North Dakota Department of Human Services

Medicaid Access Monitoring Review Plan

2019

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Introduction to Access Monitoring

The Access Rule Explained

Section 1902(a)(30)(A) of the (Social Security) Act requires states to, "assure 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".

On November 2, 2015 the Centers for Medicare and Medicaid Services (CMS) published the final rule for Medicaid Access Monitoring Review Plans (AMRPs). The final rule limits the focus of access monitoring to traditional fee-for-services (FFS) Medicaid beneficiaries. The final rule excludes managed care arrangements[1] as well as waivered services and demonstration Medicaid programs.

In accordance with 42 CFR 447.203, North Dakota developed its initial access monitoring plan that was submitted to CMS on October 1, 2016. A follow-up access analysis is required every three years. This 2019 North Dakota AMRP provides an updated report of access to health care of traditional fee-for-service Medicaid beneficiaries by the following service categories:

- Primary care services,
- Physician specialist services,
- Behavioral health services,
- Pre- and post-natal obstetric services[2], and
- Home health services.

CMS' stated goal is that Medicaid beneficiaries have access to healthcare that is comparable to that of the general population in North Dakota. The CMS Access Rule further clarifies, *"Although states must demonstrate that beneficiaries have access to covered services at least comparable to others in the geographic area, comparable access does not necessarily require that beneficiaries obtain services from the same providers, or the same number of providers, as the other individuals in the geographic area".*[3]

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[1] In North Dakota the Medicaid Expansion and Heathy Steps (i.e. Children's Health Insurance Program) populations are enrolled in managed care arrangements.
[2] includes labor and delivery
[3] 42 CFR 447.203

Rurality as an Access Variable
CMS recognizes that many states have access barriers related to rurality, as designated by Health Professional Shortage Areas (HSPAs), Medically Underserved Areas or Populations (MUAs, MUPs)[4], and similar rurality indicators. CMS recognizes that rurality often negatively impacts all rural residents regardless of the type of healthcare coverage, and therefore allows states to factor rurality into access data and monitoring.

Despite recent population increases, the North Dakota rurality indicators have not declined in volume or scope.[5] In some instances, North Dakota's population increases, alongside increases in numbers of Medicaid beneficiaries have exacerbated access challenges. For example, the 2014 implementation of Medicaid expansion has improved healthcare coverage to a monthly average of more than 19,000 North Dakotans. At the same time, population growth and Medicaid expansion implementation placed more demands on health care providers in the state to meet health care demands.

North Dakota remains the fourth most rural state in the nation. Based on the most recent 2016 rurality data of counties, 68% (36 of the state's 53 counties) hold frontier county status.[6] Frontier status is assigned to counties that have "less than 6 persons per square mile"; North Dakota's most rural county has 0.8 persons per square mile.

Nationwide, rurality is a significant barrier to accessing health care. The CMS access rule requires states to analyze access by geographical area. This 2019 AMRP will explore ND rurality access data in detail, including a comparison of traditional Medicaid household health care access data across each of North Dakota's eight regions, as well as and where statistically possible, Medicaid beneficiary survey data administered to a sample of beneficiaries in North Dakota's 53 counties.

The Specific Focus of AMRP is Access to Health Care:
Access to health care has multiple domains. The Agency for Healthcare Research and Quality recognizes six domains: safe, efficient, equitable, timely, patient-centered, and effective.[7] Each of these domains is driven by several factors including whether access is impacted by a beneficiary's perspective about the patient/provider relationship; considerations of distance, weather impacts, availability of transportation; and, by gauging whether access is similar to, or different from, the general population within a geographical region. Data collection instruments that attempt to measure access are relatively basic, and it can be challenging to identify the factors that most significantly

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[4] https://bhw.hrsa.gov/shortage-designation/hpsas
[5] see "County Health Shortages" section
[6] Center for Rural Health, University of North Dakota
[7] https://www.ahrq.gov/talkingquality/measures/six-domains.html

impact access. Additionally, a substantial number of data points are needed to understand how access differs by diverse provider specialties or by varied geographic area health system configurations. Differences between urban and rural provider availability also impacts access to healthcare.

Medicaid state plans are unique to each state rather than being generalizable. One result is that among the 50 AMRPs submitted in 2016, each is more different than similar, thereby making comparisons and lessons learned difficult. In response to this variation, CMS offers broad guidance for access monitoring but allows considerable discretion of how each state chooses and configures their access data.

The North Dakota 2019 AMRP uses several data sources to monitor access indicators such as: 1) Medicaid participating provider trends, 2) national state-by-state access ranking data, and 3) 2019 survey data from Medicaid beneficiaries. Survey responses were collected from 4,293 traditional fee-for-service Medicaid households. Survey questions asked about beneficiary experiences with access to the five core provider groups identified by CMS.

This 2019 AMRP focuses specifically on access to care data indicators while excluding other common health care metrics that do not measure access. The CMS Access Rule instructs states to limit the focus of AMRPs to access to care, and explicitly clarifies that incorporation of quality, outcome and similar non-access indicators are not required components. As such, overall health data is not being incorporated into North Dakota's 2019 AMRP. There is some North Dakota demographic data included that indirectly impacts access. That information will be utilized to describe the state's health care landscape, as well as is in some of the state-by-state ranking data from national organizations.

North Dakota has been studying its healthcare systems for the past decade to analyze barriers, provider trends, gaps and solutions to address service delivery challenges, including but not limited to access to care. Every two years the University of North Dakota School of Medicine and Health Sciences releases a comprehensive biennial report with the support and technical assistance from the North Dakota Center for Rural Health and a legislatively mandated group of 15 stakeholders invested in the North Dakota healthcare enterprise. In 2019, the Fifth Biennial Report was released, including an Executive Summary, Full Report, and Slide Deck components.[8] The full report consists of 359 pages with 12 chapters and three appendices. For readers interested in a wider perspective on North Dakota's health care landscape the biennial reports provide good background material. Some of the biennial report address indirectly and at

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[8] https://med.und.edu/publications/biennial-report/index.html

times directly, access to care. The reports also investigate quality and costs of care, population health, health care outcomes, and more. One important conclusion from the series of biennial reports is that across a variety of provider groups and geographical regions, North Dakotans do experience localized access to care challenges, regardless of type of healthcare coverage. For example, psychiatrists are highly concentrated in the eastern part of the state, but telemedicine is helping to bridge this gap. The 2019 biennial report also details instances of providers being more concentrated in urban than rural communities.

Executive Summary

Introduction

North Dakota has significant rurality barriers that challenge its residents in accessing health care. As the fourth most rural state, North Dakota has barriers that result in challenges to many residents in timeliness of appointments, travel challenges including winter weather driving, distances between patient and provider, and gaps related to availability of transportation in some areas. Despite these barriers, multiple data indicators confirm that access to care is positive for most traditional Medicaid beneficiaries, including positive views on access for beneficiaries in some of the state's most rural counties.

In 2016 and 2019 the state conducted access surveys with Medicaid fee-for-service beneficiaries. These surveys were conducted by mail over a three-month period. Participation in the survey was voluntary and beneficiaries were not given an incentive. There were 12 items on the survey and it took approximately 5 minutes to complete.[9] 6,679 and 4,293 beneficiaries completed the survey in 2016 and 2019, respectively.[10] In total, over 11,000 access to health care surveys were completed in the two years and the results suggest that Medicaid fee-for-service beneficiaries have positive access to healthcare.

A review of state-by-state rankings of the social determinants of health, which include access rankings, shows that North Dakota typically falls within the top 10 to 15 best performing states for access. This includes several notable rankings as better than the national average across multiple indicators.[11]

The most recent Medicaid-to-Medicare fee index (2016) ranks North Dakota third, behind only Alaska and Montana, in reimbursing Medicaid professional providers at or near Medicare rates. The 2019 North Dakota Legislative Assembly approved inflationary increases for providers of 2% for SFY 2020 and 2.5% for SFY 2021. These increases will likely move Medicaid reimbursement for professional services to higher levels than Medicare rates for certain provider types. The 2019 Legislative Assembly funded additional health care funding increases and authorized new programming that will further sustain or improve health care delivery and access to providers. For example, the state embarked on a four-year study of behavioral health services. As a

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[9] Survey is available upon request

[10] Response rates cannot be calculated because the surveys were mailed to households that included at least one Medicaid beneficiary; however, the household could have had more than one beneficiary.

[11] see "North Dakota Demographics Overview" section

result of the study and subsequent recommendations, the 2019 Legislative Assembly funded significant behavioral health enhancements.

Finally, an interactive story map[12] was created to allow further drill down to access monitoring data for each of North Dakota's 53 counties, in relation to how Medicaid beneficiaries fare in each of the five core provider groups.

Rurality

Despite record-setting population growth, North Dakota remains the fourth least populated state. Nationally, rurality is a significant contributor to access challenges across many rural counties. North Dakota has some of the highest rurality indicators in the country. In six healthcare professional shortage area designations, North Dakota has shortage scores ranging from 60% up to 94% of all counties.[13] This degree of rurality leads to access challenges, regardless of type of healthcare coverage.

2019 Traditional Medicaid household Access to Health Care Survey

Replicating the original survey from 2016, a second survey was administered in 2019.

Beneficiaries were asked:

> *"When you or your family member covered by Medicaid needed care from your [specified] provider, how often did your household get care as soon as you needed it?"*
>
> Four response choices were:
>
> 1. Never
> 2. Sometimes
> 3. Usually
> 4. Always.

Never and sometimes responses were coded as having access concerns, while usually or always responses were coded as having positive access.

In contrast to the national rural landscape, the North Dakota access survey results specific to rural access were positive. Specifically, the access outcomes were overall encouraging and in one instance, seemingly contradictory.

An example of an encouraging outcome pertains to the access feedback from Medicaid beneficiaries from North Dakota's most rural counties. In total, 3,697 Medicaid

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[12] https://ndgov.maps.arcgis.com/apps/MapSeries/index.html?appid=7bc33732f16148008bd0510c80563eeb

[13] see "County Health Shortages" section

respondents rated their 2019 access to primary care providers. Thirty-six of the 53 counties in North Dakota (68%) are designated as frontier, meaning that there are less than six persons per square mile. Of all 36 frontier counties, only six counties received a never response, and each of the six received only one never except one rural county that received two. This information suggests that primary care is indeed available to most North Dakota Medicaid beneficiaries living in rural counties. Some respondents do comment that timeliness, transportation and distance to providers can be a challenge. Among all counties, 40 of all 53 counties (75%) did not receive a never response regarding primary care access.

An example of the seemingly contradictory phenomenon in the 2019 survey results was identified in the statewide aggregate of all providers (as well as each of the 5 provider group responses). Among those survey responders who reported never or sometimes having a problem with access, significant numbers of those same responders agreed with question 12[14] which stated, *"We've had no problems accessing health care".*

In reconciling this seemingly contradictory response pattern we hypothesize that a significant subset of survey responders generally felt their household had no problems with overall access but did choose never or sometimes responses to reflect rurality barriers. For example, less than timely access, winter weather challenges, distances between providers and beneficiaries, transportation challenges, and similar rurality barriers. The weather and transportation challenges are not unique to access to health care but are consistent with access to other goods and services such as groceries.

Across all providers, problematic access endorsement was 2.1% for never and 9.6% for sometimes for a combined response of 11.7%. In contrast, 30.4% of households endorsed they usually receive timely access, and 57.9% reported always receiving timely access.

In aggregate, 88.3% of respondents report usually or always having positive access which is significant given North Dakota's rurality challenges.

State-by-State Ranking Data

Several national organizations offer state-by-state ranking data. These independent ranking methodologies determine high and low orders of the outcome in question, then proceed to analyze and "rank" all states based on the chosen criteria. In contrast, each state's Medicaid state plan is unique and thereby poses difficulty in identifying national benchmarks or defining national rankings of Medicaid specific data elements. State-by-

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[14] Question 12 asked respondents to check items that impacted their ability to get health care.

state rankings offer some, albeit imperfect, standardization to achieve insights into how a given state is performing in relationship to all others.

North Dakota fares well in comparison to nearby rural states and the US average in a several state-by-state rankings that directly or indirectly assess access to health care.

Medicaid-to-Medicare Fee Index

Three key points are identified in the body of the AMRP to define the importance of North Dakota's Medicaid rates in relation to Medicare rates. CMS offers guidance explaining the significance of states that offer reimbursement of Medicaid services at a rate level that meets or exceeds Medicare rates. Based on a November 2017 State Medicaid Director letter (SMD# 17-004) CMS indicated that, "*in the absence of information to the contrary (such as high volume of access complaints which would trigger the regulatory requirements), CMS has determined the following circumstances… would not invoke the (access monitoring) requirements of §447.203(b)(6)".* The CMS policy guidance offers a clarifying example regarding circumstances in which provider payment reductions would likely not result in diminished access to care, specifically exempting states that pay at or above the Medicare rate under FFS.

