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External Quality Review Annual Technical Report

Review Period: July 1, 2022 to December 31, 2023

North Dakota Department of Health and Human Services
Medical Services Division

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I. Executive Summary

Purpose of Report

Prior to the federal 2019 novel coronavirus (COVID-19) public health emergency, the North Dakota (ND) Department of Health and Human Services (HHS) had between 80,000 and 90,000 members across its traditional and expansion programs. As of July 2023, the ND Medicaid program serves 127,425 North Dakotans, including 56,750 children, 34,119 individuals covered under the Medicaid Expansion, 11,503 individuals with disabilities, 15,430 adults, and 9,623 people over age 65 years. ND Medicaid has six Centers for Medicare and Medicaid Services (CMS)-approved 1915(c) Waivers for targeted populations.

Fee-for-service (FFS) is the traditional healthcare payment system in which physicians and other providers receive a payment for each unit of service they provide. HHS is responsible for the clinical, administrative, and payment functions of the FFS population. The members of the FFS population include Medicaid beneficiaries that are not in managed care.

Medicaid provides coverage for acute and primary care services, prescription drug coverage, and behavioral health (BH) services for most of ND's Medicaid Title XIX members and ND's Title XXI Children's Health Insurance Program (CHIP). CHIP members are served through the FFS program and receive the Title XIX benefit plan. The FFS population includes children, low-income parents and caretaker relatives living with children, pregnant individuals, and children who are currently and/or were formerly in foster care and/or adoption assistance.

Although external quality review organization (EQRO) contracts are typically focused on managed care, ND contracted with IPRO, the state's EQRO for its Medicaid managed care (MMC) population, to perform similar tasks related to the FFS population.

This detailed technical report aggregates, analyzes, and evaluates information on the **quality** of, **timeliness** of, and **access** to health care services that are provided to Medicaid recipients excluding members enrolled in managed care. The report also contains an assessment of the strengths and weaknesses of ND's policies regarding health care quality, timeliness, and access, as well as recommendations for improvement.

Scope of External Quality Review Activities Conducted

This report focuses on two external quality review (EQR) activities that were conducted according to CMS's EQR protocols. Even though the protocols were established for managed care organizations (MCOs), IPRO followed them for the FFS activities as set forth in *Title 42 Code of Federal Regulations (CFR) Section (§) 438.358 Activities related to external quality review (b)(1)*; these activities are:

(i) ***CMS Optional Protocol 6:*** **Administration or Validation of Quality-of-Care Surveys** – This activity uses a member survey to measure satisfaction with care received, providers, and health plan operations. During the review period, a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) satisfaction survey was conducted for FFS members.

(ii) ***CMS Optional Protocol 9:*** **Conducting Focus Studies of Health Care Quality** – This activity assesses quality of care for a population of particular interest to HHS. In fiscal year (FY) 2023, IPRO conducted focus studies of the use of BH services by youth in foster care and use of prenatal and postpartum care by individuals who gave birth.

In addition to these two activities, IPRO also conducted a review of ND's Quality Strategy.

The results of these EQR activities are presented in individual sections of this report. Each includes information on:

- data collection and analysis methodologies;
- comparative findings; and
- where applicable, the state's performance strengths and opportunities for improvement.

High-Level Program Findings and Recommendations

IPRO used the analyses and evaluations of measurement year (MY) 2022 EQR activity findings to assess the performance of the ND Medicaid FFS Program in providing quality, timely, and accessible healthcare services to Medicaid members. The program was evaluated against state and national benchmarks, where available, for measures related to the quality, access, and timeliness domains.

The following provides a high-level summary of these findings for the ND FFS Medicaid Program. These findings are discussed in each EQR activity section, as well as in the **Strengths, Opportunities for Improvement, and EQR Recommendations** section.

Quality Strategy

To support HHS's objective of providing consistently high-quality care to all Medicaid members, IPRO and ND worked together to develop an integrated quality strategy across both MCO and FFS programs. The new quality strategy incorporates population health streams, metrics, and initiatives important to both programs. An important aspect of review and development of an incorporated strategy was to be able to measure outcomes at state level and to have a statewide strategic approach that bridged both programs. IPRO made several recommendations for BCBSND and HHS which were included in the new quality strategy. IPRO recommended that HHS expand support for BCBSND's quality improvement initiatives through ongoing education, training, and feedback on Healthcare Effectiveness Data and Information Set (HEDIS®) rates, while promoting transparency by sharing performance improvement project (PIP) reports and performance data. IPRO suggested reducing the number of active PIPs annually to focus on population health improvements and highlighting special programs aligned with state initiatives. Ensuring equal representation and alignment of goals, objectives, and measures across both FFS and MCO populations was emphasized. Additionally, IPRO advised adding measures for well-child visits and maternal and infant wellness and reporting quality measures on a statewide basis to provide a comprehensive view of achievements. Following IPRO's evaluation, ND updated its quality strategy to comprehensively include both FFS and MCO programs, aligning goals and initiatives across these populations. The new strategy incorporates CMS feedback and aims to measure state-level progress while addressing population-specific disparities and was available for public comment in December 2023.

Quality-of-Care Surveys – CAHPS

IPRO fielded three CAHPS 5.1 Surveys for the ND Medicaid FFS populations (adults, children, and children with chronic conditions [CCC]) to determine the effectiveness of the FFS program from the consumer perspective. Composite scores were developed for four areas, consistent with the CAHPS methodology: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service. The adult survey consisted of four rating questions that assessed satisfaction with healthcare, personal doctors, specialists, and the Medicaid program. Ratings of 8, 9, or 10 were considered achievements. The achievement scores were 68.0% for all healthcare, 83.9% for personal doctors, 82.3% for specialists, and 71.0% for the health plan. Composite scores for member experience domains were calculated as the proportion of positive responses ("Usually" or "Always"). Scores were calculated for each of the four domains of member experience: Getting Needed Care (84.1%), Getting Care Quickly (84.9%), How Well Doctors Communicate (92.9%), and Customer Service (84.4%). The Effectiveness of Care measure evaluated provider advice on quitting smoking or tobacco use. Achievement scores for this measure were 80.8% for Advised to Quit Smoking, 52.6% for Recommended Medication for Quitting, and 47.4% for Discussed Methods Other Than Medication. The Flu Vaccinations for Adults Ages 18–64 (FVA) measure is based on a single question about getting a flu shot or flu spray. The score represents the proportion of members ages 18–64 years who received flu vaccination since July 1 of the MY. More than half (54.8%) of the respondents indicated they received a flu shot or spray. Overall, FFS performed well across these four domains. Important areas for improvement included smoking cessation, flu vaccination, and obtaining specialized services.

Focus Studies

Foster Care Focus Study

The objectives of this study were to profile and compare the prevalence of BH conditions, polypharmacy, preventive service receipt (ages 0–20 years), and hospitalization for mental illness among youth (ages 6–17 years) in foster care to

all other youth enrolled in Medicaid; to quantify the risk for hospitalization for mental illness; and to quantify additional demographic, clinical, and utilization risk factors for hospitalization for mental illness.

A key finding of this study is that while foster care enrollees are more likely to be hospitalized for mental illness relative to all other Medicaid enrollees ages 6–17 years, being in foster care is not independent of the clinical, metabolic, psychotropic polypharmacy, and demographic drivers of hospitalization for mental illness. Therefore, understanding the disparities in the distribution of these drivers among foster care and non-foster care enrollees is key to understanding and addressing the susceptibilities of foster care enrollees. For example, ND Medicaid enrollees with mood disorders showed the greatest likelihood for behavioral hospitalization relative to those without mood disorders (odds ratio [OR] = 16.629), and the prevalence among foster care enrollees was 14.05% compared to only 4.61% of non-foster care enrollees. Compared to Medicaid youth with no psychotropic use, Medicaid youths with chronic use of two psychotropics were twice as likely to be hospitalized for mental illness, and polypharmacy was considerably more prevalent among foster care enrollees.. The following minority subsets showed a higher prevalence among Medicaid enrollees with a hospitalization for mental illness relative to those without hospitalization: enrollees of more than one race and American Indian enrollees. Of note, American Indian enrollees composed 41.97% of foster care enrollees but only 20.07% of non-foster care enrollees.

