



North Dakota

Medicaid Expansion and Federally Facilitated Marketplace Change Management Project

Assessment of Stakeholder Needs for Training, Education & Outreach

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Project Overview

In March 2010, the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 were signed into law. The two laws are collectively referred to as the Affordable Care Act (ACA). The ACA provides grant funding to assist states in planning, developing and implementing parts of the ACA.

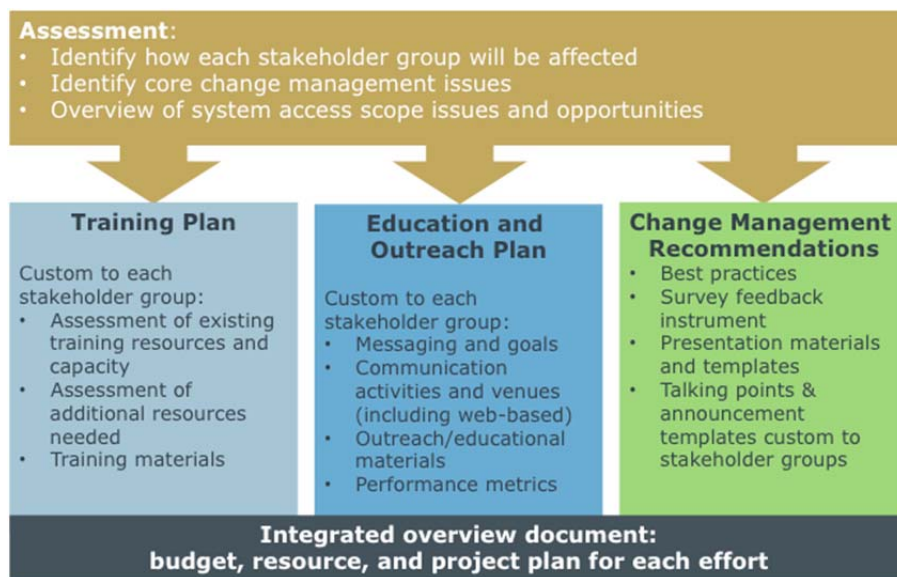
The ACA – and subsequent action by the North Dakota State Legislature during the 2013 session – introduced a range of impacts to North Dakota’s healthcare market, including Medicaid expansion and the decision to utilize the Federally Facilitated Marketplace (FFM) rather than build a state marketplace. The Federally Facilitated Marketplace is an online marketplace where individuals and small businesses can purchase health insurance. To improve the Medicaid eligibility process and integration with the FFM, the State is building a new Medicaid eligibility and enrollment system, which will be rolled out in phases over the next several years. In addition, the State will be integrating the Economic Assistance programs (Basic Care Assistance Program, Child Care Assistance Program, Low Income Home Energy Assistance Program, Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families program). To support the transitions associated with these marketplace changes, the State of North Dakota hired HTMS, a management consulting firm, to provide a number of change management services, including an assessment of stakeholder needs, which is summarized in this report.

The goals of the stakeholder assessment are to identify how key stakeholder groups are affected by ACA implementation and the Medicaid expansion, and the core change management issues that will need to be addressed to support the smooth transition to the new processes for securing private and public health coverage.

This stakeholder assessment provides the foundation for additional services to be performed as part of this project, including the development of an education and outreach plan, a training plan specific to key external stakeholders, and change management recommendations.

The components of this project, and their relation to one another, are depicted in Diagram 1.

Diagram 1: Project overview



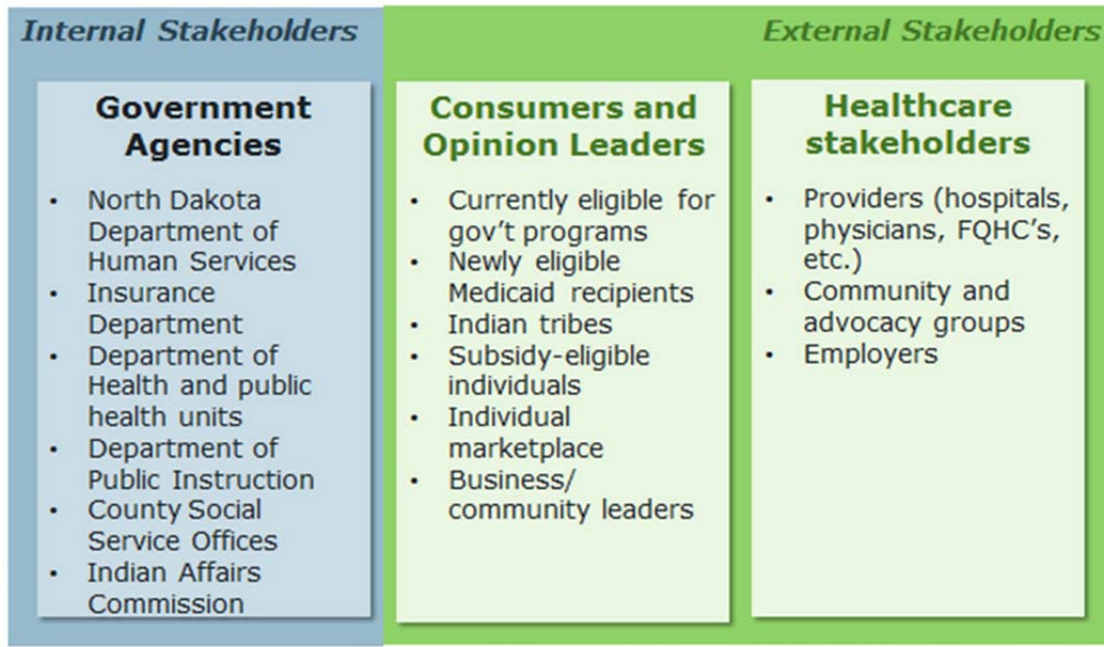
Methodology

To conduct this assessment, the project team:

- Reviewed secondary sources related to Medicaid expansion and eligibility determination changes, Health Insurance Marketplaces, efforts underway in other states, and data and information specific to the State of North Dakota;
- Met with various State departments and subject matter experts to determine critical stakeholders;
- Developed a research plan and interview schedule as an output to those meetings;
- Established an aggressive schedule to meet with numerous stakeholders in a short period of time (interviews and group meetings were conducted throughout the month of June 2013);
- Developed interview guides for each stakeholder group, including a standard set of questions for all interested parties, and targeted questions specific to the needs of particular groups;
- Conducted meetings and tested messaging themes in early July with internal and external stakeholders, including State residents that access public programs related to low income assistance, mental health, and addiction;
- Documented notes from all meetings and then filtered through findings to identify common themes, differences of opinions, gaps, and best practices; and
- Documented summarized findings so they could be used as inputs for developing the training plan for state, county, and other government employees, as well as for training, education and outreach specific to advocacy organizations and other partners, as well as North Dakotans at large.

The stakeholder groups interviewed included representatives from the following categories of stakeholders depicted in Diagram 2.

Diagram 2: Stakeholders



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ACA Context and Background

The ACA has many provisions within it related to various topics. This section is designed to give an overview of the two aspects of the ACA that directly impact this project: Medicaid expansion and the Federally Facilitated Marketplace. The following sections related to Medicaid expansion are borrowed from CMS and the State Health Reform Assistance Network resourcesⁱ.

Medicaid Expansion

Effective January 2014, all individuals under 65 years of age with income below 138 percent of the federal poverty level (FPL) will be eligible for Medicaid. While the Supreme Court upheld this provision of the ACA during the summer of 2012, it also limited the federal government's ability to penalize states for noncompliance, effectively making the expansion optional to states. North Dakota Governor Jack Dalrymple signed House Bill 1362 into law in April 2013. This new law authorizes North Dakota to participate in the Medicaid expansion program until July 31, 2017, when federal government match payments drop from 100 percent to 95 percent.

State compliance with ACA Medicaid requirements involves a number of tasks across five dimensions: eligibility and enrollment, Medicaid operations, Medicaid financing, Medicaid benefits, and consumer assistance. There are several specific provisions related to eligibility and enrollment that are summarized below. This summary is not intended to be a comprehensive overview of Medicaid changes in the ACA, but rather to highlight the key items that directly impact the scope of this project.

Enrollment Processes and Applications

The ACA requires a streamlined, automated enrollment process. Currently, North Dakota county eligibility workers use as many as five different antiquated Information Technology applications – developed and maintained by the State – when processing enrollment.

The ACA requires changes to Medicaid enrollment through both the application used and the application process overall. The ACA requires a single application form that an individual can submit to apply for all insurance affordability programs (IAPs), which includes Medicaid, the Children's Health Insurance Program (CHIP), and subsidized qualified health plans (QHPs) offered through a Federally Facilitated Marketplace. States must also comply with the "no wrong door" policy and be able to receive the application online, by mail, by phone, or in person through county social service agency.

States will be required to determine eligibility based upon a modified adjusted gross income (a MAGI standard), and cannot require an in-person interview. States may not ask for additional verification of information from the client if the information is already available electronically.

Income Eligibility

The current rules for calculating income to determine Medicaid eligibility vary from state to state. Under ACA provisions, modified adjusted gross income (MAGI), as defined in the Internal Revenue Code §36B(d)(2), will be used to determine eligibility for MAGI households, standardizing the calculation of income across the nation. The overall goals of the MAGI-based methodology are to align financial eligibility rules across all insurance affordability programs, support a seamless and coordinated system of eligibility and enrollment, and maintain the eligibility of low-income populations, especially children.

States will need to adopt the MAGI-based income methodology for most non-elderly, non-disabled individuals applying for Medicaid. States will need to determine an applicant's projected annual income by using tax documents and other data sources to verify current income or annual budgets to determined projected annual income. Asset tests, income disregards, and deductions will no longer be allowed for the MAGI population.

States must maintain the eligibility for those individuals enrolled in Medicaid as of January 1, 2014, who would otherwise become ineligible due to the new MAGI rules, through the later of either March 31, 2014 or the date of their scheduled renewal. States will need to convert existing children, parent /caretaker and pregnant women groups to new MAGI-based levels using a CMS-approved formula. Each of these four groups has some exceptions to MAGI-based eligibility determinations. States are also barred from counting certain types of income earned by American Indians and Alaskan Natives as part of their income eligibility determination.

Coordination with Marketplace

State Medicaid agencies must enter into agreements with Marketplaces that clearly delineate the responsibilities of each program to minimize the burden on individuals, ensure compliance with federal requirements, and ensure compliance with timeliness standards for eligibility decisions.

Presumptive Eligibility

States must allow "qualified" hospitals to make PE decisions. CMS is proposing to clarify that states can be reimbursed for either claims or administrative costs incurred for individuals enrolled through PE methods.

Federally Facilitated Marketplace (FFM)

Rather than create its own health insurance marketplace, the State of North Dakota has opted to participate in the federal government's Federally Facilitated Marketplace. The FFM allows individuals and small business to purchase health insurance. It will be the only place where federal tax credits or subsidies may be used to purchase health insurance. The goals of the FFM are to enable the comparison of qualified marketplace health plan options, facilitate the purchase of and enrollment into qualified health plans (QHPs), reduce transaction costs, increase transparency, and use the power of a large risk pool to generate competition for the individual marketplace.

Open enrollment for the FFM will begin on October 1, 2013 with coverage in effect for individual January 1, 2014. Coverage will be available to small business through the Small Business Health Options Program (SHOP) beginning in 2015.

While the FFM will be a marketplace for individuals and small businesses to purchase insurance, the FFM may also become the focal point for people who are accessing subsidies from the federal government. For example, individuals whose income is between 133%-400% of the FPL may be eligible for subsidies for their coverage through a tax credit. For a two-year period, credits will also be available to qualifying small businesses to offset the cost of benefits of providing health benefits to employees subject to certain conditions. Health insurance companies can continue to sell plans independent of the FFM, also subject to certain conditions.