ND Medicaid Data Specific to Traditional Medicaid Populations

The two primary data points associated with traditional Medicaid fee-for-service data are:

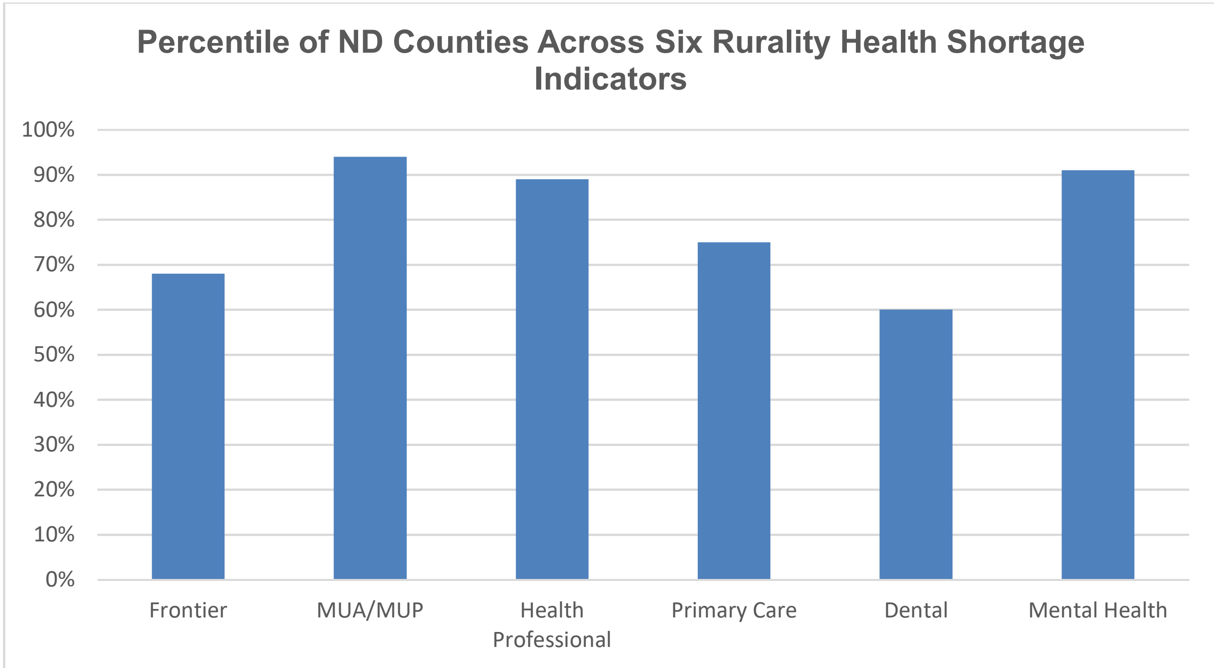
1. A three-year trend line of actual Medicaid provider participation rates by each of the five core provider groups, geographically sorted by the eight North Dakota regions; and
2. Data related to a three-year process of access monitoring of North Dakota participating providers who receive reimbursement based on the Medicaid Professional Services Fee Schedule.

The beneficiary survey data results suggest that many North Dakota residents, including those from rural areas, report positive access to care and the Medicaid data offers a hypothesis of what underlays this outcome.

A critical trend identified after analyzing the data are the participation rates from North Dakota Medicaid enrolled providers who deliver services to rural counties across the state. The percentile of participating providers delivering services to rural Medicaid beneficiaries meets and typically exceeds the percentile of Medicaid beneficiaries in the four most rural regions of the state, an outcome that we hypothesize facilitates improved access that is documented by the beneficiary access surveys.

North Dakota Access Monitoring Review Plan

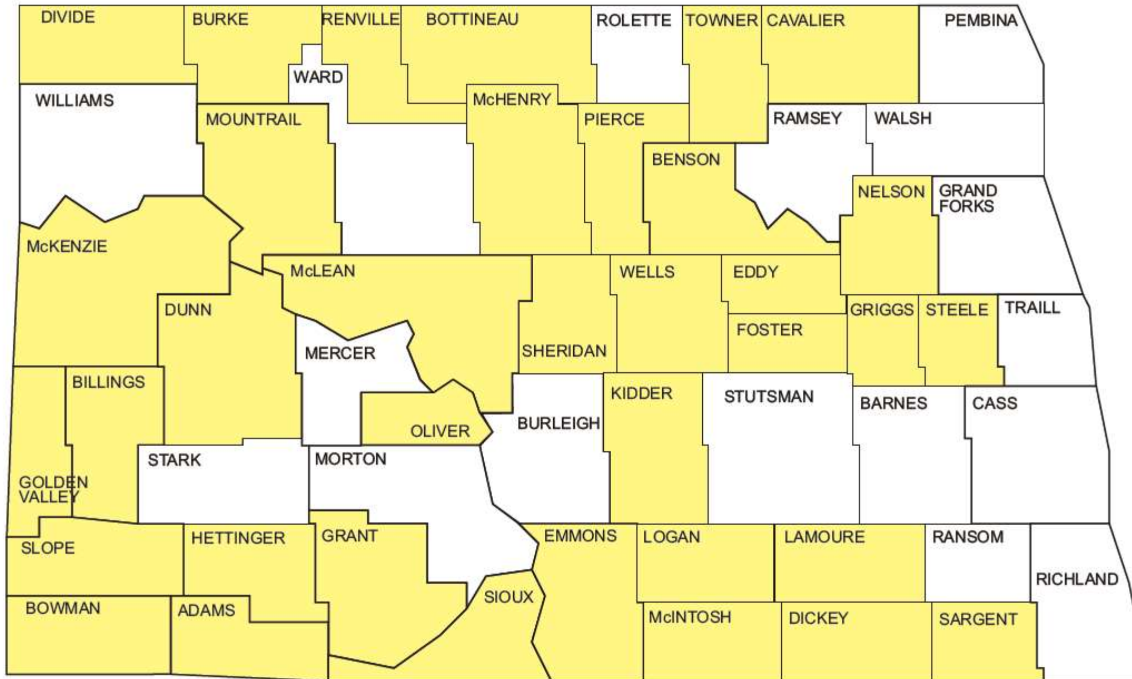
County Health Shortages



Legend:
Frontier – counties that have less than 6 people per square mile
MUA/MUP – Medically Underserved Area/Medically Underserved Population
Health Professional – Health Professional Shortage Area
Primary Care – Primary Care Shortage Area
Dental – Dental Health Professional Shortage Area
Mental Health – Mental Health Professional Shortage Area

Key Point: North Dakota rurality presents health care service delivery challenges regardless of type of healthcare coverage.

North Dakota Frontier Counties

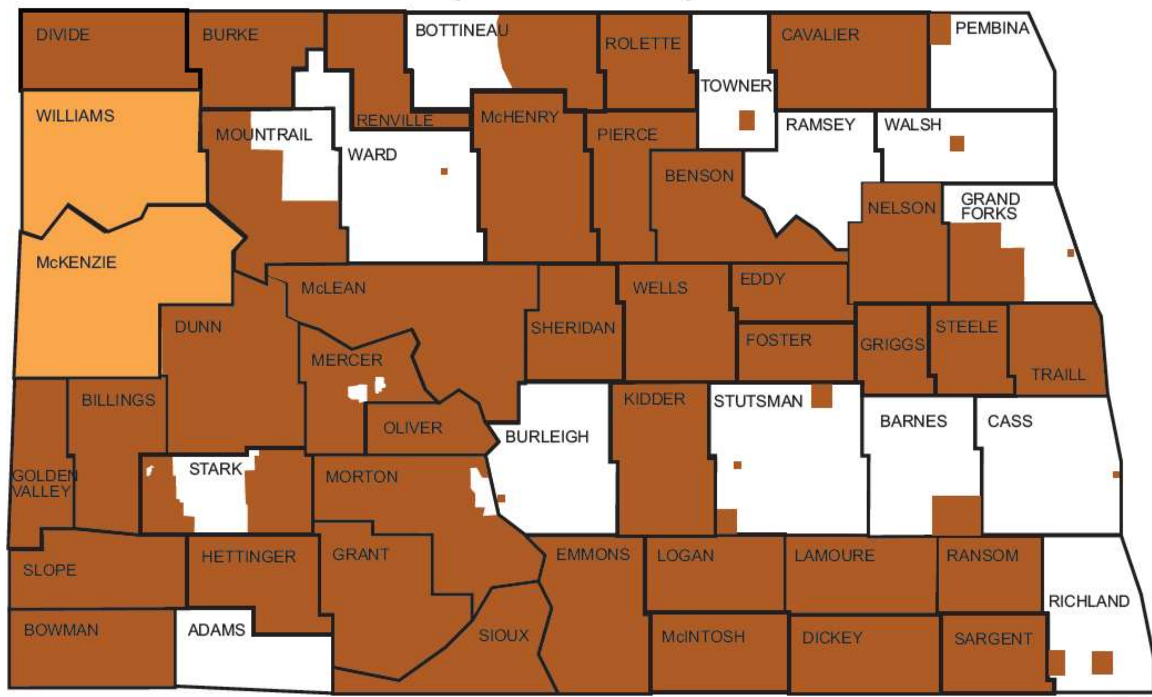


36 of 53 North Dakota Counties designated as Frontier*
*(less than 6 persons per square mile)
Based on 2016 Population Estimates

Key Point: 36 of 53 counties (68%) hold frontier county status. North Dakota's most rural county has 0.8 persons per square mile.

Source: Center for Rural Health, University of North Dakota

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

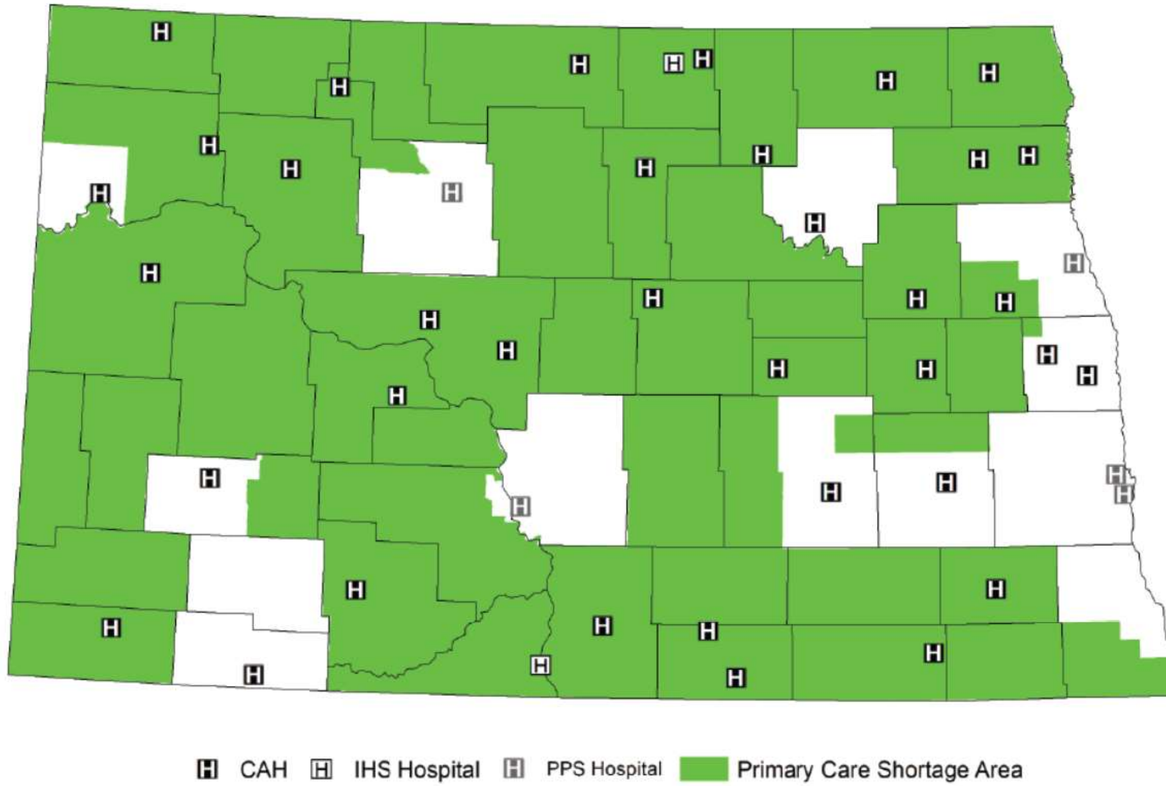


Designated Medically Underserved Area

Designated Medically Underserved Population

Key Point: 94% of all North Dakota counties have part or all of the county designated as a Medically Underserved Area or Underserved Population.

