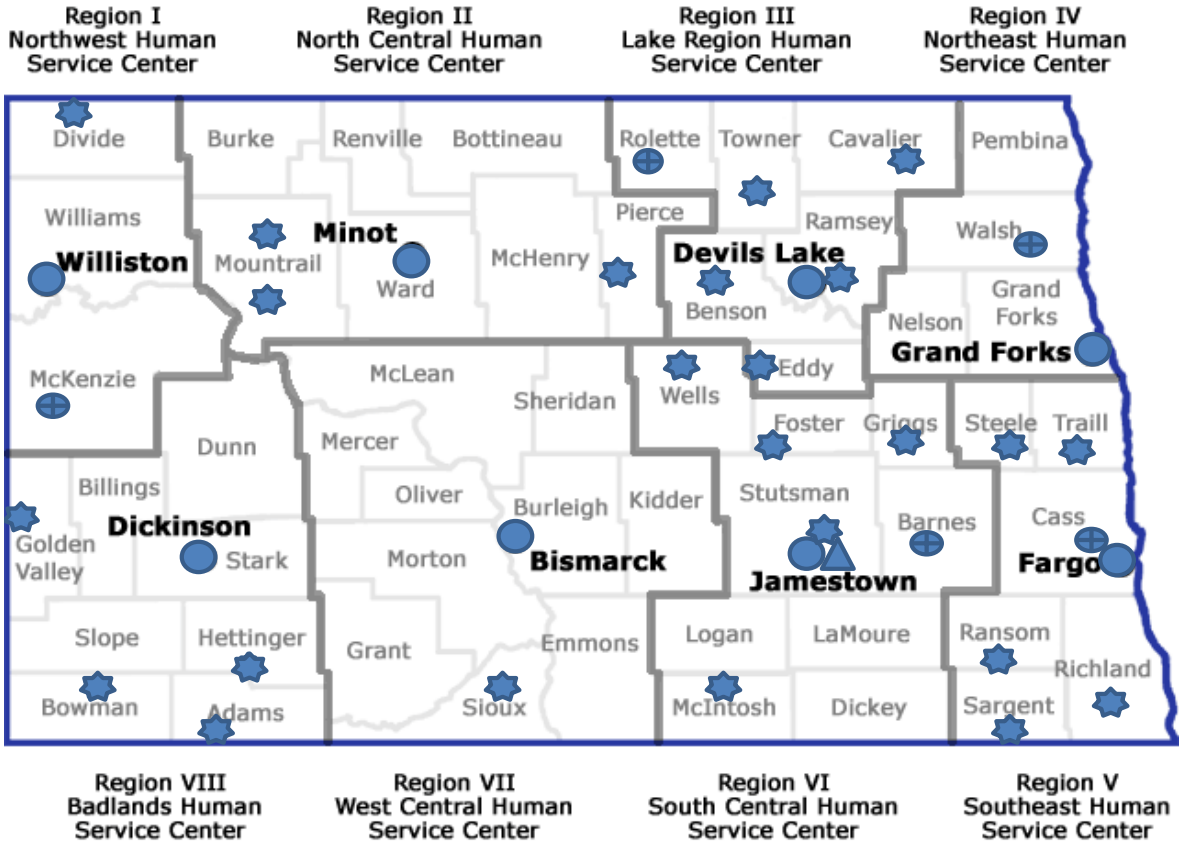
Appendix E: Behavioral Health:

E - 1

North Dakota Department of Human Services: Human Service Center locations and clinical outreach offices



Legend:

- Regional Human Service Center primary office location
- Human Service Center Outreach office locations
- HSC full-time or multi-staffed satellite office
- North Dakota State Hospital (Jamestown, ND)

The Regional Human Service Centers are part of the North Dakota Department of Human Services Division of Field Services. Divided into 8 regions, the HSCs deliver mental health and substance abuse services across North Dakota, including to Medicaid beneficiaries, and to the uninsured. Each HSC provides emergency and crisis services on a 24-hour basis, and screen all admissions to the North Dakota State Hospital to assure "least restrictive setting necessary" criteria, and rule out community-based options for treatment. South East Human Service Center in Fargo also contracts for a mobile

crisis unit. Additionally the HSCs deliver developmental disability services, vocational rehabilitation services, aging services, and provide program supervision and consultation to the counties and tribes related to child welfare service delivery. Case managers from the HSCs often meet with individuals in their homes and in local community settings, in addition to the outreach sites described in the statewide map that follows.

Region 1: Northwest Human Service Center (central office in Williston, Williams County; and outreach office hours in Watford City, McKenzie County and Crosby, Divide County)

Region 2: North Central Human Service Center (central office in Minot, Ward County; and outreach office hours in Stanley and Newtown both in Mountrail County, and in Rugby, Pierce County)

Region 3: Lake Region Human Service Center (central office in Devils Lake and full-time (10 staff) satellite office in Rolla - Rolette County; outreach office hours in Benson, Eddy, Towner, Rolette, Ramsey and Cavalier Counties)

Region 4: Northeast Human Service Center (central office in Grand Forks and full-time satellite office in Grafton – Walsh County).

Region 5: Southeast Human Service Center (central office in Fargo, Cass County; also outreach office at "Off Main" in Fargo; outreach office hours in Finley & Hope in Steele County; Hillsboro, Mayville & Hunter in Traill County; Wahpeton in Richland County; Enderlin & Lisbon in Ransom County; Milnor in Sargent County).

Region 6: South Central Human Service Center (central office in Jamestown, Stutsman County; Frequently visited outreach site in Valley City, Barnes County, as well as staff travel to Rogers and Wimbledon in Barnes County; and outreach office hours in Wishek, McIntosh County; Harvey, Wells County; Carrington and Glenfield, Foster County; and Cooperstown and Binford in Griggs County)

Region 7: West Central Human Service Center (central office in Bismarck, Burleigh County); outreach office hours in Fort Yates, Sioux County)

Region 8: Badlands Human Service Center (central office in Dickinson, Stark County; outreach office hours in Mott, Hettinger County; Hettinger, Adams County; Bowman, Bowman County; and in Beach, Golden Valley County)

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E - 2

**N.D. Licensed Substance Abuse Programs:

Programs in text box have a Medicaid provider enrollment or are a tribal 638 facility Tribal

Region 1 (Williston)

PROGRAMS WITH 1 CLINICIAN

-**ADAPT, Inc.** - Williston

-**Native American Resource Center** - Trenton

-**Choice Recovery Counseling** - Williston

-**Weishoff Alcohol & Drug** - Williston

-**Summit Counseling** - Williston

PROGRAMS WITH 2-3 CLINICIANS

-**Montgomery Counseling Services –** Williston

-**Northwest Human Service Center–Williston**

Region 2 (Minot)

PROGRAMS WITH 1 CLINICIAN

-**ADAPT, Inc.** - Minot

-**Bob Hayes Addiction Services** - Minot

-**Cornerstone Addiction Services** - Minot

-**Goodman Addiction Services** - Minot

-**Parshall Resource Center** - Parshall

PROGRAMS WITH 2-3 CLINICIANS

-**Circle of Life Alcohol Program** - New Town

PROGRAMS WITH 4-5 CLINICIANS

-**Trinity Hospitals** - Minot

PROGRAMS WITH 6-9 CLINICIANS

North Central Human Service Center - Minot

Region 3 (Devils Lake)

PROGRAMS WITH 1 CLINICIAN

-**ADAPT, Inc.** - Devils Lake

-**Heartview Foundation** - Cando

PROGRAMS WITH 2-3 CLINICIANS

-**5th Generation** - Belcourt

-**Spirit Lake Nation Recovery & Wellness Program** - Fort Totten

-**Lake Region Human Service Center, Outreach Office in Rolla**

PROGRAMS WITH 6-9 CLINICIANS

-**Lake Region Human Service Center – Devils Lake**

Region 4 (Grand Forks)

PROGRAMS WITH 1 CLINICIAN

-**ADAPT, Inc.** - Grand Forks

-**MAB Addiction Counseling Services** - Grafton

-**Quinn DUI/MIP/Evaluations** - Grafton

-**Alcohol & Drug Services, Inc.** - Grand Forks

-**Foley, Don Counseling** - Grand Forks

-**Centre, Inc.** – Grand Forks

-**Northland Christian Counseling Center** - Grand Forks

-**Stadter, Richard P. Psychiatric Center - Chemical Dependency** - Grand Forks

-**Start Somewhere Counseling Services** - Grand Forks

PROGRAMS WITH 2-3 CLINICIANS

-**Agassiz Associates, PLLC** - Grand Forks

-**UND Counseling Center Substance Abuse Program** - Grand Forks

-**Drake Counseling Services - Grand Forks**

PROGRAMS WITH 6-9 CLINICIANS

-**North East Human Service Center -Grand Forks**

Region 5 (Fargo)

PROGRAMS WITH 1 CLINICIAN

-**ADAPT, Inc.** - Fargo

-**Shiaro, Chris Counseling Services** - Fargo

-**Simon Chemical Dependency Services** - Fargo

-**McGrath, Claudia Counseling** - Fargo

-**Discovery Counseling** - Fargo

-**Eddie Burl, LLC - Fargo**

-**Fargo VA Medical and Regional Office Center Substance Abuse - Treatment Program** - Fargo

