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External Quality Review Annual Technical Report

Fee-for-Service

Review Period: January 1, 2024–December 31, 2024

North Dakota Department of Health and Human Services
Medical Services Division

Final
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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 August 31, 2024, the ND Medicaid program served 106,324 North Dakotans, including 50,262 children, 24,537 individuals covered under the Medicaid Expansion, 12,031 adults ages 21–64 years, and 8,781 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 who 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 healthcare 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) 2024, 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 calendar year (CY) 2024 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 Evaluation Summary

IPRO worked with HHS to develop the *2024 Quality Strategy Plan*, to review and update the quality strategy currently in effect as the *2025–2027 Quality Strategy*, and to evaluate the progress of the ND quality strategy. This report presents findings for the FFS population that highlight measures that showed progress and present recommendations for performance measures (PMs) that did not show progress.

Quality-of-Care Surveys – CAHPS

During the period from April 12, 2024, through June 14, 2024, 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 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 (86.5%), Getting Care Quickly (90.9%), How Well Doctors Communicate (94.2%), and Customer Service (90.0%; **Table 4**). Four overall rating questions assessed satisfaction with healthcare, personal doctors, specialists, and the Medicaid program. The achievement scores were 76.3% for all healthcare, 85.4% for personal doctors, 81.7% for specialists, and 70.5% for the health plan (**Table 4**). Overall, FFS performed well across these four domains in the adult CAHPS survey, performing at or above the quality compass 50th percentile. Important areas for improvement include Ease of Filling Out Forms and Rating of Health Plan, both of which scored below the quality compass 25th percentile. Results of the child CAHPS survey indicated opportunities for improvement across the four domains of member experience: Getting Needed Care (83.7%), Getting Care Quickly (86.9%), How Well Doctors Communicate (94.9%), and Customer Service (77.5%), all of which except How Well Doctors Communicate fell below the quality compass 50th percentile (**Table 5**). The overall ratings for the child survey all performed below the quality compass 25th percentile: Rating of Health Care (81.5%), Rating of Personal Doctor (81.8%), Rating of Specialist (82.6%), and Rating of Health Plan (74.5%; **Table 5**). The CCC CAHPS survey showed varying results across the four member experience domains: Getting Needed Care and How Well Doctors Communicate performed at or above the quality compass 50th percentile (84.8% and 95.9% respectively), while Getting Care Quickly and Customer Service performed at or below the quality compass 50th percentile (88.5% and 73.8% respectively; **Table 6**). Three of the four overall ratings performed below the quality compass 25th percentile: Rating of Personal Doctor (85.5%), Rating of Specialist (77.0%), Rating of Health Plan (70.9%). Overall rating of Health Care scored between the 25th and 50th percentile at 83.1% (**Table 6**).

Focus Studies

Foster Care Focus Study

Phase I of the *Focus Study on Health Services Utilization of North Dakota Youth in Foster Care*, conducted by IPRO in 2024, concluded that psychotropic use, polypharmacy, and hospitalization rates for mental illness are higher among foster care enrollees compared to youth enrolled in Medicaid but not in foster care. Key recommendations were to ensure evidence-based practice for provider use of psychotropic medication in youth and to link youth in foster care with accessible behavioral health providers.

In 2025, IPRO conducted Phase II of the *Focus Study on Health Services Utilization of North Dakota Youth in Foster Care* using the same eligible population used for the Phase I study: ND Medicaid enrollees, ages 1–20 years, with an expanded measurement period from January 1, 2022, through June 30, 2024. The primary aim was to assess disparities between youth in foster care and ND Medicaid enrollees not in foster care, both in receipt of evidence-based care, as measured by these relevant performance indicators, each expanded to include ND Medicaid enrollees aged 18–20 years:

- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH), ages 1–17 years.
- Follow-up After Hospitalization for Mental Illness, ages 6–17 years (FUH-CH; using member-level vs. discharge-level data).

A key disparity finding of this study is that, among ND Medicaid enrollees aged 18–20 years, youth in foster care had a lower rate of first-line psychosocial care than peers not in foster care (36.36% vs. 40.85%). Further, both non-foster care enrollees ages 18–20 years and non-foster enrollees of American Indian/Alaska Native race were disproportionately under-represented for receipt of first-line psychosocial care.

Regarding follow-up within 7 days after the first hospitalization for mental illness, among ND Medicaid enrollees aged 18-20 years, none of the foster care enrollees received follow-up compared to 10.31% of non-foster care enrollees. Children ages 6–17 years in foster care received a 30-day follow-up visit after the first hospitalization for mental illness at a rate of 36.82% of the eligible population, slightly lower than non-foster care enrollees ages 6–17 years covered by Medicaid (39.39%). Rates for receipt of a follow-up visit within 30 days of the first hospitalization for mental illness were also lower for young adults ages 18–20 years in foster care at 9.09% compared to 24.74% of non-foster care enrollees. Foster care enrollees of Black or African American race and non-foster care enrollees of American Indian/Alaska Native race were disproportionately under-represented for receipt of a follow-up visit within 30 days of hospitalization.

In summary, the findings highlight significant opportunities to improve transitions in care for ND foster care enrollees with mental illness. Addressing racial disparities and engaging community partners can improve access to quality care for ND youth, both those enrolled in foster care and all other Medicaid-enrolled youth. Overall, these findings underscore the importance of targeted interventions to support vulnerable youth and improve mental health outcomes.

Maternal Care Focus Study

This study builds on findings from Phase I of the *North Dakota Maternal Care Quality and Utilization Focus Study* to explore receipt of opioid use disorder (OUD) treatment among ND FFS Medicaid beneficiaries during the prenatal, postpartum (up to 60 days), expanded postpartum (61–365 days), and overall measurement periods, with a particular focus on racial/ethnic disparities. The primary objective of the current study was to assess disparities in access to treatment initiation for maternal OUD, providing the ND HHS with essential insights into access and quality of care.

The study found that prenatal OUD treatment was utilized by 72.50% of ND FFS Medicaid enrollees; however, only 48.98% of Medicaid FFS enrollees with OUD received treatment during the first 60 days postpartum. Treatment for OUD was more commonly received during the expanded postpartum coverage period (61–365 days postpartum) compared to care received in the first 60 days postpartum. There were 67.74% of birthing people with OUD who received treatment during the expanded postpartum period, highlighting the beneficial effects of policy changes that expanded the duration of care access postpartum.

Notable disparities were observed in maternal OUD treatment utilization by race/ethnicity. American Indian/Alaska Native, non-Hispanic birthing people were disproportionately under-represented in the receipt of OUD treatment during the prenatal period. American Indian/Alaska Native, non-Hispanic; Hispanic; and Black, non-Hispanic birthing people were disproportionately under-represented in receipt of OUD treatment during the 60 days postpartum. Overall treatment rates during the full measurement period (219 days before delivery through 365 days postpartum) showed that Black, non-Hispanic and Hispanic birthing people had lower treatment rates, reflecting potential disparities in access and utilization.