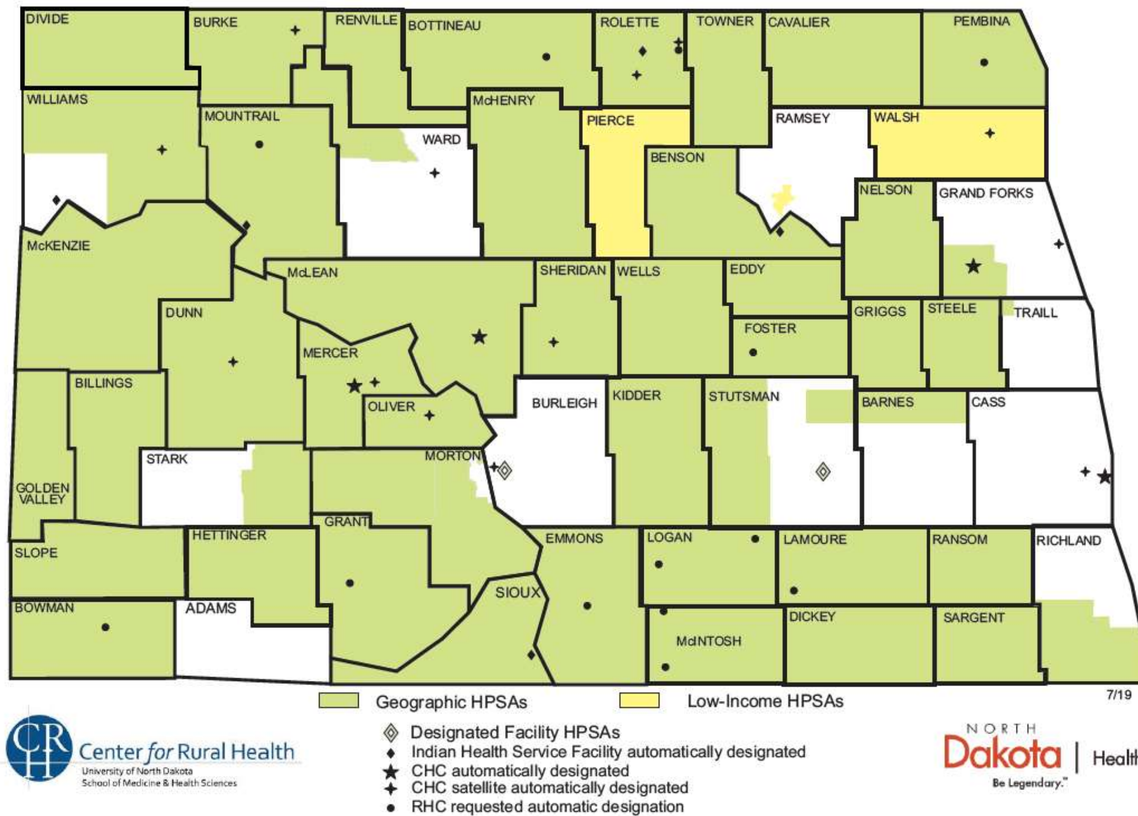
Source: Center for Rural Health, University of North Dakota



Key Point: 75% of North Dakota's 53 counties are designated as Primary Care Shortage Areas.

Source: med.und.edu/publications/biennial-report/_files/docs/fifth-biennial-report-interactive.pdf

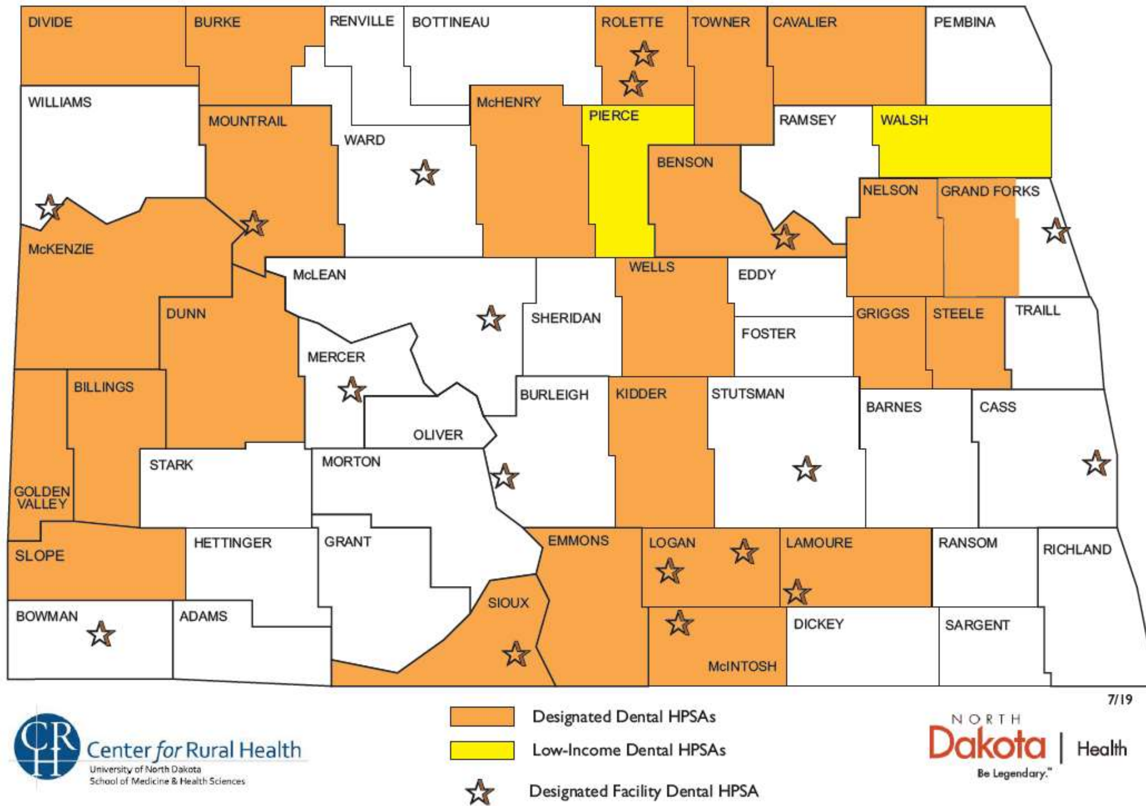
North Dakota Health Professional Shortage Areas



Key Points: Only six counties do not have Health Professional Shortage Area (HPSA) within the county, and an additional eight counties have a part of the county within a HPSA designation. 89% of all North Dakota counties have part or all of the county with a HPSA designation.

Source: Center for Rural Health, University of North Dakota

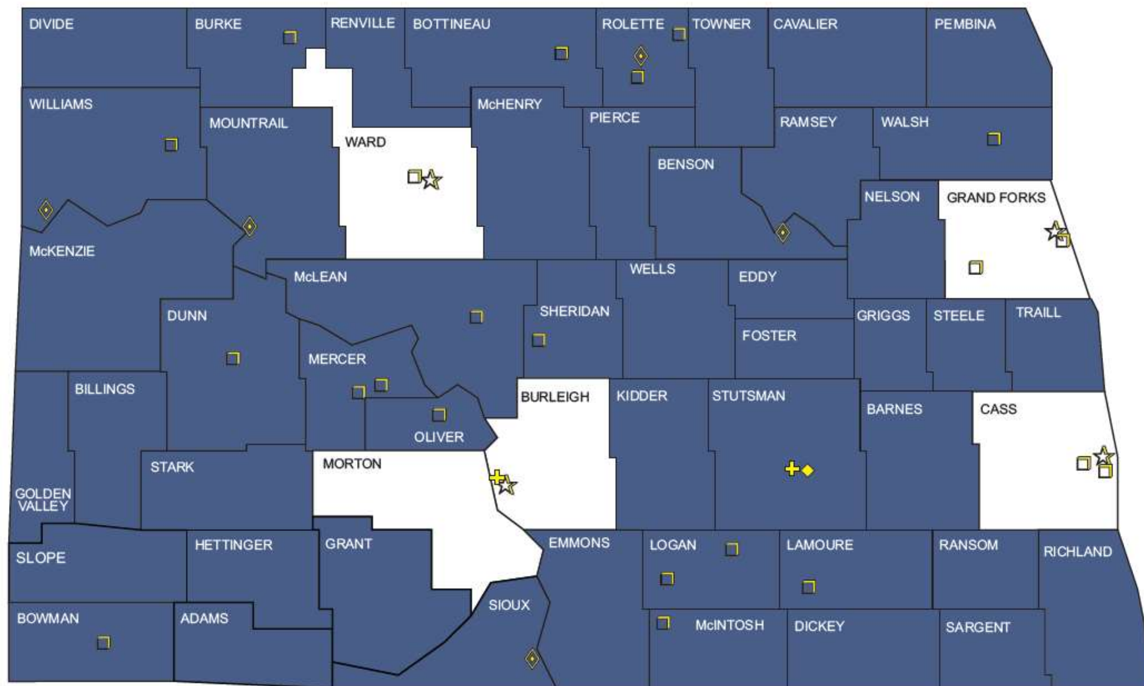
North Dakota Dental Health Professional Shortage Areas



Key Point: 60% of all North Dakota counties have either a desginated Dental Health Professional Shortage Area (HPSA) or desginated Facility Dental HPSA, or both.

Source: Center for Rural Health, University of North Dakota

North Dakota Mental Health Professional Shortage Areas



Mental Health Professional Shortage Area

Designated Health & Human Service Centers not located within current geographic area/region

Automatic designated mental health facilities

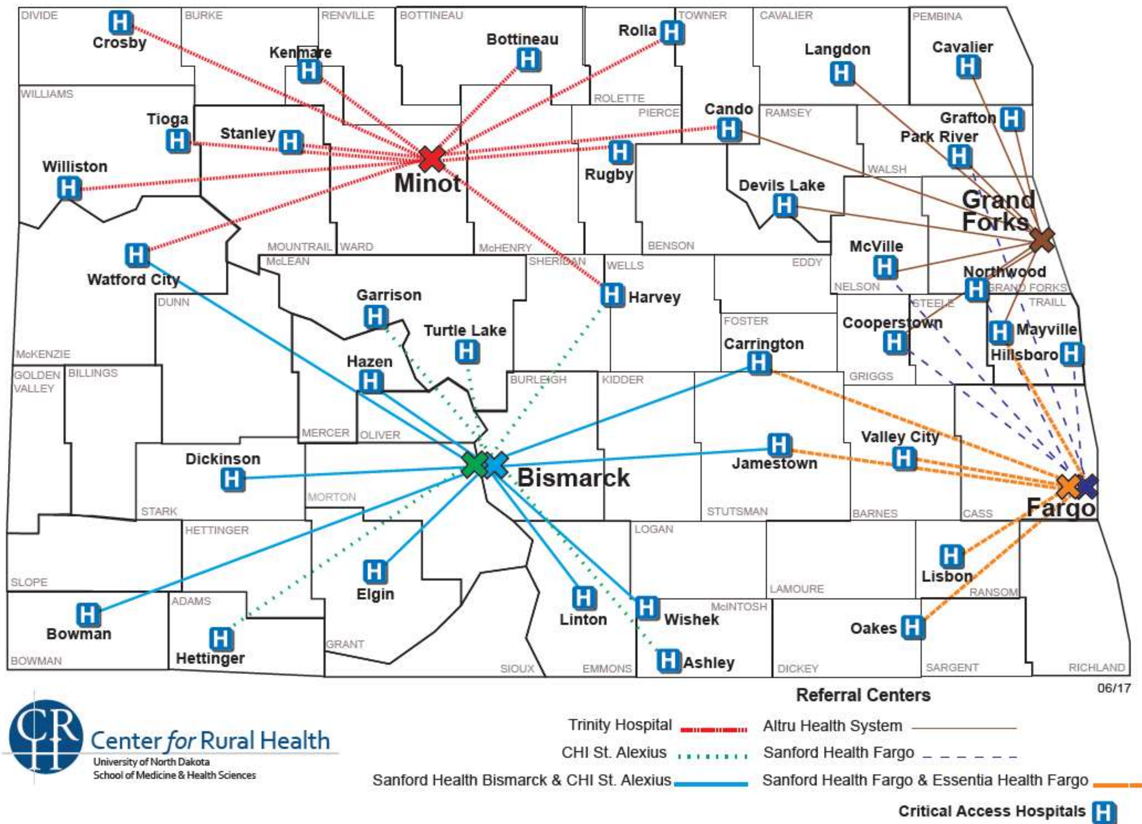
Designated State Mental Health Hospital

Automatic designated IHS facilities

Designated Correctional Facility

Key Points: Only five counties are not designated as a Mental Health Professional Shortage Area. 91% of all North Dakota counites have a mental health HPSA designation.

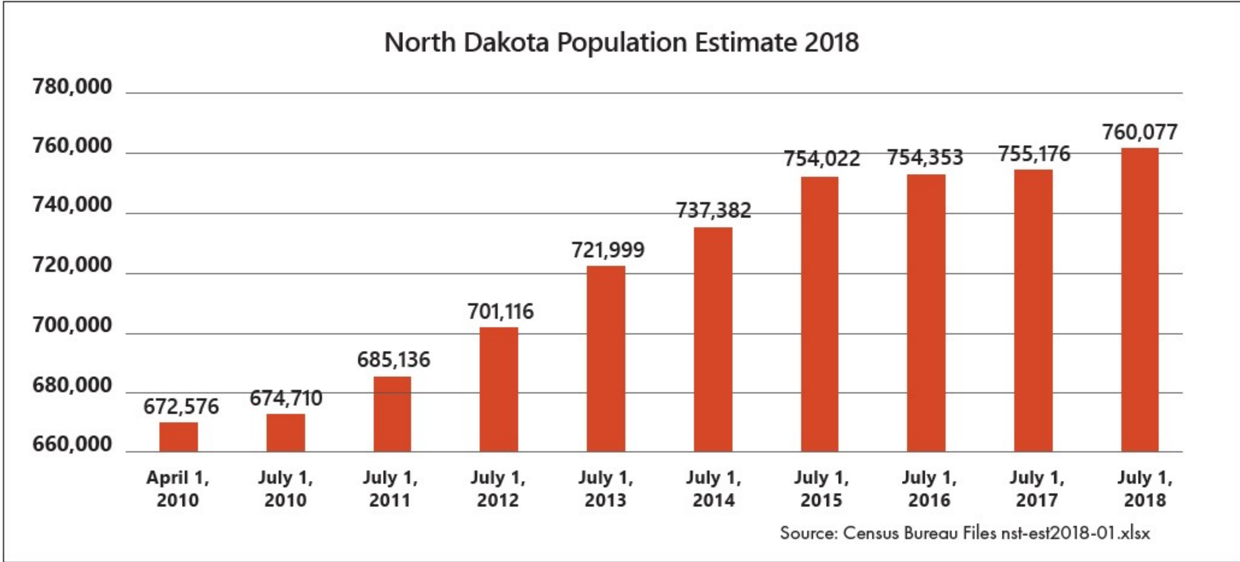
Source: Center for Rural Health, University of North Dakota



Key Point: According to the North Dakota Department of Health there are 52 hospitals in the state including: 36 critical access hospitals, six general acute prospective payment system, three psychiatric, two long-term care acute, two Indian Health Service, two transplant, and one rehabilitative.