PROGRAMS WITH 6-9 CLINICIANS

-**First Step Recovery, % The Village Family Service Center in** Fargo

-**Drake Counseling Services, Inc. - Fargo**

PROGRAMS WITH 10+ CLINICIANS

-**PSJ Acquisitions, LLC d/b/a Prairie St. John's** - Fargo

-**Share House, Inc.** - Fargo

Region 6 (Jamestown)

PROGRAMS WITH 1 CLINICIAN

-**Dockter-Evjen Recovery Choice –** Jamestown

-**Creative Therapy, PLLC –** Valley City

PROGRAMS WITH 1 CLINICIAN
-**Pathway to Freedom** - Wilton
-**Basaraba, Rose Counseling Service –** Bismarck

- **Free Counseling Services** - Bismarck

-**Chambers and Blohm Psychological Services, PC** - Bismarck

-**Kazmierczak, Audrey Counseling Service** - Bismarck
-**One 80 Programs, Dakota Institute of Trauma Therapy, PC** - Bismarck

PROGRAMS WITH 2-3 CLINICIANS

-**CHI-St. Alexius Medical Center/PHP Dual Diagnosis Program** - Bismarck

-**Coal Country Substance Abuse Services** - Beulah
-**ADAPT, Inc.** - Bismarck

PROGRAMS WITH 4-5 CLINICIANS
-**New Freedom Center, Inc.** - Bismarck

PROGRAMS WITH 10+ CLINICIANS

-**Heartview Foundation** - Bismarck

-**West Central Human Service Center** - Bismarck

Region 8 (Dickinson)

PROGRAMS WITH 1 CLINICIAN
ADAPT, Inc. - Dickinson

PROGRAMS WITH 2-3 CLINICIANS
-**Heart River Alcohol & Drug Abuse Services** - Dickinson
-**Sacajawea Substance Abuse Counseling** – Dickinson

-**Badlands Human Service Center** - Dickinson

north dakota department of human services

E – 3

Human Service Center mental health and substance use disorder services to Medicaid beneficiaries*

SFY 2013, 2014, 2015

***data excludes Medicaid Expansion population**

	Number of Events			Unique Client Count			Unique Clients Served by	Unique Total Count of
HSC Region	2013	2014	2015	2013	2014	2015	Region	Clients
1	7,868	7,339	8,801	154	153	208	247	
2	17,370	25,955	33,525	392	418	603	752	
3	10,981	12,164	13,671	350	424	532	651	
4	46,089	49,336	55,396	627	745	852	985	
5	71,591	71,059	72,675	896	960	1097	1224	
6	31,433	32,496	33,196	640	688	736	950	
7	40,219	42,252	47,932	713	779	882	1069	
8	11,917	12,156	11,322	185	195	227	285	
Grand Total	237,468	252,757	276,518	3,957	4,362	5,137	6,163	5,719

Unique Clients Served by Region is larger than Unique Total Count of Clients because some clients are seen by more than one HSC; for example an individual may receive psychiatric services by telemedicine from one center, and case management from another.

This data was pulled from the human service center electronic health record (ROAP). An individual was counted if they were eligible for Medicaid at any time during the year they received a direct service.

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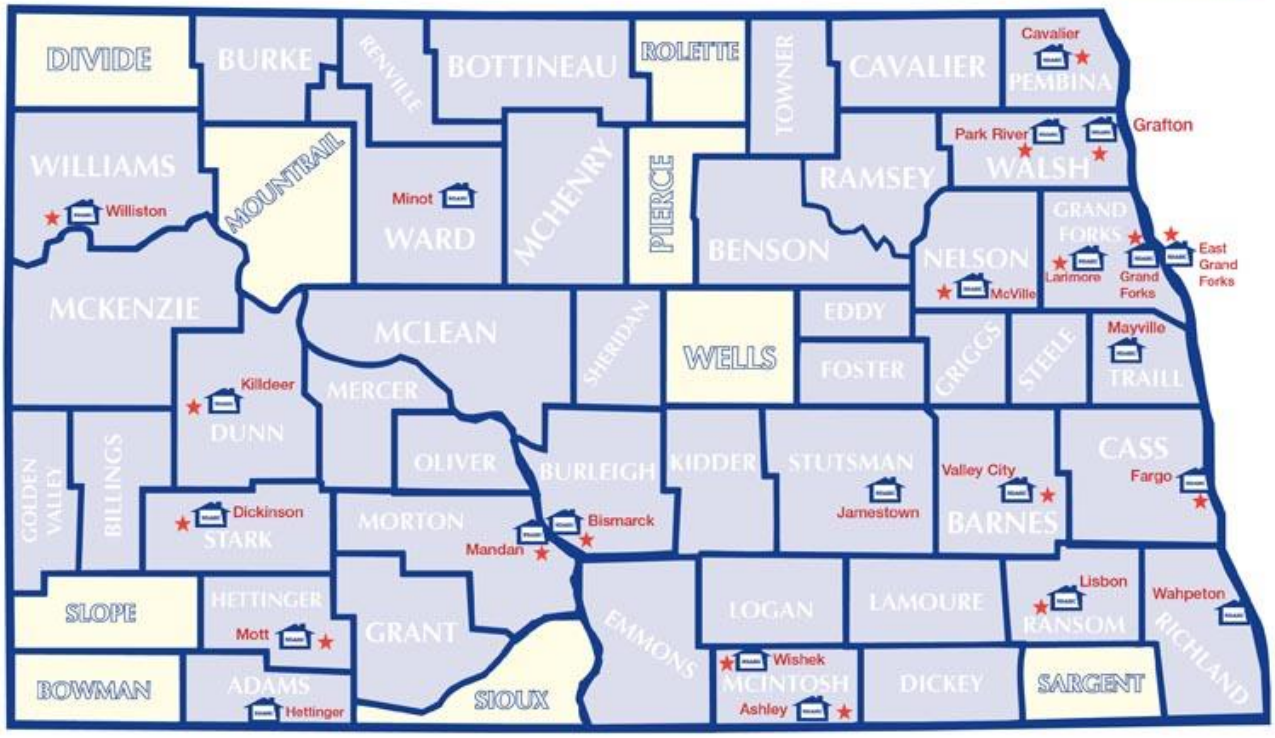
Appendix F: Home Health Information:

F - 1

NDAHC ND ASSOCIATION FOR HOME CARE



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Appendix G: Telemedicine

MEDICAID MEDICAL POLICY
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 85 (6-9-2010)

Medicaid Policy Number (This number will be generated by Medical Services.)	Date Policy was Last Reviewed
NDMP-2012-0007	1/14/2015

Title
Telemedicine Services

Effective Date
8-1-2012

Revision Date(s)
7-2-2013; 1/14/15

Replaces
Medicaid Coding Guideline; General Provider Manual information

Cross References

Description
Telemedicine is the use of interactive audio-video equipment to link practitioners and patients at different sites. Telemedicine involves two collaborating provider sites: an "originating site" and a "distant site". The client/patient is located at the originating site and the practitioner enrolled with ND Medicaid is located at the distant provider site to provide those professional services allowed/reimbursed by ND Medicaid.

Scope
Medical policies are systematically developed guidelines that serve as a resource for ND Medicaid staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the ND Medicaid program.

Policy
Telemedicine/Telehealth services via interactive audio-video equipment.

Policy Guidelines

1. To qualify as a professional service, actual visual contact (face-to-face) must be maintained between the practitioner and patient.
2. Services allowed/reimbursed by ND Medicaid include: New and established Office and Other Outpatient E/M services; Psychiatric diagnostic evaluation; Individual psychotherapy; Pharmacologic management; Speech Therapy, individual; Initial inpatient telehealth consultations.
3. Practitioners must append modifier GT to identify a service as being performed via telemedicine.
4. All services must be medically appropriate and necessary with supporting documentation of the service must be included in the patient's clinical medical record.
5. The originating and distant sites of telemedicine services cannot be in the same facility or community. The distant site must be a sufficient distance from the originating site to provide services to patients who do not have readily available access to such specialized services allowed/reimbursed by ND Medicaid via telemedicine.
6. A designated room at the originating site must have secure and appropriate equipment to ensure confidentiality, including camera(s), lighting, transmission and other needed electronics. Appropriate medical office amenities must be established in both the originating and distant sites. Skype or other unsecure web cam devices are not acceptable or allowed to be used for telehealth services.
7. Reimbursement will be made only to the distant practitioner during the telemedicine session. No reimbursement is allowed to a practitioner at the originating site if his/her sole purpose is the presentation of the patient to the practitioner at the distant site.

8. Reimbursement will be made to the originating site as a facility fee only in place of service office, inpatient hospital, outpatient hospital, or skilled nursing facility/nursing facility. There is no additional reimbursement for equipment, technicians or other technology or personnel utilized in the performance of the telemedicine service.

Benefit Application

- Coverage is limited to reimbursement for services identified by this policy via interactive audio-video telemedicine.
- Reimbursement is made for services provided by licensed professionals enrolled with ND Medicaid and within the scope of practice per their licensure only.
- All service limits set by ND Medicaid for psychiatry, speech therapy, and individual medical nutrition therapy apply to telemedicine services.
- Requires a medical professional, such as a nurse, to be present during the telehealth service; and to ensure a connection has been established with the distant physician (should a medical urgency materialize).
- Out of State requests for telemedicine services require prior authorization. The services must be in compliance with the Out of State Program requirements.

