Executive Summary
North Dakota Access Monitoring Review Plan Revised

Two appendixes added to the North Dakota Medicaid Access Monitoring Plan:

Consistent with the current framework being communicated from Centers for Medicare and Medicaid (CMS) staff, the "name" of state access monitoring plans are utilizing the title: "Access Monitoring Review Plans (AMRPs), so North Dakota is implementing this name change, hereafter the document title will be: "North Dakota Access Monitoring Review Plan".

The body of the original access monitoring plan remains unchanged from the version released for 30 day public comment on August 9, 2016, and submitted to CMS on October 1, 2016. Two appendixes are being added, and for this reason the North Dakota AMRP, specifically the append documents, are being released for an additional 30 day public comment.

The data analytics conclusion stated on page 6 of the original monitoring plan informed that: *"Based on analysis of the presently available data, the Department of Human Services (DHS) has concluded that at this time (October 1, 2016), there are no specific access challenges identified that meet the Plan of Correction standards as defined in the CMS Final Rule on Access Monitoring".* That conclusion continues to be accurate as of this submission for public comment.

The next Access Monitoring Review Plan is required to be submitted after 3 years, so submission date is anticipated to be October 1, 2019. During the interim, the DHS Medical Service Division will continue to monitor data indicators that provide information pertinent to traditional fee for service Medicaid beneficiaries in relation to their access to health care, with emphasis on 5 provider groups identified by the CMS Access Monitoring Rule (primary care, specialty care, behavioral health, obstetrics and home health care), as well as monitor beneficiary access to providers impacted by rate modifications related to the state law and constitutionally mandated requirement that North Dakota achieve a balanced budget at the end of each biennium. The reader is referred to the original monitoring plan (pages 15 and 16) for additional detail of the allotment process.

Public Notices

This February 13, 2017 public notice will be the third time DHS has solicited public comment specific to access monitoring. No public comments have been received as of 5:00 P.M. CDT March 17, 2017 deadline.

The first public notice, issued on February 22, 2016, explained the allotment rate modifications in detail and requested feedback regarding impact specific to Section 1902(a)(30) of the Act requiring that: *"payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."*

The second public notice was specific to the initial North Dakota Access Monitoring Plan – 2016, and issued on August 9, 2016. This third request for public comment is specific to the two appends to the ARMP is being added to the North Dakota AMRP, summarized as follows:

Summary of Appendix 1: Nursing Facility Rate Methodology Change, effective January 1, 2017

Given that the allotment related rate modifications to nursing facilities are now going into effect, Appendix 1 adds these facilities to the ND AMRP monitoring, discusses two specific metrics that will be monitored, and an additional metric that will be tracked outside of the AMRP.

Two Access Monitoring metrics have been identified and thresholds established:

1. **Monitoring penetration rates:**

Five years of baseline data regarding penetration rates of nursing home residents covered by Medicaid vs. residents who are private pay has been established.

2. **Analysis of access to Primary Care and Specialty Care as reported by nursing home residents covered by Medicaid:**

Beneficiary survey feedback received from seventy five (75) nursing home residents or residents' personal representatives regarding access to primary care and to specialty care is summarized, and contrasted to the results of the total Medicaid household surveys received specific to these two provider groups (see Appendix 1 detail for additional discussion, including identified thresholds).

Tracking quality of care indicators

Quality of care does not measure access to care, so it is not identified as an access monitoring metric.

Based on the CMS access monitoring guidelines, the focus of access monitoring does not include an expectation to monitor quality of care, and consultation with the Medicaid Medical Advisory Committee members from meetings held in February and July 2016 resulted in consensus that quality does not measure access but is useful information to know. Feedback from February 2016 public comments received from nursing home providers indicated that by far the most frequently mentioned concern was that the allotment may negatively impact quality of care provided by North Dakota's nursing facilities. In recognition that quality is an important component in the care of our nursing facility residents, the DHS Medical Services Division has established quality baseline trends, and will track this metric outside of the AMRP.

The 2017 Legislative Session is close to its "crossover" point where all bills need to "crossover" to the other chamber. In the first portion of the current Legislative session, the Department's budget is in the House of Representatives. Amendments to the Department's Appropriation have been proposed which will restore most of the nursing facility allotment reductions that became effective January 1, 2017. While the Department's budget now goes to the Senate, and eventually to Conference Committee, there is broad Legislative support for restoration of the nursing facility reductions, no later than July 1, 2017.

Summary of Appendix 2: Medicaid Household Beneficiary Survey Results

At the point the ND AMRP was submitted to CMS on October 1, 2016, the Medicaid Household Beneficiary Survey had been tested and an initial pilot conducted but only very preliminary results were reported (based on analysis of 141 surveys). The survey has since been delivered to traditional fee for service Medicaid households across North Dakota from September through November 2016, with six thousand six hundred and seventy nine (6,679) households responding, including responses from each of the 53 counties across North Dakota.

Appendix 2 provides information about the development of the Medicaid Household Beneficiary Survey and reports timely access to care results for primary care, specialty care, behavioral health, obstetrics and home health care.

The survey results details are offered in two formats:

1. Survey Data Summary: The final 3 pages of Appendix 2 (pages 15 - 17) provide an overview of the survey results broken out by each of the 5 provider group categories, as well as detailed response frequencies for the survey's 12 questions. The results summarize the response rates by provider, and percentile breakdown of the Medicaid household survey responders' feedback specific to their experiences over the prior six months about timely access to care.

2. GIS Heat Mapping of the Survey Data: North Point Geographic Solutions located in Duluth Minnesota worked closely with ND Medical Services Division data analytics staff to create a "story map" of survey results. The resultant "scatter maps" and graphs drill down to county-by-county levels of mapping that depict survey results about timely access to care by county, for each of the 5 health care provide groups. When navigating the story map for the first time, be aware that each heat map can take a little time to load on to your computer screen. The URL to access the Story Map is: http://arcg.is/2kKJOUN.

