



Quality Improvement Program – New Jersey (QIP-NJ)
 Measure Specifications and Submission Guidelines (Databook)
 Frequently Asked Questions (FAQ) Document
 Version v1.3 – Updated February 14, 2021

Introduction

This FAQ document is provided to support the QIP-NJ Databook and Value Set Compendium (VSC). This FAQ document has been created by compiling questions the DOH has received in the QIP-NJ inbox, Databook webinars, and Hospital Technical Contact Forums. Any new and/or revised questions or language from the prior version of the FAQs will be denoted with bold and underlined text, e.g., “**Sample**”. Please note this FAQ is a companion document to the QIP-NJ Databook and QIP-NJ VSC available on the QIP-NJ [Documents & Resources](#) webpage.

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Glossary of Terms

Abbreviation	Definition
AIM	Alliance for Innovation on Maternal Health
AOD	Alcohol and/or Drug Usage
APC	Advanced Practice Clinician
APR DRGS	All Patient Refined Diagnosis Related Groups
BH	Behavioral Health
BP	Blood Pressure
CMS	Centers for Medicare & Medicaid Services
C-SSRS	Columbia Suicide Severity Rating Scale
CTM-3	3-Item Care Transitions Measure
Databook	QIP-NJ Measurement Specifications and Submission Guidelines
DHS	Department of Human Services
DOH	Department of Health
DO	Doctor of Osteopathy
ECHO	Experience of Care and Health Outcomes
ED	Emergency Department
HER	Electronic Health Record
EPDS	Edinburgh Postnatal Depression Scale
FAQ	Frequently Asked Questions
FFS	Fee-For-Service
FUH	Follow-up After Hospitalization for Mental Illness
GME	Generalized Medical Examination
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HTN	Hypertension
MD	Doctor of Medicine
MMC	Medicaid Managed Care
MMCO	Medicaid Managed Care Organization
MMIS	Medicaid Management Information System
MY	Measurement Year
NCQA	National Committee for Quality Assurance
NJ DSRIP	New Jersey Delivery System Reform Incentive Payment
NPI	National Provider Identifier
NTSV	Nulliparous, Term, Singleton, Vertex
NUBC	National Uniform Billing Committee
OBGYN	Obstetrician-Gynecologist
PCP	Primary Care Physician
PHQ	Patient Health Questionnaire
POS	Place of Service
PQC	Perinatal Quality Collaborative

PRA	Perinatal Risk Assessment
QIP-NJ	Quality Improvement Program - New Jersey
QMC	Quality Measures Committee
SHTN	Severe Hypertension
SMM	Severe Maternal Morbidity
SUD	Substance Use Disorder
TCM	Transitional Care Management
UB	Uniform Billing
VSC	QIP-NJ Databook Value Set Compendium

Baseline Period

1. Can you confirm the baseline period (MY 0) is July 1, 2020 – December 31, 2020?

- A. Yes, the baseline period (MY 0) runs from July 1, 2020 – December 31, 2020, with a three-month claims run-out period.

2. Considering the COVID-19 pandemic and its widespread impacts, does DOH have any concerns about using last year's data as a baseline given that hospital admissions may have been lower than usual, and/or has DOH considered adjusting the baseline period?

- A. Since CMS has approved the baseline period of July 1, 2020 – December 31, 2020, DOH is unable to adjust the baseline period. Nonetheless, DOH fully appreciates the unique nature and widespread impacts of COVID-19, relative to care patterns and health care services. As a result, DOH will continue to engage and work closely with industry and policy experts as necessary to understand and implement ways to mitigate any impacts to QIP-NJ.

3. If we report zero in the baseline, will we be eligible in future MYs?

- A. Reporting zero on any of the non-claims-based measures except for M2 in the baseline period (7/1/2020 – 12/31/2020) will not have any impact on payment associated with these measures in MY1 and hospitals will still be eligible for incentive payments in MY2 and beyond. Please note, however, that no payment is tied to measures BH10, BH11, M8 and M9. These measures are reporting only.