Rationale Source

42 CFR 410.78 - Telehealth services - http://cfr.vlex.com/vid/410-78-telehealth-services-19805820; CMS Issues Final Regulations on Telemedicine Credentialing Conditions of Participation - http://www.bricker.com/publications-and-resources/publications-and-resources-details.aspx?Publicationid=2165; Telemedicine - Medicaid.gov - http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html

Code of Federal Regulations Citation(s)

42 CFR 410.78 - Telehealth services.

CODES	NUMBER	DESCRIPTION
CPT®	99201-99215	New and established Office and Other Outpatient E/M services
	90785	Interactive complexity (list separately in addition to the code for primary procedure)
	90791	Psychiatric Diagnostic Evaluation
	90792	Psychiatric Diagnostic Evaluation with medical services
	90832	Psychotherapy, 30 minutes with patient and/or family member
	90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
	90834	Psychotherapy, 45 minutes with patient and/or family member
	90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
	90837	Psychotherapy, 60 minutes with patient and/or family member
	90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
	92507	Speech Therapy, Individual
	99307-99310	Subsequent nursing facility care services

	G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
	G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
	G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth
Applicable Modifier(s)	GT	Via interactive audio and video telecommunication systems
ICD-9 Procedures(s)	N/A	
ICD-9 Diagnosis(es)		Must support medical necessity and coded to the highest specificity.
Applicable Revenue Codes(s)	780	Telemedicine – Facility charges related to the use of telemedicine
HCPCS Code(s)	Q3014	Telehealth originating site facility fee
Type of Service	Medicine	As listed in the Medicine section of CPT®.
Place of Service	11	Office
	21	Inpatient Hospital
	22	Outpatient Hospital
	31	Skilled Nursing Facility
	32	Nursing Facility

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Appendix H: Medicaid Medical Advisory Committee recommendations on Access Monitoring data indicators:

Review of 15 possible Access-related Data Points

The following list of 15 data items were suggested by stakeholders during the Department's request for input following the budget allotment. The list was then discussed at the May 12, 2016 Medical Medicaid Advisory Committee meeting. The comments noted are from that discussion.

1. **Monitor Changes in Service Volume** **(KEEP as an access measure)**
    a. *MMAC comments*: Difficult to measure because it would require providers to stop seeing or reduce the number of clients they see, and some providers verbalize wanting to continue to accept Medicaid beneficiaries if they can manage the rate modifications. Considerations: How to measure access vs. workforce changes/shortages, scope changes of professionals (mid-levels)? Wellness and preventative services may make sense for recipient measures.
    b. **DHS Note: Measuring utilization does appear to have merit as an access indicator, while keeping in mind sources of data bias as identified by the advisory committee.**

2. **Monitor Changes in Provider Enrollment Volume** **(Consider modifying to a disenrollment report, and consider a no billing activity report for currently enrolled providers.)**
    c. *MMAC comments*: Some advisory committee members expressed concern that this is not necessarily a reliable indicator of access; a primary concern is that enrollment does not directly equate to access. It would be difficult to say there are access issues if there are more providers enrolling.
    d. Consider looking rate of hiring of PT, OT and ST to graduates of schools. For physicians, most health care systems require their practitioners to enroll in Medicaid. It is more difficult for "systems" vs. independent practitioners. Noted it would be important for data collection for providers to dis-enroll if they are no longer accepting Medicaid.
    e. **DHS Note: Measuring provider enrollment trends appears to be only a soft measure of access; the larger health care provider networks routinely enroll new providers in Medicaid but this does not always result in Medicaid appointment slots being opened up. Providers have asked that efforts be made to reduce regulation and documentation burdens, and expanding the tracking requirements of available slots is assessed to be an undue burden. Possibly the more reliable measure of access may be**

volume of disenrollment? Also, consider a report that measures enrolled providers who provided no services to Medicaid beneficiaries over a given time frame.

3. **Monitor Profit and Loss of those facilities who report this (Do not KEEP)**
    f. *MMAC comments*: providers had no interest in using this as a measure of access; too many complicating variables.

4. **Do Rate and Fee Schedule Comparisons with surrounding states (Keep)**
    g. *MMAC comments*: Yes, this is good information, as long as they (other states) respond to requests. Fee schedule comparison – good tool to use – there was concern that the some other state fee schedules are lower than ND.

5. **Establish a rebasing schedule for all codes at regular intervals (Monitor)**
    h. *MMAC comments*: Advisory committee comments suggested support for this idea. Physical Therapists will provide information to legislature. Rebase at regular intervals – create a grid identifying past rebasing.
    i. DHS Note: Rate rebasing is not a measurement of access data per se, but committee members support the concept of periodic rate rebasing and that it may contribute to a reasonable reimbursement solution, for example allowing the SP/OT/ PT provider group to make their case to the ND legislature.

6. **Consider Medicaid reimbursement rates as recommended by CMS (Do not keep, this is not an access data measure)**
    j. *MMAC comments*: Consider Medicaid rates as recommended by Medicare – feedback was yes from PT, OT and ST. No, for the other providers. ND Legislature unlikely to support an outside source (even CMS) that would be in control of future increases. Public comments suggest a significant subset of providers consider Medicare rates as being too low even though at this rate continues to allow North Dakota to remain one of the higher Medicaid reimbursing states in the nation.

7. **Utilize Surveys of Medicaid beneficiaries' access to services in their geographical area (Keep)**
    k. *MMAC comments*: Utilize survey of recipients – not good overall success in recipient return of surveys. Idea – can we develop something to send to the practitioner's office? Others did not like providers being the middle man. Providers could notify patients when survey is going out. Prepare a database to keep track of complaints/concerns about access. If providers know about surveys, they can reinforce importance of

completing the survey. Develop a "business" card with phone number, email, etc. Can include the business card idea in to the upcoming Medicaid beneficiary newsletter.

8. Utilize Surveys of Enrolled Providers **(Keep but recognize risk of bias)**

MMAC comments: Would you be controlling your Medicaid population? Correlate to the recipient questions asked. Tie to recruitment of practitioner's for the health systems.

9. Survey Child Welfare agencies (to monitor for diminished access of beneficiaries to behavioral health services) **(Keep)**

l. *MMAC comments*: Yes it would be relevant to hear what they (agencies) are experiencing. Also, DHS should include regular attendance at County Director meeting to solicit feedback.

10. Measure impact on quality of patient care **(Keep as discretionary question-not a direct measure of access but quality of care is an important indicator to ND providers and would be good to know if we are losing ground)**

m. *MMAC Comments*: A good measurement – have you made a referral to a specialty service? For facilities, this information is readily available (ND Quality Health Care has data). Hospitals also have data. Mixed belief on whether this will measure access.

11. Monitor if there is an increase in referrals to higher level, more expensive care. **(Do not keep-consider if data can be modified in any way to better measure access?)**

n. *MMAC comments*: For more complex cases, it may be applicable to measure home care. This could also be readmissions or longer length-of-stay. This indicator appears to have only an indirect relation to access so making access-related conclusions may be challenging.

12. Monitoring the wait time for appointments for Medicaid patients **(Do Not Keep)**

o. *MMAC comments*: This measurement would also need to include other payer sources. Need to measure with providers and recipients. This could be part of the beneficiary survey. Given the diverse composition of providers, even for those who do have wait time measurements, the processes would measure so differently that it would be virtually impossible to aggregate the data, and would pose an undue burden to providers to attempt to align wait time measurement statewide.

13. Monitoring the amount of patients signing up for Medicaid (Keep)

p. *MMAC comments*: Some recipients do not enroll until they need medical care. The data could be muddied and influenced by health care issues and trends. Still if beneficiary enrollments are going up and provider disenrollment is also increasing, this may alert to a possible access challenge.

14. Monitor whether out of state referrals become more difficult (Further consideration)

q. *MMAC comments*: Monitor whether out of state referrals become more difficult. Measure the number of OOS referrals. Loss of specialty care in ND – would this indicate access issues or workforce issues?

15. Monitoring access for all phases of pediatric care (Keep but modify to align with access data capture for provider groups in general)

r. *MMAC comments*: This seems to be global to all of the other items in the data.

MMAC Discussion:

How much of this is the state's responsibility to solve? North Dakota's significant number of frontier counties and significant Health Professional Shortage Area (HSPA) designations and complicating variables in regard to interpreting/differentiating access challenges goes well beyond the Medicaid population.

Appendix I: ND national rankings in detail:

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Strengths:
- Few poor physical health days
- Low rate of drug deaths
- Low levels of air pollution

Challenges:
- High prevalence of excessive drinking
- High occupational fatalities rate
- High prevalence of obesity

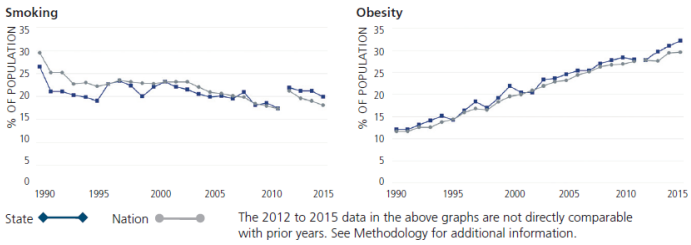
Ranking:
North Dakota is 12th this year; it was 9th in 2014.