The Executive Summary Tab in the Story Map discussed "Survey Disclaimer and Limitations" in detail.
The survey results should be viewed as a point in time snapshot from 6,679 Medicaid households representing each household's perspective about timely access to five identified health care provider groups.
The limitations include:

- The ND survey does not include the CAHPS trademark
- The ND survey is not generalizable
- The rurality of some ND counties results in limitations of interpretation of data

Appendix 1 detail

Nursing Facilities are being added to the North Dakota Access Monitoring Review Plan (AMRP)

Circumstances that led to the allotment rate modification

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 North Dakota Office of Management Budget (OMB) released the revised revenue forecast. As a result of the

forecast, and as required by state law and the state's constitution, State agencies were required to submit an allotment plan to reduce general fund expenditures by 4.05% to achieve a balanced budget.

The 4.05% general fund reduction target for the Department of Human Services (DHS) equated to $53.95 million dollars. Medical Assistance grants account for sixty-seven percent (67%) of the DHS general fund appropriation. If reductions were not made to the Medical Assistance grants, other programs and services in the Department would have been disproportionately impacted. The total Medicaid allotment reductions were approximately $29 million, which is only fifty-four percent (54%) of the total allotment.
State agencies were required to submit their allotment plans by February 17, 2016. The allotment process does not afford the opportunity for public discussion of the components of the allotment plan. Medicaid providers were not consulted on the reductions prior to the February 17th allotment plan submission. Note: No DHS stakeholders were consulted during the development of the allotment plan.

Summary of public comments received in February and March 2016

On February 17, 2016, the North Dakota Department of Human Services (DHS) submitted its budget allotment plan and held a Medicaid Medical Advisory Committee (MMAC) meeting on February 19, 2016 to review the allotment plan and discuss the reductions. During the MMAC meeting in February and another MMAC meeting in July 2016, the allotment reductions were reviewed in detail, and committee members provided feedback on access monitoring, including recommendations about data to use to track access.

A public notice was issued on February 22, and public comments were solicited, followed up with a variety of ongoing conversations with provider groups and stakeholders. A majority (70%) of comments received were submitted by stakeholders in regard to anticipated impact specific to the nursing facility rate methodology change (47 public comments from Nursing Facility stakeholders). The Department also followed up with letters to each of the public commenters, including to the nursing facilities.

The most frequently identified concern verbalized to DHS by providers and stakeholders was that quality of care may be negatively impacted. Providers note that North Dakota nursing home facilities generally rate above national averages in quality of care indicators and were concerned that quality may decline. The second most frequently verbalized concern relates to workforce challenges; pointing out that competitive salary is an issue in some locations due to low unemployment, competitive high oil field wages and so forth.

Some feedback identified budget concerns that derive from a variety of causes, including recent capital improvement projects initiated by some facilities, failed electronic health record implementation and other reasons, such that cash flow is a concern to some health care businesses' bottom lines.

Another general theme is that some providers are asking for consideration that regulatory burden be reduced and documentation simplified where possible, so they can direct their staff toward provision of direct services.

DHS response: Most of the regulatory burdens identified by nursing home facilities are outside of the purview of the Department as they are tied to survey and certification requirements. DHS is reviewing nursing facility rate setting requirements for areas that could be streamlined.

In summary, the highest frequency of concerns were: possible impact on quality of care; possible increases in workforce staffing challenges; request for consideration of reducing regulation and administrative burden so that staff could emphasize direct care services.

Access Monitoring

The public comment responders who indicated concerns for nursing facility impacts did not offer any recommendations for data sources to use in monitoring access. However, additional input on the Access Monitoring Plan was incorporated into the original AMRP based on input from a representative of the long-term care association who is a member of the Medicaid Medical Advisory Committee, including updated data regarding numbers of long-term care facilities in ND (see original Monitoring Plan pp 13); improving the narrative description of Assisted Living Facilities vs. Basic Care Facilities (pp 14); and enhancement of the CPI Index table (pp. 43 – 44).

The ND AMRP also was opened to 30 day public comment prior to the submission to CMS on October 1, 2016. No public comments were received.

Rate adjustments to nursing homes as a result of the allotment were effective January 1, 2017 so access monitoring is now being incorporated in to the AMRP per this append to the plan.

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Analysis of the effect of the change in nursing facility payment rates on access

The rate modifications contained in this allotment are the removal of the operating margin and incentive components of the nursing facility rate methodology. The North Dakota Medicaid providers have received annual inflationary increases each year since at least 2005. The following chart shows the rate increases for 2005 through 2015. As a comparison, the Skilled Nursing Facility Market Basket for each of these years is provided, as is the overall and medical care consumer price index (CPI). Overall, since 2007, the Inflationary increases authorized by the North Dakota Legislature have outpaced market basket; and clearly the ND increases have been significantly higher than since 2008.

	ND Legislative Inflationary Increases for NF Providers	Nursing Facility Market Basket (FFY)	Overall CPI (CY)	CPI Medical Care
July 1, 2015	3%	2.0%	0.2%	2.6%
July 1, 2014	4%	1.8%	2.0%	2.4%
July 1, 2013	3% **	1.8%	2.0%	2.5%
July 1, 2012	3%	1.7%	1.7%	2.7%
July 1, 2011	3%	2.3%	3.6%	3.0%
July 1, 2010	6%	2.2%	1.2%	3.4%
July 1, 2009	6% *	3.4%	-2.1%	3.2%
July 1, 2008	5%	3.3%	5.6%	3.7%
July 1, 2007	4%	3.1%	2.4%	4.4%
July 1, 2006	2.65%	3.1%	4.1%	4.0%
July 1, 2005	2.65%	2.8%	3.2%	4.2%

*In addition to the inflationary increase, nursing facility providers also received an increase of $0.80 per hour for salary and benefit enhancement.

**In addition to the inflationary increase, nursing facility providers also received an increase of $1.00 per hour for salary enhancement.