For M2, reporting zero for the baseline will mean your hospital will be ineligible for the incentive pool on this measure for MY1. If your hospital reports something other than zero on measure M2 in MY1, then you will be eligible for the incentive pool in MY2, consistent with the requirements as outlined in the Databook.

Target Population

1. Does Medicaid refer to Medicaid FFS, MMC, or a combination of both?

- A. To be eligible for attribution in QIP-NJ, an individual must be enrolled in one of the five NJ health plans, or MMCOs, that participate in the NJ FamilyCare program (see the most recent version of the Databook) by the last day of the applicable MY (i.e., December 31st). That said, DOH recognizes that some individuals may begin the year in FFS and then transition to MMC before the end of the MY. For those individuals, both Medicaid FFS and MMCO claims may be considered for measurement.

2. Does QIP-NJ attribution include individuals with presumptive eligibility status?

- A. Individuals with presumptive eligibility status who are then subsequently enrolled in a MMCO by the close of the MY will be included for purposes of QIP-NJ attribution.

3. What is the "minimal gap" permitted with regards to continuous enrollment?

- A. The minimal gap applies to the specific measures as described in the Measure Specification Funding Mechanics Protocol, QIP-NJ Databook. Please consult each measure's "Continuous Eligibility / Sampling Methodology" section for details.

- 4. How is “primary discharge diagnosis” defined?**
 - A. The primary (principal) discharge diagnosis, as defined in the NUBC Official UB-04 Data Specifications Manual, is "the condition established after study to be chiefly responsible for occasioning the admission of the patient for care" and reported as primary diagnosis on the claim.

- 5. For BH under Payment Arrangements, the Databook references “individuals with a behavioral health diagnosis who receive services from the hospital in the measurement [year]” (v 0.1, Page 9). Are these just BH services or ANY services provided at the hospital?**
 - A. Please consult the “Attribution of the Behavioral Health Population” section in the Databook for additional information as well as a description of how both BH and physical health services contribute to identifying the attributed population for the hospital.

- 6. What is the population age range for BH and maternal health measures?**
 - A. Only individuals aged 18 years and older are attributed for BH. There is no restriction on individual age for maternal health for attribution. However, certain maternal health measures may have age restrictions; please refer to the most recent version of the Databook for measure specific age criteria.

- 7. Can DOH clarify what “the setting appropriate to the measure” means?**
 - A. For measures where the steward is NCQA, the most recent value sets (MY 2020 & 2021) allow for telemedicine (online assessments and other telemedicine accommodations). For other measures, these are specific to the State of New Jersey POS, Type of Bill, discharge disposition, or UB revenue codes. Please consult the affiliated tables with the given measure for further detail on place of service.

- 8. Will QIP-NJ’s target funding split between BH and maternal health be adjusted in future MYs?**
 - A. Funding for QIP-NJ is split 70/30, with 70% of funding for BH and 30% for maternal health. As payments are tied to attribution, and attribution is tied to utilization during the MY, payments may fluctuate year-over-year as service utilization changes across all participating hospitals. At this time, DOH does not intend to adjust the target funding in subsequent MYs.

Attribution

- 1. When are hospitals expected to receive attribution lists and reporting templates for measures?**
 - A. QIP-NJ attribution is retrospective. Hospitals will receive their baseline attribution list no later than the end of July 2021. Baseline attribution is used to determine performance targets for MY1. Please note that MY1 attribution will be the attribution that determines hospital specific funding. On an annual basis thereafter, hospitals will receive an attribution list that will include individual-specific information (i.e., name, DOB, etc.) following the three-month claims run out period for the MY.

- 2. How is QIP-NJ generating the attribution lists?**
 - A. The attribution data captures individuals who have enrolled in MMC by the end of the MY (December 31st). QIP-NJ uses the Medicaid ID(s) listed in combination with the billing provider

NPI(s) to identify individuals who delivered at the hospital using APR DRGs, or individuals who met the definition of BH in the program.

- 3. How is QIP-NJ using Medicaid IDs and billing provider NPIs to generate its attribution list?**
 - A. QIP-NJ is using a combination of Medicaid IDs and billing provider NPIs to determine a hospital's attribution. Both must be included to accurately capture all hospitals' services.