This focus study provides evidence to suggest that children in foster care are more likely to be hospitalized for mental illness, and that disparities in clinical, polypharmacy, and associated metabolic factors represent underlying vulnerabilities for this susceptible Medicaid subpopulation. Further research is merited to evaluate foster care enrollees' receipt of timely preventive care, as well as evidence-based care for children on psychotropic medications.

Maternal Care Focus Study

The objectives of this study were to identify the prevalence of receipt of recommended prenatal and postpartum care, as well as risk factors associated with underuse of care; to produce rates of preterm delivery and low birthweight; and to describe the potential impact of extending Medicaid eligibility from 60 days to one year postpartum. Delayed access to prenatal and postpartum healthcare can result in a number of negative maternal and infant health outcomes, including premature birth, low birthweight, maternal mortality, severe maternal morbidity, and increased risk of postpartum depression. Extended insurance coverage can increase utilization of contraceptive services, decrease incidence of short-interval pregnancies, and increase utilization of mental and BH services.

The study found just 56.3% of enrollees received a prenatal care visit in the first trimester and that only 40.5% attended a postpartum care visit 7−84 days post-delivery. A total of 5.4% of births occurred prematurely (before 37 weeks gestation). Nearly 9% of the babies born during the study period weighed less than 2,500 grams.

Risk factors for late initiation of prenatal care were substance use disorder (SUD) or alcohol dependence, as well as tobacco use. Risk factors for preterm delivery were tobacco use and overweight/obesity/excessive weight gain during pregnancy. Characteristics associated with preterm delivery were tobacco use and weight. Risk factors for low birthweight were race (Black and Asian American/Pacific Islander); residing in a maternity shortage and rural area, SUD/alcohol dependence, severe mental illness, and premature delivery. Risk factors for lack of timely postpartum care were race (American Indian/Alaska Native), Hispanic ethnicity, rural residence, and maternity shortage area.

Use of health services postpartum for those birthing people who maintained Medicaid coverage was assessed. The study found 36.0% received preventive care other than maternity related, 29.8% had a visit for contraceptive care, 15.9% had a dental visit, and 9.5% had a dental visit.

Improving the health of birthing people and infants is key for preventing unnecessary illness and death and advancing overall population health. The study suggested several possible programs and services be considered, including:

- Conduct outreach and education for members about the benefits of comprehensive care, from prenatal to postpartum.
- Increase access to a broader array of services and providers that support maternal and infant health, including perinatal home visitation.
- Promote use of midwives and doulas, which can reduce health disparities by providing support to birthing people before, during, and after labor and delivery.

- Collaborate with local emergency departments and utilize the North Dakota Health Information Network (NDHIN) to proactively outreach to patients with positive pregnancy test results.
- Consider group prenatal care models of delivery where small groups of patients of similar gestational age meet at scheduled intervals for both medical care and facilitated educational discussions.
- Utilize care coordination staff (e.g., care manager, care coordinator, community health worker, or patient navigator) to address clinical and health-related social needs, provide touchpoints prior to first prenatal appointment, and provide wrap around services.
- Provide resources for healthcare professionals on ways to reduce racial/ethnic disparities, such as with The Council on Patient Safety in Women's Health Care and the Alliance for Innovation in Maternal Health (AIM Program) "Reduction of Peripartum Racial/Ethnic Disparities Patient Safety Bundle."[1]
- Create customized and targeted interventions that address barriers specific to vulnerable subpopulations, including age and race/ethnicity disparity subpopulations.
- Obtain member feedback on knowledge about and barriers to prenatal and postpartum care.
- Target interventions that support healthy behaviors including smoking cessation, nutrition, and physical activity.[2]
- Consider applying to the new CMS Transforming Maternal Health (TMaH) Model designed to focus exclusively on improving maternal healthcare. CMS will release a Notice of Funding Opportunity (NOFO) for state Medicaid agencies in Spring 2024. Applications will be due in Summer 2024.[3]

II. North Dakota Medicaid Program

Fee-for-Service in North Dakota

In ND, the Medicaid program has historically been FFS. However, through House Bill 1362, the 2013 ND Legislative Assembly directed the HHS to expand medical assistance as authorized by the federal Patient Protection and Affordable Care Act (ACA; *Pub. L. 111-148*), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; *Pub. L. 111-152*), to individuals under 65 years of age with income below 138% of the federal poverty level, based on modified adjusted gross income. This included implementing the expansion by bidding through private carriers or using the health insurance exchange (HIE), for which HHS chose the option of utilizing a private MCO.

North Dakota Medicaid Quality Strategy

The ND Medicaid Quality Strategy supports the mission of the state, which is, "To provide quality, efficient and effective human services, which improve the lives of people."

The Medical Services Division ensures that its enrollees receive high-quality care by providing effective oversight of its FFS population to promote accountability and transparency for improving health outcomes.

Guiding Principles for Improving Healthcare Outcomes

The guiding principles and expected outcomes have been developed and include the following:

- improved coordination of care;
- better health outcomes;
- increased quality of care as measured by metrics, such as HEDIS;
- greater emphasis on disease prevention and management of chronic conditions;
- earlier diagnosis and treatment of acute and chronic illness;
- improved access to essential specialty services;
- outreach and education to promote healthy behaviors;
- increased personal responsibility and self-management;
- a reduction in the rate of avoidable hospital stays and readmissions;
- monitoring of and a decrease in fraud, abuse, and wasteful spending;
- greater accountability for the dollars spent; and
- a more financially sustainable system.

Figure 1 depicts ND's Medicaid Quality Strategy, showing the conceptual linkages between healthcare needs, quality processes, and outcomes.