Highlights:
- In the past year, physical inactivity decreased 23% from 27.6% to 21.3% of adults.
- In the past 5 years, preventable hospitalizations decreased 27% from 69.0 to 50.6 per 1,000 Medicare beneficiaries.
- In the past 10 years, lack of health insurance decreased 8% from 9.9% to 9.1% of the population.
- In the past 20 years, cancer deaths decreased 8% from 190.4 to 176.0 per 100,000 population.
- Since 1990, children in poverty decreased 31% from 17.3% to 12.0% of children.

State Health Department Website:
www.ndhealth.gov

Policy			
Lack of Health Insurance (% of population)	9.1	10	3.5
Public Health Funding (dollars per person)	$110	7	$227
Immunizations—Children (% of children aged 19 to 35 months)	71.3	27	84.7
Immunizations—Adolescents (combined value of HPV, MCV4, and Tdap)*	0.73	7	1.31
Immunizations—HPV Females (% of females aged 13 to 17 years)	41.7	20	54.0
Immunizations—HPV Males (% of males aged 13 to 17 years)	25.3	12	42.9
Immunizations—MCV4 (% of adolescents aged 13 to 17 years)	91.8	6	95.2
Immunizations—Tdap (% of adolescents aged 13 to 17 years)	92.1	10	94.8
Policy Total*	0.09	10	0.16
Clinical Care			
Low Birthweight (% of live births)	6.4	4	5.8
Primary Care Physicians (number per 100,000 population)	122.4	25	206.7
Dentists (number per 100,000 population)	54.4	26	81.2
Preventable Hospitalizations (discharges per 1,000 Medicare beneficiaries)	50.6	23	24.4
Clinical Care Total*	0.04	18	0.17
All Determinants*	0.23	18	0.67
Outcomes			
Diabetes (% of adult population)	8.6	8	7.1
Poor Mental Health Days (days in previous 30)	2.8	3	2.7
Poor Physical Health Days (days in previous 30)	2.9	1	2.9
Disparity in Health Status (% difference by education level)**	24.5	8	14.9
Infant Mortality (deaths per 1,000 live births)	6.2	26	4.2
Cardiovascular Deaths (deaths per 100,000 population)	224.8	17	186.5
Cancer Deaths (deaths per 100,000 population)	176.0	10	146.1
Premature Death (years lost per 100,000 population)	7,098	26	5,414
All Outcomes*	0.22	5	0.33
Overall*	0.45	12	0.89

*Negative value denotes below US average; positive value denotes above US average.
**Difference in the percentage of adults aged 25 and older with vs. without a high school education who report their health is very good or excellent.



The 2012 to 2015 data in the above graphs are not directly comparable with prior years. See Methodology for additional information.

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I- 2. OECD

Organization for Economic Co-operation and Development

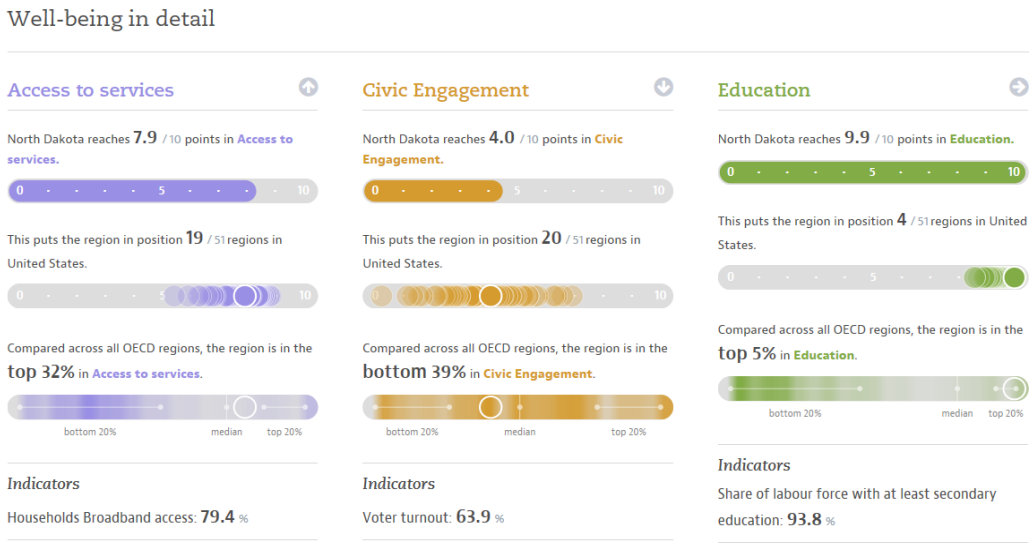
Re: North Dakota – 2016

The Organization for Economic Co-operation and Development (OECD) (18) is an intergovernmental economic organization of 35 countries, founded in 1961. The OECD divided the United States into 51 regions based on states. It found that the top five U.S. states ranked by well-being were:

1. New Hampshire (77.6)
2. Minnesota (76.2)
3. Vermont (74.8)
4. Iowa (72.9)
5. **North Dakota (72.4)**

Well-being detail:

Access to Services:	19th place ranking (out of 51)
Civic Engagement:	20th place ranking
Education:	4th place ranking
Jobs:	1st place ranking
Community:	46th place ranking (New indicator)
Environment:	26th place ranking
Income:	6th place ranking
Health:	30th place ranking
Safety:	11th place ranking
Housing:	3rd place ranking
Life Satisfaction:	3rd place ranking (New indicator)



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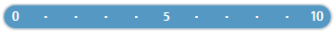
Jobs

North Dakota reaches **10.0** / 10 points in **Jobs.**



This puts the region in position **1** / 51 regions in United States.

Compared across all OECD regions, the region is in the **top 5%** in **Jobs.**

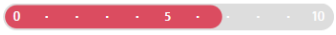
Indicators

Employment rate: **83.1** %

Unemployment rate: **2.9** %

Community

North Dakota reaches **6.4** / 10 points in **Community.**



This puts the region in position **46** / 51 regions in United States.

Compared across all OECD regions, the region is in the **bottom 31%** in **Community.**

Indicators

Perceived social support network: **87.7** %

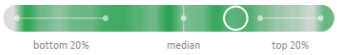
Compare United States to other countries

Environment

North Dakota reaches **7.2** / 10 points in **Environment.**

This puts the region in position **26** / 51 regions in United States.

Compared across all OECD regions, the region is in the **top 30%** in **Environment.**



Indicators

Average level of PM2.5 in the region experienced by the population: **7.1** µg/m³

Income

North Dakota reaches **10.0** / 10 points in **Income.**

This puts the region in position **6** / 51 regions in United States.

Compared across all OECD regions, the region is in the **top 5%** in **Income.**

Indicators

Disposable income per capita: **43 906** USD

Health

North Dakota reaches **4.3** / 10 points in **Health.**

This puts the region in position **30** / 51 regions in United States.

Compared across all OECD regions, the region is in the **bottom 35%** in **Health.**

Indicators

Mortality rate: **9.4** deaths per 1 000 people

Life expectancy: **79.5** years

Safety

North Dakota reaches **7.1** / 10 points in **Safety.**

This puts the region in position **11** / 51 regions in United States.

Compared across all OECD regions, the region is in the **bottom 35%** in **Safety.**

Indicators

Homicide rate: **2.2** homicides per 100 000 people

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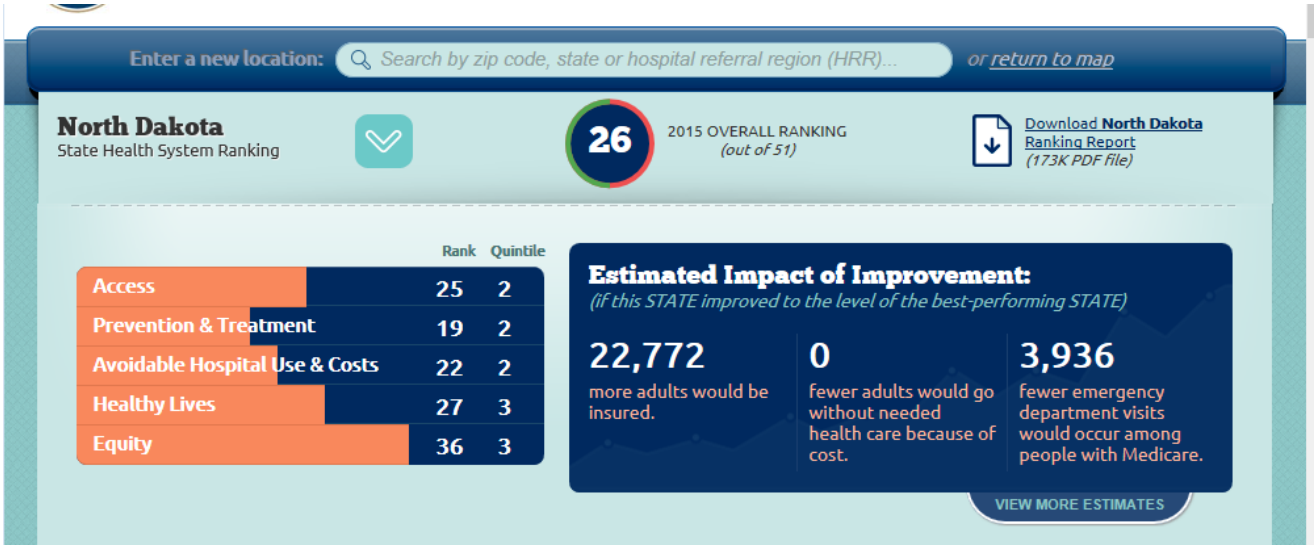
I – 3. The Commonwealth Fund – Health System Data Center: ND 2015 ranking:



Dimension and Indicator	State Rate	U.S. Average	Best State Rate	Rank	State Rate	U.S. Average	Actual Change in State Rate
Access	2015 Scorecard Performance			25	Baseline Performance		Change in Rate
Adults ages 19–64 uninsured	10%	15%	5%	8	14%	19%	-4
Children ages 0–18 uninsured	7%	6%	2%	34	8%	7%	-1
Adults who went without care because of cost in past year	7%	16%	7%	1	7%	15%	0
Individuals under age 65 with high out-of-pocket medical costs relative to their annual household income	17%	16%	10%	34	N/A	N/A	N/A
At-risk adults without a routine doctor visit in past two years	17%	14%	6%	39	17%	14%	0
Adults without a dental visit in past year	16%	15%	11%	27	15%	15%	1

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Prevention & Treatment	2015 Scorecard Performance			19	Baseline Performance		Change in Rate
Adults with a usual source of care	71%	77%	89%	42	73%	77%	-2
Adults ages 50 and older who received recommended screening and preventive care	39%	41%	48%	32	37%	42%	2
Children with a medical home	62%	57%	69%	8	N/A	N/A	N/A
Children with a medical and dental preventive care visit in the past year	61%	68%	81%	42	N/A	N/A	N/A
Children with emotional, behavioral, or developmental problems who received needed mental health care in the past year	86%	62%	86%	1	N/A	N/A	N/A
Children ages 19–35 months who received all recommended doses of seven key vaccines	71%	72%	85%	27	72%	71%	-1
Medicare beneficiaries who received at least one drug that should be avoided in the elderly	11%	16%	9%	4	14%	19%	-3
Medicare beneficiaries with dementia, hip/pelvic fracture, or chronic renal failure who received a prescription drug that is contraindicated for that condition	14%	19%	13%	3	16%	19%	-2
Medicare fee-for-service patients whose health provider always listens, explains, shows respect, and spends enough time with them	73%	76%	80%	47	71%	74%	2

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Commonwealth Fund: Prevention and Treatment Continued:

Prevention & Treatment	2015 Scorecard Performance			19	Baseline Performance		Change in Rate
Adults with a usual source of care	71%	77%	89%	42	73%	77%	-2
Adults ages 50 and older who received recommended screening and preventive care	39%	41%	48%	32	37%	42%	2
Children with a medical home	62%	57%	69%	8	N/A	N/A	N/A
Children with a medical and dental preventive care visit in the past year	61%	68%	81%	42	N/A	N/A	N/A
Children with emotional, behavioral, or developmental problems who received needed mental health care in the past year	86%	62%	86%	1	N/A	N/A	N/A
Children ages 19–35 months who received all recommended doses of seven key vaccines	71%	72%	85%	27	72%	71%	-1
Medicare beneficiaries who received at least one drug that should be avoided in the elderly	11%	16%	9%	4	14%	19%	-3
Medicare beneficiaries with dementia, hip/pelvic fracture, or chronic renal failure who received a prescription drug that is contraindicated for that condition	14%	19%	13%	3	16%	19%	-2
Medicare fee-for-service patients whose health provider always listens, explains, shows respect, and spends enough time with them	73%	76%	80%	47	71%	74%	2

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Avoidable Hospital Use & Costs	2015 Scorecard Performance			22	Baseline Performance		Change in Rate
Hospital admissions for pediatric asthma, per 100,000 children	N/A	113	28	N/A	N/A	110	N/A
Hospital admissions among Medicare beneficiaries for ambulatory care–sensitive conditions, ages 65–74, per 1,000 beneficiaries	22	26	13	14	24	28	-2
Hospital admissions among Medicare beneficiaries for ambulatory care–sensitive conditions, age 75 and older, per 1,000 beneficiaries	N/A	64	36	N/A	65	69	N/A
Medicare 30-day hospital readmissions, rate per 1,000 beneficiaries	31	30	10	28	35	34	-4
Short-stay nursing home residents readmitted within 30 days of hospital discharge to nursing home	16%	20%	13%	6	18%	21%	-2
Long-stay nursing home residents hospitalized within a six-month period	15%	17%	7%	16	14%	18%	1
Home health patients also enrolled in Medicare with a hospital admission	17%	16%	13%	37	15%	16%	2
Potentially avoidable emergency department visits among Medicare beneficiaries, per 1,000 beneficiaries	178	181	127	25	187	187	-9
Total single premium per enrolled employee at private-sector establishments that offer health insurance	$5,521	$5,859	$4,392	15	$5,330	$5,633	N/A
Total Medicare (Parts A & B) reimbursements per enrollee	$7,585	$8,274	$5,421	14	$7,529	$8,295	N/A

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Healthy Lives	2015 Scorecard Performance			27	Baseline Performance		Change in Rate
Mortality amenable to health care, deaths per 100,000 population	70	83	56	16	70	94	0
Years of potential life lost before age 75	6,655	6,730	4963	29	6,473	6,716	182
Breast cancer deaths per 100,000 female population	17.9	20.7	15.5	3	16.9	21	1
Colorectal cancer deaths per 100,000 population	15.9	14.8	10.9	37	13.2	15	2.7
Suicide deaths per 100,000 population	17.3	14.4	5.8	39	15.2	14.4	2.1
Infant mortality, deaths per 1,000 live births	6	6.1	4.2	23	6.3	6.2	-0.3
Adults ages 18–64 who report fair/poor health or activity limitations because of physical, mental, or emotional problems	20%	26%	19%	2	20%	25%	0
Adults who smoke	19%	18%	9%	31	21%	19%	-2
Adults ages 18–64 who are obese (BMI >= 30)	33%	30%	21%	41	31%	29%	2
Children ages 10–17 who are overweight or obese (BMI >= 85th percentile)	N/A	31%	22%	N/A	36%	N/A	N/A
Percent of adults ages 18–64 who have lost six or more teeth because of tooth decay, infection, or gum disease	7%	11%	6%	2	9%	11%	-2
Children ages 10–17 who are overweight or obese (BMS>=85th percentile)	36%	31%	22%	45	N/A	N/A	N/A

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The equity profile displays gaps in performance for vulnerable populations for selected indicators. An equity gap is defined as the difference between the U.S. national average for a particular indicator and the rate for the state's most vulnerable group by income and race/ethnicity. For all equity indicators, lower rates are better; therefore, a positive or negative gap value indicates that the state's most vulnerable group is better or worse than the U.S. average for a particular indicator.

Dimension and Indicator	Vulnerable Group Rate	U.S. Average	Gap	Rank	Vulnerable Group Rate	U.S. Average	Gap	Change in Gap	Change in Vulnerable Group Rate
Equity	2015 Scorecard Performance			36	Baseline Performance			Change in Rate and Vulnerable Group Rate	
Income									
Uninsured ages 0–64	18%	13%	-5	17	24%	17%	-7	2	6
Adults who went without care because of cost in past year	14%	14%	0	1	15%	16%	1	-1	1
At-risk adults without a routine doctor visit in past two years	24%	13%	-11	44	15%	14%	-1	-10	-9
Adults without a dental visit in the past year	25%	16%	-9	29	24%	15%	-9	0	-1
Adults without a usual source of care	25%	23%	-2	18	22%	24%	2	-4	-3
Adults ages 50 and older who did not receive recommended preventive care	74%	60%	-14	40	74%	58%	-16	2	0
Children without a medical home	49%	46%	-3	10	N/A	N/A	N/A	N/A	N/A
Children without a medical and dental preventive care visit in the past year	47%	32%	-15	46	N/A	N/A	N/A	N/A	N/A
Children ages 19 to 35 months without all vaccines	39%	30%	-9	39	39%	32%	-7	-2	0
Medicare beneficiaries who received at least one drug that should be avoided in the elderly	16%	17%	1	12	16%	20%	4	-3	0

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Hospital admission for pediatric asthma, per 100,000 children	N/A	143	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicare admissions for ambulatory care-sensitive conditions	87	45	-42	22	81	48	-33	-9	-6
Medicare 30-day hospital readmissions, per 1,000 beneficiciares	40%	38%	-2	6	38%	43%	5	-7	-2
Potentially avoidable ED visits among Medicare beneficiaries, per 1,000 beneficiaries	346	181	-165	29	327	188	-139	-26	-19
Adults with poor health-related quality of life	34%	27%	-7	6	37%	26%	-11	4	3
Adults who smoke	29%	17%	-12	30	28%	18%	-10	-2	-1
Adults who are obese	45%	29%	-16	50	39%	29%	-10	-6	-6
Adults who have lost six or more teeth	14%	10%	-4	12	21%	10%	-11	7	7