Qualified Health Plans (QHPs)

All QHPs that sell health benefit programs on the FFM, are to provide coverage at four "precious metal" categories (platinum, gold, silver and bronze) that correspond to different actuarial levels. This is designed to enable consumers to compare plans with similar levels of coverage, promote competition on premiums, and allow plans flexibility in designing cost sharing structures. QHPs are required by the ACA to provide coverage for the following ten essential health benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder treatment, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices

- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

QHPs must also follow established limits on cost sharing and meet additional criteria related to product design, pricing, sales and distribution, and enrollment and eligibility.

Consumer Assistance

To help consumers understand and enroll into a QHP, the United States Department of Health and Human Services (HHS) has established a grant program to fund entities or individuals to provide assistance through a Navigator program. Navigators will provide consumer assistance through the following mechanisms:

- Maintaining expertise on Marketplaces
- Providing information to consumers in a fair, accurate, and impartial manner
- Facilitating QHP selection
- Referring consumers to other resources
- Providing information in a culturally and linguistically appropriate manner

Native American Population

Under the ACA, the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA) authorizes new programs within Indian Health Services (IHS) designed to raise the health status of American Indians and Alaska Natives. It also establishes the IHS as the payer of last resort for these populations.

3 Overview of North Dakota Demographics

North Dakota, with a population of 699,628, is among the states with the smallest population in the country, second only to Wyoming. It is also one of the most rural states in the country, with an average of 9.7 persons per square mile compared to 87.4 for the United States.ⁱⁱ The size of the population and the rural nature of the state have implications for any potential outreach and education efforts related to Medicaid expansion and ACA implementation.

Sixty one percent of North Dakota’s population (approximately 400,000 people) is between the ages of 19-64ⁱⁱⁱ, the age group that will be most directly impacted by coverage options associated with Medicaid expansion and/or the FFM.

While North Dakota’s population is a fairly homogenous overall (84% of its population is White^{iv}), 5% of the population is Native American^v. More than half (54.6%)^{vi} of the Native American population lives on reservations, which are located in rural areas. Notably, 18%^{vii} of the uninsured population in North Dakota is Native American and face unique barriers to coverage, including financial barriers, a lack of understanding of how insurance works, a lack of trust in insurance companies and in government programs, and access/eligibility issues^{viii}. Any education and outreach efforts to this population will require special considerations to overcome existing access issues.

North Dakotans, in general, are less likely to be poor compared to residents of surrounding states and the United States as a whole. This is derived from per capita average income data from the Census Bureau. ND leads the nation in growth in per capita personal income. While this is the case, there are some counties in North Dakota with a large percentage of the population living in poverty as summarized in Table 1^{ix}:

Table 1

North Dakota Counties % Living in Poverty	
Sioux	47.2%
Benson	35.6%
Rolette	31.8%
Sheridan	18.9%
Kidder	17.9%
Grand Forks	17.5%
Mountrail	16.5%
Emmons	16.1%
Divide	14%

These counties, and others with a majority of their residents under 138% FPL, may see a significant increase in the number of people eligible for Medicaid as a result of the program’s expansion. These counties are also likely to see higher subsidies and cost sharing amounts through the FFM than counties with a higher percentage of residents in the higher FPL ranges.

With more than 75% of its population having access to the Internet, and almost 50% of its population using Facebook, the Internet and social networking

sites offer an additional channel for potential outreach and education to North Dakotans. In addition, as the number of wireless phones (525,000 in 2013) in North Dakota increases (+18% versus 2012) and the number of landlines (255,000 in 2013) decreases (-10% versus 2012)^x, the number of North Dakotans

The lack of telephone landlines represents another consideration – mainly a barrier – for any potential communications efforts.

At the same time, the ubiquity of mobile phone ownership means that newer tactics, such as text messaging, may be needed to get information out to large numbers of residents and should be considered.

with Internet access will likely continue to increase.

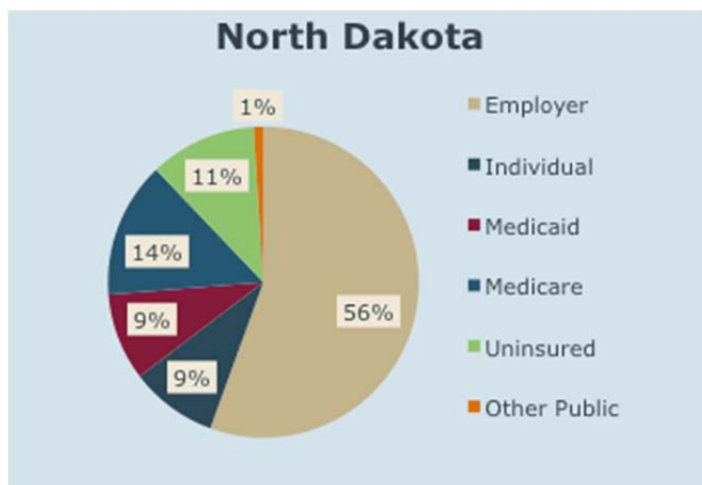
When compared to the rest of the country, North Dakotans are more likely to be covered through employer-sponsored insurance (ESI) than through individual or government sources (56% in North Dakota compared to 49% in the United States). A summary of insurance coverage for North Dakota is provided in Diagram 3^{xi}:

Diagram 3

As a result of Medicaid expansion and the integration to the FFM, the number of uninsured is likely to be significantly reduced, while the number of Medicaid enrollees and those with individual coverage are likely to significantly increase.