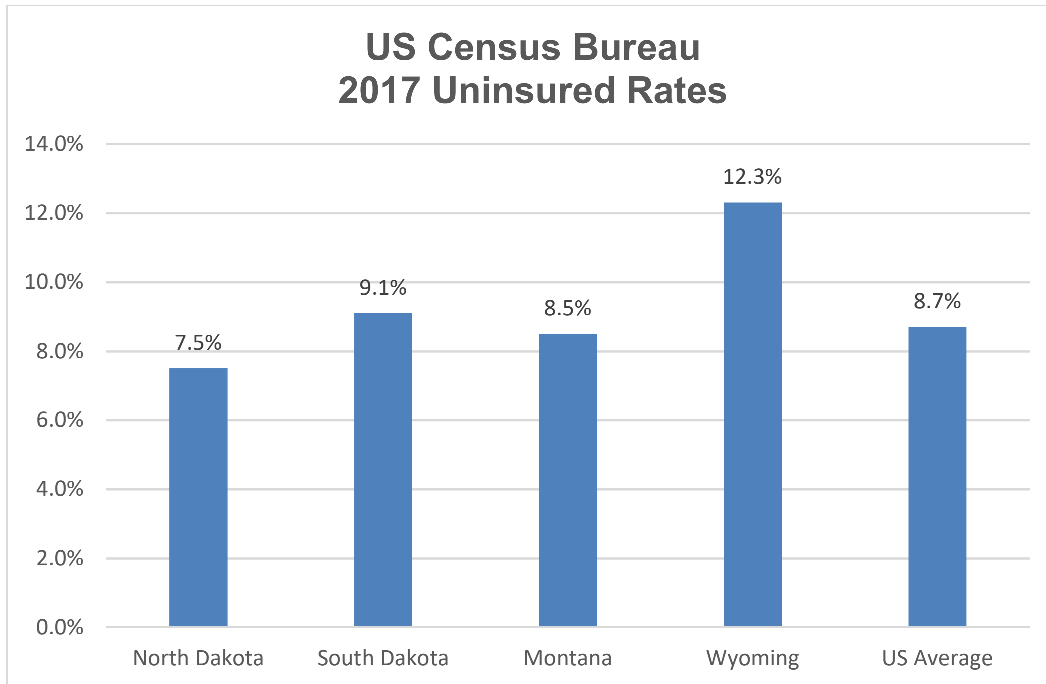
Source: Center for Rural Health, University of North Dakota

North -Dakota Demographics Overview



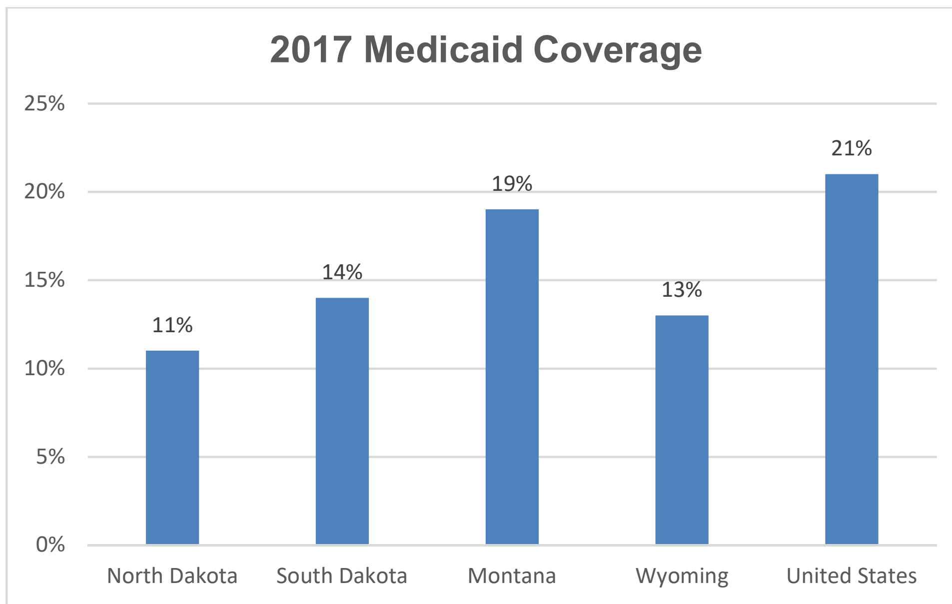
Key Point: North Dakota’s population continues to slowly increase.

Source: commerce.nd.gov/uploads/34/CensusNewsletterJan2019.pdf



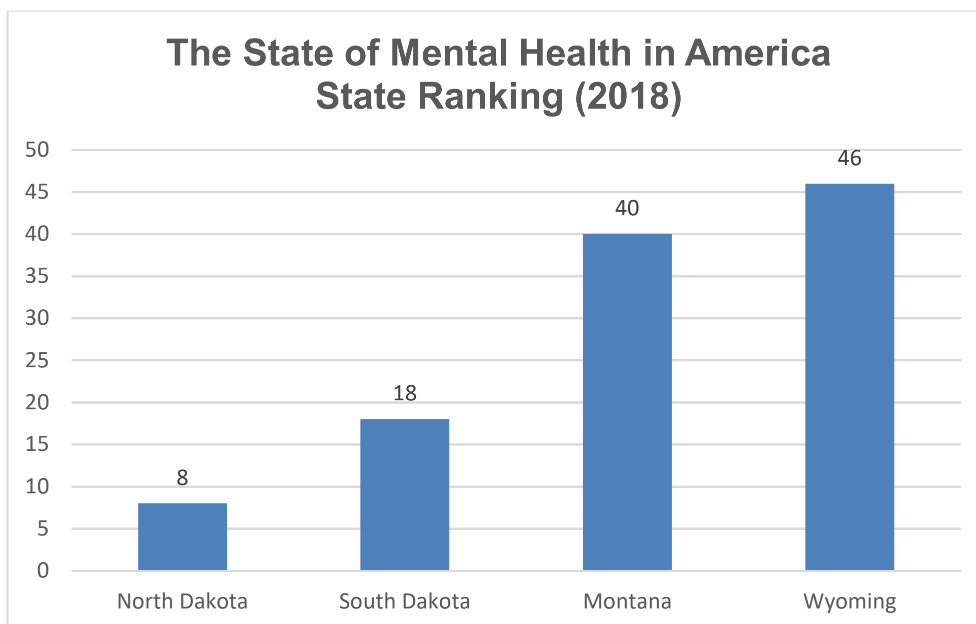
Key Point: North Dakota has the lowest uninsured rate among nearby rural states and ranks lower than the national average as well.

Source: www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf



Key Point: North Dakota has the lowest Medicaid coverage among nearby rural states and ranks lower than the national average as well.

Source: www.kff.org/other/state-indicator/total-population/currentTimeframe

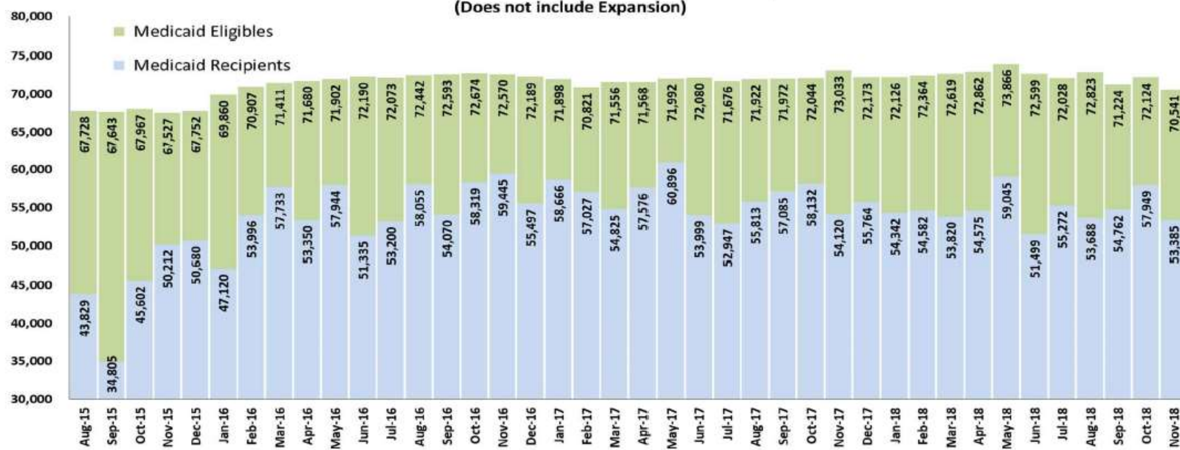


Key Point: North Dakota has the highest overall ranking among nearby rural states from The State of Mental Health in America (2018). A higher overall ranking indicates lower prevalence of mental illness and higher rates of access to care.

Source: www.mhanational.org/issues/state-mental-health-america

NORTH DAKOTA MEDICAID ELIGIBLES AND RECIPIENTS

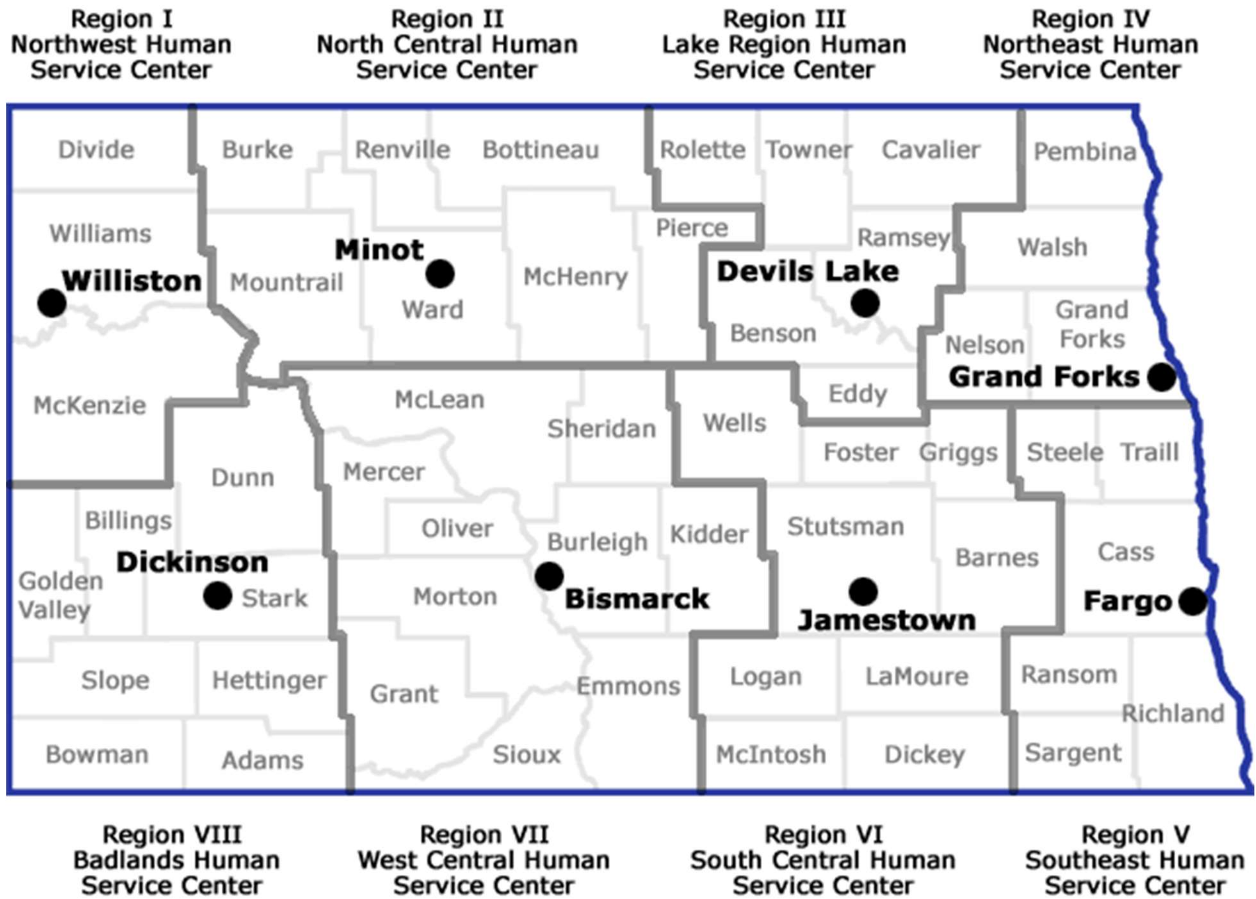
Traditional Medicaid Eligibles and Recipients
(Does not include Expansion)



January 2016 to September 2016 Eligibles were restated due to Eligibility System transitions.
SFY 2017 shows an increase of 3.03% of Eligibles and an increase of 13.59% in Recipients.
SFY 2017 average Eligible children increased 4.49% to 41,418 children.