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	Race/Ethnicity								
Uninsured ages 0–64	25%	13%	-12	22	31%	17%	-14	2	6
Adults who went without care because of cost in past year	23%	14%	-9	13	13%	16%	3	-12	-10
At-risk adults without a doctor visit	32%	13%	-19	48	22%	14%	-8	-11	-10
Adults without a dental visit in the past year	36%	16%	-20	50	N/A	15%	N/A	N/A	N/A
Adults without a usual source of care	60%	23%	-37	49	41%	24%	-17	-20	-19
Adults age 50 and older who did not receive recommended preventive care	64%	60%	-4	19	83%	58%	-25	21	19
Children without a medical home	49%	46%	-3	3	N/A	N/A	N/A	N/A	N/A
Children without a medical and dental preventive care visit in the past year	47%	32%	-15	43	N/A	N/A	N/A	N/A	N/A
Children age 19 to 35 months without all recommended vaccines	41%	30%	-11	29	40%	32%	-8	-3	-1
Mortality amenable to health care, deaths per 100,000 population	146	84	-62	24	161	85	-76	14	15
Infant mortality, deaths per 1,000 live births	12.5	6	-6.5	35	15.6	6.5	-9.1	2.6	3.1
Adults with poor health-related quality of life	29%	27%	-2	7	26%	26%	0	-2	-3
Adults who smoke	45%	17%	-28	51	25%	18%	-7	-21	-20
Adults who are obese	41%	29%	-12	36	33%	29%	-4	-8	-8
Adults who have lost six or more teeth	13%	10%	-3	19	15%	10%	-5	2	2

Medicare fee-for-service patients whose health provider always listens, explains, shows respect, and spends enough time with them	73%	76%	80%	47	71%	74%	2
Risk-adjusted 30-day mortality among Medicare beneficiaries hospitalized for heart attack, heart failure, or pneumonia	12.2	12.7	11.8	5	12.8	13.1	-0.6
Hospitalized patients given information about what to do during their recovery at home	82%	86%	90%	49	86%	85%	-4
Hospitalized patients who reported hospital staff always managed pain well, responded when needed help to get to bathroom or pressed call button, and explained medicines and side effects	70%	76%	72%	7	65%	67%	5
Home health patients who get better at walking or moving around	61%	89%	69%	37	56%	60%	5
Home health patients whose wounds improved or healed after an operation	89%	89%	95%	27	87%	89%	2
High-risk nursing home residents with pressure sores	4%	6%	3%	3	4%	6%	0
Long-stay nursing home residents with an antipsychotic medication	18%	17%	9%	17	18%	18%	0

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Prevention & Treatment	2015 Scorecard Performance			19	Baseline Performance		Change in Rate
Adults with a usual source of care	71%	77%	89%	42	73%	77%	-2
Adults ages 50 and older who received recommended screening and preventive care	39%	41%	48%	32	37%	42%	2
Children with a medical home	62%	57%	69%	8	N/A	N/A	N/A
Children with a medical and dental preventive care visit in the past year	61%	68%	81%	42	N/A	N/A	N/A
Children with emotional, behavioral, or developmental problems who received needed mental health care in the past year	86%	62%	86%	1	N/A	N/A	N/A
Children ages 19–35 months who received all recommended doses of seven key vaccines	71%	72%	85%	27	72%	71%	-1
Medicare beneficiaries who received at least one drug that should be avoided in the elderly	11%	16%	9%	4	14%	19%	-3
Medicare beneficiaries with dementia, hip/pelvic fracture, or chronic renal failure who received a prescription drug that is contraindicated for that condition	14%	19%	13%	3	16%	19%	-2
Medicare fee-for-service patients whose health provider always listens, explains, shows respect, and spends enough time with them	73%	76%	80%	47	71%	74%	2
Risk-adjusted 30-day mortality among Medicare beneficiaries hospitalized for heart attack, heart failure, or pneumonia	12.2	12.7	11.8	5	12.8	13.1	-0.6
Hospitalized patients given information about what to do during their recovery at home	82%	86%	90%	49	86%	85%	-4

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Appendix J: Medicaid Beneficiary Survey

BENEFICIARY SURVEY
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 61091 (8-2016)

Source
E

This is a 5 minute survey. Your input matters!

The survey asks if you and your family members who have Medicaid coverage are able to see health care providers when you need to. The Department of Human Services will use this information to study access across North Dakota, including identifying areas where access concerns may exist.

Your privacy is protected. All information that would let someone identify you or your family is confidential. You may choose to answer this survey or not. If you choose not to, your Medicaid benefits will not be affected.

If you live in rural North Dakota there aren't as many families, so to make the data stronger; we need a higher survey response rate from the smaller communities.

Please answer the questions for only those household members with Medicaid coverage.

You can complete and return this paper version, or for your convenience you may complete the survey on-line at https://eforms.nd.gov/lfserver/SFN61091BeneficiarySurvey

SURVEY INSTRUCTIONS

Be sure to fill the response ovals completely. Use only black or blue ink or dark pencil to complete the survey.

Correct Mark ● Incorrect Marks ⊘ ✓ ☁

You are sometimes told to skip over some questions in the survey. When this happens you will see an arrow that tells you what question to answer next, like this:

◉ Yes ⇨ Go to Question 1
○ No

START SURVEY HERE

1. County we live in: ☐ Enter 2 digit code from chart on the right

County Codes	
Adams	01
Barnes	02
Benson	03
Billings	04
Bottineau	05
Bowman	06
Burke	07
Burleigh	08
Cass	09
Cavalier	10
Dickey	11
Divide	12
Dunn	13
Eddy	14
Emmons	15
Foster	16
Golden Valley	17
Grand Forks	18
Grant	19
Griggs	20
Hettinger	21
Kidder	22
LaMoure	23
Logan	24
McHenry	25
McIntosh	26
McKenzie	27
McLean	28
Mercer	29
Morton	30
Mountrail	31
Nelson	32
Oliver	33
Pembina	34
Pierce	35
Ramsey	36
Ransom	37
Renville	38
Richland	39
Rolette	40
Sargent	41
Sheridan	42
Sioux	43
Slope	44
Stark	45
Steele	46
Stutsman	47
Towner	48
Traill	49
Walsh	50
Ward	51
Wells	52
Williams	53
Unknown	99

GETTING HELP FROM PRIMARY CARE

2. A primary care provider is someone you would see if you need a check-up, want advice about a health problem, get sick or hurt, or if you need a prescribed medication. **In the past 6 months, approximately how many times have you and family members covered by Medicaid seen a primary care provider?**

○ None ⇨ Go to Question 4
○ 1 time
○ 2 times
○ 3 times
○ 4 times
○ 5 to 9 times
○ 10 or more times

3. When you or your family member covered by Medicaid needed care from your primary care provider, how often did your household get care as soon as you needed it?

○ Never
○ Sometimes
○ Usually
○ Always

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GETTING HELP FROM MEDICAL SPECIALISTS

4. Specialists are health care providers such as radiologists who interpret x-rays, cardiologists who evaluate heart-related concerns or urologists who evaluate urinary tract problems. **In the past 6 months, approximately how many times have you and family members covered by Medicaid seen a medical specialist?**

- ○ None ⇨ Go to Question 6
- ○ 1 time
- ○ 2 times
- ○ 3 times
- ○ 4 times
- ○ 5 to 9 times
- ○ 10 or more times

5. When you or your family member needed care from a medical specialist, how often did your household get care as soon as you needed it?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

GETTING HELP FROM A BEHAVIORAL HEALTH PROVIDER

6. A behavioral health provider offers services related to mental health or substance abuse. **In the past 6 months, approximately how many times have you and family members covered by Medicaid seen a behavioral health provider?**

- ○ None ⇨ Go to Question 8
- ○ 1 time
- ○ 2 times
- ○ 3 times
- ○ 4 times
- ○ 5 to 9 times
- ○ 10 or more times

7. When you or your family member needed care from a behavioral health provider, how often did your household get care as soon as you needed it?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

GETTING HELP FROM AN OBSTETRICIAN

8. Obstetric providers help with pregnancy, child birth and post-delivery care. **In the past 6 months, approximately how many times have you and family members covered by Medicaid seen an obstetric provider?**

- ○ None ⇨ Go to Question 10
- ○ 1 time
- ○ 2 times
- ○ 3 times
- ○ 4 times
- ○ 5 to 9 times
- ○ 10 or more times

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SFN 61091 (8-2016)
Page 3 of 3

GETTING HELP FROM AN OBSTETRICIAN (continued)

9. When you or your family member covered by Medicaid needed care from an obstetrician, how often did your household get care as soon as you needed it?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

GETTING HELP FROM A HOME HEALTH CARE PROVIDER

10. Home health care services are provided in your home to help with care after certain hospital stays. **In the past 6 months, approximately how many times have you and family members covered by Medicaid received services from a home health provider?**

- ○ None ⇨ Go to Question 12
- ○ 1 time
- ○ 2 times
- ○ 3 times
- ○ 4 times
- ○ 5 to 9 times
- ○ 10 or more times

11. When you or your family members covered by Medicaid needed care from a home health provider, how often did your household get care as soon as you needed it?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

12. Please check all that impacted you or your family members' ability to access services:

- ☐ We've had no problems accessing healthcare
- ☐ We've not seen any health care provider within the past 6 months
- ☐ Some provider(s) are not accepting ANY new referrals
- ☐ Some provider(s) are not accepting Medicaid referrals
- ☐ Some provider(s) offices are far from my home
- ☐ Appointments are not timely
- ☐ We've been hesitant to schedule because of copays or recipient liability
- ☐ Transportation is difficult
- ☐ Have used telemedicine and found it helpful
- ☐ A provider we work with helped with referrals or coordination of care

Other Concerns or Clarifying Comments

An email address for the Department of Human Services is available for those who want to provide more details about their experiences in accessing health care services. Please write to us at: ndmedicaid@nd.gov or mail information to:

Division of Medical Services, Attn: Doug Boknecht
Department of Human Services
600 East Boulevard Ave., Dept. 325
Bismarck, ND. 58505-0250

Submit Go

THANK YOU FOR COMPLETING THE SURVEY !