With just over 75,000 Medicaid enrollees (enrollment numbers vary based on source and year; it has been communicated that the current enrollment number is closer to 66,000

lives)^{xii}, North Dakota currently has the lowest Medicaid enrollment in the country. North Dakota is also expected to experience one of the highest percent increases in enrollment among states due to Medicaid expansion. While estimates vary on the number of new Medicaid enrollees, these estimates from a number of external sources generally fall between 20,000-42,000 lives (a 25-55% increase), as detailed in the table below. Variables driving this uncertainty include a range of factors, such as the likely uptake of the following groups:



- **Newly eligible:** Those who become newly eligible for Medicaid due to the new income-based eligibility rules up to 138% FPL (previously 100% of FPL for most individuals).

- **Woodwork Group:** Those who are already eligible according to current rules, and have not previously applied. It is believed some in this group will apply due to the ACA attention, thus, these people are known to be coming out of the ‘woodwork’.

These uncertainties introduce challenges to forecasting staffing requirements and enrollee numbers specific to Medicaid expansion. Please see Table 2.

Table 2: Estimates of Newly Eligible

Source	Estimate	Additional Notes
Center on Budget and Policy	32K	29K are currently uninsured <ul style="list-style-type: none"> • 24K of those are newly eligible; • 5K of those are eligible today, but not enrolled
BCBS of ND	20K	Specific to those currently ineligible for Medicaid
State of North Dakota	20K	As derived from Maggie Anderson’s testimony on House Bill 1362 on March 13 th 2013
Urban Institute (2012)	42K	Refers to new enrollment only
Referenced from Interviews	20-40K	Various interviewees referenced expected enrollment numbers

A number of variables, including the following, drive the variation in enrollment estimates:

Timing: Whether there is any delay for implementation of required elements (delays include later start date, extended open enrollment period, phased capabilities, etc.);

Effectiveness of communications: The effectiveness and reach of state-specific marketing efforts to drive awareness and enrollment in Medicaid;

Regulations: Legislative action or guidance by CMS or state authorities could shift the impact and potential results of the number of eligible and enrolled lives.

4 Stakeholder Needs Assessment

To assess the needs of critical stakeholders and identify audiences for outreach and educational purposes, HTMS conducted extensive information gathering meetings – in-person and by telephone – with a broad range of State and County agencies, provider organizations and professional associations, as well as special interest and advocacy organizations.

Some of the specifics included:

- Meeting with various State departments and subject matter experts to determine critical stakeholders (e.g. DHS, Insurance Department, Department of Health, Indian Affairs Commission);
- Developing a research plan and interview schedule as an output from those discussions;
- Meeting with more than 100 internal and external stakeholders in Bismarck, Fargo and other areas around the State (e.g. health providers, advocacy organizations, county eligibility workers, business groups, professional associations, DHS regional human service centers, etc.); and
- Summarized findings and extracted key takeaways relevant to the scope of the project.

Findings - Internal Stakeholders

This section summarizes the key findings from several of the group meetings and interviews described above. The information gathered from these sessions will inform DHS about findings specific to internal stakeholders, the development of a training plan and education and outreach plan for external stakeholders.

There is a common set of topics that will need to be included in training, education and outreach for all stakeholders, and there may be a need for stakeholder-specific content for each group as well. For instance, providers, consumers, and advocates may all have different communication roles and needs.

Currently, the roughly 500 county eligibility workers in North Dakota follow a common process for determining eligibility and enrolling consumers into Medicaid and other public assistance programs.

This process includes the following components:

- Heavy reliance on walk-ins and referrals (anecdotal feedback suggested that a small but growing number of applications are being submitted online);
- Conducting an initial screening (typically in office, but can be done via telephone) to determine likely eligibility;
- Completion of a paper application (can also be done online and printed)
- Scheduling an in-depth interview (exceptions for Medicaid);
- Approval and/or denial – with additional referral to a different program if appropriate.

“One of the best training sessions the state provided was when they sat us down in front of computer monitors and showed us the differences between the old system and the new system.”

Burleigh County Eligibility Worker describing previous training program.

Eligibility workers currently receive training through a number of mechanisms, including webinars, e-learning modules, training manuals, and in-person trainings. Interviewees indicated that, in recent years, training has been increasingly administered through the States’ e-learning modules, supplemented by other methods.

The following table describes the advantages and disadvantages of different training mechanisms, as articulated by eligibility workers.

Table 3: Learning Tools & Methods

Method	Disadvantages	Advantages
Webinar	<ul style="list-style-type: none"> • Previously unsuccessful due to technology limitations • Locations not on state network 	<ul style="list-style-type: none"> • Less time consuming than in person meetings • Ability to interact with questions <p><i>*While the state identified cost savings as another advantage, it was not highlighted by interview participants</i></p>
eLearning	<ul style="list-style-type: none"> • No ability to ask questions and receive answers in real time • Typically does not involve walking through the enrollment process or demonstrate linking to the various systems 	<ul style="list-style-type: none"> • Users can take training when best for their own schedule • Enables scenario-based training <p><i>*While the state identified cost savings as another advantage, it was not highlighted by interview participants</i></p>
Manuals	<ul style="list-style-type: none"> • Reading does not facilitate learning • Various interpretations • No ability to ask questions and receive answers in real time • Cannot cover all the possible scenarios • Releases are not always timely (come after effective program change) 	<ul style="list-style-type: none"> • Ability to refer back to materials when needed
In Person training	<ul style="list-style-type: none"> • Difficult to find availability during the normal work day 	<ul style="list-style-type: none"> • Enables interactions between users • Facilitates transfer of best practices • Allows for contact and exchange of information with regional reps and/or directors

Interviews offered a number of recommendations to improve the training program, including the following:

Personal: Increase person-to-person interactions. Face-to-face trainings are greatly preferred. The e-learning sessions, when conducted in a group setting or with dedicated training days that include DHS policy personnel and regional representatives, can facilitate productive dialogue.

Relevant: Establish training that is more closely modeled after day-to-day activities such as scenario-based training.

Simple / Clear: It is also important to translate policy content into “plain English” and to identify the links between the written policy and the systems used.