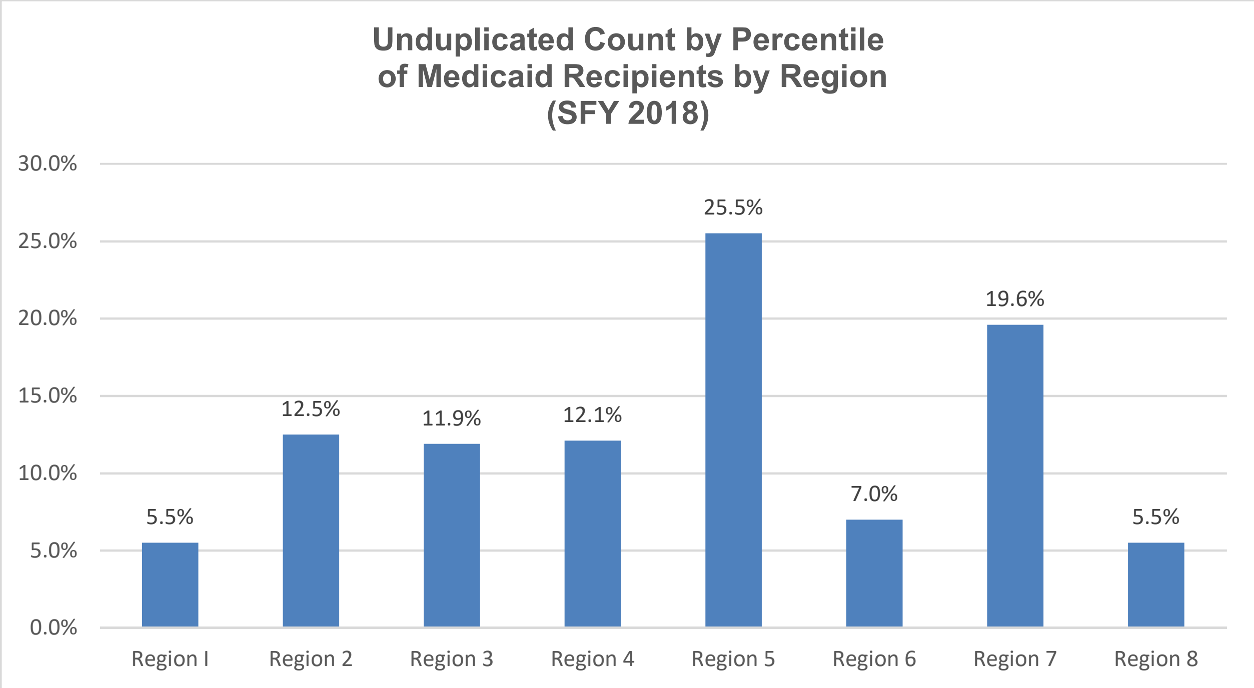
Key Points: From August 2015 through November 2018 North Dakota's traditional Medicaid eligible population increased by 3% and recipients increased by 13.6% during SFY 2017. The graph suggests a relatively stable population trendline of the North Dakota traditional Medicaid population.

Source: North Dakota Department of Human Services



Key Point: North Dakota’s 53 counties are divided into eight regions. Each region is served by a regional Human Service Center.

Source: North Dakota Department of Human Services



Key Points: All regions have some rurality, but Regions 2 (Minot), 4 (Grand Forks), 5 (Fargo) and 7 (Bismarck) have larger urban towns including six major hospitals. Regions 1 (Williston), 3 (Devils Lake), 6 (Jamestown) and 8 (Dickinson) are more rural communities and have critical access hospitals.

Source: North Dakota Department of Human Services

Access: What does the comparison of North Dakota Medicaid to Medicare fees imply?

North Dakota was subject to a budget allotment process in 2016 and state agencies were required to reduce expenditures in order to achieve a balanced biennial budget, as required by the state's constitution. The Department of Human Services Medical Services Division reduced medical assistance expenditures by eliminating proposed increases and reducing some Medicaid provider rates.

The initial AMRP of October 2016 incorporated access monitoring of provider groups impacted by the rate reductions. The North Dakota Legislature convenes every other year. During the 2017 Legislative Assembly, most of the Medicaid specific budget balancing rate reductions were restored to original funding levels or higher. Per CMS consultation, the subsequent rate restorations resulted in discontinuing the additional access monitoring of the associated provider groups.

It is important to note that the Professional Services Fee Schedule (PSFS) rate reduction was not restored by the 2017 or 2019 Legislative Assembly. The PSFS providers include primary care, specialist care, behavioral health care, and obstetric care. These are identified core provider groups specified by CMS for access monitoring, with the exception of home health care providers. The Medical Services Division has continued ongoing analysis of access to care for these five PSFS provider types.

Prior to the 2016 allotment, the PSFS rates were greater than Medicare rates. Then during the allotment, rates between Medicaid and Medicare were equalized at a 1:1 ratio. It should be noted that many Medicaid versus Medicare services have different coverage parameters so maintaining an exact comparison between the two rates presents challenges. However, over the past three years North Dakota has maintained quite comparable Medicaid to Medicare rates, ranging from slightly below to exactly equal depending on provider type.

The Urban Institute has the most current state rankings of Medicaid to Medicare Fee Index (published March 2017). Their methodology compares fees across 27 procedure codes.

Medicaid-to-Medicare Fee Index by Service Type (2016)

State	All Services	Primary Care	Obstetric Care
Range	0.38 – 1.26	0.33 – 1.27	0.35 – 1.30
US Average	0.72	0.66	0.81
North Dakota	0.98	1.00	0.99

Key Point: Second only to Alaska and Montana, North Dakota ranks third highest in the nation in this index (2017 report from the Urban Institute state-by-state Fee Index ranking data)

Source: www.urban.org/sites/default/files/publication/88836/2001180-medicaid-physician-fees-after-the-aca-primary-care-fee-bump_0.pdf [15]

The 2019 North Dakota Legislative Assembly has appropriated funding to support provider annual inflationary increases of 2% and 2.5%. As a result, the 2019 North Dakota PSFS Medicaid rate will now likely exceed the Medicare rate for comparable services for SFY 2020 and SFY 2021.

Maintaining this equalized Medicaid-to-Medicare fee index is important for three reasons:

1. North Dakota has among the best Medicare participation rates in the country.
   Multiple national sources report that a significant majority of providers across the United States accept Medicare referrals. A 2018 physician survey[16] reports that behind only South Dakota and Maine, North Dakota ranks third among the top five states for lowest numbers of physicians who currently do not see Medicare patients (5.7%). We hypothesize that one of the reasons why beneficiaries report success in gaining access to care is the 1:1 rate ratio for professional provider services delivered to traditional Medicaid beneficiaries.
2. Significant numbers of physicians across the United States are declining new referrals.
   The same 2018 physician survey cited above reported that nationwide, 80% of physicians were at capacity or over extended. Comments from the 2019 Medicaid beneficiary survey suggest that some beneficiaries are finding that some providers are at capacity and not accepting referrals regardless of type of healthcare coverage. Significant numbers of survey responders do report access to primary care and specialists but comment that timely appointments can be challenging. We hypothesize that maintaining Medicaid-to-Medicare rate equalization of the PSFS fee schedule is important in that it allows Medicaid beneficiaries access on a level comparable to Medicare beneficiaries.

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[15] see "Data and Methods" section
[16] www.physiciansfoundation.org

3. CMS guidance grants waivers of access monitoring when Medicaid rates are equal to or greater than Medicare rates.
   Based on a November 2017 State Medicaid Director letter (SMD# 17-004) CMS indicates that using the experience gained from wholesale review of states' (2016) access monitoring efforts, *"this letter describes guidance on implementation approaches for the Medicaid access to care fee for service (FFS) requirements found at 42 CFR 447.203(b)… we are issuing this letter to offer the flexibilities available to us prior to finalizing new regulations…CMS is offering additional guidance to clarify circumstances that would likely not result in diminished access and, as such, would not require the analysis and monitoring procedures described in the regulations"*.

   The CMS letter indicates that: "*in the absence of information to the contrary (such as high volume of access complaints which would trigger the regulatory requirements), CMS has determined the following circumstances… would not invoke the (access monitoring) requirements of §447.203(b)(6)".* The CMS policy guidance offers a clarifying example regarding circumstances in which provider payment reductions would likely not result in diminished access to care, specifically exempting states that pay at or above the Medicare rate under FFS.[17]

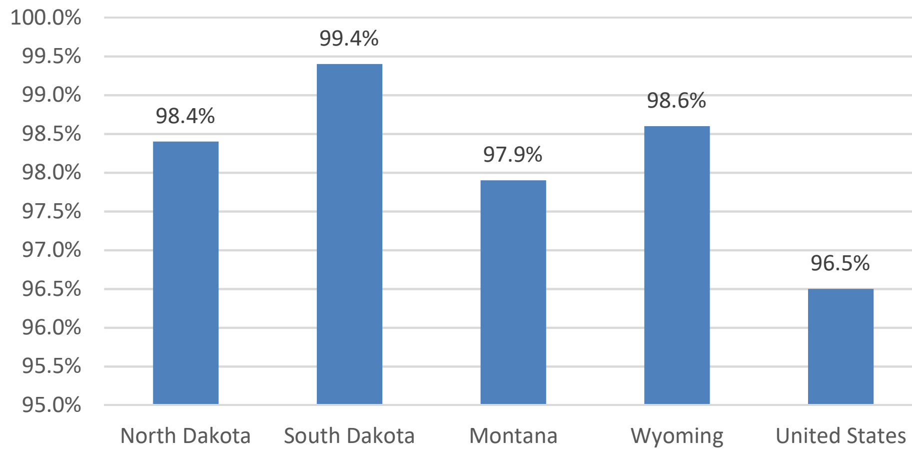
Access: What do National State-by-State Rankings Say About North Dakota's Access to Health Care?

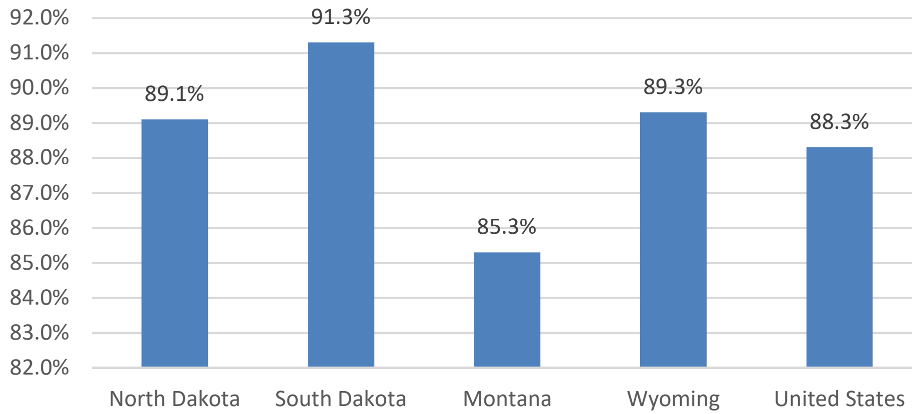
North Dakota is above the United States average for the following 2017 rankings:
- Percent told that provider does accept insurance type in the past year
- Percent who had a usual source of medical care other than the emergency department

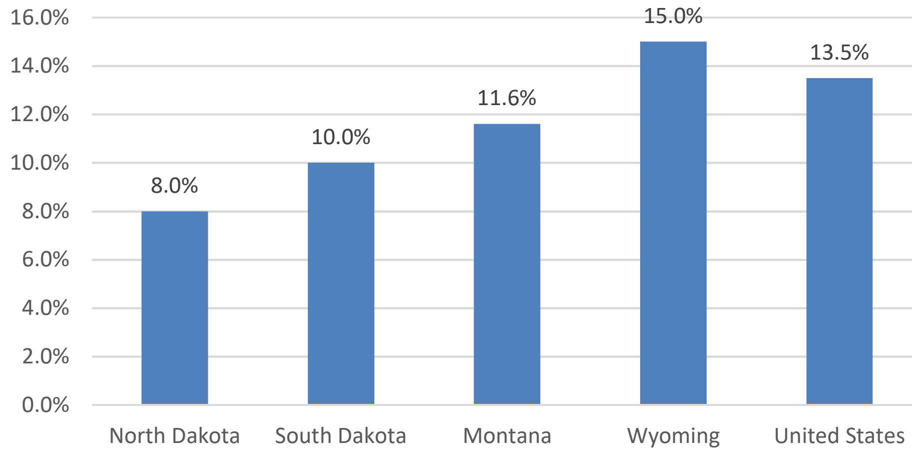
North Dakota is below the United States average for the following 2017 rankings:
- Average number of days during the last 30 days when an adult's physical or mental health was not good