Prior to allotment rate modifications, the daily rate for North Dakota nursing facilities of $258.78 per day was greater than the daily rates in Medicaid programs in surrounding rural states. With the modifications, the North Dakota daily rate is still considerably higher than the nearby state Medicaid rates:

North Dakota 1/1/17	South Dakota 7/1/16	Wyoming 1/1/17	Montana 7/1/16 *
$257.90	$137.88	$184.31	$176.06

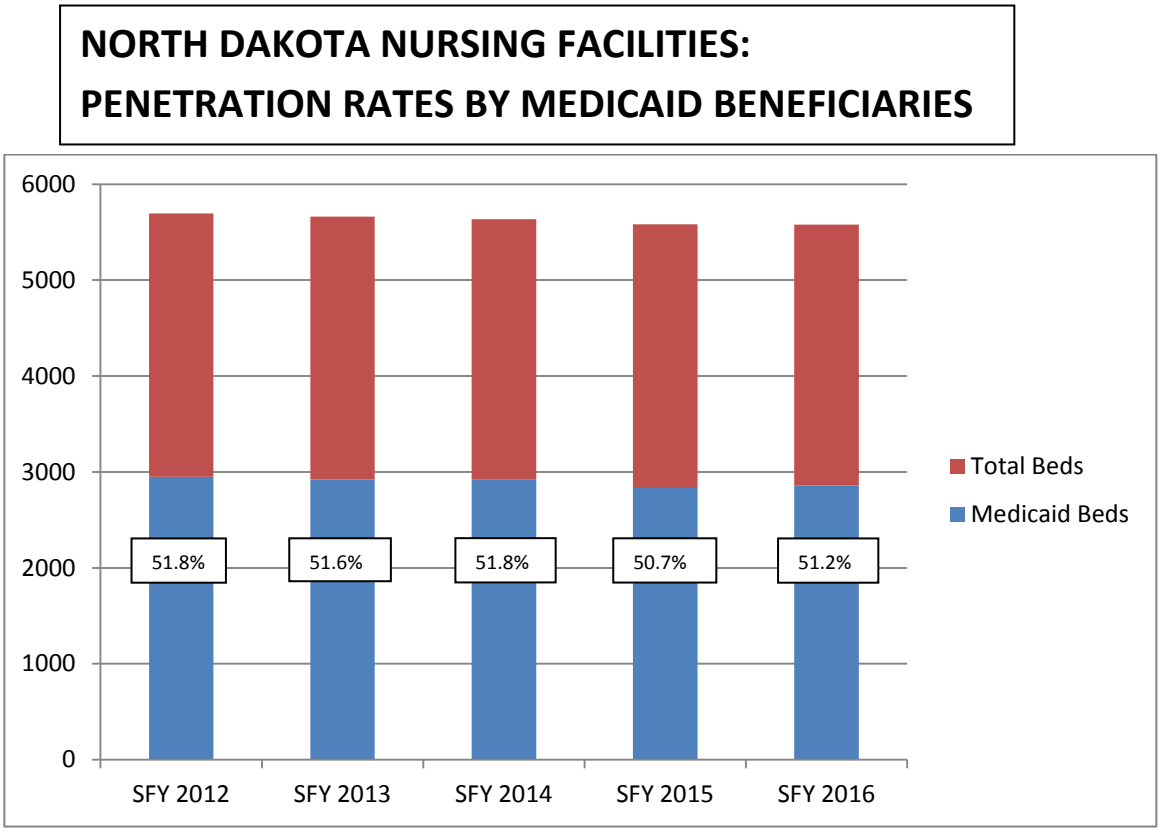
*The average daily rate for Montana does not include therapy services

Of the state's total 81 licensed nursing facilities there are 80 facilities enrolled as Medicaid providers. The 80 facilities are dispersed across all regions of the state, and all currently have Medicaid eligible residents. The only licensed nursing facility that is not an enrolled Medicaid provider is a transitional care unit within a North Dakota acute care hospital.

Access Monitoring indicators, methodology, and thresholds

Based on analysis of public comment, input from the Medicaid Medical Advisory Committee members, and Medical Services Division data analytics staff assessment, 2 data indicators will be added to the Access Monitoring Review Plan specific to North Dakota Nursing Facilities, as well as one additional indicator will be tracked:

1. Nursing Home Facility penetration rates of residents with Medicaid coverage in comparison to private pay residents (monitor);
2. Medicaid beneficiary survey data regarding timely access to primary and specialty care providers (monitor); and
3. Quality of Care as measured by three identified quality indicators (track).



Nursing facilities SFY 2012 through SFY 2016: Total bed occupancy vs. Medicaid bed occupancy

In North Dakota over the past five years (SFY 2012 through SFY 2016), both the number of and percentage of nursing facility beds occupied by Medicaid recipients has remained stable, with a five year average population of 2,910 Medicaid residents, which averages to 51.42% Medicaid occupied beds in comparison to total beds.

North Dakota has an ongoing moratorium on additional nursing home beds, and has rate equalization* between Medicaid and private pay rates, both of which lend to the present stability of the bed-related data.

While the data demonstrates a month by month churning of occupancy data, the annual numbers have been remarkable stable, with the statewide annual change in total Medicaid beneficiary residents ranging from an annual increase of 26, to a one year decline of 87. The variation in total beds has ranged from an increase of 49 to a decline of 65, suggesting that both metrics have remained steady.

*North Dakota has a state law called "equalized rates". This law prohibits private pay residents of nursing facilities from being charged more than the Medicaid rate. While the decision to include nursing facility rates in the allotment savings plan was not made lightly, the North Dakota equalized rate law would ensure Medicaid clients and private pay clients are on "equal footing" in terms of consideration for nursing facility admissions.