- 4. Where did DOH obtain the list of Medicaid IDs and billing provider NPIs that generates baseline attribution?**
 - A. From a state perspective and to ensure both consistency in approach across our state programs/initiatives, as well as to reduce administrative burden on participating hospitals in QIP-NJ, DOH leveraged Medicaid ID and billing provider NPI data that is collected on an annual basis by DHS, and already used for other state programs/initiatives (e.g., GME, charity care etc.). Moving forward, Medicaid IDs and billing provider NPIs must be submitted by the hospital as part of the Letter of Intent (LOI) process.

- 5. As a general rule, what billing provider NPIs are appropriate for inclusion for purposes of QIP-NJ?**
 - A. Acute Care Hospitals (provider type 60) are the only facilities eligible to participate in and earn payment for meeting performance targets on QIP-NJ quality measures. That said, there may be additional billing provider NPIs appropriate for inclusion in QIP-NJ. These may include, but are not limited to, acute care and inpatient units, on-site clinics, etc. Please note that for billing provider NPIs, the following are not appropriate for inclusion: independent clinics, dialysis centers, freestanding survey centers, freestanding diagnostic centers, sub-acute rehab units, etc.

- 6. For hospitals working within a large system, how can hospitals be sure that only the appropriate Medicaid ID and Billing Provider NPIs will be utilized for claims-based measures?**
 - A. Please see responses to questions #3-5 above. As stated previously, QIP-NJ uses the Medicaid ID listed in combination with the Billing Provider NPI to identify hospital specific claims for purposes of attribution and performance. Please note that for MY1 and ongoing, DOH is having internal discussions and exploring options with DHS to improve and/or streamline the attribution process, and more information will be released once a final approach is identified.

- 7. Will DOH confirm which individuals are enrolled in MMC, based on attribution lists which are provided to hospitals prior to hospital reporting each year?**
 - A. Yes, DOH will confirm MMC enrollment. Attribution includes individuals that are enrolled in at least one month of MMC during the MY, but they may not be continuously enrolled as specified by the measure. For MMIS measures, DOH will calculate continuous enrollment. For non-claims-based measures, DOH recognizes that hospitals only have access to data in their own system for determining individual patient compliance with numerator and denominator. The current guidance is to only exclude individuals known through available hospital data to have lost eligibility. DOH will be reviewing the continuous eligibility requirement for this and other measures prior to the release of the next version of the Databook.

- 8. Is there any thought to having the MMCOs provide eligible attribution lists on a more frequent basis so hospitals can track during the year more effectively?**

- A. No. As a general rule, DOH will not dictate how hospitals interact and build relationships with MMCOs, relative to participation in QIP-NJ. However, hospitals may choose to work with MMCOs to develop more frequent lists and strategies for tracking throughout the year.

9. Will the attribution methodology for MMCO maternity cases be based on Medicaid enrollment files, MMCO encounter (claims) data, or both?

- A. Attribution for maternal care is based on both MMCO enrollment files and claims data. As noted above, the individual must be enrolled in an MMCO by end of the MY (12/31/21 for MY1) and have delivered a baby in the hospital.

10. Are individuals required to choose a PCP with MMC for QIP-NJ?

- A. Participation in QIP-NJ does not require individuals to choose a PCP; however, it may be helpful for performance on outpatient measures requiring follow-up. In addition, please see the “Attribution Methodology Overview” section in the Databook for more information on how individuals will be attributed.

Non-Claims-Based Measure Submissions

1. Will there be an abstraction tool available for collecting chart abstracted measures?

- A. Yes, there will be an abstraction tool available for collecting chart-based measures. DOH will provide these materials by July 2021; please note these materials will be updated annually. Further, DOH will be providing a list of attributed individuals, but this will not be measure specific. The abstraction tool for collecting chart-based measures is the [Standard Reporting Template](#) located on the [QIP-NJ Website](#). An accompanying [Guidance Document](#) is also available on the [QIP-NJ website](#).

2. Can hospitals submit data both ways, through the tool and by flat file?

- A. Yes, DOH will accommodate hospitals choosing a hybrid approach (i.e., submitting data using the tool AND flat file). More information regarding this process will be released in July 2021 via the QIP-NJ email, QIP-NJ newsletters, and QIP-NJ website.