This study highlights the substantial progress made in providing OUD treatment to ND Medicaid FFS birthing people, particularly in the prenatal and expanded postpartum periods. However, results also underscore the need to address disparities in treatment access and ensure equitable care. Addressing maternal opioid use in ND requires a comprehensive strategy. This should include expanding access to addiction treatment and medication-assisted treatment (MAT), developing culturally tailored and trauma-informed care programs, enhancing tribal support through Substance Abuse and Mental Health Services Administration (SAMHSA) resources, and fostering collaboration among healthcare providers, community organizations, and peer support networks.

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 purpose of the ND Medicaid Quality Strategy is to: improve the health status of North Dakotans by promoting healthy lifestyles, preventive care, disease management and disparity elimination; improve access to quality healthcare at an affordable price to improve outcomes; increase effectiveness and efficiency in the delivery of healthcare programs and ensure value in healthcare contracts; and enhance member and provider experience. IPRO and HHS reviewed the *2024 Quality Strategy* and updated it for 2025, for alignment with the following four aims:

- **Healthier Populations:** Improve the overall health of North Dakotans by increasing access to preventive services, including cancer screenings and postpartum care, and by strengthening behavioral health follow-up and engagement.
- **Better Outcomes:** Enhance health outcomes for Medicaid members with chronic conditions and substance use disorders through better treatment initiation, care coordination, and reduced avoidable hospitalizations.
- **Better Experience:** Elevate the healthcare experience by promoting timely access to care and increasing member satisfaction with both health plans and overall care received.
- **Smarter Spending:** Ensure the efficient use of public resources by reducing avoidable hospital readmissions and supporting value-based care initiatives that prioritize quality over volume.

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

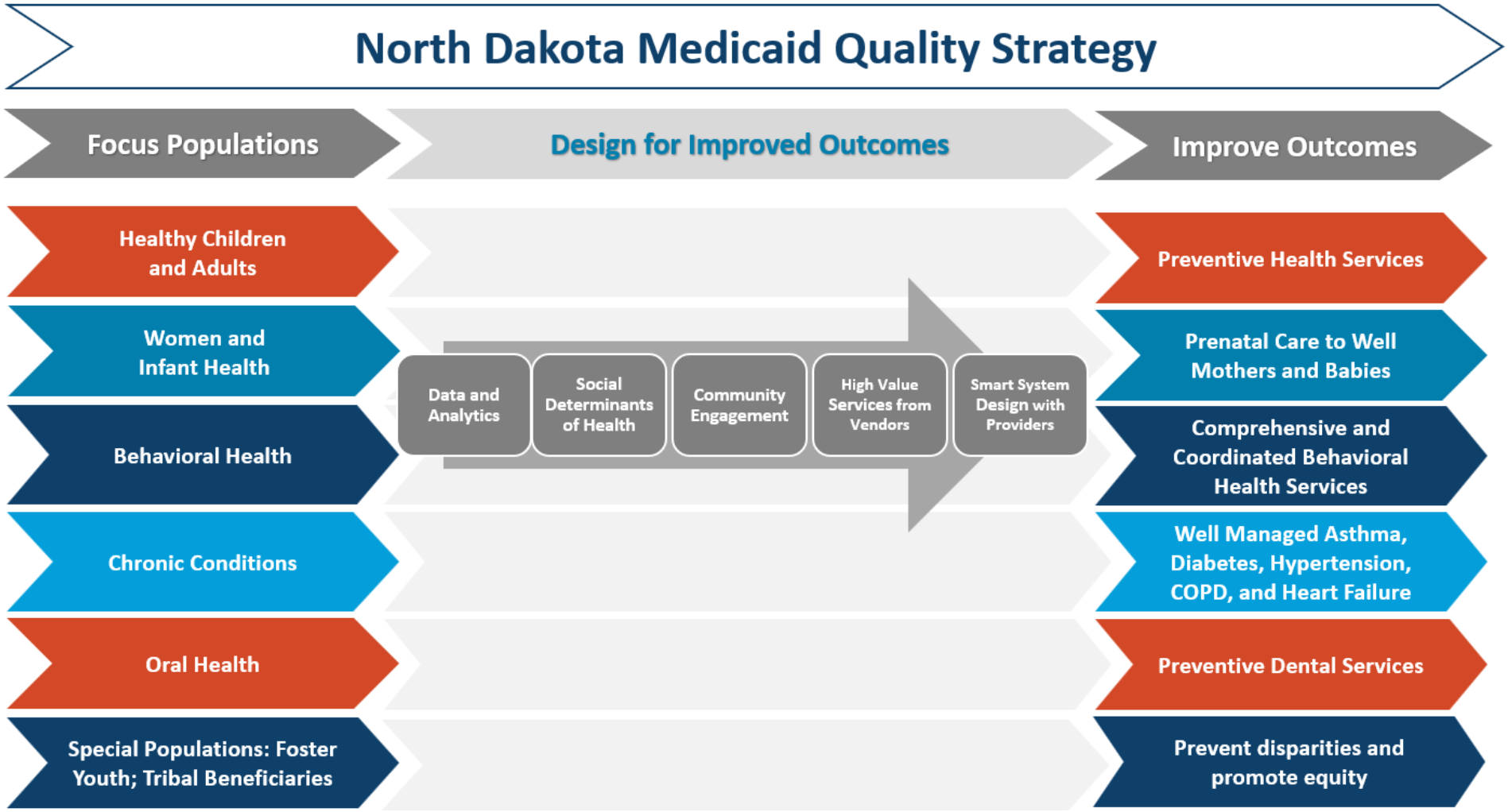

Figure 1: North Dakota Medicaid Quality Strategy. COPD: chronic obstructive pulmonary disease.

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. 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. Corresponding 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.

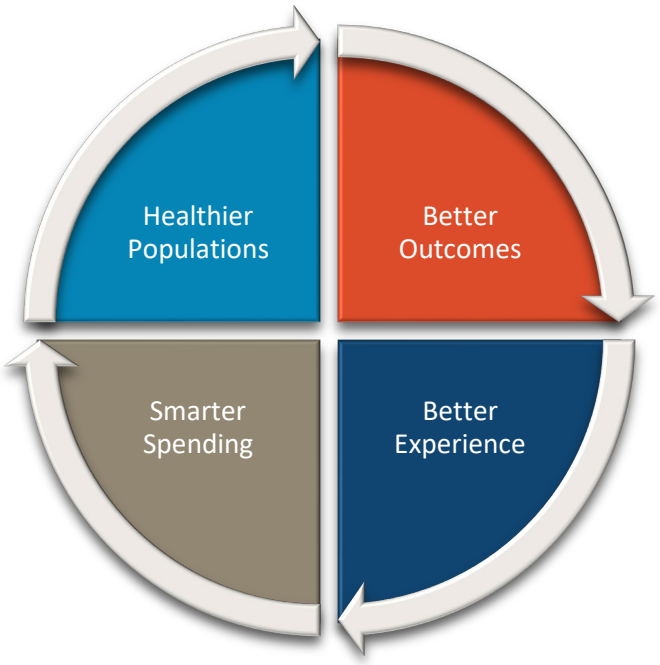

Figure 2: North Dakota's Quadruple Aim. Resource: Institute for Healthcare Improvement (IHI).