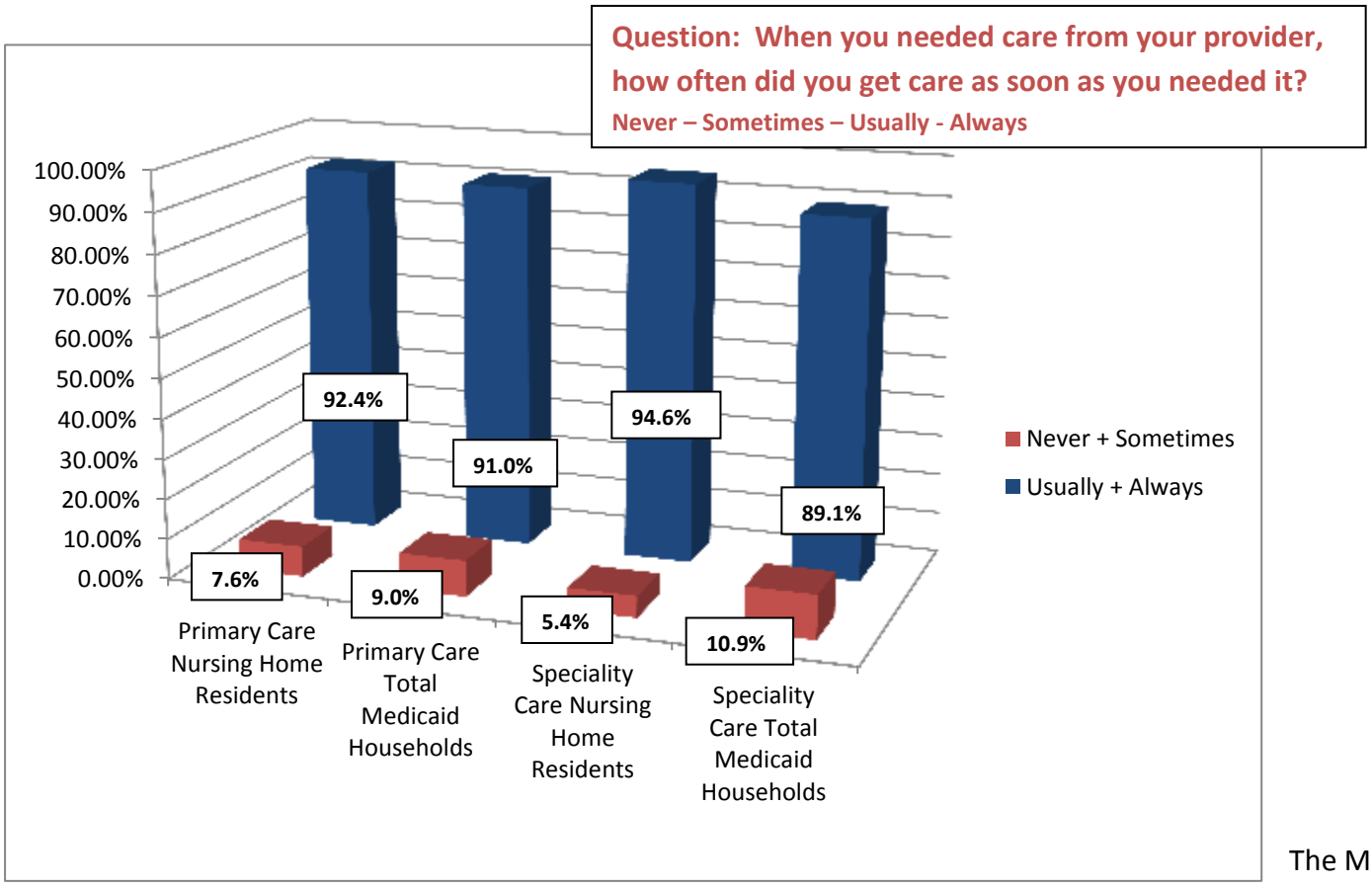
Penetration rate threshold

Based on this five year trend line, it is hypothesized that an annual decline in the relative number of Medicaid beneficiary residents of 5.0% or greater (approximately 150 residents) would be a likely data anomaly, particularly if the "total beds" do not reflect a comparable change. If the 5.0% Medicaid occupied bed decline threshold of residents is exceeded, Medical Services Division staff will analyze the data for variables that may be driving the data change, including the potential contribution of the January 1, 2017 rate modification impact. Other potential variables that could drive changes in Medicaid occupancy data include changes at the national level that impact admissions or reimbursement formulas, or changes at the state level such as an expansion of Home and Community Based Services.

If a 5.0% Medicaid occupied bed decline is identified, and analysis concludes attribution to the January 2017 rate modification, a plan of correction will be advanced. (Note: no national benchmarks exist to our knowledge that can be used to establish or compare to an all-state threshold for Medicaid beneficiary vs. total bed occupancy pertinent to access to nursing home admissions. Until such national benchmarks exist, establishing access to care thresholds will continue to be highly variable one state to the next).

North Dakota Medicaid Household Beneficiary Survey

ACCESS TO CARE: Comparison of Primary Care and Specialty Care
Nursing Home Medicaid Residents vs. All Medicaid Households



The Medical

Services Division conducted an access to care survey of traditional fee for service Medicaid households in September through November 2016. Six thousand six hundred and seventy nine (6,679) households from across North Dakota responded, with surveys received from Medicaid beneficiaries residing in all of North Dakota's 53 counties.

While the survey did not specifically identify nursing home residency, seventy five (75) Medicaid beneficiaries or their personal representatives identified nursing home residency within the survey comment section. The responses from nursing facility residents establishes an initial statewide baseline snapshot regarding access to care of Medicaid beneficiary responders residing in nursing facilities.

In describing the survey outcomes, the chart above indicates:

- that a significant number of Medicaid household responders receive timely access to care from both primary care and specialty care providers;
- that the majority of Medicaid beneficiary responders who reside in North Dakota's nursing homes receive even more timely access to care from primary care and specialty care providers.