3. How did DOH develop the list of approved screening tools for the chart-based measures and instrument-based measures?

- A. DOH first solicited feedback from all acute care hospitals in November 2020 to inform acceptable screening tools for use in QIP-NJ, recognizing that there are a variety of tools (e.g., homegrown and/or hybrid models) used. In February 2021, an additional, follow-up communication was sent to hospitals to reiterate our request that hospitals identify any preferred tools currently in use in their respective clinical settings. Recognizing that our hospital partners have many competing priorities, DOH continued to consider ad hoc submissions and requests up until the launch of QIP-NJ.

As a result, for MY1 the approved screening list included ten depression screening tools between BH07 and M03, as well as three Social Determinants of Health (SDOH) screening tools for BH11

and M09. A full listing of the approved screening tools for each measure can be found in the Databook.

4. How does a hospital submit a tool for consideration for the screening chart-based measures and instrument-based measures?

- A. Given that MY1 of QIP-NJ has already started and to ensure a consistent, equitable approach across participating hospitals, DOH is unable to consider additional screening tools at this time for MY0 and MY1 of QIP-NJ. As a result, hospital will need to utilize one of the previously approved tools for MY1. The Department understands this decision may require hospitals to transition to a new tool during the current MY; therefore, the Department will continue to provide technical assistance to mitigate and/or resolve any potential difficulties and will also support hospitals throughout the program to ensure accurate reporting for these measures.

DOH, through the Quality Measures Committee (QMC), will undergo an official review process at the end of MY1, which will entail engaging clinical and quality experts to assist in reviewing additional screening tools for potential use in subsequent years of QIP-NJ. To this end, hospitals can email QIP-NJ@pcgus.com to submit a screening tool for consideration for future MYs.

5. If hospitals send in a file that does not upload correctly, will the QIP-NJ team send the hospital an email?

- A. Yes, if the file does not upload correctly, the submitting hospital will receive correspondence from the QIP-NJ team. The QIP-NJ team anticipates that this is going to be an iterative process, and is willing to work with individual, impacted hospitals to the greatest extent possible to ensure files upload correctly.

6. Do hospitals need to report exclusions?

- A. In an effort to relieve administrative burden, DOH is not requiring hospitals to report exclusions for non-claims-based measures. Hospitals may choose to report exclusions if their hospital is having trouble meeting the minimum denominator or would like to demonstrate a pattern of exclusions that may impact performance.

7. Do hospitals need to report exceptions?

- A. Exceptions are relevant only to measure BH7 and must be reported in the Standard Reporting Template for consideration. DOH would like hospitals to report exceptions to monitor patterns of procedures that are causing numerator noncompliance for the next MY.

Sampling

1. What is the process for sampling?

For more information on the Minimum Sample Size for the measure based on the attribution size (denominator) please refer to the Databook for MY1 on the QIP-NJ Documents & Resources webpage. Hospitals are responsible for ensuring that all sampling requirements associated with the

measure have been met. Each measure reported through a sample must include a description of steps taken to validate that all sampling requirements have been met.

2. Should hospitals sample from the Denominator eligible group and then exclude patients, or should hospitals first exclude patients and then sample?

A. Hospitals should first remove exclusions and then sample. However, for hospitals with a manual abstraction process who choose to sample and then remove exclusions, DOH recommends backfilling patients to ensure the denominator meets the 30-patient requirement. When a sample is taken for a measure and exclusions force that population below the 30- patient denominator requirement, the process for backfilling patients is as follows:

Table 1

<i>Step 1</i>	Identify the eligible population from the attribution roster and remove all required exclusions based upon the respective measure specifications. All required exclusions must be removed from the final eligible population.
<i>Step 2</i>	Search chart/EHR systems to identify numerator events for all members in the eligible population.
<i>Step 3</i>	If applicable, for members for whom non-claims-based data do not show a positive numerator event (numerator compliance), search non-claims-based data for an exclusion to the service/procedure being measured.
<i>Step 4</i>	Exclude from the eligible population, members from step 3 for whom system data identified an exclusion to the service or procedure being measured.