Measure: Define ways to measure knowledge absorption such as quizzes.

Networking: Facilitate knowledge transfer among counties. Participants noted that information is shared within a county, but not often across counties.

“When we have the opportunity to sit down and get trained, there are two things that would help: 1) make sure the State’s policy experts are there – they are really good, and 2) create case scenarios so we can dig down into what may happen in real life.”

Cass County Eligibility Worker

Eligibility workers also highlighted concerns around the bandwidth to support the influx of clients expected with Medicaid expansion. The number of cases that a worker can handle varies tremendously by public assistance program. The policy changes and automation introduced with ACA implementation may provide efficiencies that should be highlighted to staff.

These principles can be used by DHS as it creates a training program for Eligibility Workers on the topics of Eligibility Modernization, Medicaid expansion, and connecting with the FFM. This training plan should incorporate the consistent theme, key messages, tools and information that will be featured in the external stakeholder training, as well as the education and outreach plan.

“We have more than 50 eligibility workers and while we don’t know how much our volumes will increase, we have submitted a preliminary request for up to four more employees.”

Cass County Eligibility Supervisor

Findings - External Stakeholders

There is a sizeable group of North Dakota based advocacy organizations and entities that help drive relevant information to the general population and to selected demographic groups. These groups will be targeted for external training, education and outreach.

HTMS conducted interviews with a variety of these external stakeholders to better understand important considerations for any training, education and outreach. Interviews included community and advocacy groups, provider organizations, employers, as well as individuals who access public health and assistance programs. We also took the opportunity with these individuals to explore prospective communications themes, messages and visuals.

Advocacy Organizations

Interviews were conducted with a number of North Dakota-based community and advocacy organizations to better understand consumer awareness around ACA issues and how to best communicate with consumer stakeholder groups. HTMS met with representatives from the following organizations: Protection and Advocacy Project, Independent Living Centers, AARP, Family Voices, North Dakota Disabilities Advocacy Coalition, Lutheran Social Services, Family Health Care Center of Fargo, Community Action, Great Plains Food Bank, homeless shelters in Bismarck and Fargo, Migrant Legal Services, Indian Health Services, WIC program, 1-877-KIDS-NOW, the Public Health Department, and social service offices in Burleigh, Cass, Morton, and Sioux counties.

North Dakota's county eligibility workers depend on the organizations listed above for many client referrals, as they do minimal active outreach themselves. These organizations may also offer potential distribution channels for the dissemination of outreach and education materials. Churches and other community-based channels should be considered as well. The State AARP chapter stood out as one of the few external organizations that is actively already engaging its membership when it comes to insurance reform and Medicaid expansion. Their leadership expressed direct interest in working with the State.

The information gathered during meetings with external stakeholders will be used to create external training, education and outreach plans around Medicaid expansion, the FFM and to a lesser extent needed background about the ACA. The objectives of the education and outreach plan include creating a series of key messages designed to:

- Inform target audiences about health care reform, the FFM and Medicaid expansion

- Connect and/or direct stakeholders to the appropriate places for additional information or assistance
- Assist individuals with understanding basic concepts of health care coverage and health care reform
- Establish a common theme for North Dakotans that reinforces national education and outreach activities

Respondents indicated that they rely upon a number of outlets to communicate to their constituents, including newspapers, home mailings, websites, brochures, social media, media and electronic messaging. Most of these organizations do minimal advertising or direct marketing outreach – and of those that have done some, they have not conducted any market testing to determine the efficacy of these methods of communication.

Interviewees indicated that many of the populations served by these organizations are overwhelmed with an abundance of information – much of it related to issues and topics of utmost importance to their day-to-day living (e.g. housing, transportation, medication, food, etc.) – and that healthcare coverage may not be their highest priority. They also indicated that there is also competing misinformation circulating about Medicaid expansion, the ACA, and healthcare reform that could confuse messaging and make individuals more hesitant to absorb new information. When confronted with conflicting information, they may hesitate and be confused about what sources they should trust. This is an issue that may cause real consternation, especially in Native American and New American communities.

This means that getting the right information into the right hands is critical. By giving the right information to the professionals working directly with eligible citizens, the state can help partnering organizations and professionals build trusted relationships with residents who may benefit from the Medicaid expansion.

These organizations were also able to provide recommendations on how to appropriately and effectively communicate with consumer groups. These findings are summarized in the Table 4.

Table 4: Communication Channels

Outlets	Perceived Effectiveness	Supporting Interview Content
Word of mouth	Very Effective	"Many people will benefit from hearing this live from another person"
Newspapers	Effective	
Websites	Effective	"People will rely on Internet"
Social media	Moderately Effective (trending to Effective)	"The young 20 and 30 year olds have smartphones and are constantly on Facebook or Twitter."
Media (TV and Radio)	Moderately Effective	"We have found Public Service Announcements to be worthwhile, especially in transit advertising" "A lot of people listen to AM radio in the morning"
Home mailings	Moderately Effective	"Rainbow envelopes go out to parents of school children; reaches over 165,000"
Brochures	Minimally Effective	"Most of the time, as they're walking away, our brochures get thrown in the trash"
Phone	Minimally Effective	"People switch or discontinue phone numbers a lot"

Native American population

The Native American population in North Dakota will require more targeted communication tools and messages. Native Americans are more likely to be living in poverty, often receive care through a different delivery system (IHS), and may hold a greater mistrust of government regulations. Many Native Americans also face additional barriers to seeking care. IHS often requires a Medicaid denial before providing services because they are the payer of last resort. When specialized services are not available or when funding is limited, this population is often redirected to hospitals and clinics outside of IHS. Native Americans also have a number of exemptions from the ACA eligibility and enrollment rules, including an exemption from the individual mandate penalty for failure to maintain minimum essential coverage and from the cost sharing requirements for those at or below 300 percent of FPL.