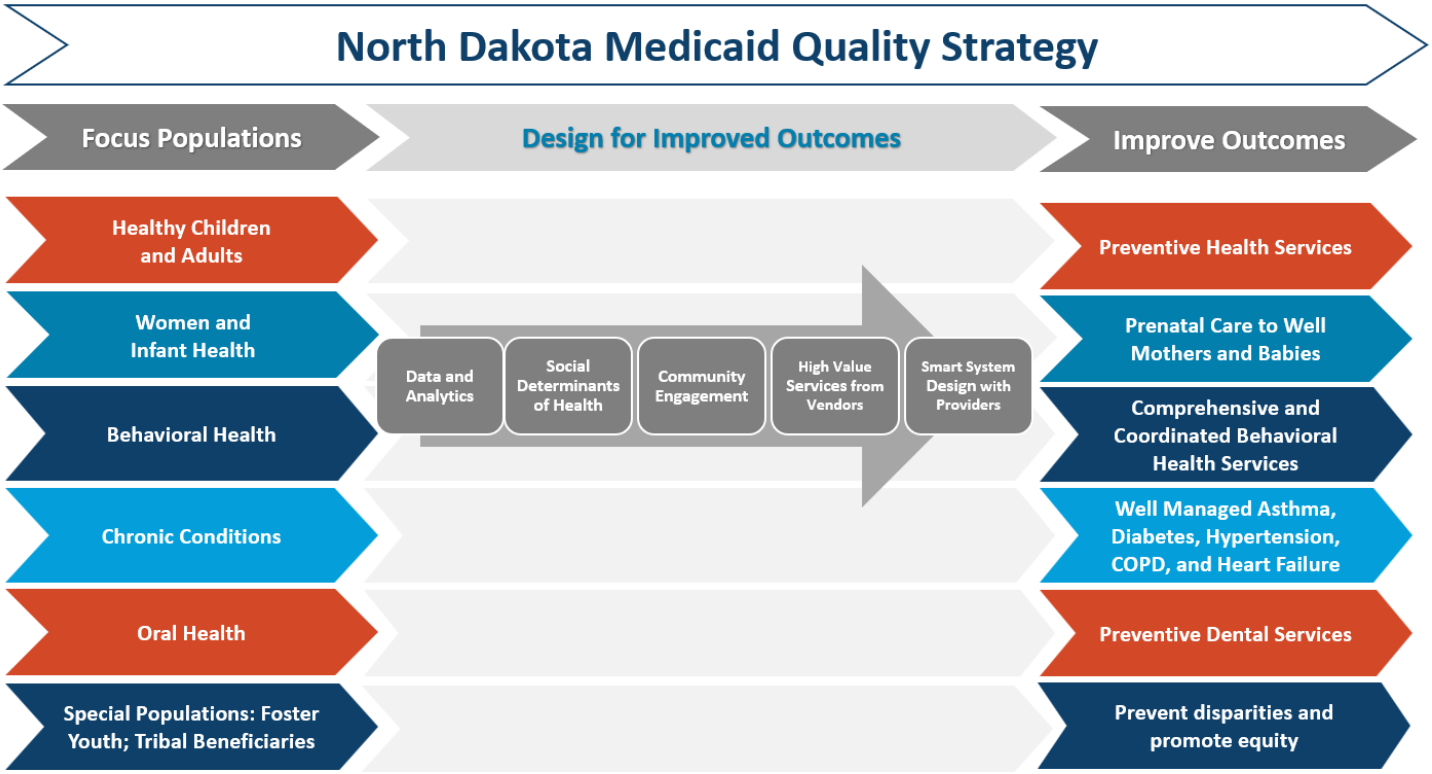

Figure 1: North Dakota Medicaid Quality COPD: chronic obstructive pulmonary disease.

Figure 2, which is based on the Institute for Healthcare Improvement's quadruple aim, appears in the quality strategy as a guidepost to the scientific basis of quality improvement processes. Included within each of the four aims in **Figure 2** is a series of goals and corresponding objectives, intended to highlight key areas of expected progress and quality focus. Together, these aims create a framework through which ND defines and drives the overall vision for advancing the quality of care provided to the Medicaid program members. These aims, goals, and objectives were designed to align closely with CMS's quality strategy, adapted to address ND's local priorities, challenges, and opportunities for its Medicaid program.

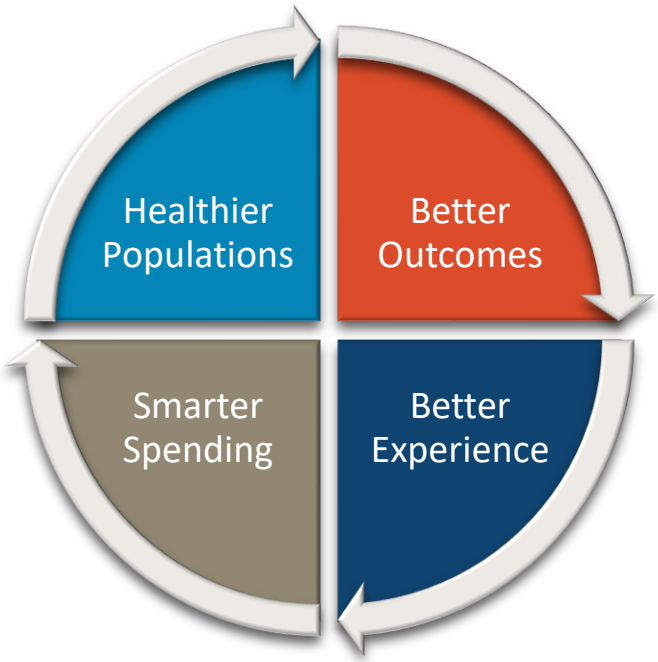

Figure 2: North Dakota's Quadruple Aim Resource: IHI – Institute for Healthcare Improvement

IPRO's Assessment of the North Dakota Medicaid Quality Strategy

Using the CMS Managed Care Quality Strategy Toolkit as a guide, IPRO has undertaken a complete evaluation of ND's 2023 Medicaid Quality Strategy Plan. The plan adheres to the recommendations provided by CMS for creating an effective strategy. EQR activities are incorporated into techniques for assessing and tracking MCO progress toward improving health outcomes, and goals and aims are well-defined and facilitated by well-planned interventions. HHS's extensive clinical and non-clinical activities and its implementation of MCO responsibility demonstrate how important it is to continue improving health outcomes. HHS's intent is to align this quality strategy to include both MCO and FFS populations, and as such, IPRO took this under consideration during this evaluation. IPRO concluded that ND's strategy towards population health fits both MCO and FFS populations.

Recommendations to HHS

IPRO identified the following recommendations for BCBSND and HHS:

- HHS can expand their support of BCBSND's quality improvement (QI) initiatives by promoting ongoing education and training related to key clinical areas. For example, they can give BCBS feedback on HEDIS rate improvement by holding in-person or virtual conferences and trainings that draw on the knowledge gained from PIPs, focus studies, and national best practices. It can be instructive to contact other states and host webinars where they can discuss their QI projects.
- Support transparency to promote QI by releasing PIP reports and sharing quality performance data outcomes with key constituents, such as via the HHS website.
- Help BCBSND focus population health improvements by reducing the number of PIPs that are active each year.
- Use the quality strategy to highlight special programs that align with strategic initiatives across the state or with specific focus populations. Identify community-based programs that would help achieve outlined objectives to further describe the state's strategy towards population health.
- Ensure both FFS and MCO populations have equal representation throughout the quality strategy and program initiatives and goals are aligned across these populations.
- Ensure goal, objective, and measure alignment across both FFS and MCO populations.
- Add measures related to well-child visits, as well as maternal, care and baby wellness measures, in the first aim for healthier populations.
- Report quality measures on a statewide basis, averaging MCO and FFS across all measures/objectives, to give a holistic view of the state's achievements.

Quality Strategy Update

Following the evaluation of the state's quality strategy, ND undertook a process to update and incorporate the above recommendations into a new quality strategy. The main purpose of this update was to develop a strategy that comprehensively includes both FFS and MCO programs. The new strategy takes the core approach from the past strategy and aligns program goals across both FFS and MCO through goals, objectives, and strategic initiatives. Comments on the previous strategy from CMS were reviewed and feedback was incorporated into the new version. This alignment allows ND to measure progress toward goals at the state level, while targeting disparities unique to each program's population. At the time of this report, the new quality strategy was available for public comment in December 2023.

III. Administration or Validation of Quality-of-Care Surveys – CAHPS Member Experience

Objectives

Results from fielding the CAHPS 5.1 Survey for ND Medicaid provide a comprehensive tool for assessing consumers' experiences with health care services.

Technical Methods of Data Collection and Analysis

The survey procedure and questionnaire were developed by the Agency for Healthcare Research and Quality (AHRQ). The survey drew as potential respondents the adult and child members of ND Medicaid who were continuously enrolled for the prior six months as of September 1, 2022, with no more than one enrollment gap of 45 days or less. The survey was offered in English and Spanish.

Two types of ratings were used: achievement scores and composite scores. Member responses to survey questions were summarized as achievement scores. Responses indicating a positive experience were labeled as achievements, and an achievement score was computed equal to the proportion of responses qualifying as achievements. The lower the achievement score, the greater the need for the program to improve. Composite scores were built from achievements for groups of survey items that make up broad domains of members' experience: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service.

The surveys took place during the period from January 27, 2023, through April 21, 2023, using a mail-only protocol and the Medicaid 5.1H questionnaires for adults, children, and CCC.