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Appendix K: Medicaid Data Reports

Report # 1

NORTH DAKOTA MEDICAID

Provider Enrolled and Participating by Provider Type - Statewide

Incurred by State Fiscal Year	FY 2013	FY 2013	FY 2014	FY 2014	FY 2015	FY 2015
Provider Type	**Providers Enrolled**	**Providers Participating**	**Providers Enrolled**	**Providers Participating**	**Providers Enrolled**	**Providers Participating**
Behav Health & Social Svc Prov	703	332	970	364	1,040	349
Chiropractic Providers	381	207	392	217	402	213
Dental Providers	393	194	426	202	422	179
Dietary & Nutritional Svc Prov	114	40	125	41	140	43
Eye and Vision Svc Prov	190	135	206	135	203	134
Nursing Service Providers	8	3	36	2	64	14
Other Service Providers	446	181	544	183	597	185
Physicians	3,129	2,072	3,364	2,135	3,459	2,126
Podiatric Med & Surgery Svc	40	28	46	33	49	29
Resp, Devl, Rehab & Rest Srvc	677	239	742	262	1,000	284
Speech, Lang, and Hearing Svc	551	252	596	270	667	294
Agencies	72	48	83	51	85	47
Amb Health Care Facilities	862	454	977	452	1,033	465
Hospital Units	45	36	47	39	48	36
Hospital	49	48	61	58	61	56
Laboratories	14	5	19	6	19	9
Nursing & Custodial Care Fac	95	81	99	84	99	83
Residential Treatment Facility	14	7	14	7	15	6
Supplier	272	221	334	243	349	250
Transportation	916	232	543	211	435	195
PAs and Advanced Nursing	1,216	856	1,360	927	1,470	1,018
Developmental Disabilities	688	161	716	166	717	170
Basic Care	59	55	56	54	62	57
Qualified Service Provider	2,134	929	2,369	896	2,435	844
Aggregate:	**13,068**	**6,816**	**14,125**	**7,038**	**14,871**	**7,086**

"**Providers Enrolled**" are the total number of active North Dakota Medicaid providers enrolled in the program by type.
"**Providers Participating**" are the total number of North Dakota Medicaid active providers who submitted a claim for services during the period of measurement

north dakota department of human services

Report # 2

NORTH DAKOTA MEDICAID

Provider Enrolled and Participating by Provider Type & Participant Region

Incurred by State Fiscal Year

Participant Region	Provider Type	FY 2013 Providers Enrolled	FY 2013 Providers Participating	FY 2014 Providers Enrolled	FY 2014 Providers Participating	FY 2015 Providers Enrolled	FY 2015 Providers Participating
Region I - Northwest	Behav Health & Social Svc Prov	18	6	28	6	32	10
Region I - Northwest	Chiropractic Providers	13	6	12	6	11	4
Region I - Northwest	Dental Providers	22	14	25	16	26	11
Region I - Northwest	Dietary & Nutritional Svc Prov	1		1		1	
Region I - Northwest	Eye and Vision Svc Prov	15	10	16	11	17	9
Region I - Northwest	Nursing Service Providers	1		1		1	
Region I - Northwest	Other Service Providers	33	7	40	12	44	14
Region I - Northwest	Physicians	101	65	171	92	164	107
Region I - Northwest	Podiatric Med & Surgery Svc			2	1	2	2
Region I - Northwest	Resp, Devl, Rehab & Rest Srvc	24	9	25	6	24	4
Region I - Northwest	Speech, Lang, and Hearing Svc	18	7	20	7	19	6
Region I - Northwest	Agencies	4	3	4	3	4	3
Region I - Northwest	Amb Health Care Facilities	39	27	42	25	43	21
Region I - Northwest	Hospital Units	3	3	4	2	4	
Region I - Northwest	Hospital	4	4	4	4	4	4
Region I - Northwest	Laboratories	4	2	5	2	5	3
Region I - Northwest	Nursing & Custodial Care Fac	5	4	5	5	5	4
Region I - Northwest	Residential Treatment Facility	1		1		1	
Region I - Northwest	Supplier	11	10	15	11	15	10
Region I - Northwest	Transportation	54	8	22	6	17	7
Region I - Northwest	PAs and Advanced Nursing	42	30	56	28	57	34
Region I - Northwest	Developmental Disabilities	33	7	34	8	34	7
Region I - Northwest	Basic Care	5	4	4	4	4	3
Region I - Northwest	Qualified Service Provider	80	37	79	33	81	28
Region II - North Central	Behav Health & Social Svc Prov	91	44	126	49	135	43
Region II - North Central	Chiropractic Providers	33	20	37	21	40	23
Region II - North Central	Dental Providers	54	24	58	21	58	19
Region II - North Central	Dietary & Nutritional Svc Prov	4		5	1	6	
Region II - North Central	Eye and Vision Svc Prov	23	15	24	16	24	15
Region II - North Central	Nursing Service Providers	1	1	1	1	1	1
Region II - North Central	Other Service Providers	66	27	84	23	90	28
Region II - North Central	Physicians	451	243	495	252	473	245
Region II - North Central	Podiatric Med & Surgery Svc	6	5	7	6	8	5
Region II - North Central	Resp, Devl, Rehab & Rest Srvc	46	9	53	10	50	12
Region II - North Central	Speech, Lang, and Hearing Svc	81	24	87	25	87	20
Region II - North Central	Agencies	6	3	6	4	6	4
Region II - North Central	Amb Health Care Facilities	83	44	101	44	108	51
Region II - North Central	Hospital Units	6	5	6	5	7	6
Region II - North Central	Hospital	6	6	6	6	6	6
Region II - North Central	Laboratories	2		2		2	
Region II - North Central	Nursing & Custodial Care Fac	8	7	9	7	9	7
Region II - North Central	Residential Treatment Facility	2	2	2	2	2	2
Region II - North Central	Supplier	31	26	38	27	38	26
Region II - North Central	Transportation	113	33	70	31	68	35
Region II - North Central	PAs and Advanced Nursing	172	108	197	110	197	121
Region II - North Central	Developmental Disabilities	80	21	90	24	89	30
Region II - North Central	Basic Care	5	5	5	5	6	6
Region II - North Central	Qualified Service Provider	268	106	293	104	297	111
Region III - Lake Region	Behav Health & Social Svc Prov	37	13	68	20	69	15
Region III - Lake Region	Chiropractic Providers	8	6	9	7	9	7
Region III - Lake Region	Dental Providers	24	13	26	13	28	12
Region III - Lake Region	Dietary & Nutritional Svc Prov	3		3		3	
Region III - Lake Region	Eye and Vision Svc Prov	9	6	9	6	9	7
Region III - Lake Region	Other Service Providers	25	5	33	7	40	6
Region III - Lake Region	Physicians	105	34	137	31	133	35

north dakota department of human services

Report # 3

NORTH DAKOTA MEDICAID

Provider Participation by Provider Group and Participant Region

Incurred by State Fiscal Year

Provider Group	Participant Region	FY 2013	FY 2014	FY 2015
Behavioral Health	Region I - Northwest	14	13	14
	Region II - North Central	21	18	25
	Region III - Lake Region	13	16	25
	Region IV - Northeast	27	19	22
	Region V - Southeast	28	27	30
	Region VI - South Central	26	28	32
	Region VII - West Central	29	30	31
	Region VIII - Badlands	18	17	15
	Aggregate:	**82**	**83**	**91**
Home Health	Region I - Northwest	4	2	2
	Region II - North Central	3	4	3
	Region III - Lake Region	8	5	7
	Region IV - Northeast	5	3	4
	Region V - Southeast	11	10	9
	Region VI - South Central	10	5	6
	Region VII - West Central	9	8	6
	Region VIII - Badlands	4	3	2
	Aggregate:	**24**	**20**	**20**
Primary Care	Region I - Northwest	450	406	402
	Region II - North Central	613	567	575
	Region III - Lake Region	646	641	651
	Region IV - Northeast	612	542	502
	Region V - Southeast	876	821	808
	Region VI - South Central	702	704	661
	Region VII - West Central	751	705	690
	Region VIII - Badlands	375	401	356
	Aggregate:	**1,230**	**1,227**	**1,328**
Specialist	Region I - Northwest	42	40	36
	Region II - North Central	59	66	60
	Region III - Lake Region	72	79	71
	Region IV - Northeast	49	49	49
	Region V - Southeast	78	65	60
	Region VI - South Central	78	82	67
	Region VII - West Central	65	62	66
	Region VIII - Badlands	34	30	35
	Aggregate:	**113**	**112**	**106**