Access to care threshold

Disclaimer: The Beneficiary Survey results reflect a point in time snapshot of what 6,679 Medicaid households are reporting about their access to care experiences as of November 2016; the access to care data is not generalizable to all North Dakota Medicaid beneficiaries or households. The same limitation is true of the 75 nursing home residents and is not generalizable to the access experiences of all Medicaid residents of North Dakota nursing homes.

An additional beneficiary survey will be initiated prior to the October 2019 submission of the AMRP, and the identified access to care threshold will be that nursing home residents or their personal representatives who respond to the survey will report that access to primary care and to specialty care will continue to be as good as or better than the total survey responders access to care experiences to those two provider groups.

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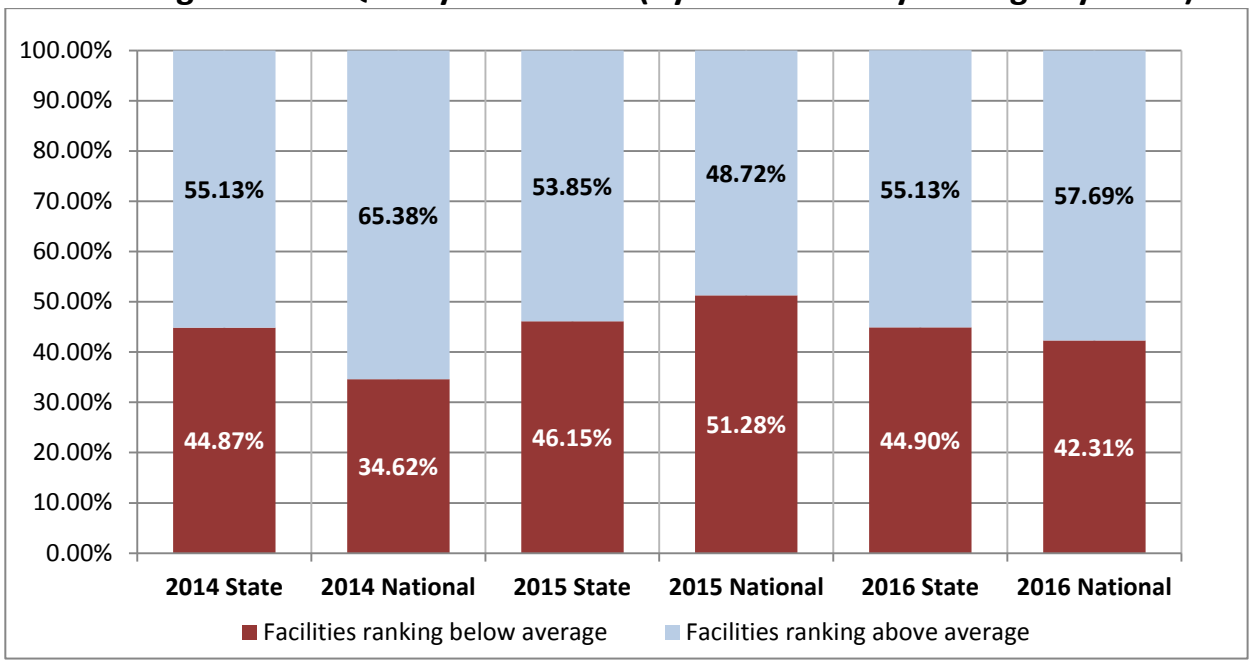
North Dakota Nursing Facilities:

Tracking of Three Quality Indicators[1] (By All ND Facility Average by Year[2])



This Chart compares the percentages of North Dakota Nursing Facilities that rank above and rank below the average performance, both within state and nationally, for three combined quality indicators, across years 2014, 2015, and 2016.

Quality Indicators[1] Identified for Tracking Are:

- Percent of High Risk Long Stay Residents with Pressure Ulcers
- Percent of long Stay Residents with Urinary Tract Infection
- Percent of Long Stay Residents Experiencing One or More Falls with Major Injury

1. The three quality indicators are taken from the Medicare.gov Nursing Home Compare Website
2. Above Average and Below Average percentiles are determined by comparing individual North Dakota facility rankings of the 3 indicators to: a.) state indicator average compared to Individual North Dakota Nursing Facilities; and b.) national indicator average compared to individual North Dakota Nursing Facilities.
3. Disclaimer: while North Dakota nursing facility licensure and regulations promote facility similarities that allow improved comparisons one facility to the next, national comparisons may not be as uniform because each state approaches licensing and regulations differently; the national-level comparison has the benefit of adding a broader benchmark to the comparative data.

The composite of the 3 quality indicators will be tracked annually but not monitored; that is, no data threshold is identified specific to access monitoring.

Nursing facility staffing concerns will not be tracked or monitored within the AMRP

Public comment included feedback that staffing is already a challenge to some nursing facilities, and concern was verbalized that allotment impact may further exacerbate hiring and retention.

The original North Dakota AMRP explored a wide array of staffing challenges across the state, including frequent references to the *University of North Dakota School of Medicine and Health Sciences Third Biennial Report – 2015*. Staffing is a concern across multiple provider groups and diverse health care facilities, and the UND biennial report discusses staffing dynamics and complexities in considerable detail, some of which are referenced in the original AMRP, including heightened rurality challenges and a differential dispersion along rural vs. urban locations, competition among facilities seeking to hire from a limited pool of candidates, competition with manufacturing and oil industry vacancies, and other variables.

DHS concludes that staffing is a highly complex indicator in North Dakota with many contributing variables, such that separating out allotment rate impact from other contributors is difficult. Obtaining staffing details and trends for nursing facilities on an annual basis involves a substantial work effort, let alone monitoring staffing for other provider groups as well. We conclude that staffing will not be a monitoring or tracking indicator for all of these reasons, as well as that DHS does not have the resources to monitor staffing dynamics of provider groups, nor is this a DHS core function.