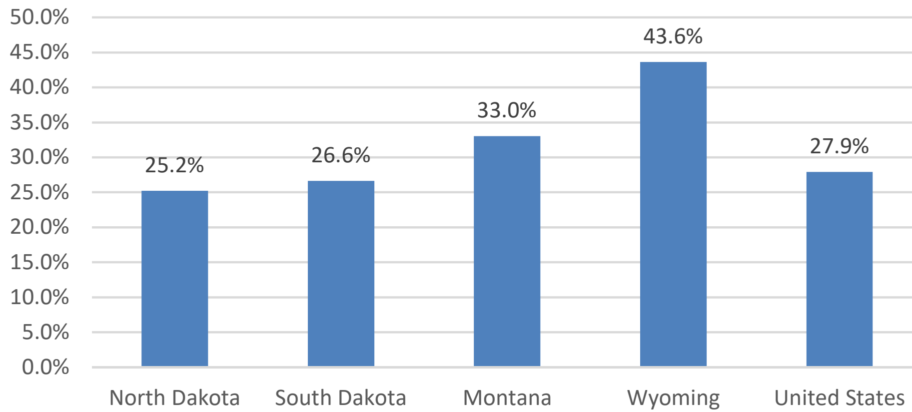
Source: State Health Compare statehealthcompare.shadac.org/

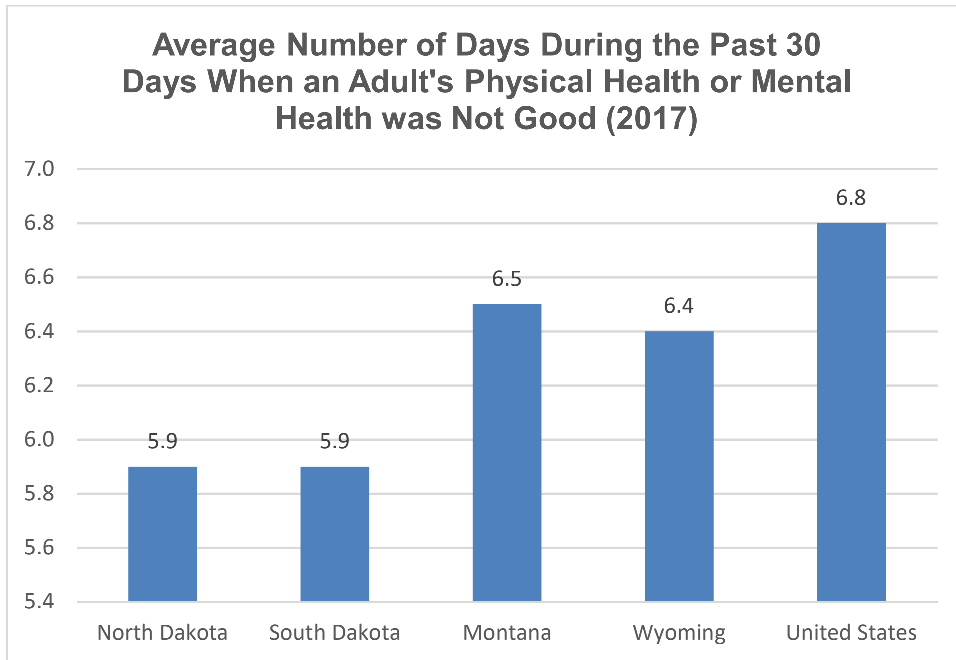
[17] https://www.medicaid.gov/federal-policy-guidance/downloads/smd17004.pdf


Percent Told That Provider Does Accept Insurance Type in the Past Year (2017)
100.0%
99.5%
99.0%
98.5%
98.0%
97.5%
97.0%
96.5%
96.0%
95.5%
95.0%
98.4%
99.4%
97.9%
98.6%
96.5%
North Dakota
South Dakota
Montana
Wyoming
United States


Percent Who Had A Usual Source of Medical Care Other than the Emergency Department (2017)
92.0%
91.0%
90.0%
89.0%
88.0%
87.0%
86.0%
85.0%
84.0%
83.0%
82.0%
89.1%
91.3%
85.3%
89.3%
88.3%
North Dakota
South Dakota
Montana
Wyoming
United States


Percent of Adults Who Could Not Get Medical Care When Needed Due to Cost (2017)
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
8.0%
10.0%
11.6%
15.0%
13.5%
North Dakota
South Dakota
Montana
Wyoming
United States


Percent Who Had Trouble Paying Off Medical Bills in the Past Year or Were Currently Paying off Medical Bills (2017)
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
25.2%
26.6%
33.0%
43.6%
27.9%
North Dakota
South Dakota
Montana
Wyoming
United States

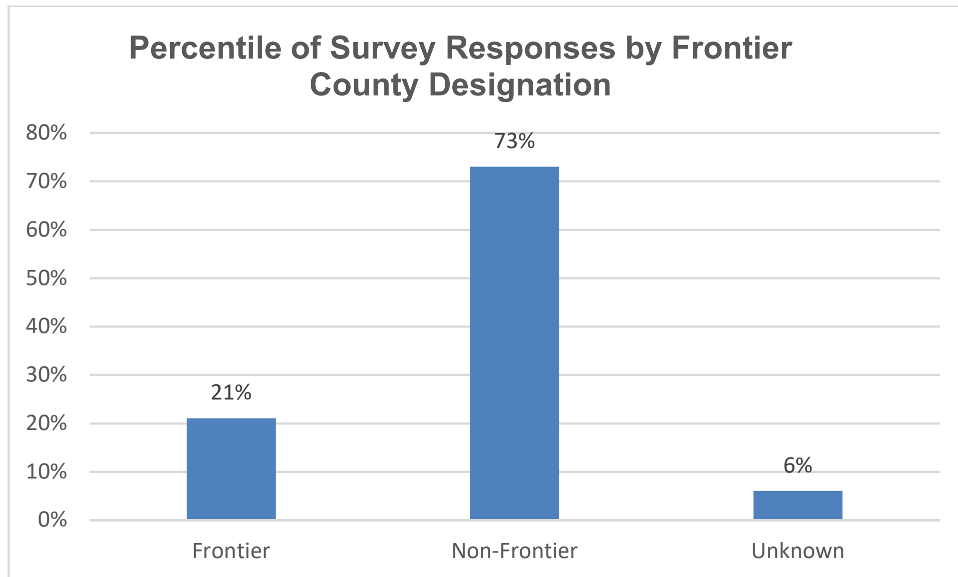


Access: What Do Beneficiaries Think?

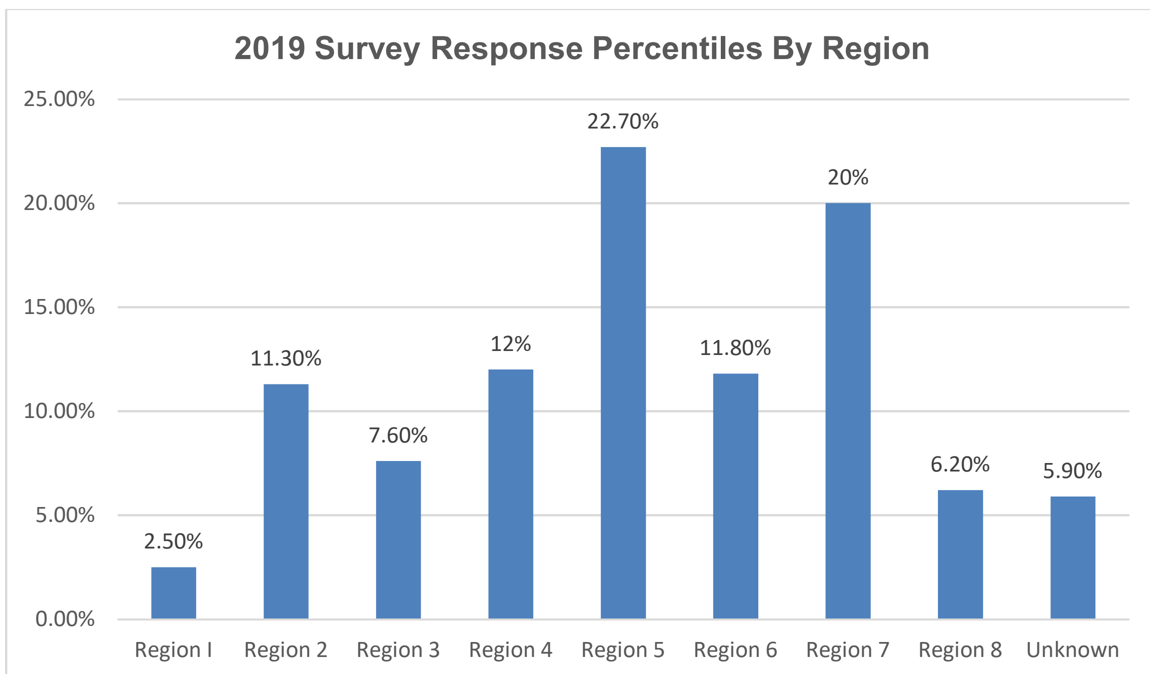
In conjunction with the development of the North Dakota 2016 AMRP, and the dissemination of the first traditional Medicaid Household Access to Care survey in 2016, an email account was created (ndmedicaid@nd.gov) to allow Medicaid households an additional, ongoing alternative to offer comments about their access to care experiences. In addition to informing Medicaid households of the email through the 2016 recipient newsletter, the email account was referenced in two subsequent newsletters and noted on both the 2016 and the 2019 Medicaid Household surveys.

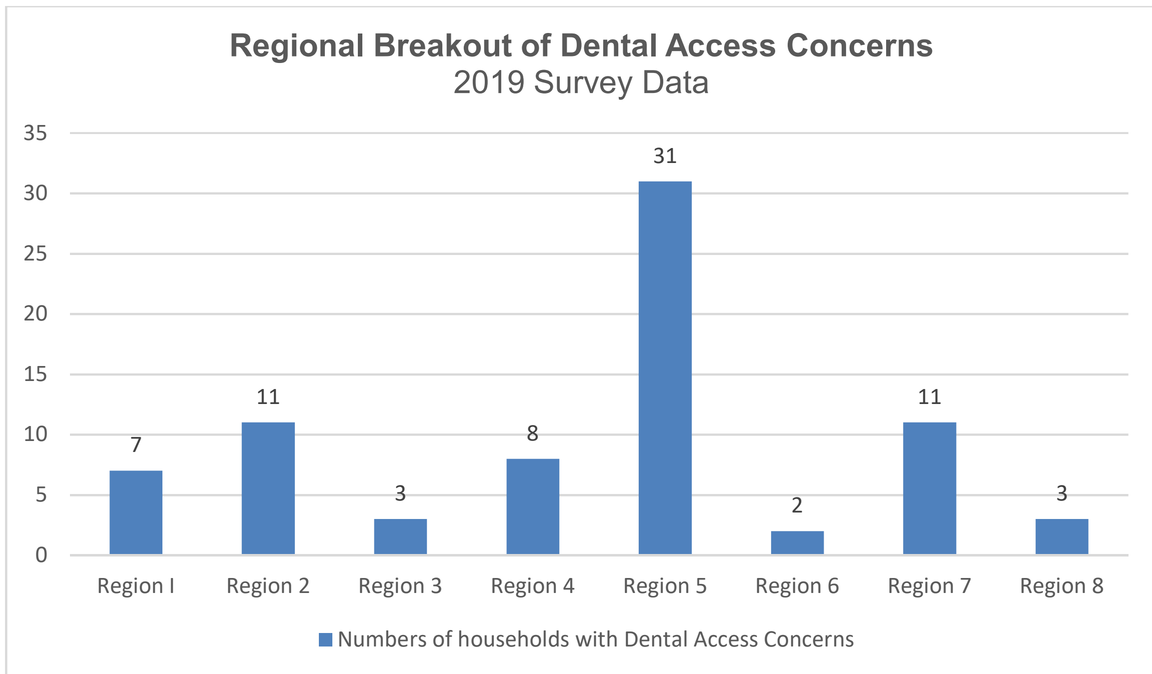
The volume of email responses has been low, consisting of nine emails between September 2016 through March 2019. Two responses were access surveys that were scanned and emailed, and the others had to do with claim questions or claim denials, including one parent expressing concern about a denial of an out-of-state request, and others advocating for changes in Medicaid covered services.