Existing outreach and communication efforts related to health care services and coverage are outsourced to organizations that are familiar with the unique preferences of tribal populations and have established trust. GoodHealthTV programming in IHS facilities is one example of culturally appropriate information

“We look to the State for up-to-date information about the impact of Medicaid expansion. We realize it is very difficult for them to answer all our questions right now – but we really need information sooner as opposed to later.”

Sioux County Eligibility Supervisor

and outreach efforts that deliver health-related messages to Native Americans.

Based on discussions and interviews with representatives of the Native American population, there seems to be low awareness about Medicaid expansion or the FFM for this demographic group. Anecdotal information suggests that IHS providers have basic knowledge of the ACA, and that ACA may be perceived as an opportunity to increase revenues for IHS facilities, but, they are still waiting for more information which means there is a reluctance to communicate definitive information to the people they serve.

While the general Native American population seems somewhat familiar with Medicaid, it was suggested that the population would be reluctant to take part in the FFM if it required any out-of-pockets expense.

Contributors identified several messages and considerations that would encourage the Native American population to participate in either the Medicaid expansion or the FFM, including the following points of emphasis:

- Increase in choices, for services and providers
- Better quality of life for families
- The use of local people, tribal leaders and images

Participants also suggested that messages related to reimbursement could be received as demonstrating commitment to the Native American health system. On the other hand, participants also said that Native American people do not respond well to being told what to do by “outsiders” and suggested steering clear of words indicative of government directives.

There are similarities to these observations about the Native American community with the New American community. Additional considerations for this group will include identifying methods for overcoming language and cultural barriers that may hinder the New American community from purchasing and consuming

coverage. The training, education and outreach plans will more fully address the needs for the New American community across North Dakota.

Medical Professionals

Interviews were conducted with the North Dakota Hospital Association (NDHA) and the North Dakota Medical Association (NDMA) to better understand how to best communicate with these stakeholder groups.

NDHA is a trade association that provides education to member hospitals. Current outreach to members is conducted primary through the Bio-Terrorism Wide Area Network (BTWAN), a videoconferencing network designed for emergency situations but is also used for educational purposes. NDHA also releases a weekly electronic newsletter to its members and publishes materials to its website. While NDHA occasionally holds conventions, there is limited face-to-face communication with its members and there is no active education of the public by NDHA.

The interviews with NDHA revealed that providers have a broad understanding of the changes associated with ACA implementation. However, the organization has not yet developed any training or educational materials for its members. The primary concern articulated by NDHA is not yet knowing what coverage will actually look like.

NDMA presents over 1,000 physicians in North Dakota (almost 70% of all North Dakota physicians), 80% of whom are employed by hospital facilities. Many physicians may be unclear about the implications of the ACA and want to understand “how this is going to work.” Physicians may or may not support the ACA but many understand that increased coverage will increase reimbursement.

To communicate with its members, NDMA sends a weekly email, publishes materials to its website, and publishes a member magazine three times a year. NDMA also works with eleven district medical societies to disseminate relevant information. NDMA does not have any mechanisms in place for distributing educational materials to patients.

For these audiences, the information should be fact-based and focused on the changes resulting from Medicaid expansion or the FFM, and give providers the information needed to direct patients to the right place(s) for more information.

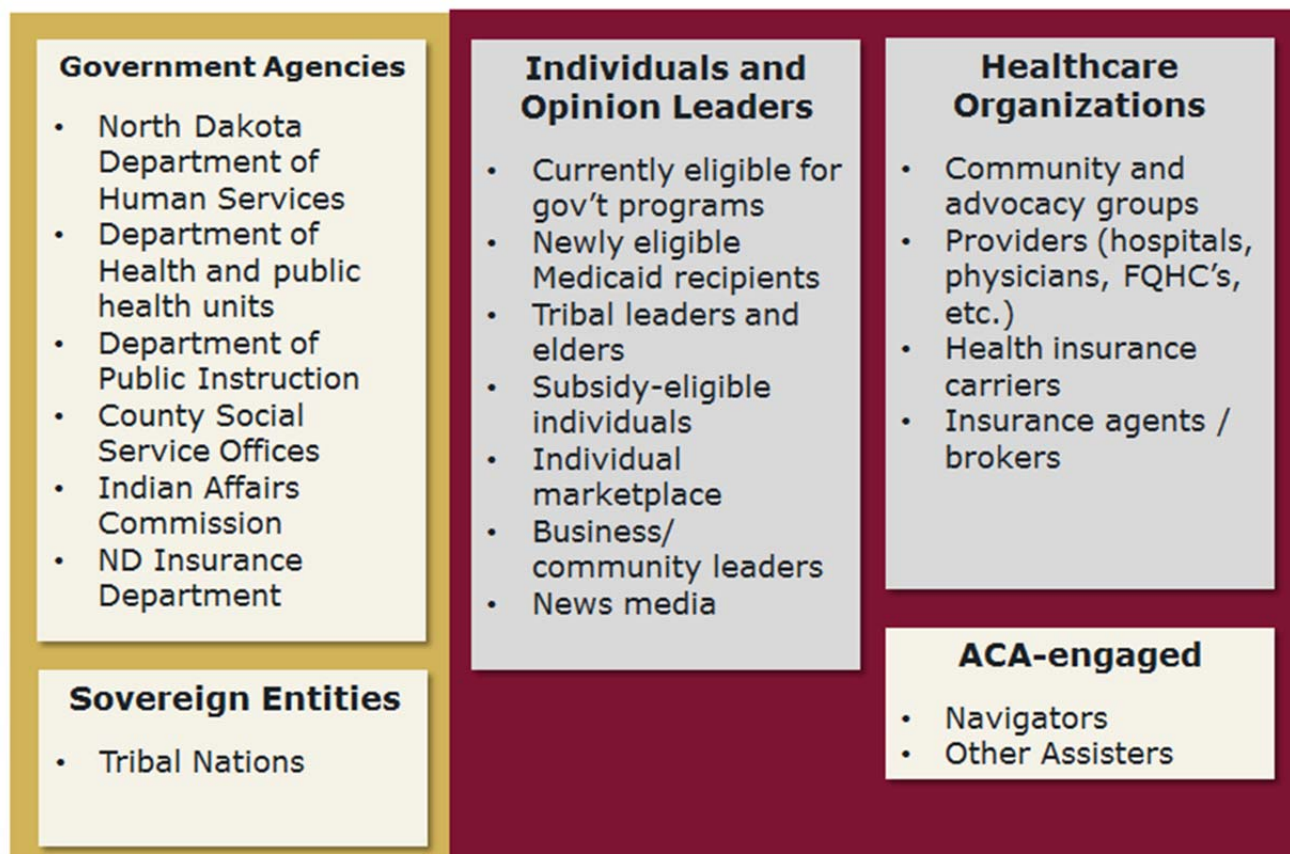
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Training, Education, and Outreach