IPRO's Evaluation of the North Dakota Medicaid Quality Strategy

States are required by *Title 42 CFR § 438.340* to draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by each MCO, Prepaid Ambulatory Health Plan (PAHP), prepaid inpatient health plan (PIHP), and primary care case management (PCCM) entity. To support HHS in meeting this requirement, IPRO, as the EQRO for ND, worked with HHS to develop the *2024 Quality Strategy*, to review and update the quality strategy currently in effect as the *2025–2027 Quality Strategy*, and to evaluate the progress of the ND quality strategy. This section of the FFS annual technical report (ATR) describes the quality strategy evaluation methodology and presents findings for FFS; specifically, PMs that showed progress, PMs that did not show progress and, thus, represent opportunities for improvement, with corresponding recommendations.

Evaluation Methodology

- Evaluate CY 2023 performance indicator rate percentage point (pp) change from CY 2022 rate.
- Evaluate whether CY 2023 performance indicator rate performed better or worse than the CY 2021 Medicaid national median rate.
- For those PMs that neither met the CY 2021 Medicaid median nor made progress from CY 2022 to CY 2023, include recommendations for improving the quality of health care services to better support the quality strategy aims of healthier populations, better outcomes, better experience, and smarter spending.

Findings and Recommendations

Table 1 shows FFS progress on meeting ND quality strategy goals. Overall, six of the ten performance indicators with target rates set met the target objective. Two of the four performance indicators for Aim 1: Healthier Populations met the target objective. For Aim 2: Better Outcomes, three of the five performance indicator rates met the target objective. There were no performance indicators with target rates set for Aim 3: Better Experience. For Aim 4: Smarter Spending, the single performance indicator met the target objective.

Performance Measures that Showed Progress

The FFS PMs that showed progress are summarized in the following narrative.

Aim 1: Healthier Populations

Goal 1.1: Improve Preventive Health

- **Breast Cancer Screening (BCS-AD):** FFS CY 2023 rate for beneficiaries ages 50–64 years increased by 2.2 percentage points from CY 2022 (but fell below the Medicaid median CY 2021 rate).
- **Colorectal Cancer Screening (COL-AD, ages 4649 years):** FFS CY 2023 rate increased by 7.1 percentage points from CY 2022.
- **Colorectal Cancer Screening (COL-AD, ages 50-64 years):** FFS CY 2023 rate increased by 5.5 percentage points from CY 2022.

Goal 1.2: Improve Postpartum Care

- **Timely postpartum care (PPC-AD):** FFS CY 2023 rate increased by 15 percentage points (but fell below the Medicaid median CY 2021 rate).

Goal 1.3: Improve Behavioral Health Care for Beneficiaries

- **Follow-up After Emergency Department Visit for Mental Illness (FUM-AD-30 days):** FFS CY 2023 rate increased by 4.3 percentage points from CY 2022 and exceeded the CY 2021 Medicaid median rate.
- **Follow-up After Emergency Department Visit for Mental Illness (FUM-AD-7 days):** FFS CY 2023 rate increased by 2.9 percentage points from CY 2022 and exceeded the CY 2021 Medicaid median rate.

Aim 2: Better Outcomes

Goal 2.2: Improve Health for Members with Chronic Conditions

- **Inpatient Hospital Admissions for Heart Failure (lower rate is better; PQI08-AD):** FFS CY 2023 rate decreased by 31.1 percentage points from CY 2022 and fell below the Medicaid median CY 2021 rate (lower is better).
- **Inpatient Hospital Admissions for Diabetes Short-Term Complications (lower rate is better; PQI01-AD):** FFS CY 2023 rate decreased by 1.6 percentage points from CY 2022 and fell below the Medicaid median CY 2021 rate (lower is better).
- **Inpatient Hospital Admissions for COPD (lower rate is better; PQI05-AD):** FFS CY 2023 rate decreased by 28.2 percentage points and fell below the Medicaid median CY 2021 rate (lower is better).

Aim 3: Better Experience

Goal 3.1: Enhance Member Experience

- **Getting Care Quickly (CPA-AD):** FFS CY 2023 rate increased by 6.0 percentage points from CY 2022.
- **Rating of All Health Care (CPA-AD):** FFS CY 2023 rate increased by 22.1 percentage points from CY 2022.

Aim 4: Smarter Spending

Goal 4.1: Focus on Paying for Value

- **Ratio of Observed All-Cause Readmissions to Expected Readmissions (lower rate is better; O/E Ratio):** The FFS CY 2023 rate fell below the Medicaid median CY 2021 rate (lower is better).

Opportunities for Improvement

Findings and recommendations for performance indicators that did not show progress are summarized in the following narrative.

Aim 1: Healthier Populations

Goal 1.3: Improve Behavioral Health Care for Beneficiaries

- **Follow-up after Emergency Department Visit for Mental Illness (FUM-AD-7 days):** To build on the progress of this measure, review findings and recommendations of Phase I and Phase II (estimated completion by August 2025) *Focus Study on Health Services Utilization of North Dakota Youth in Foster Care* to identify opportunities for improving the effectiveness of behavioral health care among foster care youth and other vulnerable populations.

Aim 2: Better Outcomes

Goal 2.1: Improve Outcomes for Members with Substance Use Disorder

- **Initiation and Engagement in Alcohol, Opioid, or Other Drug Abuse Treatment (IET-AD):** To prepare for implementation in 2026 of the IET-AD measure as part of the ND prospective payment system (PPS) Hospital Value-Based Purchasing (VBP) Program, FFS providers can collaborate with eligible health systems to identify patient-provider relationships for the quality incentive program.

Goal 2.2: Improve Health for Members with Chronic Conditions

- **Inpatient Hospital Admissions for Heart Failure (PQI08-AD), Diabetes (PQI01-AD), and COPD (PQI05-AD):** Consider spreading the success of the PQI performance measures by expanding the ND PPS Hospital VBP Program to additional hospital systems.

Aim 3: Better Experience

Goal 3.1: Enhance Member Experience

- **Rating of Health Plan (CPA-AD):** Beneficiary focus groups might be conducted to identify the reasons for beneficiary dissatisfaction and ask beneficiaries how satisfaction might be improved.

Aim 4: Smarter Spending

Goal 4.1: Focus on Paying for Value

- **Ratio of Observed All-Cause Readmissions to Expected Readmissions (O/E):** Consider spreading the success of the observed/expected (O/E) performance measure by expanding the ND PPS Hospital VBP Program to additional hospital systems.