Results from the 2019 Medicaid Beneficiary Access to Health Care Survey



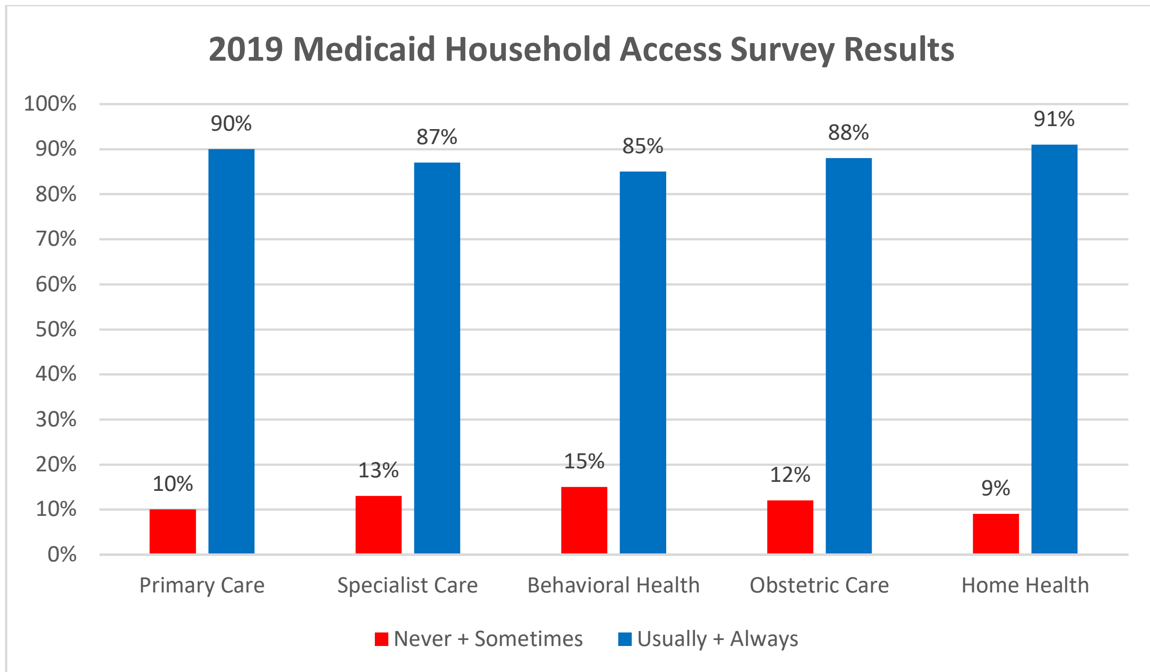
Although only 17 North Dakota counties have non-frontier designation, total Medicaid populations in those counties comprise 81% of all Medicaid eligibles for SFY 2018. Given the lower Medicaid populations in frontier counties, rural recipients had a slightly higher per capita response rate compared to the more urban counties.





1.8% of responding households identified dental access concerns. Access barriers included that some dentists are not accepting new Medicaid patients, some available appointment slots are far from the beneficiary's home, and that ND Medicaid does not cover as many adult dental services as beneficiaries would prefer.

Households from 20 counties (38%) identified dental access concerns (range 1 to 25 households per county). Statewide, more Medicaid households cluster in the most urban counties. Seventy percent of dental concerns orginated from Burleigh (5), Cass (25), Grand Forks (7), Ward (10) and Williams (6).



A surprising, seemingly contradictory phenomenon showed up in the 2019 results. Among those responders who reported “never” or “sometimes” rankings, significant numbers of those same responders endorsed in Question 12 that:

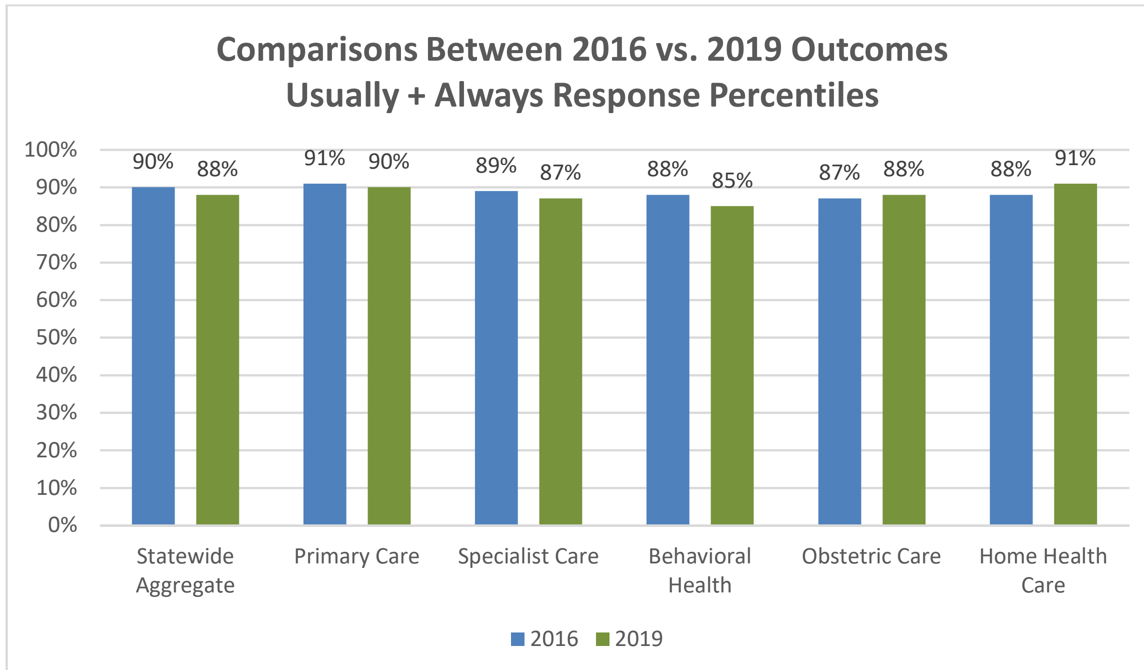
“We’ve had no problems accessing health care”.

Of survey respondents who endorsed “Never” or “Sometimes”, the percentiles below indicate households that also endorsed the “no access problem” statement:

Primary Care:	30% endorsed the “no problems” statement on Q 12
Specialist Care:	30% endorsed the “no problems” statement on Q 12
Behavioral Health:	24% endorsed the “no problems” statement on Q 12
Obstetric Care:	26% endorsed the “no problems” statement on Q 12
Home Health Care:	41% endorsed the “no problems” statement on Q 12

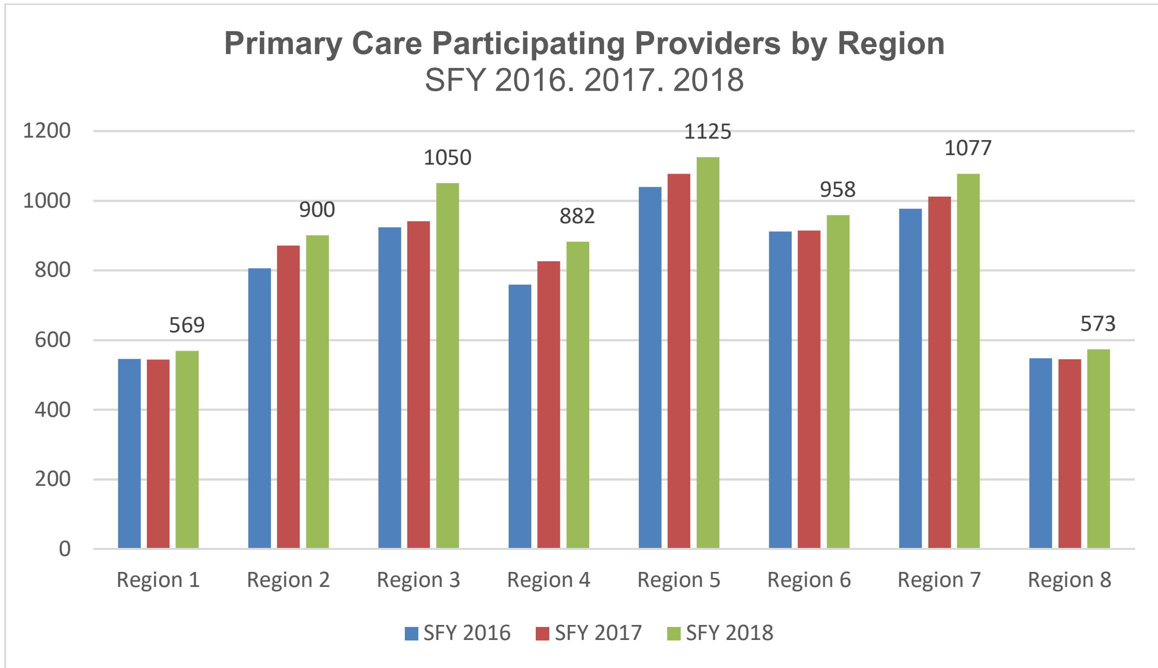
In reconciling this seemingly contradictory response pattern, we hypothesize that a significant subset of survey responders generally felt their household had no problems with overall access but did rank never or sometimes responses to reflect rurality barriers. For example, less than timely access, winter weather challenges, distances between providers and beneficiaries, transportation challenges, and similar rurality barriers.

2016 vs. 2019 Survey Comparisons

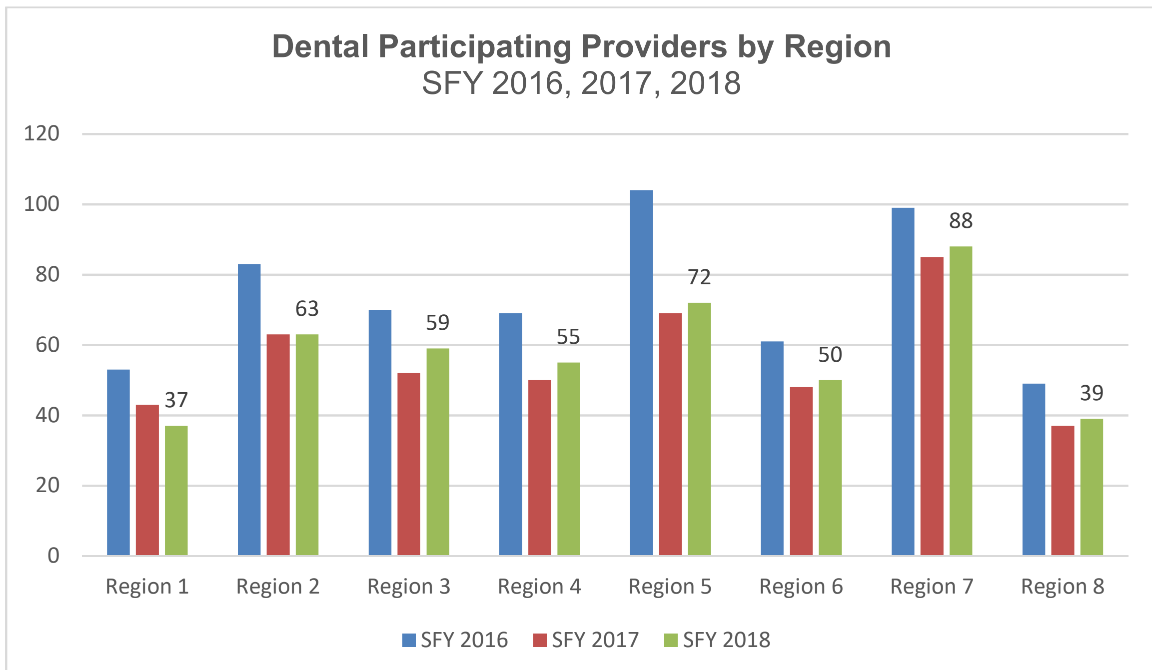


- 6,679 household surveys were returned in 2016 as compared with 4,293 in 2019.
- 2016 surveys were conducted in mid-September through November; the 2019 survey period was January through mid-March.
- The 2019 survey was conducted during worse winter weather compared to 2016. Weather was noted as an access barrier in some 2019 survey responses, while not noted in 2016.
- Access percentile changes in 2019 were 1% to 3% with a statewide aggregate of 2%. By provider type they were:
    - Primary Care – 1% decline
    - Specialist Care – 2% decline
    - Behavioral Health – 3% decline
    - Obstetric Care – 1% improvement
    - Home Health Care – 1% improvement.

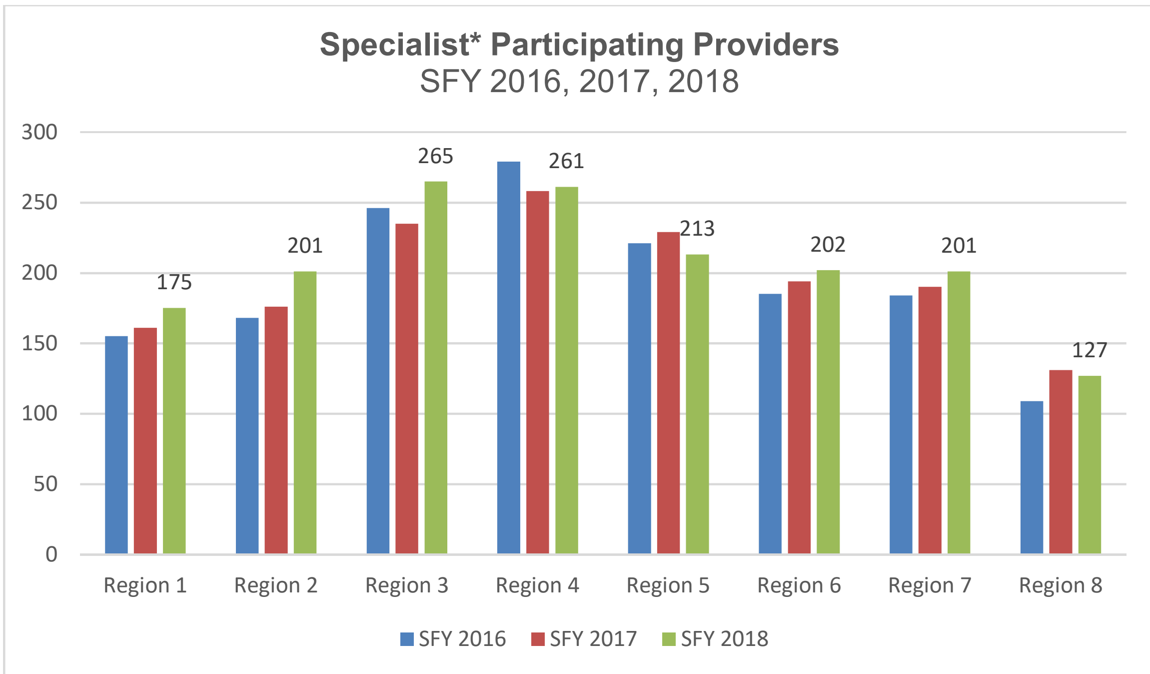
Access: What does Medicaid data tell us?