Strategy for Training, Education, and Outreach

The assessment findings and discussions with many North Dakotans have provided considerable data and insight into the types of training, education and outreach strategies and tactics that are likely to succeed. These findings offer guidance on the primary, secondary and tertiary audiences that can best help expand access to care – if appropriately trained (See Diagram 4 below). The findings also help identify the key tactics and outlets that can be incorporated into the State’s education and outreach plan.

Diagram 4: Stakeholders



Budget and other constraints require a concentrated and efficient educational effort. Therefore, the plan outlined is cost-effective and grass roots-oriented. The training, education and outreach plans will not include broadcast, print or online advertising and extensive marketing tactics, but will incorporate activities that would be more traditionally defined as educational in nature – including earned-

media (public relations), basic collateral materials, public service announcements, website content and appropriate outreach to primary and secondary stakeholders.

The education and outreach plan will include the following components:

- Target audiences
- Key messages
- Tools and Tactics
- Implementation timeline and responsibilities
- Evaluation Opportunities

Themes for Training, Education, and Outreach

Because the FFM is being established by the Centers for Medicare & Medicaid Services (CMS), and based on the HTMS strategic approach, there will not be a fully branded promotional strategy or advertising campaign specific to a North Dakota-created online marketplace. At the same time, it will be important for North Dakotans to have a clear notion of the coverage requirements and/or options available to them – and the place(s) where they can learn more, or sign up for healthcare coverage.

HTMS has subsequently created and explored a number of options to establish one communication theme that will serve to unify training and educational and outreach activities as they are deployed to multiple target audiences. Four potential communication themes were explored, and verbally presented to the DHS core team. Two themes were selected and tested in a series of informal focus groups.

1. **I am North Dakotan**
2. **Proud and Covered**
3. **I Trust...**
4. **Taking Responsibility**

These four potential themes included Options 1 and 2 that were ruled out, and Options 3 and 4 that were described and tested with the informal focus groups:

1: “I am a North Dakotan”

The concept of this theme was to engage both internal and external audiences in a personal conversation, based on an understanding of where they come from and who they are. It was grounded in North Dakotans’ strong sense of individualism.

HTMS and the core team decided that this theme had limitations with some demographic populations in the State, and that other options could still communicate the sense of individualism while creating the sense of a personal conversation.

2: "Proud and Covered."

The concept of this theme revolved around Prairie Pride and North Dakotan Pride. It was intended to appeal to the nature of North Dakotans, and separates what is happening in the state from Federal activities.

The core project team and HTMS felt that this theme did not have the same potential for success or the ability to appeal to a variety of audiences compared to other options that were presented.

3: "I Trust... "

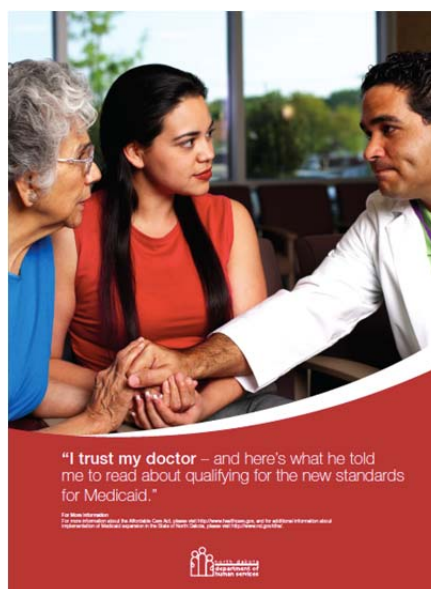
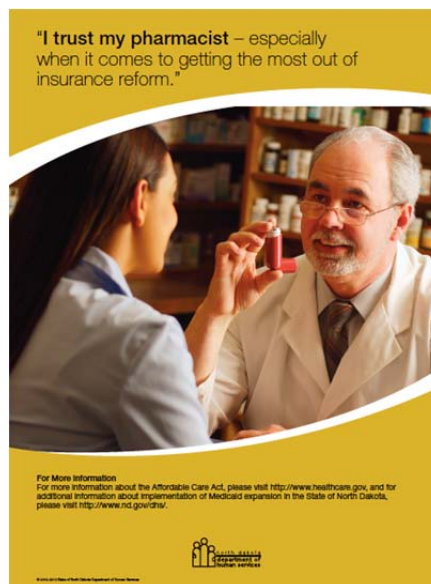
This is one of the two options that we explored in-depth with a series of informal focus groups. Ultimately, this is the option that is the runner-up to the chosen thematic approach.

While North Dakotans generally do not put their trust in big government or big insurance companies, they have people in their communities they respect and trust, and word-of-mouth can go a long way.

While North Dakota is geographically dispersed, there is a strong connection to communities and neighbors – even if those communities and neighbors are five miles away. People trust the friends and neighbors they know, not the government agencies or health insurers that are telling them how they must act.