Description of Data Obtained

From the sample frames, a random sample of 1,350 adult cases was drawn. There were 1,650 members drawn for the child survey and 3,490 members drawn for the CCC survey. Complete surveys were obtained from 278 adult members with a response rate of 20.7%, 223 child members with a response rate of 13.6%, and 503 CCC members with a response rate of 14.5%.

Surveys were considered complete based on the following criteria:

- The respondent answered at least three out of five key items.
- Responses indicated that the respondent met the eligible population criteria.

Conclusions and Findings

Adult Survey

Summary of Overall Rating Questions

Four rating questions assessed overall consumer satisfaction with their health care, personal doctor, specialist talked to most often, and the Medicaid program (labeled as “health plan”). Response options for overall rating questions ranged from 0 (worst) to 10 (best). **Table 2** displays the results for the overall rating questions. Ratings of 8, 9, or 10 were considered achievements, and the achievement score was calculated as the proportion of members whose response was an achievement. The rating of all health care was 68.0%; rating of personal doctor was 83.9%; rating of specialist most talked to was 82.3%; and rating of health plan was 71.0% (**Table 2**).

Summary of Composites

A composite score was calculated for each of the four domains of member experience: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service. The composite scores provide a summary assessment of how the program performed across the domain. In **Table 2**, proportions of positive responses were reported as achievement scores. For all composites, responses of "Usually" or "Always" were considered achievements. The composite score for Getting Needed Care was 84.1%; for Getting Care Quickly was 84.9%, for How Well Doctors Communicate was 92.9%; and for Customer Service was 84.4% (**Table 2**).

Summary of Effectiveness of Care Measure

The Effectiveness of Care measure was composed of three questions. Scores represented the proportion of adult members whose provider 1) advised them to quit smoking or using tobacco (Q33); 2) recommended or discussed medication to assist with quitting smoking or using tobacco (Q34); and 3) discussed or provided methods and strategies other than medication to assist with quitting smoking or using tobacco (Q35). For each question, a response of "Sometimes," "Usually," or "Always" was considered an achievement. The proportion of achievements for Q33 was 80.8%, for Q34 was 52.6%, and for Q35 was 47.4% (**Table 2**).

Summary of Flu Vaccination

The Flu Vaccinations for Adults Ages 18–64 (FVA) measure is based on a single question about getting a flu shot or flu spray. The score represents the proportion of members ages 18–64 years who received flu vaccination since July 1 of the MY. More than half (54.8%) of the respondents indicated they received a flu shot or spray (**Table 2**).

Table 1 provides a color key for how ND adult survey rates compare to the NCQA HEDIS MY 2022 Quality Compass® national percentiles. Overall, 15 of the 24 rates scored at or above the NCQA Quality Compass 50th percentile.

Table 1: Color Key – Adult Survey Rate Comparisons to NCQA HEDIS MY 2022 Quality Compass Percentiles

Color Key	How Rate Compares to the NCQA HEDIS MY 2022 Quality Compass National Percentiles
< P10	Below the national Medicaid 10th percentile.
P10–P25	At or above the national Medicaid 10th percentile but below the 25th percentile.
P25–P50	At or above the national Medicaid 25th percentile but below the 50th percentile.
P50–P75	At or above the national Medicaid 50th percentile but below the 75th percentile.
P75–P90	At or above the national Medicaid 75th percentile but below the 90th percentile.
≥ P90	At or above the national Medicaid 90th percentile.

NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; P: percentile.

Table 2: Adult CAHPS Results

Composite/Attribute/Measure/Rating Item	ND FFS	FFS Rate Comparison to Quality Compass
Getting Needed Care (Usually + Always)	84.1%	P50–P75
Q9. Ease of getting necessary care, tests, or treatment needed	89.4%	P75–P90
Q20. Getting appointments with specialists as soon as needed	78.7%	P25–P50
Getting Care Quickly (Usually + Always)	84.9%	P50–P75
Q4. Got care as soon as needed when care was needed right away	86.2%	P75–P90
Q6. Got check-up/routine care appointment as soon as needed	83.6%	P50–P75
How Well Doctors Communicate (Usually + Always)	92.9%	P50–P75
Q12. Personal doctor explained things in an understandable way	92.2%	P25–P50
Q13. Personal doctor listened carefully to you	90.9%	P10–P25
Q14. Personal doctor showed respect for what you had to say	95.2%	P50–P75
Q15. Personal doctor spent enough time with you	93.2%	P75–P90
Coordination of Care (Q17; Usually + Always)	82.2%	P25–P50
Customer Service (Usually + Always)	84.4%	< P10
Q24. Customer service provided information or help	77.7%	< P10
Q25. Customer service treated member with courtesy and respect	91.1%	P10–P25
Ease of Filling Out Forms (Q27; Summary Rate = 8 + 9 + 10)	96.6%	P75–P90
Overall Ratings (Summary Rate = 8 + 9 + 10)		
Rating of Health Care (Q8)	68.0%	< P10
Rating of Personal Doctor (Q18)	83.9%	P50–P75
Rating of Specialist (Q22)	82.3%	P50–P75
Rating of Health Plan (Q28)	71.0%	< P10

Composite/Attribute/Measure/Rating Item	ND FFS	FFS Rate Comparison to Quality Compass
Effectiveness of Care Measures		
Advising Smokers and Tobacco Users to Quit	80.8%	≥ P90
Discussing Cessation Medications	52.6%	P50–P75
Discussing Cessation Strategies	47.4%	P50–P75
Flu Vaccinations for Adults Ages 18–64	54.8%	≥ P90

CAHPS: Consumer Assessment of Healthcare Providers and Systems; ND: North Dakota; FFS: fee-for-service; Q: question; P: percentile.

Child Survey

Summary of Overall Rating Questions

Four rating questions assessed overall consumer satisfaction with their health care, personal doctor, specialist talked to most often, and the Medicaid program (labeled as "health plan"). Response options for overall rating questions ranged from 0 (worst) to 10 (best). **Table 4** displays the results for the overall rating questions. Ratings of 8, 9, or 10 were considered achievements, and the achievement score was calculated as the proportion of members whose response was an achievement. Rating of all health care was 66.9%; rating of personal doctor was 82.6%; rating of specialist talked to most often was 85.4%; and rating of health plan was 71.9% (**Table 4**).

Summary of Composites

A composite score was calculated for each of the four domains of member experience: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service. The composite scores provide a summary assessment of how the program performed across the domain. In **Table 4**, proportions of positive responses were reported as achievement scores. For all composites, responses of "Usually" or "Always" were considered achievements. The composite score for Getting Needed Care was 81.1%; for Getting Care Quickly was 88.7%; for How Well Doctors Communicate was 94.8%; and for Customer Service was 87.9% (**Table 4**).

Table 3 provides a color key for how ND child survey rates compare to the NCQA HEDIS MY 2022 Quality Compass national percentile. Overall, 9 of the 20 rates scored at or above the NCQA Quality Compass 50th Percentile.

Table 3: Color Key – Child Survey Rate Comparisons to NCQA HEDIS MY 2022 Quality Compass Percentiles

Color Key	How Rate Compares to the NCQA HEDIS MY 2022 Quality Compass National Percentiles
< P10	Below the national Medicaid 10th percentile.
P10–P25	At or above the national Medicaid 10th percentile but below the 25th percentile.
P25–P50	At or above the national Medicaid 25th percentile but below the 50th percentile.
P50–P75	At or above the national Medicaid 50th percentile but below the 75th percentile.
P75–P90	At or above the national Medicaid 75th percentile but below the 90th percentile.
≥ P90	At or above the national Medicaid 90th percentile.

NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; P: percentile.