On a positive note, the recently released University of North Dakota School of Medicine and Health Sciences *4th Biennial Report: Health Issues for the State of North Dakota - 2017* includes a new component, specifically a detailed analysis of North Dakota Nursing Facility staffing dynamics and challenges. The detailed analysis of Nursing Facility workforce trends specific to 24 staff categories can be found in Chapter 5 of the biennial report, starting on page 55. This report can be accessed at: http://www.med.und.edu/biennial-report/. The results of the survey are summarized as follows:

The UND Biennial Report – 2107 indicates (direct quotes are in italics)
NORTH DAKOTA NURSING FACILITY WORKFORCE SURVEY
In September 2016, the Center for Rural Health, in collaboration with the North Dakota Long Term Care Association, performed a workforce survey of all of North Dakota's nursing facilities. Center for Rural Health staff modeled the questionnaire after one previously used in the state of Washington. The questionnaire was modified based on feedback from North Dakota nursing facility chief executive officers (CEOs), North Dakota Long Term Care Association staff (i.e., CEO Shelly Peterson and Executive Assistant Carol Ternes), and Center for Rural Health staff. The questionnaires were sent to all 81 rural and urban nursing facility CEOs who met the eligibility criteria. All 81 CEOs were asked to participate by filling out a mailed paper workforce questionnaire. The questionnaire included 20 questions, one of which involved asking for staffing information (e.g., number of full-time equivalent internal employees and contract employees, longest vacant position by employee types, and difficulty in recruiting by employee type for 24 nursing facility employee types). Other questions inquired about CEO turnover, employee turnover rates, difficulty recruiting and retaining nurses, external service contracting, and overtime and salary information. The data included in this report are for 95.1% of the nursing facility locations (77 of 81 locations).

Limitations

While the findings from the 2016 North Dakota Nursing Facility Workforce Survey tell us much about the nursing facility workforce, they may not be generalizable to all of North Dakota's providers (e.g., those registered nurses [RNs] working in short-term hospitals, physician clinics, and so forth). Caution should be taken in interpreting the

data findings because some vacancy rates are based on relatively small numbers of employees (e.g., regional rates for employee types that are not numerous even at the state level). For example, regional (e.g., southwest) and rural/urban vacancy rates for NPs and PAs should be viewed with caution.

Nursing Facility Workforce Survey Results Summary

The North Dakota Nursing Facility Workforce Survey provides a snapshot of nursing facility workforce as of September 2016 that includes data from nearly all of North Dakota's nursing facilities. The findings show that the vacancy rates across the 24 provider types are not excessively high. The highest rates are only moderately high and, considering the numbers of employees in the type categories, are most concerning for CNAs, RNs, and LPNs. NP and PA vacancy rates are high, but the numbers of FTEs are low (36.7 and 12.9).

Clearly, the largest components of the nursing facility workforce are nurses (RNs, LPNs, and CNAs), dietary staff, housekeeping staff, activity staff, nurse managers, and business office staff. Clinical-provider vacancy rates were most often higher in North Dakota's rural areas than in urban areas.

All in all, the nursing facility CEOs reported that they currently employed 7,550.9 FTE personnel (not counting FTE vacancies). Many times, nursing facilities are one of the largest employers in North Dakota's rural towns. North Dakota's total vacant positions at nursing facilities as of September 2016 was 582.3 FTEs for an overall employee vacancy rate of 7.2%.1 The vacancy rates for nurses and a few other employee types are higher.

Further staffing details can be viewed on Chapter 5 of the UND 2017 Biennial Report. We anticipate an additional Biennial report may be available prior to the submission of the North Dakota AMRP in 2019 although it is not certain whether an additional nursing facility workforce analysis will be integrated in to that document.

Appendix 2 Detail

North Dakota Medicaid Household Beneficiary Survey Results

The beneficiary survey results are being presented in two summary formats:

Format # One: The high-level survey results are summarized at the end of this Appendix in a three page format that breaks out survey detail by each of the 5 health care provider groups identified for access monitoring: primary care; specialty care; behavioral health care; obstetric care; and home health care, including:

1. The number of responses by county, by region, by Frontier County vs. Non-Frontier County, and by each provider group.
2. Results of all 12 survey questions are documented by number of Beneficiary Household Responses and by Timely Access Percentile (see Appendix J on page 107 of the original Access Monitoring Review Plan to review the survey, or view survey in the home page of the Executive Summary of the Format # 2 described and hyperlinked below).
3. The survey format essentially asked:
    a. County of residence
    b. Asked two questions specific to each of the 5 provider groups: 1. frequency of health care contacts by provider group during the recent six months, and 2. Timeliness of access inquiring whether care was received as soon as was needed, along a Likert Scale of Never – Sometimes – Usually – Always.
    c. Question # 12 asked responder to: "Please check all that impacted you or your family members' ability to access (health care) services. The survey responder was offered 10 variables to consider.

4. The survey additionally offered: a small comment box to add detail; (offered) the option of completing the survey on-line; and identified an email address that allowed sharing of more narrative details, if needed.

Format # Two: In addition to the high-level data summary described above, the survey details have been plotted into an interactive **Story Map** format that presents additional survey results detail, combining narrative, GIS heat mapping by individual county, and bar charts.
There are multiple heat maps for each provider group, and the map is interactive, for example the user can click on an individual county to view a pop-up that displays the county population, as well as view pop-up numerical and bar chart data by individual county for each of the provider groups.

Rurality: While 6,679 Medicaid households responded to the survey, the "by total" and "by county" response numbers decline for some of the provider groups. Primary Care and Specialty Care have larger numbers; Behavioral Health Care more moderate numbers, and Obstetrics and Home Health Care have small response rates, so for these latter three providers, data is further broken out by aggregate data summaries of all counties that had a response rate of 10 or fewer responders for each provider group. That is, the user can view each county response rate for each provider by percentile and bar chart breakout, but also see aggregate data for the more rural and frontier counties.