Table 1: FFS Progress on Meeting North Dakota Quality Strategy Goals

Aim/Goal	Rate Definition	FFS[1] 2022	FFS[2] 2023	FFS Progress[3] by Percentage Point Difference	Medicaid Median[4]	Met Target Objective
Aim 1: Healthier Populations						
Goal 1.1: Improve Preventive Health	Breast Cancer Screening, ages 50 to 64 years	25.5%	**27.7%**	**+2.2**	48.8%	**No**
	Colorectal Cancer Screening, ages 46 to 49 years	16.7%	**23.8%**	**+7.1**	N/A	**N/A**
	Colorectal Cancer Screening, ages 50 to 64 years	37.9%	**43.4%**	**+5.5**	N/A	**N/A**
Goal 1.2: Improve Postpartum Care	Prenatal and Postpartum Care, Timely Postpartum Care	41.3%	**56.3%**	**+15.0**	75.0%	**No**
Goal 1.3: Improve Behavioral Health Care for Beneficiaries	FUM-AD 30-Day Follow-up, ages 18 to 64 years	63.0%	**67.3%**	**+4.3**	52.5%	**Yes**
	FUM-AD 7-Day Follow-up, Ages 18 to 64 years	43.9%	**46.8%**	**+2.9**	38.9%	**Yes**
Aim 2: Better Outcomes						
Goal 2.1: Improve Outcomes for Members with Substance Use Disorder	IET-AD, Initiation: Total AOD Abuse or Dependence, ages 18 to 64 years	45.2%	**38.3%**	**-6.9**	43.4%	**No**
	IET-AD, Engagement: Total AOD Abuse or Dependence, ages 18 to 64 years	19.8%	**14.7%**	**-5.1**	15.8%	**No**
Goal 2.2: Improve Health for Members with Chronic Conditions	Inpatient Hospital Admissions for Heart Failure, ages 18 to 64 years (lower is better)	39.1	**8.0**	**-31.1**	23.9	**Yes**
	Inpatient Hospital Admissions for Diabetes Short-Term Complications, ages 18 to 64 years (lower is better)	15.1	**13.5**	**-1.6**	17.2	**Yes**

Aim/Goal	Rate Definition	FFS[1] 2022	FFS[2] 2023	FFS Progress[3] by Percentage Point Difference	Medicaid Median[4]	Met Target Objective
	Inpatient Hospital Admissions for COPD or Asthma in Older Adults, ages 40 to 64 years (lower is better)	56.7	**28.5**	**-28.2**	29.8	**Yes**
Aim 3: Better Experience						
Goal 3.1: Enhance Member Experience	CPA-AD Getting Care Quickly (CAHPS)	84.9	**90.9**	**+6.0**	N/A	**N/A**
	CPA-AD Rating of Health Plan (CAHPS)	71.0	**70.5**	**-0.5**	N/A	**N/A**
	CPA-AD Rating of All Health Care (CAHPS)	68.1	**90.2**	**+22.1**	N/A	**N/A**
Aim 4: Smarter Spending						
Goal 4.1: Focus on Paying for Value	Plan All-Cause Readmission, Observed/Expected (O/E) Ratio (lower is better)	NR	0.5758	**N/A**	1.0	**Yes**

[1] Federal fiscal year (FFY) 2023 (calendar year [CY] 2022) data.
[2] FFY 2024 (CY 2023) data.
[3] Percentage points indicate absolute percentage point change from measurement year (MY) 2022 to MY 2023, where plus (+) shows an increase in percentage, and minus (–) shows a decrease in percentage. Plus (+) represents better performance, and minus (–) represents worse performance from MY 2022 to MY 2023, except for measures indicated by "lower is better," for which minus (–) represents better performance.
N/A: not applicable; NR: not reported; FUM-AD: Follow-up After Emergency Department Visit for Mental Illness; IET-AD: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment. COPD: chronic obstructive pulmonary disease; CPA-AD: CAHPS Health Plan Survey, Adult Version; CAHPS: Consumer Assessment of Healthcare Providers and Systems.
[4] FFY 2022 (CY 2021) data.

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 January 1, 2024, 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 April 12, 2024, through June 14, 2024, using a mail-only protocol and the Medicaid 5.1H questionnaires for Adult, Child, and Child with a Complex Clinical Condition (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 317 adult members with a response rate of 23.8%, 147 child members with a response rate of 8.9%, and 268 CCC members with a response rate of 7.7%.

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

Table 2 provides a color key for how ND adult, child, and CCC survey rates compare to the NCQA Healthcare Effectiveness Data and Information Set (HEDIS®) MY 2022 Quality Compass® national percentiles. Overall, the following rates scored at or above the NCQA Quality Compass 50th percentile:

- Adult: 19 of 23 rates,
- Child: 6 of 20 rates, and
- CCC: 10 of 22 rates.

Table 2: Color Key – Survey Rate Comparisons to NCQA HEDIS MY 2023 Quality Compass Percentiles

Color Key	How Rate Compares to the NCQA HEDIS MY 2022 Quality Compass National Percentiles
Orange	Below the national Medicaid 25th percentile.
Light Orange	At or above the national Medicaid 25th percentile but below the 50th percentile.
Gray	At or above the national Medicaid 50th percentile but below the 75th percentile.
Light Blue	At or above the national Medicaid 75th percentile but below the 90th percentile.
Blue	At or above the national Medicaid 90th percentile.
White	No national benchmarks available for this measure or measure not applicable (N/A).

NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year.

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 3** 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 76.3%; rating of personal doctor was 85.4%; rating of specialist most talked to was 81.7%; and rating of health plan was 70.5% (**Table 3**).

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 3**, 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 86.5%; for Getting Care Quickly was 90.9%, for How Well Doctors Communicate was 94.2%; and for Customer Service was 90.0% (**Table 3**).

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 Advising Smokers and Tobacco Users to Quit was 82.4%; for Discussing Cessation Medications was 53.6%; and for Discussing Cessation Strategies was 51.5% (**Table 3**).