Table 4: Child CAHPS Results

Composite/Attribute/Measure/Rating Item	ND FFS	FFS Rate Comparison to Quality Compass
Getting Needed Care (Usually + Always)	81.1%	P25–P50
Q9. Ease of getting necessary care, tests, or treatment needed	87.7%	P25–P50
Q23. Getting appointments with specialists as soon as needed	74.5%	P10–P25
Getting Care Quickly (Usually + Always)	88.7%	P50–P75
Q4. Got care as soon as needed when care was needed right away	91.3%	P50–P75
Q6. Got check-up/routine care appointment as soon as needed	86.1%	P75–P90

Composite/Attribute/Measure/Rating Item	ND FFS	FFS Rate Comparison to Quality Compass
How Well Doctors Communicate (Usually + Always)	94.8%	P50–P75
Q12. Personal doctor explained things in an understandable way	94.8%	P50–P75
Q13. Personal doctor listened carefully to you	94.1%	P25–P50
Q14. Personal doctor showed respect for what you had to say	96.3%	P25–P50
Q17. Personal doctor spent enough time with you	94.0%	≥ P90
Coordination of Care (Q20; Usually + Always)	85.9%	P50–P75
Customer Service (Usually + Always)	87.9%	P50–P75
Q27. Customer service provided information or help	86.2%	P75–P90
Q28. Customer service treated member with courtesy and respect	89.7%	< P10
Ease of Filling Out Forms (Q30; Summary Rate = 8 + 9 + 10)	94.0%	P10–P25
Overall Ratings (Summary Rate = 8 + 9 + 10)		
Rating of Health Care (Q8)	66.9%	< P10
Rating of Personal Doctor (Q18)	82.6%	< P10
Rating of Specialist (Q22)	85.4%	P25–P50
Rating of Health Plan (Q28)	71.9%	< P10

CAHPS: Consumer Assessment of Healthcare Providers and Systems; ND: North Dakota; FFS: fee-for-service; Q: question; P: percentile.

Child with Chronic Conditions Survey

Summary of Overall Rating Questions

Four rating questions assessed overall consumer satisfaction with their health care, personal doctor, specialist talked to most often, and the Medicaid program (labeled as “health plan”). Response options for overall rating questions ranged from 0 (worst) to 10 (best). **Table 6** displays the results for the overall rating questions. Ratings of 8, 9, or 10 were considered achievements, and the achievement score was calculated as the proportion of members whose response was an achievement. Rating of all health care was 77.7%; rating of personal doctor was 89.9%; rating of specialist most talked to was 74.7%; and rating of health plan was 69.5% for the total and CCC groups, respectively (**Table 6**).

Summary of Standard Composites

A standard composite score was calculated for each of the four domains of member experience: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service. The composite scores provide a summary assessment of how the program performed across the domain. In **Table 6**, proportions of positive responses were reported as achievement scores. For all composites, responses of "Usually" or "Always" were considered achievements. The standard composite score for Getting Needed Care was 85.5%; for Getting Care Quickly 88.7%; for How Well Doctors Communicate was 95.2%; and for Customer Service was 78.2% for the total and CCC groups, respectively (**Table 6)**.

A CCC score was calculated for each of the three domains of member experience: Access to Specialized Services, Family-Centered Care: Personal Doctor Who Knows Child, and Coordination of Care. The composite scores provide a summary assessment of how FFS performed across the domain. In **Table 6**Error! Reference source not found., proportions of positive responses are reported as achievement scores. For all composites, responses of "Usually" or "Always" are considered achievements. The CCC composite score for Access to Specialized Services was 66.8%; for Family-Centered Care: Personal Doctor Who Knows Child was 89.1%; and for Coordination of Care was 81.5% for the CCC groups (**Table 6**Error! Reference source not found.).

Table 5 provides a color key for how ND CCC survey rates compare to the NCQA HEDIS MY 2022 Quality Compass national percentile. Overall, 8 of the 20 rates scored at or above the NCQA Quality Compass 50th Percentile.

Table 5: Color Key – CCC Survey Rate Comparisons to NCQA HEDIS MY 2022 Quality Compass Percentiles

Color Key	How Rate Compares to the NCQA HEDIS MY 2022 Quality Compass National Percentiles

< P10	Below the national Medicaid 10th percentile.
P10–P25	At or above the national Medicaid 10th percentile but below the 25th percentile.
P25–P50	At or above the national Medicaid 25th percentile but below the 50th percentile.
P50–P75	At or above the national Medicaid 50th percentile but below the 75th percentile.
P75–P90	At or above the national Medicaid 75th percentile but below the 90th percentile.
≥ P90	At or above the national Medicaid 90th percentile.

CCC: children with chronic conditions; NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; P: percentile.

Table 6: CCC CAHPS Results

Composite/Attribute/Measure/Rating Item	ND FFS	FFS Rate Comparison to Quality Compass
Getting Needed Care (Usually + Always)	85.5%	P25–P50
Q10. Ease of getting necessary care, tests, or treatment needed	91.0%	P50–P75
Q41. Getting appointments with specialists as soon as needed	80.0%	P25–P50
Getting Care Quickly (Usually + Always)	88.7%	P25–P50
Q4. Got care as soon as needed when care was needed right away	91.3%	≥ P90
Q6. Got check-up/routine care appointment as soon as needed	86.1%	P25–P50
How Well Doctors Communicate (Usually + Always)	95.2%	P50–P75
Q27. Personal doctor explained things in an understandable way	94.8%	P50–P75
Q28. Personal doctor listened carefully to you	95.4%	P50–P75
Q29. Personal doctor showed respect for what you had to say	95.4%	P25–P50
Q32. Personal doctor spent enough time with you	95.4%	≥ P90
Coordination of Care (Q35; Usually + Always)	83.9%	P50–P75
Customer Service (Usually + Always)	78.2%	< P10
Q45. Customer service provided information or help	74.4%	< P10
Q46. Customer service treated member with courtesy and respect	82.1%	< P10
Ease of Filling Out Forms (Q48; Summary Rate = 8 + 9 + 10)	93.5%	< P10
Overall Ratings (Summary Rate = 8 + 9 + 10)		
Rating of Health Care (Q9)	77.7%	< P10
Rating of Personal Doctor (Q36)	89.9%	P75–P90
Rating of Specialist (Q43)	74.7%	< P10
Rating of Health Plan (Q49)	69.5%	< P10
Access to Specialized Services	66.8%	< P10
Family Centered Care	89.1%	< P10

CCC: children with chronic conditions; CAHPS: Consumer Assessment of Healthcare Providers and Systems; ND: North Dakota; FFS: fee-for-service; Q: question; P: percentile.

IV. Focus Studies

Foster Care Focus Study

Objectives

The objectives of this study were to profile and compare the prevalence of BH conditions, polypharmacy, preventive services receipt (ages 0–20 years), and hospitalization for mental illness (ages 6–17 years) among youth in foster care to all other youth enrolled in Medicaid; to quantify the risk for any hospitalization for mental illness among youth in foster care to all other youth enrolled in Medicaid (ages 6–17 years); and to quantify additional demographic, clinical, and utilization risk factors for any hospitalization for mental illness among Medicaid enrollees ages 6–17 years.

Technical Methods of Data Collection and Analysis

The clinical, demographic, and healthcare utilization data were extracted from claims and enrollment data files for the eligible population of ND Medicaid enrollees, ages 0–20 years, during the measurement period from January 1, 2022, to December 31, 2022.

The *chi*-squared test was used to identify statistically significant associations between foster care status and clinical characteristics, demographic characteristics, and healthcare utilization. The *chi*-squared test was also used to identify statistically significant associations between enrollee characteristics and hospitalization for mental illness. Narrative findings are presented for enrollee characteristics that were significantly associated with foster care status and hospitalization for mental illness.

Multiple logistic regression was utilized to quantify the risk factors for any hospitalization for mental illness among Medicaid enrollees ages 6–17 years, including foster care status, as well as clinical and demographic enrollee characteristics. Multiple logistic regression findings are presented for each enrollee characteristic, adjusted for all other characteristics, except for "enrolled in foster care – unadjusted analysis," which represents unadjusted findings from simple logistic regression.