There is also a slide bar option to view two presentations of "top box" indicators, meaning those indicators that highlight county response rates that stand out as notable for positive and timely access to care. The user grabs the slide bar with their computer mouse, and by moving the bar, can switch view between one view of all counties that submitted 100% Usually + Always responses (0 Never and Sometimes responses) by each county for each provider, and by sliding the bar to the other side of the map, can view a heat map of all counties that had no "Never" responses for each provider; that is in response to the question: "How often did your household get care as soon as you needed it", no one in the county had responded "Never".

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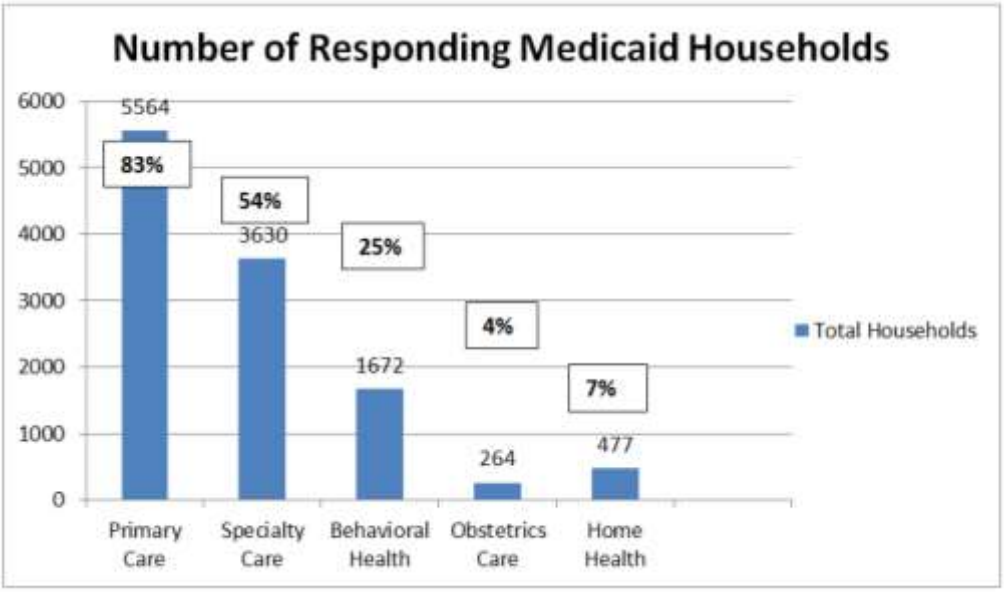
This graph summarizes the number and percentile of Medicaid household responses by each provider group.



This chart describes the number of Medicaid households who indicated that one or more Medicaid recipients in their family met with the identified provider within the past six months.

The frequency of contact with primary care providers is very positive, in that primary care access is a broad goal in North Dakota, and the data is suggestive that the majority of Medicaid households who responded to this survey are able to access this provider group with an overall good access to care rate.

While frequency of access to specialty care is lower, the access is also positive, in that often primary care providers can manage an array of health care services, but access is sometimes critical with specialists when appropriate.

Response rate is more moderate for volume of contact with behavioral health care providers, and much lower for obstetric care and home health care. The lower numbers require more caution interpreting the data, because with small numbers, small changes can result in large impact on data and percentiles. To balance this dynamic, each of the 3 providers have an additional analysis that can be viewed in the story map version of the data, such that in addition to "by individual county detail", a graph and data analysis is also available that summarizes aggregate comparisons of all counties that had 10 or fewer total responses for each of these three providers.

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MEDICAID HOUSEHOLD BENEFICIARY SURVEY - NDDHS SUMMARY RESULTS

1. County we live in:

Adams	35
Barnes	166
Benson	76
Billings	7
Bottineau	95
Bowman	38
Burke	24
Burleigh	708
Cass	1,050
Cavalier	45
Dickey	59
Divide	15
Dunn	27
Eddy	44
Emmons	61
Foster	34
Golden Valley	15
Grand Forks	459
Grant	49
Griggs	35
Hettinger	21
Kidder	25
LaMoure	42
Logan	38
McHenry	70
McIntosh	45
McKenzie	28
McLean	98
Mercer	78
Morton	266
Mountrail	37
Nelson	54
Oliver	20
Pembina	84
Pierce	52
Ramsey	182
Ransom	70
Renville	30
Richland	128
Rolette	145
Sargent	31
Sheridan	32
Sioux	62
Slope	8
Stark	266
Steele	16
Stutsman	258
Towner	22
Traill	75
Walsh	149
Ward	552
Wells	85
Williams	190
Unknown	378
TOTAL:	**6,679**

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, how many times have you and family members covered by Medicaid seen a primary care provider?

Responses	Option		Percent
1,082	None	→ *Go to question 4*	16.2%
1,320	1 time		19.8%
1,341	2 times		20.1%
981	3 times		14.7%
682	4 times		10.2%
886	5 to 9 times		13.3%
387	10 or more times		5.8%
6,679	TOTAL		100.0%

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?

Responses	Option		Percent	Percent	Option	Combined
83	Never		1.2%	1.5%	Never	9.0%
420	Sometimes		6.3%	7.5%	Sometimes	
1,584	Usually		23.7%	28.5%	Usually	91.0%
3,477	Always		52.1%	62.5%	Always	
1,076	Question Not Applicable		16.1%			
39	Didn't Provide a Response		0.6%			
6,679	TOTAL	5,564 TOTAL	100.0%	100.0%		100.0%

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?

Responses	Option		Percent
2,998	None	→ *Go to question 6*	44.9%
1,370	1 time		20.5%
867	2 times		13.0%
556	3 times		8.3%
343	4 times		5.1%
388	5 to 9 times		5.8%
157	10 or more times		2.4%
6,679	TOTAL		100.0%

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?