"**Specialist**" consists of Cardiology, Radiology, and Urology.

north dakota department of human services

Report # 4

NORTH DAKOTA MEDICAID

Visits & Services by Provider Group and Participant Region (per 1000)

Incurred by State Fiscal Year

		Visits Per 1000			Services Per 1000		
Provider Group	**Participant Region**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2013**	**FY 2014**	**FY 2015**
Behavioral Health	Region I - Northwest	4,737.54	4,340.77	3,336.96	19,543.39	15,604.27	14,697.21
	Region II - North Central	2,859.62	2,751.40	2,694.13	11,704.40	8,440.75	9,595.22
	Region III - Lake Region	1,712.13	1,630.70	1,437.26	5,846.32	4,860.27	5,393.55
	Region IV - Northeast	6,466.90	6,193.74	5,442.24	25,339.87	17,611.18	19,868.13
	Region V - Southeast	5,249.42	4,745.12	3,859.01	19,238.50	16,224.09	14,904.94
	Region VI - South Central	6,896.74	6,532.22	5,382.30	30,213.74	25,415.89	23,118.61
	Region VII - West Central	3,952.03	3,472.73	3,221.86	18,465.62	15,248.98	15,009.49
	Region VIII - Badlands	4,676.06	3,932.61	3,017.27	22,074.03	14,931.50	13,358.32
	Aggregate:	**4,387.37**	**4,025.48**	**3,496.19**	**17,860.15**	**14,116.86**	**14,083.49**
Home Health	Region I - Northwest	29.42	13.63	25.44	286.81	69.03	273.75
	Region II - North Central	29.99	26.61	19.36	623.14	600.19	415.96
	Region III - Lake Region	63.48	57.36	55.62	505.11	373.75	435.67
	Region IV - Northeast	36.53	37.38	28.37	905.98	910.57	740.50
	Region V - Southeast	119.41	117.93	92.56	2,791.21	2,692.84	1,824.10
	Region VI - South Central	138.84	129.55	99.60	1,959.95	1,880.57	1,322.92
	Region VII - West Central	82.75	81.85	74.65	1,104.45	805.09	811.16
	Region VIII - Badlands	105.23	24.20	23.36	1,351.11	262.67	301.29
	Aggregate:	**79.99**	**72.80**	**61.16**	**1,377.49**	**1,203.37**	**940.30**
Primary Care	Region I - Northwest	4,208.53	3,960.43	3,778.52	9,285.83	9,316.92	7,972.41
	Region II - North Central	4,232.40	4,063.26	3,804.30	8,497.58	10,237.81	10,285.57
	Region III - Lake Region	3,667.17	3,405.02	3,125.97	6,960.75	6,575.61	5,694.09
	Region IV - Northeast	5,550.37	5,401.26	4,771.05	17,919.76	17,802.55	15,772.17
	Region V - Southeast	5,409.75	5,382.27	4,436.38	12,479.96	14,088.84	11,191.23
	Region VI - South Central	4,820.58	4,495.95	4,020.42	10,590.41	12,832.45	14,161.59
	Region VII - West Central	4,539.56	4,286.97	3,747.73	11,020.29	13,807.81	10,976.39
	Region VIII - Badlands	4,964.57	4,887.66	4,403.28	10,818.80	15,338.19	11,919.59
	Aggregate:	**4,726.26**	**4,551.37**	**4,015.79**	**11,178.73**	**12,628.10**	**10,954.37**
Specialist	Region I - Northwest	815.82	737.83	792.76	1,185.49	1,054.85	1,408.97
	Region II - North Central	870.08	853.72	781.72	1,298.07	1,490.92	1,562.66
	Region III - Lake Region	675.92	685.13	589.04	1,001.00	1,114.02	924.41
	Region IV - Northeast	1,058.81	984.15	860.77	1,642.32	1,441.66	1,368.88
	Region V - Southeast	1,117.93	928.61	893.59	1,834.08	1,452.37	1,404.80
	Region VI - South Central	903.77	801.50	815.13	1,298.14	1,134.00	1,321.46
	Region VII - West Central	1,041.43	941.51	858.64	1,999.46	1,505.52	2,272.91
	Region VIII - Badlands	883.20	853.18	811.12	1,344.64	1,660.31	1,883.16
	Aggregate:	**957.74**	**870.32**	**811.30**	**1,561.80**	**1,383.00**	**1,541.46**

"**Specialist**" consists of Cardiology, Radiology, and Urology.

north dakota department of human services

Report # 5

NORTH DAKOTA MEDICAID

Office Visits by Specialty (per 1000)

Incurred by State Fiscal Year

Specialty	FY 2013	FY 2014	FY 2015
General Practitioner	1,670.24	1,593.78	1,385.83
Internist	155.52	124.66	112.72
Pediatrician	736.17	751.93	691.76
Other Specialties	333.50	327.34	360.33

"**Other specialties**" consists of Cardiology, Radiology, and Urology.

north dakota department of human services

Report # 6

NORTH DAKOTA MEDICAID

PT, OT, ST Enrolled and Participating - Statewide

Incurred by State Fiscal Year	FY 2013	FY 2013	FY 2014	FY 2014	FY 2015	FY 2015
Provider Type	**Providers Enrolled**	**Providers Participating**	**Providers Enrolled**	**Providers Participating**	**Providers Enrolled**	**Providers Participating**
Physical Therapist	445	157	475	157	596	164
Occupational Therapy	260	91	297	109	396	118
Speech-Language Pathologist	494	218	539	238	612	265
Aggregate:	**1,199**	**466**	**1,311**	**504**	**1,604**	**547**

"**Providers Enrolled**" are the total number of active North Dakota Medicaid providers enrolled in the program by type.
"**Providers Participating**" are the total number of North Dakota Medicaid active providers who submitted a claim for services during the period of measurement

north dakota department of human services

Report # 7

NORTH DAKOTA MEDICAID

Ambulance Enrolled and Participating - Statewide

Incurred by State Fiscal Year	FY 2013	FY 2013	FY 2014	FY 2014	FY 2015	FY 2015
Provider Type	**Providers Enrolled**	**Providers Participating**	**Providers Enrolled**	**Providers Participating**	**Providers Enrolled**	**Providers Participating**
Ambulance	124	105	129	111	139	110
Aggregate:	**124**	**105**	**129**	**111**	**139**	**110**

"**Providers Enrolled**" are the total number of active North Dakota Medicaid providers enrolled in the program by type.
"**Providers Participating**" are the total number of North Dakota Medicaid active providers who submitted a claim for services during the period of measurement

north dakota department of human services

Report # 8

NORTH DAKOTA MEDICAID

Professional Services Providers (per 1000)

Incurred by State Fiscal Year

	Visits Per 1000			Services Per 1000		
Provider Specialty	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2013**	**FY 2014**	**FY 2015**
Professional Services Providers	7,656.75	7,231.34	6,410.18	13,235.54	12,566.17	11,222.64

Visits per 1000 Med is the average number of visits, per 1000 members per year.
Services per 1000 is the average number of professional services (units) per 1000 members per year

north dakota department of human services

Report # 9

NORTH DAKOTA MEDICAID

Speech Therapy, Physical Therapy, Occupational Therapy Providers (per 1000)

Incurred by State Fiscal Year

	Visits Per 1000			Services Per 1000		
Provider Specialty	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2013**	**FY 2014**	**FY 2015**
Speech Therapy	1,250.91	1,107.28	900.84	1,260.45	1,118.57	908.76
Physical Therapy	162.63	183.86	156.35	362.82	418.79	342.04
Occupational Therapy	302.03	319.35	241.39	661.57	736.98	511.40

Visits per 1000 Med is the average number of visits, per 1000 members per year.

Services per 1000 is the average number of professional services (units) per 1000 members per year

north dakota department of human services

Report # 10

NORTH DAKOTA MEDICAID

Ambulance Providers (per 1000)

Incurred by State Fiscal Year

	Visits Per 1000			Services Per 1000		
Provider Specialty	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2013**	**FY 2014**	**FY 2015**
Ambulance	136.36	137.56	119.99	3,991.75	4,092.78	3,836.46

Visits per 1000 Med is the average number of visits, per 1000 members per year.

Services per 1000 is the average number of professional services (units) per 1000 members per year

north dakota department of human services

Report # 11

NORTH DAKOTA MEDICAID

Additional Metrics (per 1000)

Incurred by State Fiscal Year

Metric	FY 2013	FY 2014	FY 2015
Short Length of Stay Discharge	2,396.23	2,289.27	2,051.89
Outpatient Hospital Visits	2,490.06	2,376.37	2,149.46
Emergency Room Visits	862.56	812.76	753.18