Enrollee characteristics were each evaluated for a statistically significant association with any hospitalization for mental illness relative to the referent with 95% confidence intervals (CIs) not containing the value of 1, demonstrating significance. The primary comparison was foster care enrollment associated with hospitalization for mental illness relative to non-foster care enrollment. ORs and 95% CIs were used for these analyses.

Description of Data Obtained

Foster care status was used to compare enrollees in foster care to all other ND Medicaid youth (ages 0–20 years). The following characteristics were profiled by foster care status:

- Demographic characteristics: age group, gender, American Academy of Pediatrics (AAP) age group, race, ethnicity, race/ethnicity combined, area of residence, and county quartile for health ranking. Enrollee counties of residence were grouped into quartiles from Most Healthy to Least Healthy based on county measures of social and economic factors including education, employment, income, family and social support, and community safety. The county with the best health was ranked number 1 in that state, and the county with the worst health was assigned the lowest rank in that state.
- Clinical or BH conditions: serious mental illness (SMI) and SUD substance (drug) use disorder, autism spectrum disorder (ASD), other neurodevelopmental disorders, attention-deficit/hyperactivity disorder (ADHD), and impulse control. SMI included diagnoses of schizophrenia or other psychotic disorders, mood disorders, and anxiety/trauma. SUD included alcohol use/dependence or substance (drug) abuse/dependence.
- Clinical or metabolic risk factors: blood glucose disorders (prediabetes, other abnormal blood glucose, type 1 and type 2 diabetes), hyperlipidemia, weight diagnosis, and metabolic risk.
- Psychotropic polypharmacy: three concurrent classes of psychotropic use, two concurrent classes of psychotropic use, and single-class psychotropic use. Such combinations included ADHD medications, antidepressants, and antipsychotics. Psychotropic polypharmacy was defined as the concurrent use of at least two classes of psychotropic medications with at least a 90-day overlap. The polypharmacy categories were not mutually exclusive, as an enrollee could have been in one category for one three-month period and another for a different three-month period.

- Preventive care: annual well-care visit, topical fluoride application by dentist or primary care provider (PCP), BH screening/assessments.
- Healthcare utilization: the measurement for any hospitalization for mental illness used the denominator specifications for the CMS Child Core Set Follow-up After Hospitalization for Mental Illness: Ages 6–17 Years (FUH-CH) measure. The measure for any hospitalization for mental illness (6–17 years) was profiled by:
  - demographic characteristics,
  - clinical or BH conditions,
  - metabolic risk factors, and
  - psychotropic polypharmacy.

Findings

A key finding of the study is that while foster care enrollees are more likely to be hospitalized for mental illness relative to all other Medicaid enrollees ages 6–17 years, being in foster care is not independent of the clinical, metabolic, psychotropic polypharmacy, and demographic drivers of hospitalization for mental illness. Therefore, understanding the disparities in the distribution of these drivers among foster care and non-foster care enrollees is key to understanding and addressing the susceptibilities of foster care enrollees.

The BH diagnoses with the greatest likelihood for hospitalization for mental illness, as well as greater prevalence among foster care enrollees relative to non-foster care enrollees, provided insights into the clinical nature of foster care enrollees' vulnerabilities. ND Medicaid enrollees with mood disorders showed the greatest likelihood for behavioral hospitalization relative to those without mood disorders (OR = 16.629), and the prevalence among foster care enrollees was 14.05% compared to only 4.61% of non-foster care enrollees. Enrollees with anxiety and trauma comprised the subset with the next highest likelihood relative to those without these conditions (OR = 5.713), with prevalence among foster care enrollees of 38.76% compared to only 13.78% of non-foster care enrollees. Similar likelihood for BH hospitalization was observed for Medicaid enrollees with SUDs (compared to those without SUDs); although the prevalence was lower compared to the aforementioned diagnoses, disparities were observed when comparing prevalence among foster care enrollees (4.11%) to non-foster care enrollees (1.24%).

Compared to Medicaid youth with no psychotropic use, Medicaid youths with chronic use of two psychotropics were twice as likely to be hospitalized for mental illness, and polypharmacy was considerably more prevalent among foster care enrollees. Specifically, a greater prevalence of the following polypharmacy drug classes was observed among foster care enrollees relative to all other Medicaid youth: three concurrent classes, ADHD medication and antidepressants, and the dual combinations of ADHD medication or antidepressants with antipsychotics. Use of three concurrent classes of psychotropics showed a similar likelihood for hospitalization as use of two psychotropics, albeit findings were not statistically significant likely due to the smaller number of enrollees with three concurrent classes of psychotropics. Metabolic side effects of antipsychotics include abnormal blood glucose and hyperlipidemia, both of which showed greater prevalence among foster care enrollees. It is notable that Medicaid enrollees with one or more metabolic risk factors had approximately twice the odds for hospitalization for mental illness.

Disparities were observed among demographic subsets. Adolescents and females were the only demographic subsets among Medicaid enrollees ages 6–17 years with increased likelihood for hospitalization for mental illness, yet the following minority subsets showed a higher prevalence among Medicaid enrollees with a hospitalization for mental illness relative to those without hospitalization: enrollees of more than one race and American Indian enrollees. Of note, American Indian enrollees composed 41.97% of foster care enrollees but only 20.07% of non-foster care enrollees. Another notable disparity was that 26.76% of foster care enrollees resided in the counties with the lowest ranked socioeconomic status, compared to 20.01% of all other Medicaid enrolled youth.

Annual preventive care was received by a greater proportion of foster care enrollees than all other Medicaid youth, including well-child visits, topical fluoride application, and BH screenings and assessments. It should be noted, however, that ND Medicaid's reported 2022 administrative rate of 37.8% for Child and Adolescent Well-Care Visits, ages 3−21 years, fell below the national median of 54.2% and below the bottom quartile of 48.8%. Further research is merited to assess whether children in foster care received timely preventive care in accordance with foster care requirements.

Specifically, foster care case managers must ensure each foster child has a Health Tracks or a well-child check completed within 30 days of entry into foster care.

Conclusions

This focus study provides evidence to suggest that children in foster care are more likely to be hospitalized for mental illness and that disparities in clinical, polypharmacy, and associated metabolic factors represent underlying vulnerabilities among this susceptible subpopulation of Medicaid enrollees. Further research is merited to evaluate foster care enrollees' receipt of timely preventive care, as well as evidence-based care for children on psychotropic medications.

Maternal Care Focus Study

Objectives

The objectives of this study were to identify the prevalence, risk factors, and disparities in receiving timely prenatal and postpartum care, preterm delivery, and delivering a baby with low birthweight among ND Medicaid beneficiaries. Further, the study examined the impact of extending Medicaid eligibility from 60 days to one year postpartum by looking at utilization during COVID by those women who retained their coverage.

Technical Methods of Data Collection and Analysis

To identify beneficiaries eligible for the data analysis, IPRO started with vital statistics records to identify birthing people with any live births, on or between September 1, 2021, and March 31, 2022 (to allow for 12 months of utilization and 90 days claims run out after the last possible delivery date). To be included in the sample, beneficiaries also had to have at least one Medicaid claim in that time period. Only claims data from 1−365 days after delivery were included as part of the analyses. These claims were matched to beneficiary characteristics from enrollment data. Beneficiaries were excluded if they were enrolled in BCBSND Medicaid Expansion health insurance program or if their Medicaid Category of Eligibility code was unknown. This created a sample of only FFS enrollees. The final dataset included 1,233 birthing people enrolled in FFS Medicaid.

Statistically significant associations between demographic, clinical, pregnancy and delivery characteristics, and healthcare utilization were assessed using the *chi*-squared test. In instances with small sample sizes, the Fisher's exact test was used. Multiple logistic regression was utilized to quantify the risk factors of not receiving timely prenatal care, incidences of preterm delivery and low birth weight, and not receiving timely postpartum care.