Table 3: Adult CAHPS Results

Composite/Attribute/Measure/Rating Item	ND FFS	FFS Rate Comparison to Quality Compass
Getting Needed Care (Usually + Always)	86.5%	≥90th
Q9. Ease of getting necessary care, tests, or treatment needed	90.2%	≥90th
Q20. Getting appointments with specialists as soon as needed	82.7%	≥50th and <75th
Getting Care Quickly (Usually + Always)	90.9%	≥90th
Q4. Got care as soon as needed when care was needed right away	91.6%	≥90th
Q6. Got check-up/routine care appointment as soon as needed	90.2%	≥90th
How Well Doctors Communicate (Usually + Always)	94.2%	≥50th and <75th
Q12. Personal doctor explained things in an understandable way	95.8%	≥75th and <90th
Q13. Personal doctor listened carefully to you	94.7%	≥75th and <90th
Q14. Personal doctor showed respect for what you had to say	95.2%	≥50th and <75th
Q15. Personal doctor spent enough time with you	91.0%	≥25th and <50th
Coordination of Care (Q17; Usually + Always)	85.2%	≥50th and <75th
Customer Service (Usually + Always)	90.0%	≥50th and <75th
Q24. Customer service provided information or help	84.0%	≥50th and <75th
Q25. Customer service treated member with courtesy and respect	96.0%	≥75th and <90th
Ease of Filling Out Forms (Q27; Summary Rate = 8 + 9 + 10)	92.2%	<25th
Overall Ratings (Summary Rate = 8 + 9 + 10)		
Rating of Health Care (Q8)	76.3%	≥50th but <75th
Rating of Personal Doctor (Q18)	85.4%	≥50th and <75th
Rating of Specialist (Q22)	81.7%	≥25th and <50th
Rating of Health Plan (Q28)	70.5%	<25th
Effectiveness of Care Measures		
Advising Smokers and Tobacco Users to Quit	82.4%	≥90th
Discussing Cessation Medications	53.6%	≥50th and <75th
Discussing Cessation Strategies	51.5%	≥75th and <90th

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

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. The rating of all health care was 81.5%; the rating of personal doctor was 81.8%; the rating of specialist talked to most often was 82.6%; and the rating of health plan was 74.5% (**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 83.7%; for Getting Care Quickly was 86.9%; for How Well Doctors Communicate was 94.9%; and for Customer Service was 77.5% (**Table 4**).

Table 4: Child CAHPS Results

Composite/Attribute/Measure/Rating Item	ND FFS	FFS Rate Comparison to Quality Compass
Getting Needed Care (Usually + Always)	83.7%	≥25th and <50th
Q9. Ease of getting necessary care, tests, or treatment needed	92.4%	≥50th and <75th
Q23. Getting appointments with specialists as soon as needed	75.0%	≥25th and <50th
Getting Care Quickly (Usually + Always)	86.9%	≥25th and <50th
Q4. Got care as soon as needed when care was needed right away	92.2%	≥50th and <75th
Q6. Got check-up/routine care appointment as soon as needed	81.6%	≥25th and <50th
How Well Doctors Communicate (Usually + Always)	94.9%	≥50th and <75th
Q12. Personal doctor explained things in an understandable way	97.8%	≥90th
Q13. Personal doctor listened carefully to you	93.5%	<25th
Q14. Personal doctor showed respect for what you had to say	94.6%	<25th
Q17. Personal doctor spent enough time with you	93.5%	≥75th and <90th
Coordination of Care (Q20; Usually + Always)	84.7%	≥50th and <75th
Customer Service (Usually + Always)	77.5%	<25th
Q27. Customer service provided information or help	65.0%	<25th
Q28. Customer service treated member with courtesy and respect	90.0%	<25th
Ease of Filling Out Forms (Q30; Summary Rate = 8 + 9 + 10)	91.7%	<25th
Overall Ratings (Summary Rate = 8 + 9 + 10)		
Rating of Health Care (Q8)	81.5%	<25th
Rating of Personal Doctor (Q21)	81.8%	<25th
Rating of Specialist (Q25)	82.6%	<25th
Rating of Health Plan (Q31)	74.5%	<25th

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

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 5** 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 83.1%; the rating of personal doctor was 85.5%; the rating of specialist most talked to was 77.0%; and the rating of health plan was 70.9% for the total and CCC groups, respectively (**Table 5**).

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 5**, 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 84.8%; for Getting Care Quickly was 88.5%; for How Well Doctors Communicate was 95.9%; and for Customer Service was 73.8% (**Table 5**).

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 5**, 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 77.6%; for Family-Centered Care: Personal Doctor Who Knows Child was 91.0%; and for Coordination of Care was 75.4% (**Table 5**).

Table 5: CCC CAHPS Results

Composite/Attribute/Measure/Rating Item	ND FFS	FFS Rate Comparison to Quality Compass
Getting Needed Care (Usually + Always)	84.8%	≥50th and <75th
Q10. Ease of getting necessary care, tests, or treatment needed	89.0%	≥50th and <75th
Q41. Getting appointments with specialists as soon as needed	80.6%	≥50th and <75th
Getting Care Quickly (Usually + Always)	88.5%	≥25th and <50th
Q4. Got care as soon as needed when care was needed right away	93.4%	≥50th and <75th
Q6. Got check-up/routine care appointment as soon as needed	83.5%	<25th
How Well Doctors Communicate (Usually + Always)	95.9%	≥75th and <90th
Q27. Personal doctor explained things in an understandable way	96.2%	≥50th and <75th
Q28. Personal doctor listened carefully to you	95.2%	≥50th and <75th
Q29. Personal doctor showed respect for what you had to say	97.1%	≥50th and <75th
Q32. Personal doctor spent enough time with you	95.1%	≥90th
Coordination of Care (Q35; Usually + Always)	75.4%	<25th
Customer Service (Usually + Always)	73.8%	<25th
Q45. Customer service provided information or help	60.0%	<25th
Q46. Customer service treated member with courtesy and respect	87.5%	<25th
Ease of Filling Out Forms (Q48; Summary Rate = 8 + 9 + 10)	88.2%	<25th
Overall Ratings (Summary Rate = 8 + 9 + 10)		
Rating of Health Care (Q9)	83.1%	≥25th and <50th
Rating of Personal Doctor (Q36)	85.5%	<25th
Rating of Specialist (Q43)	77.0%	<25th
Rating of Health Plan (Q49)	70.9%	<25th
Access to Specialized Services	77.6%	≥50th and <75th
Family Centered Care	91.0%	≥25th and <50th

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

IV. Focus Studies

Foster Care Focus Study Phase II

Background and Rationale

Phase I of the *Focus Study on Health Services Utilization of North Dakota Youth in Foster Care* concluded that psychotropic use, polypharmacy, and hospitalization rates for mental illness are higher among foster care enrollees compared to youth enrolled in Medicaid but not in foster care.[1] Key recommendations were to ensure evidence-based practice for provider use of psychotropic medication in youth and to link youth in foster care with accessible behavioral health providers.

National comparisons highlight two opportunities for improvement pertinent to these Phase I study findings, one of which is to assess receipt of evidence-based prescribing practices by providing first-line psychosocial care. The HEDIS performance indicator Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP): Ages 1–17 Years measures the percentage of youth who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment. In 2022, the North Dakota (ND) Medicaid rate (including FFS) for the HEDIS APP measure (54.3%) fell below the national bottom quartile (58.6%).[2]

Second, to assess receipt of follow-up care after hospitalization for mental illness, the HEDIS performance indicator Follow-up After Hospitalization for Mental Illness (FUH): Ages 6–17 Years measures the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 7 days or 30 days after discharge. In 2022, among children ages 6–17 years, the ND Medicaid rate of 32.6% for the HEDIS FUH 7-day measure (including FFS) fell below the national bottom quartile rate of 40.1%, as did the FUH 30-day rate (56.2% vs. 62.1%).**Error! Bookmark not defined.**

Phase II Study Aims

IPRO conducted a Phase II study using the same eligible population used for the Phase I study: ND Medicaid enrollees, ages 1–20 years, with an expanded measurement period from January 1, 2022, through June 30, 2024.