With this theme, we can highlight different aspects of trust. For instance: "I trust my neighbor ... "I trust my doctor ... "I trust my pharmacist ... "I trust my community ... "I trust my instincts ... "

Why this Option was Ruled Out? When compared to Option #4 – Taking Responsibility – this messaging did not test as well with our target audiences. It is not as easy to appeal to the readers' emotions with this creative approach. And, people who do not have access to health coverage do not generally have contact with pharmacists or doctors.



4: "Taking Responsibility"

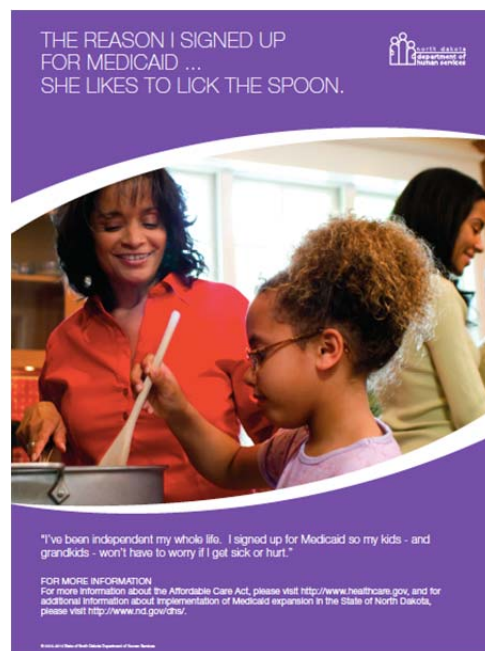
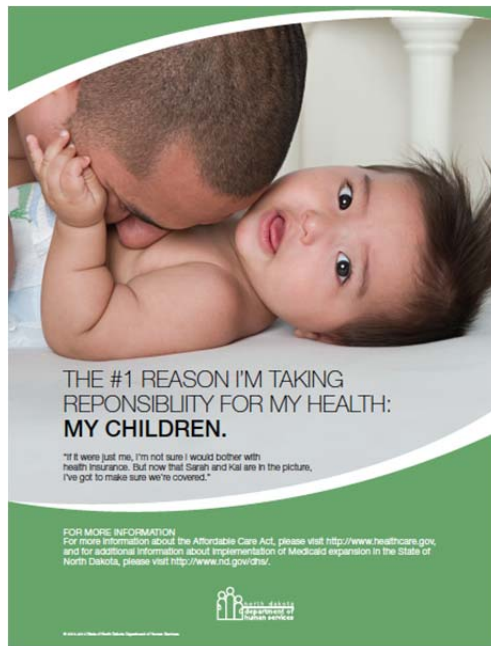
From the DHS project team and the HTMS team to some of the people who provide services and to those individuals who use a number of public health and assistance programs, this concept had stronger emotional and objective appeal. This is the theme that will be fully developed and used as the overarching theme for the training, education and outreach plans.

The concept of this theme is to focus on the importance of having healthcare coverage by appealing to North Dakotans' sense of taking responsibility for themselves and their families.

Residents of the Peace Garden State take responsibility and focus on what needs to be accomplished. They don't sugarcoat tough issues, and they face up to business and financial realities.

"The reason I'm taking responsibility ... The reason I signed up for Medicaid ... I took it upon myself to learn more about health care reform ... I figure part of taking care of my family is making sure that if I get sick or hurt, I can afford the care I need to get better again ... If it were just me, I'm not sure I would bother with health insurance ... "

This theme had universal appeal from professionals, men and women, as well as people who are the recipients of Medicaid and other assistance programs. It provides an emotional bond and was easily understood.



6

Conclusion

The findings from this assessment will be used in the development of both a training plan focused on external healthcare audiences, and an outreach and an education plan specific to appropriate stakeholder groups. While the details of these plans will be developed as part of a separate deliverable, there are several findings from this assessment that will to be incorporated into these efforts.

For county eligibility workers, it is important to consider the time required to participate in any training and also the fact that that ACA implementation represents a big and complex change – about which many strong opinions and emotions exist. Eligibility workers also currently feel at capacity and expressed concern about the additional caseload. Finally, cultural differences in the populations and differences in program requirements mean that variations in training will need to be incorporated into the training documentation depending on the audience to be trained.

Any training content for eligibility workers should be interactive and should allow them to test the system prior to its use and utilize scenarios to help eligibility workers apply the information to theirs jobs. Case manager training should focus on how they can help connect clients to coverage. Training content also needs to be timely and presented more than once and through a range of mechanisms such as reference materials, in-person trainings, and eLearning modules.

For the general public, there has not been much testing or measurement related to the effectiveness of current outreach methods. Any training, education and outreach efforts for advocacy organizations or the general public should establish an overarching theme, should focus on driving individuals to the right resource, and should utilize various distribution channels to ensure key messages are delivered as effectively as possible.

ⁱ States' Medicaid ACA Checklist for 2014. State Health Reform Assistance Network Issue Brief. April 2013.

ⁱⁱ Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits. 2010.

ⁱⁱⁱ Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey (CPS: Annual Social and Economic Supplements).

^{iv} ¹US Census Bureau, 2010 Census and 2010 American Community Survey

^v ²The American Indian and Alaska Native Population: 2010. Census Briefs.

^{vi} <http://www.nd.gov/indianaffairs/?id=34>

^{vii} US Census Bureau, 2010, American Community Survey; , "Barriers to Obtaining Health Insurance Among Native Americans in New Mexico," January 2006. Commissioned by the New Mexico Human Services Department; and interviews with state departments.

^{viii} ²Derived from HTMS Health Benefit Exchange Planning analysis completed for the State of North Dakota in 2011, and supplemented with additional work completed to date.

^{ix} U.S. Census Bureau, American Community Survey, 5-Year Estimates. Updated every year. <http://factfinder2.census.gov>

^x Source: ND cell phone use rises as 'land lines' decline. Seattlepi.com. June 7, 2013

^{xi} Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey (CPS: Annual Social and Economic Supplements)

^{xii} Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2009 MSIS, 2012.