All primary care participating providers increased across all regions during the 3-year period.

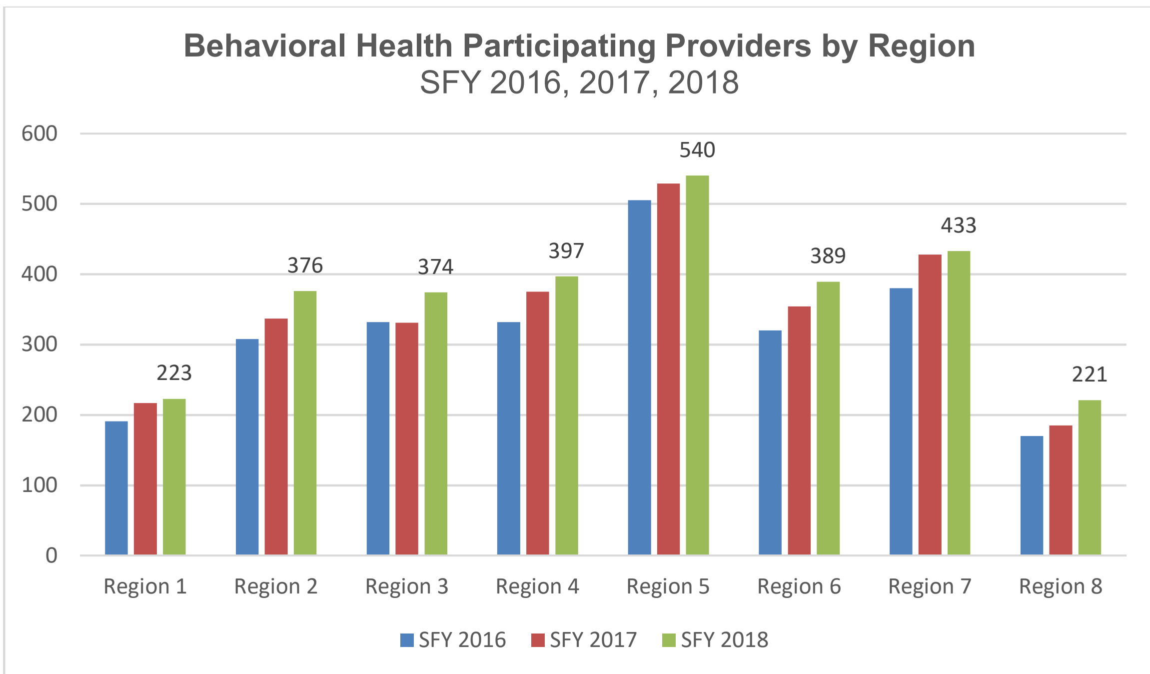


The number of participating dentists declined for all regions between 2016 to 2017 but in 2018 started to stabilize or increase for 7 regions. Only Region 1 had a further decline.

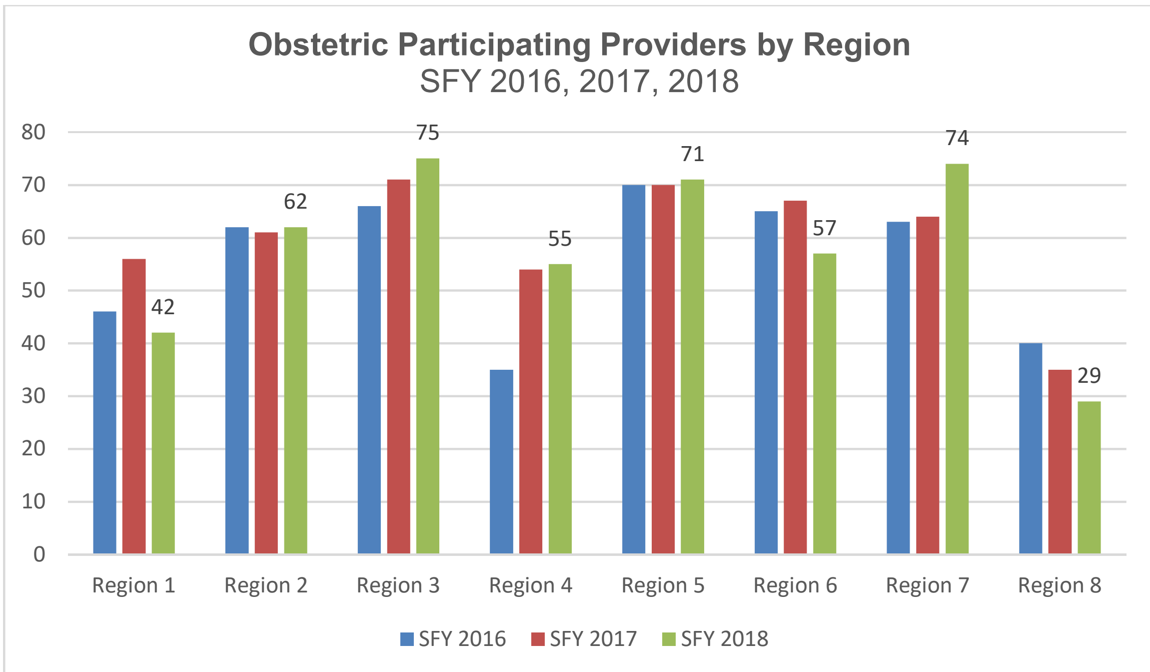


* Specialist consists of Cardiology, Radiology, and Urology.

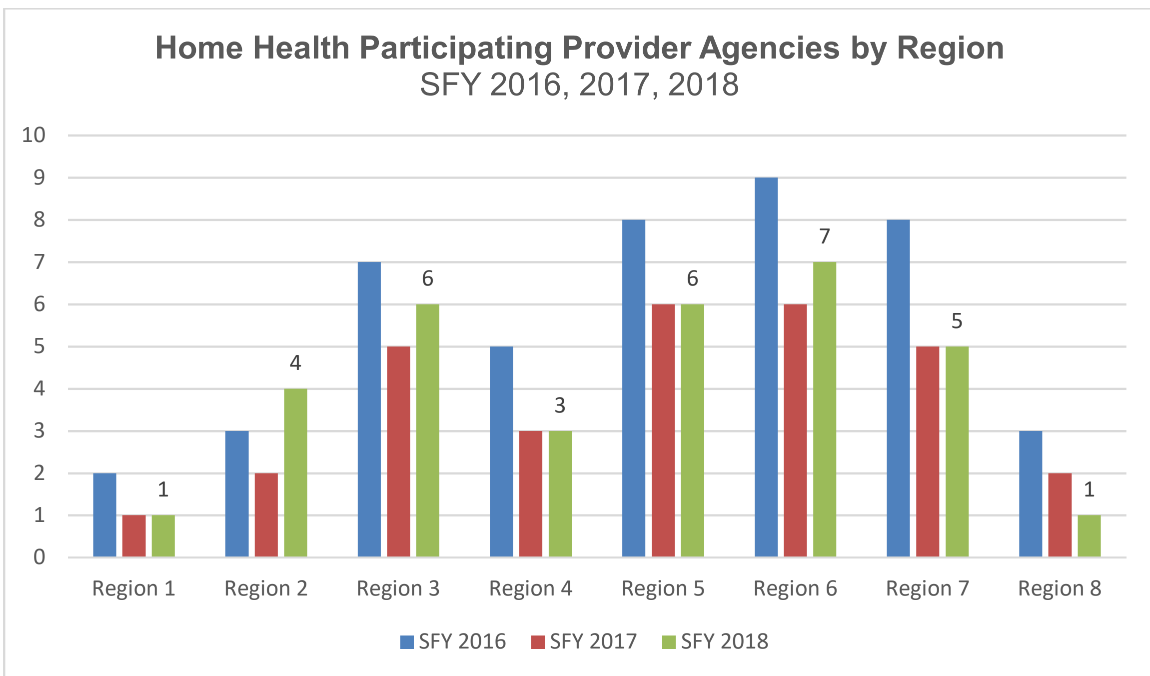
The numbers of specialists participating providers increased between 2016 to 2018 for six regions.



Behavioral Health participating providers increased across all eight regions over this 3-year period.



Obstetric participating providers increased across five regions during this 3-year period.



There are few home health provider agencies statewide. All regions experienced a decline in home health participating providers from 2016 to 2017. Region 8 lost one additional provider agency into 2018. The remaining seven regions maintained or increased participating provider agencies between 2017 to 2018.

Results from the Professional Services Fee Schedule Baseline Analysis

The original AMRP analyzed SFY 2015 participating provider and Medicaid beneficiary baseline data in combination with 2016 beneficiary survey data to gauge access to care. Analyses determined that access to care to these provider populations was positive, including access to providers in North Dakota's most rural counties. We hypothesize that the atypical favorable access to even the most rural North Dakota Medicaid beneficiaries was a result of strong Medicaid provider participation across rural North Dakota regions, in relationship to Medicaid beneficiary enrollment in those regions.[18]

North Dakota is divided into eight regions. Four are relatively urban and four are rural. Using data from the Department of Human Services, two data variables were calculated and cross-tabulated for each region:

1. Percentage of participating Medicaid providers; and,
2. Percentage of Medicaid beneficiaries.

The SFY 2015 baseline analyses concluded that in all four rural regions (Regions 1, 3, 6 and 8) the percentile of participating providers exceeded the percentile of Medicaid beneficiaries, suggesting that rural providers are enrolling and participating in Medicaid at higher than state average rates and at higher rates compared to the percentile of participation in the urban regions.

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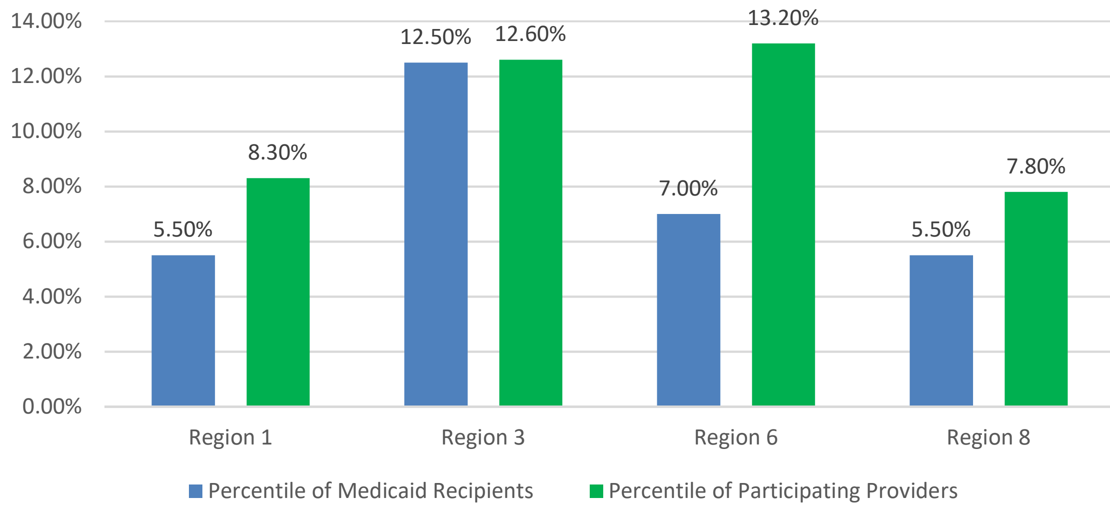
[18] Medicaid beneficiaries living in the four more urban regions (Regions 2, 4, 5, and 7) benefit by having the "big 6 hospitals" located within their catchment areas.


Percentile of Participating Providers Continues to Exceed
Percentile of Medicaid Recipients
in all Four of ND's most Rural Regions (2018)
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
5.50%
8.30%
12.50%
12.60%
7.00%
13.20%
5.50%
7.80%
Region 1
Region 3
Region 6
Region 8
Percentile of Medicaid Recipients
Percentile of Participating Providers

Summary

North Dakota proposes to discontinue access monitoring of providers in relation to the claims to the Professional Services Fee Schedule for these provider types: primary care, specialist care, behavioral health care, and obstetric care participating providers.

- The identified access monitoring threshold of 5% more rural recipients over rural participating providers has not been triggered.
- The 2019 access data continues to be very positive statewide and notably positive for the four most rural regions of North Dakota.
- Rates for the professional services providers were equalized in 2016 to the Medicare rates, which CMS has since determined, absent other evidence of access concerns, results in exclusion from access monitoring.
- North Dakota is increasing inflation to providers, including to professional services providers, 2% the first year of the upcoming biennium and 2.5% the second year which will result in North Dakota rates likely exceeding Medicare rates.
- North Dakota is investing heavily in expanding the depth and scope of Medicaid behavioral health services during this upcoming biennium, and participating provider numbers of this provider group has already increased in all eight regions during 2018.