The primary aim was to assess disparities between youth in foster care and those not in foster care, both in receipt of evidence-based care, as measured by these relevant performance indicators:

- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH), ages 1–17 years.
- Follow-up After Hospitalization for Mental Illness, ages 6–17 years (FUH-CH; using member-level vs. discharge-level data).

The Phase II study also evaluated disparities in receipt of first-line psychosocial care and follow-up visits after hospitalization for mental illness among demographic subgroups, i.e., age group, race, ethnicity, and biological sex.

Methodology

Technical Methods of Data Collection and Analysis

IPRO used claims/encounter data to calculate HEDIS APP and FUH rates among demographic subgroups during the measurement period from January 1, 2022, through June 30, 2024.

Data Obtained

The HEDIS APP rates were calculated separately for foster care and non-foster care enrollees covered by ND Medicaid, using the CMS Child Core Set federal fiscal year (FFY) 2024 measurement year (MY) 2023 APP-CH specifications to calculate rates for Use of First-Line Psychosocial Care for

Children and Adolescents on Antipsychotics. The CMS Core Set APP-CH measure is restricted to enrollees ages 1–17 years. This focus study also evaluated the APP-CH rate among foster care and non-foster care enrollees ages 18–20 years, as this age group is included in the foster care population. Thus, the eligible population for the APP-CH measure included ND Medicaid enrollees aged 1–20 years. The FUH rates were calculated separately for foster care and non-foster care enrollees, using a modified CMS Child Core Set FFY 2024 MY 2023 FUH specification that analyzed data at the individual enrollee level rather than the visit level. The CMS Child Core Set FUH-CH measure is restricted to enrollees ages 6–17 years. This focus study also evaluated the FUH-CH rate among foster care and non-foster care enrollees ages 18–20 years. Thus, the eligible population for the FUH-CH measure included ND Medicaid enrollees aged 6–20 years.

Data Analysis

Analysis of disproportionate representation was conducted to identify subpopulations who were under-represented for receipt of first-line psychosocial care and follow-up visits after hospitalization for mental illness. Calculating an index of disproportionate under-representation (IDU) provides a way to identify when certain subgroups are significantly under-represented in a specific outcome compared to their representation in the overall population and is especially useful for identifying potential equity issues where interventions might be needed. The IDU was calculated by dividing the percentage that the subset composed of the total APP and FUH denominator, respectively, by the percentage that the subset composed of the APP and FUH numerator, respectively. Values over 100% indicate disproportionate under-representation because the subset composed a greater proportion of the total ND Medicaid eligible population (denominator) than the proportion that same subset composed of the ND Medicaid population who received the evidence-based care (numerator).

Key Findings

- A greater proportion of youth ages 1–17 years in ND foster care received first-line psychosocial care, compared to Medicaid youth not in foster care (69.95% vs. 60.34%) and the national median (60.50%). However, for ages 18–20 years, youth in foster care had a lower rate of psychosocial care than peers not in foster care (36.36% vs. 40.85%).
- Non-foster care enrollees ages 18–20 years and non-foster enrollees of American Indian/Alaska Native race were disproportionately under-represented for receipt of first-line psychosocial care.
- Only 17.27% of ND foster care enrollees ages 6–17 years received a 7-day follow-up visit after the first hospitalization for mental illness, slightly higher than non-foster care enrollees ages 6–17 years (14.74%). Seven-day follow-up rates after the first hospitalization for mental illness were even lower for young adults ages 18–20 years, with 0% of foster care enrollees receiving follow-up compared to 10.31% of non-foster care enrollees.
- Non-foster care enrollees ages 18–20 years, non-foster care enrollees of American Indian/Alaska Native race, and non-foster care enrollees of Black or African American race were disproportionately under-represented for receipt of a follow-up visit within 7 days of hospitalization for mental illness.
- Children ages 6–17 years in foster care received a 30-day follow-up visit after the first hospitalization for mental illness at a rate of 36.82% of the eligible population, slightly lower than non-foster care enrollees ages 6–17 years covered by Medicaid (39.39%). Rates for receipt of a follow-up visit within 30 days of the first hospitalization for mental illness were lower for young adults ages 18–20 years in foster care at 9.09% compared to 24.74% of non-foster care enrollees.
- Foster care enrollees of Black or African American race and non-foster care enrollees of American Indian/Alaska Native race were disproportionately under-represented for receipt of a follow-up visit within 30 days of hospitalization.

Conclusion

In summary, the findings highlight significant opportunities to improve transitions in care for ND foster care enrollees with mental illness. Addressing racial disparities and engaging community partners can improve access to quality care for ND youth, both those enrolled in foster care and all other Medicaid-enrolled youth. Overall, these findings underscore the importance of targeted interventions to support vulnerable youth and improve mental health outcomes.

Recommendations for ND HHS

ND HHS can collaborate with the ND Department of Children and Families to develop and implement educational outreach to primary care providers, adolescents in foster care, and their guardians regarding transitioning to adult primary care. For all Medicaid-enrolled youth, there is an opportunity to address racial disparities by building on the work of the ND Community Health Worker (CHW) Task Force to implement CHW training and certification, as well as providing Medicaid coverage for CHW services as preventive services. The ND PPS Hospital VBP program is another recommended partnership with whom to work on integrating assessment of social determinants of health (SDoH) into transition-in-care planning, as well as increasing the number of outpatient mental health providers signing up for Encounter Alerts & Notifications service through the North Dakota Health Information Network (NDHIN). ND HHS might also consider incorporating into the FFS ATR the performance measures Follow-up After Hospitalization for Mental Illness, ages 6–17 years (FUH7-CH and FUH30-CH) with the aim to exceed the Medicaid national median rates. Stratification of these measures by demographic characteristics would inform opportunities to address disparity subpopulations. Consider conducting a focus study to identify disparities in the outcomes of Initiation and Engagement of Substance Use Disorder treatment (HEDIS IET measure) and Pharmacotherapy for Opioid Use Disorder (HEDIS POD measure).

Maternal Care Quality and Utilization Focus Study Phase II

Background and Rationale

This study builds on findings from Phase I of the *North Dakota Maternal Care Quality and Utilization Focus Study* to explore receipt of opioid use disorder (OUD) treatment among ND FFS Medicaid beneficiaries during the prenatal, postpartum (up to 60 days), expanded postpartum (61–365 days), and total measurement period, with a particular focus on racial/ethnic disparities. IPRO conducted a Phase II study that identified birthing people with a diagnosis from the Opioid Abuse and Dependence Value Set with any births, on or between October 8, 2021, and June 30, 2023.