Enrollee characteristics (i.e., demographic, clinical, pregnancy and delivery, and healthcare characteristics) were each evaluated for a statistically significant association with healthcare utilization, preterm delivery, and low birthweight relative to the referent. Results with 95% CIs not containing the value of 1 demonstrate statistical significance. The primary comparison for healthcare utilization was receiving care relative to not receiving care. The primary comparison for preterm delivery was not delivering a baby prematurely (37+ weeks gestation) relative to delivering a baby prematurely (having a live birth before 37 weeks gestation).

Description of Data Obtained

Variables examined in this study included:

- Demographic characteristics: age group, race/ethnicity, and area of residence. Enrollee counties of residence were grouped into maternity shortage counties (i.e., residing in a county without access to hospitals or birth centers offering obstetric care and no obstetric providers) and rural counties.
- Clinical characteristics: tobacco use, SMI, alcohol dependence, SUD, weight diagnosis, any high blood pressure, and any diabetes. SMI included diagnoses of schizophrenia or other psychotic disorders, mood disorders, and anxiety/trauma. Weight diagnosis included overweight, obesity, and excessive weight gain during pregnancy. Any high blood pressure included preexisting hypertension, unspecified hypertension, eclampsia, gestational hypertension, and preeclampsia. Any diabetes included preexisting diabetes and gestational diabetes.

- Pregnancy and delivery characteristics: preterm delivery, type of delivery, and birthweight.
  - Preterm delivery: birth before 37 weeks gestation identified using International Classification of Diseases, Tenth Revision (ICD-10) codes.
  - Type of delivery: vaginal or Caesarean.
  - Birthweight: low birthweight was defined as a birthweight of less than 2,500 grams.
- Healthcare utilization: receiving timely prenatal and postpartum care.
  - Timely prenatal care: one or more prenatal care visits in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization, using the Timeliness of Prenatal Care measure as specified in the CMS Core Set Measure PPC-AD: Prenatal and Postpartum Care.
  - Timely postpartum care: one or more postpartum visit(s) on or between 7−84 days after delivery, as specified in the CMS Core Set Measure PPC-AD: Prenatal and Postpartum Care.
- Extended healthcare coverage: frequency of healthcare utilization to measure the use of extended Medicaid coverage for eligible pregnant and birthing people from 60 days to 12 months after pregnancy.
  - Postpartum preventive care visit: one or more ambulatory or preventive care visits, using the Ambulatory Value sets and excluding any individuals with at least one postpartum care visit on or between 7−84 days, as specified in the CMS Core Set Measure PPC-AD: Prenatal and Postpartum Care.
  - Dental care visit: one or more dental care visits, using procedure codes.
  - Contraception services: one or more contraception services using Contraceptive Care Postpartum CCP-C codes to identify the provision of most or moderately effective contraceptive methods and Contraceptive Care Postpartum CCP-D codes to identify the provision of long-acting reversible contraception methods.
  - BH visit: defined using ICD-10, Current Procedural Terminology (CPT®), and Healthcare Common Procedure Coding System (HCPCS) codes with provider type claim code (i.e., 10), provider specialty codes, or provider taxonomy claim code.

Findings

Prenatal care was underutilized by Medicaid enrollees. Just 56.3% of Medicaid FFS enrollees received a prenatal care visit in the first trimester, far less than the overall state average of 78.9% or the national average of 74.9%. Some subgroups of pregnant people were more likely to get prenatal care than others, possibly due to their established connections with health care providers. For example, pregnant people with a diagnosis of overweight, obesity, or excessive weight gain during pregnancy were more likely to receive timely prenatal care (one or more prenatal care visits in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization) compared to pregnant people without such a diagnosis. Subgroups who were less likely to get prenatal care in the first trimester were those living with a BH condition including SUD or alcohol dependence and tobacco users.

Utilization of postpartum care was comparable for people giving birth in ND who were Medicaid enrollees and non-Medicaid enrollees. For example, 41% of Medicaid FFS enrollees with a live birth attended a postpartum care visit in the recommended time period of 7 to 84 days post-delivery, compared with the statewide average of 43.8%.

Birthing people living with SMI or diabetes, or who had timely prenatal care, were more likely to receive postpartum care. Those living in maternity shortage and/or rural areas were less likely to receive timely postpartum care. Racial disparities were identified, with birthing people identifying as Hispanic and American Indian/Alaska Native being less likely to receive timely postpartum care compared to individuals identifying as white, non-Hispanic. Birthing people over 40 years of age received less postpartum care than younger birthing people.

Preterm births (before 37 weeks gestation) are less common among Medicaid members compared to the overall ND population. Just 5.4% of births to Medicaid members occurred prematurely compared to a statewide average of 10.3%. Using tobacco products; living with a diagnosis of overweight, obesity, or excessive weight gain during pregnancy; and delivering a baby with low birthweight were correlated with delivering a baby prematurely.

Babies born to Medicaid members were slightly more likely to have a low birthweight (e.g., weighed less than 2,500 grams) compared to the statewide population. A total of 8.5% of babies born to Medicaid birthing people during the

study period were low birthweight, compared to 7.1% of live births in ND. Correlates of delivering a low birthweight baby included identifying as Black, non-Hispanic or Asian American/Pacific Islander, non-Hispanic; living with a BH diagnosis such as both SUD or alcohol dependence and SMI, or only having SUD or alcohol dependence; and residing in rural areas without access to obstetric health providers or facilities (maternity shortage areas). Attending a timely prenatal care visit served as a protective factor. Individuals who received timely prenatal care were significantly less likely to deliver a baby with low birthweight.

Healthcare utilization during the period between 61 and 365 days postpartum was also explored using claims data. Although the study period predated the January 2023 expansion of Medicaid benefits to 12 months postpartum, many people retained Medicaid coverage during this period due to the COVID-19 Public Health Emergency; therefore, these results provide insights into utilization during the extension of benefits postpartum. For those people giving birth in the study period and retaining coverage, 36.0% of Medicaid FFS enrollees attended a preventive care visit that did not include a postpartum care visit.

Nearly 30.0% of birthing people received contraception care, including hormonal contraception, intrauterine devices (IUDs), and permanent contraception, compared to 28.3% and 6.2% of ND Medicaid beneficiaries ages 21–44 years who were provided most/moderately effective methods of contraception or long-acting reversible methods of contraception, respectively. Access to effective contraception decreases the risk of short interval pregnancy and preterm birth. Additionally, 15.9% obtained dental services including preventive, diagnosis, and restorative care, and 10.0% utilized BH services, including inpatient and outpatient services for mental health and SUDs.

Conclusions

This study highlights barriers and facilitators related to maternal healthcare utilization among ND Medicaid FFS enrollees. Fewer than 60% of enrollees received a prenatal care visit in the first trimester (56.3%). This is less than the 83.0% that is reported for Medicaid beneficiaries nationally. Comparatively across the state, 78.9% of birthing people received prenatal care within the first three months of pregnancy in 2022. Educating birthing people about the benefits of prenatal care, for both birthing person and baby, are recommended.

Pregnant birthing people who do not receive early prenatal care face an increased risk of complications that may either be undetected or treated too late in pregnancy, increasing the possibility of adverse outcomes for both the birthing person and baby. Several clinical risk factors identified in this study are associated with a decreased likelihood of a birthing person's receipt of timely healthcare and/or developing poor health outcomes. Birthing people with BH conditions and those who used tobacco products were at significantly greater risk of not attending a timely prenatal care appointment.