Responses	Option		Percent	Percent	Option	Combined
71	Never		1.1%	2.0%	Never	10.9%
323	Sometimes		4.8%	8.9%	Sometimes	
1,033	Usually		15.5%	28.5%	Usually	89.1%
2,203	Always		33.0%	60.7%	Always	
2,969	Question Not Applicable		44.5%			
80	Didn't Provide a Response		1.2%			
6,679	TOTAL	3,630 TOTAL	100.0%	100.0%		100.0%

1. County we live in:

Adams	35
Barnes	166
Benson	76
Billings	7
Bottineau	95
Bowman	38
Burke	24
Burleigh	708
Cass	1,050
Cavalier	45
Dickey	59
Divide	15
Dunn	27
Eddy	44
Emmons	61
Foster	34
Golden Valley	15
Grand Forks	459
Grant	49
Griggs	35
Hettinger	21
Kidder	25
LaMoure	42
Logan	38
McHenry	70
McIntosh	45
McKenzie	28
McLean	98
Mercer	78
Morton	266
Mountrail	37
Nelson	54
Oliver	20
Pembina	84
Pierce	52
Ramsey	182
Ransom	70
Renville	30
Richland	128
Rolette	145
Sargent	31
Sheridan	32
Sioux	62
Slope	8
Stark	266
Steele	16
Stutsman	258
Towner	22
Traill	75
Walsh	149
Ward	552
Wells	85
Williams	190
Unknown	378
TOTAL:	**6,679**

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?

Responses	Option		Percent
4,980	None	→ *Go to question 8*	74.6%
491	1 time		7.4%
387	2 times		5.8%
219	3 times		3.3%
140	4 times		2.1%
250	5 to 9 times		3.7%
212	10 or more times		3.2%
6,679	TOTAL		100.0%

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?

Responses	Option		Percent	Percent	Option	Combined
49	Never		0.7%	2.9%	Never	12.1%
153	Sometimes		2.3%	9.2%	Sometimes	
499	Usually		7.5%	29.8%	Usually	87.9%
971	Always		14.5%	58.1%	Always	
4,938	Question Not Applicable		73.9%			
69	Didn't Provide a Response		1.0%			
6,679	TOTAL	1,672 TOTAL	100.0%	100.0%		100.0%

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?

Responses	Option		Percent
6,411	None	→ *Go to question 10*	96.0%
74	1 time		1.1%
35	2 times		0.5%
38	3 times		0.6%
15	4 times		0.2%
57	5 to 9 times		0.9%
49	10 or more times		0.7%
6,679	TOTAL		100.0%

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?

Responses	Option		Percent	Percent	Option	Combined
8	Never		0.1%	3.0%	Never	12.5%
25	Sometimes		0.4%	9.5%	Sometimes	
57	Usually		0.9%	21.6%	Usually	87.5%
174	Always		2.6%	65.9%	Always	
6,356	Question Not Applicable		95.2%			
59	Didn't Provide a Response		0.9%			
6,679	TOTAL	264 TOTAL	100.0%	100.0%		100.0%

1. County we live in:

Adams	35
Barnes	166
Benson	76
Billings	7
Bottineau	95
Bowman	38
Burke	24
Burleigh	708
Cass	1,050
Cavalier	45
Dickey	59
Divide	15
Dunn	27
Eddy	44
Emmons	61
Foster	34
Golden Valley	15
Grand Forks	459
Grant	49
Griggs	35
Hettinger	21
Kidder	25
LaMoure	42
Logan	38
McHenry	70
McIntosh	45
McKenzie	28
McLean	98
Mercer	78
Morton	266
Mountrail	37
Nelson	54
Oliver	20
Pembina	84
Pierce	52
Ramsey	182
Ransom	70
Renville	30
Richland	128
Rolette	145
Sargent	31
Sheridan	32
Sioux	62
Slope	8
Stark	266
Steele	16
Stutsman	258
Towner	22
Traill	75
Walsh	149
Ward	552
Wells	85
Williams	190
Unknown	378
TOTAL:	6,679

GETTING HELP FROM A HOME HEALTH 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?

Responses	Option		Percent
6,199	None	→ *Go to question 12*	92.8%
73	1 time		1.1%
55	2 times		0.8%
49	3 times		0.7%
33	4 times		0.5%
84	5 to 9 times		1.3%
186	10 or more times		2.8%
6,679	TOTAL		100.0%

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?

Responses	Option		Percent	Percent	Option	Combined
19	Never		0.3%	4.0%	Never	11.7%
37	Sometimes		0.6%	7.8%	Sometimes	
109	Usually		1.6%	22.9%	Usually	88.3%
312	Always		4.7%	65.4%	Always	
6,142	Question Not Applicable		92.0%			
60	Didn't Provide a Response		0.9%			
6,679	TOTAL	477 TOTAL	100.0%	100.0%		100.0%

ACCESS TO SERVICES

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

4,673	We have had no problems accessing healthcare
796	We have not seen any health care provider within the past 6 months
302	Some provider(s) are not accepting ANY new referrals
476	Some provider(s) are not accepting Medicaid referrals
651	Some provider(s) offices are far from my home
473	Appointments are not timely
302	We have been hesitant to schedule because of copays or recipient liability
644	Transportation is difficult
108	Have used telemedicine and found it helpful
1,011	A provider we work with helped with referrals or coordination of care

9,436 TOTAL
6,392 TOTAL UNIQUE RECIPIENTS THAT ANSWERED AT LEAST ONE

COUNTS BY REGION AND COUNTY DESIGNATION

Region I - Northwest	233	3.5%
Region II - North Central	860	12.9%
Region III - Lake Region	514	7.7%
Region IV - Northeast	746	11.2%
Region V - Southeast	1,370	20.5%
Region VI - South Central	762	11.4%
Region VII - West Central	1,399	20.9%
Region VIII - Badlands	417	6.2%
UNKNOWN	378	5.7%
TOTAL:	6,679	100.0%

FRONTIER	1,475
NON-FRONTIER	4,826
UNKNOWN	378
TOTAL:	6,679