Phase II Study Aims

The primary aim was to assess racial/ethnic disparities among birthing people in receipt of opioid use or dependence treatment, as measured by these relevant performance indicators:

- One or more of the following: inpatient opioid drug admissions, outpatient visits, intensive outpatient encounters, partial hospitalizations, telehealth services, or MAT. The following measurement periods are reported:
    - Prenatal treatment: during the 219 days prior to the delivery date
    - Postpartum treatment: beginning with the delivery date through the 60 days following the delivery discharge date
    - Expanded postpartum treatment: beginning with 61 days following the delivery discharge date until 365 days following the delivery discharge date
    - Anytime during the measurement period: during the 219 days prior to the delivery date through the 365 days following the delivery discharge date

Methodology

Technical Methods of Data Collection and Analysis

IPRO used claims/encounter data to calculate OUD treatment initiation rates during the measurement period January 1, 2021, through June 30, 2024.

Data Obtained

To identify beneficiaries eligible for the data analysis, IPRO started with vital statistics records to identify birthing people with any births, on or between October 8, 2021, and June 30, 2023 (to allow for 12 months of utilization and 90 days claims run out after the last possible delivery date).

The eligible focus study population consisted of beneficiaries who met the following criteria:

- Had at least one Medicaid claim during the measurement period (claims were matched to beneficiary characteristics using enrollment data).
- Were not enrolled in the Blue Cross Blue Shield of ND Medicaid Expansion health insurance program.
- Had a known Medicaid Category of Eligibility code (beneficiaries with unknown codes were excluded).
- Were FFS enrollees only.
- Had at least one claim with a diagnosis from the Opioid Abuse and Dependence Value Set (included all claims, not just primary diagnoses).

Data Analysis

Fisher's exact tests were used to assess statistically significant differences in treatment receipt across racial/ethnic groups. The Index of Disproportionate Under-Representation (IDU) was calculated to evaluate the unequal distribution of OUD treatment services among different racial/ethnic groups of birthing people. The IDU was calculated by dividing the percentage each subgroup composed of the ND Medicaid eligible population of birthing people with OUD by the percentage each subgroup composed of birthing people with OUD who received opioid-related treatments. Values over 100% indicate disproportionate under-representation because the subset composed a greater proportion of the ND Medicaid eligible population (denominator) than the proportion that same subset composed of the ND Medicaid population who received the evidence-based care (numerator). Because an IDU > 100% does not necessarily equate to a statistically significant finding, a test was applied to determine statistical significance. Statistical significance was determined by calculating a maximum threshold for under-representation by subtracting the standard deviation of the subset's population proportion from its observed population proportion. Numerator proportions below the threshold were interpreted as statistically significant under-representation. The underlying equity expectation is that the numerator distribution should be similar to the subset's distribution in the denominator. This method helps ensure the equitable distribution of treatment services across different racial/ethnic groups of birthing people, reflecting fair access to care during the prenatal, postpartum, expanded postpartum, and total measurement periods.

Key Findings

- The statewide data indicated that only 51.00% of Medicaid FFS beneficiaries with OUD received U.S. Food and Drug Administration (FDA)-approved OUD medications, while 59.21% of maternal beneficiaries in this study received some form of OUD treatment (i.e., inpatient opioid drug admissions, outpatient visits, intensive outpatient encounters, partial hospitalizations, telehealth services, or MAT.
- Prenatal opioid use or dependence treatment was widely utilized among ND FFS Medicaid enrollees. Approximately 72.50% of Medicaid FFS birthing people with an opioid abuse or dependence diagnosis claim received treatment during the prenatal period (219 days prior to delivery).

    - Most common services included receipt of OUD medication (60.00%) and outpatient behavioral health services (55.00%).
    - Notable disparities were observed in prenatal OUD treatment utilization by race/ethnicity. American Indian/Alaska Native, non-Hispanic birthing people were disproportionately under-represented in the receipt of OUD treatment.
- Postpartum treatment for OUD was less frequently utilized. Only 48.98% of Medicaid FFS enrollees with OUD received treatment during the first 60 days postpartum. This marks a critical gap in care.
    - White, non-Hispanic birthing people had the highest treatment rate at 61.02%.
    - The study identified racial/ethnic disparities in postpartum OUD treatment utilization. American Indian/Alaska Native, non-Hispanic; Hispanic; and Black, non-Hispanic birthing people were disproportionately under-represented in receipt of OUD treatment.
- Treatment for OUD was more commonly received during the expanded postpartum care (61–365 days postpartum) compared to care received in the first 60 days postpartum. There were 67.74% of birthing people with OUD who received treatment during the expanded postpartum period. This highlights the beneficial effects of policy changes that expanded the duration of care access postpartum.
    - American Indian/Alaska Native, non-Hispanic birthing people had an OUD treatment rate of 70.00%, indicating that almost three-quarters of those with an opioid abuse or dependence diagnosis claim received OUD treatment following delivery.
    - While treatment rates were high for Hispanic; Black, non-Hispanic; and Multiracial/Unknown, non-Hispanic birthing people, sample sizes were small for these groups.
- Overall treatment during the total measurement period (219 days before delivery through 365 days postpartum) showed that 59.21% of Medicaid FFS birthing people with OUD received some form of treatment.
    - White, non-Hispanic birthing people had the highest rate of treatment (62.90%), followed closely by American Indian/Alaska Native, non-Hispanic birthing people at 60.27%.
    - Black, non-Hispanic (60.00%) and Hispanic (40.00%) birthing people had lower treatment rates, reflecting potential disparities in access and utilization.
    - Hispanic birthing people and Multiracial/Unknown, non-Hispanic birthing people were found to be disproportionately under-represented in receipt of OUD treatment.

Conclusion

This study highlights the substantial progress made in providing OUD treatment to ND Medicaid FFS birthing people, particularly in the prenatal and expanded postpartum periods. However, results also underscore the need to address disparities in treatment access and ensure equitable care, particularly for certain racial/ethnic groups.

Recommendations for ND HHS

Addressing maternal opioid use in ND requires a multifaceted approach. The following recommendations are proposed:

- Expansion of Healthcare Services and MAT Access: Expanding access to addiction treatment, especially in rural areas, and increasing the availability of MAT programs is crucial for addressing opioid dependence throughout and after pregnancy.
- Culturally Tailored Treatment Programs: Culturally tailored addiction treatment programs improve engagement and reduce dropout rates for racial/ethnic minority populations.[3,4] Tribal Opioid Response Grants and Educational Opportunities: The SAMHSA website provides resources, support, and treatment locators for mental health and substance use disorders. This includes crisis helplines, prevention, recovery, and grant opportunities, with a focus on culturally appropriate services for Tribal communities.