Seeking to understand potential challenges to obtaining timely prenatal care are warranted. For example, healthcare professionals could consider utilizing community health workers or nurses to connect with patients following a positive pregnancy test to facilitate the first prenatal appointment. A touchpoint connection could serve as an opportunity to address potential barriers and solutions, including transportation. The use of care coordination staff (e.g., care manager, care coordinator, community health worker, or patient navigator) can help to address clinical and health-related social needs and provide wrap around services. This will be particularly impactful for those birthing people living with BH conditions who are at significant risk of not receiving timely prenatal care. For example, group prenatal care models can be implemented to provide prenatal care in group settings according to racial/ethnic identification, age, or due date. Another supportive, group-based prenatal care approach could focus on specific health conditions such as providing patients with diabetes self-management education. Providers should also consider customized and targeted interventions that address barriers specific to vulnerable subpopulations.

ND could encourage providers to collaborate with their local emergency departments and utilize the NDHIN to proactively outreach to patients with positive pregnancy results. Incentive programs for appointment adherence, such as baskets containing personal and newborn care items, are also suggested. It is also recommended that ND continue to educate birthing people about telehealth coverage for maternity care services. Live video, remote patient monitoring, and audio services can address gaps in access to care.[4]

Preterm babies, born before 37 weeks of pregnancy, often have serious health problems. Just over 5% of beneficiaries in this study delivered prematurely (5.3%) compared to 10.3% of all births in ND in 2022. Among ND Medicaid enrollees in this study, tobacco usage, living with an overweight/obesity/excessive weight gain during pregnancy diagnosis, and delivering a baby with low birthweight were significant risk factors related to preterm delivery. ND Medicaid beneficiaries would benefit from targeted interventions to promote healthy eating, physical activity, and smoking cessation support.

A total of 8.5% of newborns in this study were born with low birthweight compared to 7.1% of all live births in ND. Identifying as Black, non-Hispanic or Asian American/Pacific Islander, non-Hispanic increased a birthing person's likelihood of delivering a baby with low birthweight. Other risk factors included residing in a maternity shortage and rural area, living with a BH condition, and delivering prematurely. Opportunities exist to reduce the prevalence of low birthweight. This can include expanding access to providers and hospitals that provide culturally and linguistically appropriate care and promoting timely prenatal care utilization.

The postpartum period for a birthing person and their newborn is very important for both short-term and long-term health and well-being. Only 40.5% of ND birthing people received timely postpartum care compared to 77.0% of Medicaid birthing people nationally. Significant racial disparities were observed. American Indian, non-Hispanic and Hispanic birthing people were significantly less likely to receive timely postpartum care compared to those who identify as white, non-Hispanic. Improving timely postpartum care access for American Indian/Alaska Native and Hispanic women will help address the significant and persistent racial and ethnic disparities in maternal and infant mortality and morbidity. Providers should be encouraged to consider ways to reduce maternal and infant racial/ethnic disparities, such as providing staff-wide education on implicit bias and incorporating a disparities dashboard that monitors process and outcome metrics stratified by race and ethnicity. Healthcare professionals should also consider potential barriers to postpartum care, including childcare responsibilities. Scheduling well-baby checkup appointments during the same time as a postpartum visit can help birthing people overcome barriers to care.

Successes within the ND Medicaid healthcare system are also noted. Birthing people with a diagnosis of overweight/obesity/excessive weight gain during pregnancy were significantly more likely to receive timely prenatal care than those without such a diagnosis. Similarly, those with SMI and diabetes were more likely to receive timely postpartum care compared to those without such a diagnosis. It is possible that these birthing people are already engaged with a specialist or other healthcare services that help guide care pathways. Receiving timely prenatal care was also significantly related to a lesser likelihood of delivering a baby with low birthweight and a higher likelihood of attending a postpartum care appointment. Timely prenatal care visits provide the opportunity to monitor the health of birthing people, those living with chronic conditions, and their babies.

Results of this study also suggest that birthing people utilize the healthcare system with their Medicaid postpartum extended coverage. About 9.5% of beneficiaries accessed BH services 61−365 days postpartum, including care for substance abuse, alcohol dependence, and mental health. Extended healthcare coverage improved access to postpartum services, including preventive care. Over 35% of birthing people in this study attended a preventive care visit during the postpartum period who had not otherwise received postpartum care on or between 7−84 days after delivery (36.0%).

Extended healthcare coverage increased access to contraception services which decreases the risk for short interval pregnancies, a known risk factor for poor health outcomes. About 30% received contraception services between 61−365 days post-delivery (29.9%). Use of dental care was also noted with 15.9% having received some type of preventive or restorative care during this extended coverage period.

V. Strengths, Opportunities for Improvement, and EQR Recommendations

Table 7 highlights the FFS performance strengths and opportunities for improvement, follow-up on prior EQRO recommendations, and this year's recommendations based on the aggregated results of MY 2022 EQR activities as they relate to **quality**, **timeliness**, and **access**.

Table 7: Strengths, Opportunities for Improvement, and EQR Recommendations

Activity	EQR Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Quality-of-care surveys	FFS performed well across the four domains Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service.	X	X	X
Foster care focus study	Annual preventive care was received by a greater proportion of foster care enrollees than all other Medicaid youth, including well-care visits, topical fluoride application, and BH screenings and assessments.	X	X	X
Maternal care focus study	Access to timely prenatal care, living with diabetes, and living with a weight diagnosis increased the likelihood of postpartum care attendance, suggesting that these individuals may be involved with services or seeing specialists that promote healthcare engagement.	X	X	X
Opportunities for Improvement				
Quality-of-care surveys	Focus areas for improvement for FFS could include improving access to specialty care and care coordination across adults, children, and children with chronic conditions.	X	X	X
Foster care focus study	Children in foster care are at greater risk for hospitalization for mental illness than other children due to underlying BH diagnoses, polypharmacy, and associated metabolic factors.	X	X	X
Maternal care focus study	Underuse of prenatal and postpartum care, particularly by birthing persons who are minorities and live in rural areas or maternity care shortage areas, requires targeted interventions.	X	X	X
Recommendations to ND to Address Quality, Timeliness, and Access				
Quality-of-care surveys	ND could work on setting and achieving new access standards for the FFS population, especially around specialty care to ease the member burden when accessing these services.	X	X	X
Foster care focus study	A recommended strategy for ND is to collaborate with providers to ensure evidence-based prescribing practices consistent with the American Academy of Child & Adolescent Psychiatry's "Practice Parameter on the Use of Psychotropic Medication in Children and Adolescent."[1] Enhanced care coordination or case management is also merited to address enrollee's BH needs.	X	X	X
Maternal care focus study	Home visiting, telehealth visits, and outreach are needed to connect beneficiaries to care during this vulnerable period.	X	X	X

[1] Source: Walkup, J., & Work Group on Quality Issues (2009). Practice parameter on the use of psychotropic medication in children and adolescents. *Journal of the American academy of child and adolescent psychiatry*, *48*(9), 961–973.
EQR: external quality review; FFS: fee-for-service; ND: North Dakota; BH: behavioral health.

VI. References

[1] Alliance for Innovation on Maternal Health. *Patient safety bundles*. Patient Safety Bundles For Safer Birth | AIM.

[2] Heslehurst, N., Hayes, L., Jones, D., Newham, J., Olajide, J., McLeman, L., McParlin, C., de Brun, C., & Azevedo, L. (2020). The effectiveness of smoking cessation, alcohol reduction, diet and physical activity interventions in changing behaviours during pregnancy: A systematic review of systematic reviews. *PloS one*, *15*(5). https://doi.org/10.1371/journal.pone.0232774 .

[3] Centers of Medicare & Medicaid Services (CMS). Transforming Maternal Health (TMaH) Model. Transforming Maternal Health (TMaH) Model | CMS.

[4] Wu, K. K., Lopez, C., & Nichols, M. (2022). Virtual visits in prenatal care: An integrative review. *Journal of midwifery & women's health*, *67*(1), 39–52. https://doi.org/10.1111/jmwh.13284 .