- Collaboration Between Healthcare Providers and Community Organizations: Partnerships between healthcare providers, addiction specialists, and community organizations can improve support for pregnant women by combining prenatal care, addiction treatment, and mental health services.[5,6] Faces & Voices of Recovery offers a toolkit for establishing and sustaining recovery community organizations. This resource provides a collection of innovative case studies and strategies for building community partnerships aimed at reducing health disparities.
- Training Healthcare Providers on Implicit Bias and Trauma-Informed Care: Implicit bias training for healthcare providers can improve care and reduce disparities in maternal health outcomes.[7] Providers should be encouraged to utilize a trauma-informed approach that combines harm reduction and motivational interviewing. This should prioritize the development of trust, enhance self-efficacy, and empower the birthing person by strengthening their skills and resources.[8]
- Expansion of Peer Support Networks: Develop peer support programs where individuals with lived recovery experience offer guidance and emotional support to pregnant birthing people with substance use disorder.[9]
- Telehealth and Mobile Unit Options for Remote Areas: Use telehealth and mobile services to make addiction treatment and prenatal care more accessible to pregnant individuals in rural and underserved areas.[10,11]
- Incorporate Community Health Workers: CHWs improve healthcare access and reduce disparities by offering culturally relevant education and advocacy, particularly in underserved communities.[12]
- Postpartum Follow-up Care: Strengthen postpartum care to ensure continued access to substance use treatment, mental health services, and other support.

V. Strengths, Opportunities for Improvement, and EQR Recommendations

Table 6 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 EQR activities conducted during CY 2024 as they relate to **quality**, **timeliness**, and **access**.

Table 6: Strengths, Opportunities for Improvement, and EQR Recommendations

Activity	EQR Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Measures (Quality Strategy Evaluation)	The majority of performance measures showed improvement including measures regarding breast cancer screening, colorectal screening, follow-up after an ED visit for mental illness, prenatal and postpartum care, all-cause readmission, diabetes short-term complications, COPD or asthma, heart failure admissions, timely access to care, and member satisfaction.	**X**	**X**	**X**
Quality-of-Care Surveys	FFS performed well across the four adult CAHPS domains Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service, all of which scored above the quality compass 50th percentile. For the child CAHPS survey, the domain for How Well Doctors Communicate performed between the 50th and 75th percentile. For the CCC CAHPS survey Getting Needed Care performed between the 50th and 75th percentile and How Well Doctors Communicate performed between the 75th and 90th percentile.	**X**	**X**	**X**
Focus Studies	Phase II Foster Care Focus Study: A greater proportion of youth ages 1–17 years in ND foster care received first-line psychosocial care, compared to Medicaid youth not in foster care (69.95% vs. 60.34%) and the national median (60.50%). Phase II Maternal Care Focus Study: Maternal Medicaid fee-for-service beneficiaries in North Dakota had higher rates of opioid use disorder (OUD) treatment (59.21%) than the statewide average for Medicaid recipients (51.00%), with particularly strong engagement during prenatal (72.50%) and extended postpartum periods (67.74%).	**X**	**X**	**X**

Activity	EQR Assessment/Recommendation	Quality	Timeliness	Access
Opportunities for Improvement				
Performance Measures (Quality Strategy Evaluation)	Opportunities for improvement are evident in the performance measures that did not show improvement including the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD), which saw a decline in both engagement and initiation rates. Additionally, the Member Satisfaction: Beneficiary rating of health plan measure (CPA-AD) experienced a slight decrease.	X	X	X
Quality-of-Care Surveys	Focus areas for improvement for FFS could include any rating item that performed below the quality compass 25th percentile across the adult, child, and CCC surveys.	X	X	X
Focus Studies	Phase II Foster Care Focus Study: Findings highlight significant opportunities to improve transitions in care for ND foster care enrollees and non-foster care enrollees with mental illness. Non-foster care enrollees ages 18–20 years and non-foster enrollees of American Indian/Alaska Native race were disproportionately under-represented for receipt of first-line psychosocial care. Foster care enrollees of Black or African American race and non-foster care enrollees of American Indian/Alaska Native race were disproportionately under-represented for receipt of a follow-up visit within 30 days of hospitalization. Addressing racial disparities and engaging community partners can improve access to quality care for ND youth, both those enrolled in foster care and all other Medicaid-enrolled youth. Phase II Maternal Care Focus Study: Significant racial and ethnic disparities were observed, with American Indian/Alaska Native, Hispanic, and Black birthing people consistently under-represented in OUD treatment across all timeframes, especially in the critical early postpartum phase. Opportunities to improve MOUD access include increasing treatment during the early postpartum period, where fewer than half of birthing people currently receive care. Addressing racial and ethnic disparities through culturally responsive, trauma-informed approaches is essential to ensure equitable access to MOUD.	X	X	X

Activity	EQR Assessment/Recommendation	Quality	Timeliness	Access
Recommendations to ND to Address Quality, Timeliness, and Access				
Quality Strategy Evaluation	Based on a review of the performance measures in the Quality Strategy, it is suggested that to prepare for implementation in 2026 of the IET-AD measure as part of the ND prospective payment system (PPS) Hospital Value-Based Purchasing (VBP) Program, FFS providers can collaborate with eligible health systems to identify patient-provider relationships for the quality incentive program. To enhance member experience, beneficiary focus groups might be conducted to identify the reasons for beneficiary dissatisfaction and ask beneficiaries how satisfaction might be improved.	X	X	X
Quality-of-Care Surveys	FFS beneficiary focus groups might be conducted to identify the reasons for beneficiary dissatisfaction and ask beneficiaries how satisfaction might be improved. To improve response rates HHS may want to offer incentives for participation in the survey with a small offer or inclusion in a drawing for a larger prize.	X	X	X
Focus Studies	Phase II Foster Care Focus Study: Key recommendations include facilitation of a workgroup of caseworkers from the ND Department of Children and Family Services to conduct provider, youth, and family educational outreach regarding transitioning to adult primary care providers; collaborate with primary care providers and hospitals participating in the ND PPS Hospital VBP program to integrate assessment of social determinants of health into transition planning; increase the number of outpatient mental health providers signing up for Encounter Alerts & Notifications service to receive notifications of hospital admission; implement community health worker training and certification; and consider a focus study to identify disparities in the outcomes of Initiation and Engagement of Substance Use Disorder treatment (HEDIS IET measure) and Pharmacotherapy for Opioid Use Disorder (HEDIS POD measure). Phase II Maternal Care Focus Study: Key recommendations include the expansion of medication-assisted treatment (MAT) programs to address opioid dependence throughout and after pregnancy, especially in	X	X	X

Activity	EQR Assessment/Recommendation	Quality	Timeliness	Access
	rural areas; the implementation of culturally tailored treatment; the fostering of collaboration between healthcare providers and community organizations; training for healthcare providers on implicit bias and trauma-informed care; expansion of peer support networks and telehealth options; and utilization of community health workers.			

EQR: external quality review; FFS: fee-for-service; ED: emergency department; COPD: chronic obstructive pulmonary disease; CAHPS: Consumer Assessment of Healthcare Providers and Systems; CCC: children with chronic conditions; ND: North Dakota; PPS: prospective payment system; VBP: value-based purchasing; HEDIS: Healthcare Effectiveness Data and Information Set.

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