3. The Standard Reporting Template states that the minimum random sample size for a total patient population size of 126-500 is 20% of the population. Is that 20% of the eligible population or 20% of the attributed population?

- A. Sampling is permitted based upon the volume of attributed individuals.
1. For BH, this is determined by the total number of individuals in the attributed population with an encounter in an appropriate setting during the MY.
 2. For maternal health, sampling is determined by the total number of attributed individuals admitted to the hospital for labor and delivery during the MY. As stated, sampling is based on the attributed population in terms of what the minimum random sample size for the hospital is.
 - a. For example (from the Databook v1.2 page 11), a hospital’s maternal health total attributed individuals is 400. Using the stated methodology, $400 * (0.20) = 80$ attributed individuals may be sampled for each Maternal Health measure.

Although attribution is used to determine designated sample size, the sample should be drawn from the population eligible for the measure (denominator eligible individuals). For hospitals that do not remove exclusions before they sample, additional context from NCQA methodology is provided below:

1. First, the starting sample size must be higher than the designated sample size because medical records must be substituted if a member is ineligible for the measure; for example, if a member meets exclusion criteria for the measure.
 2. To adjust for this, divide the sample size by the percentage of charts expected to be inappropriate for review.
 - a. Example: Suppose 10 percent of charts are expected to be inappropriate for the measure (exclusions).
 3. To determine the oversample, multiply the minimum required sample size (MRSS) by the oversample percent and round up to the nearest whole number.
 4. $411 \times 0.10 = 41.1$
 5. (rounded up to 42 = oversample).
 6. The recommended methodology for substitution is:
 7. Replace the member's chart with that of the first member in the oversample list.
 8. Continue replacing each ineligible member with the next consecutive member of the oversample list.
- 4. Measures M3, M6, M7 are not included in the table of measures listed as permitting random sampling. If random sampling is not permitted, please explain why.**
- A. Thank you for identifying this discrepancy. [Databook v1.0](#) has been amended to allow random sampling for M3 and M7 in [Databook v1.2](#). Sampling had previously been approved for M6. Please refer to "Sampling Methodology" section in the most recent version of the Databook for further detail.
- 5. Can you please confirm that the steps hospitals used for sampling in the NJ DSRIP, and further supported by page 16 of the QIP-NJ Databook, are valid for QIP-NJ?**
- A. The QIP-NJ sampling process described in the most recent version of the Databook aligns with DSRIP and is how sampling should occur.

Statewide Benchmarks

- 1. Can you provide the source of data used to develop the statewide targets?**

A. The benchmarks were discussed and approved in consultation with the QMC, DOH, DHS, and identified subject-matter experts in BH and maternal health.
- 2. For M2, why did DOH determine a statewide benchmark of 23.6%, which is below the national benchmark of 23.9%? Are hospitals expected to perform better than the national average?**

A. Statewide benchmarks were determined by DOH in consultation with maternal health experts, as reasonable five-year goals. The statewide benchmark for M2 referenced in in [Databook v1.0](#), and [Databook v1.2](#), is 23.6 per 1000 deliveries, which is 2.36%, not 23.6%.

Measure-Specific Questions

ALL MEASURES

- 1. What measures can be delivered via telehealth modalities?**

A. BH2, BH3, BH4, BH5, BH6, BH7, BH8, M4 and M5.

2. If a hospital does not yet have a standardized tool in place for screening measures, BH7, BH8, BH11, and M9, what should be reported?

For QIP-NJ, between two of the depression screening measures, BH7 and M3, ten depression screening tools are approved. Similarly, for BH8, a substance use screening measure, eight screening tools are approved. Likewise, for BH11 and M9, three Social Determinants of Health (SDOH) tools are approved. A full listing of the approved screening tools for each measure can be found in the Databook. If a hospital does not have an approved screening tool in place during the MY and is not able to utilize one of the previously approved tools listed in the Databook, the hospital can report zero for the measure and include in the Standard Reporting Template's "Sampling Instructions" tab an explanation as to why they are reporting zero in the MY.

BH1

1. Is the attributed BH population operationally defined as those individuals admitted to the inpatient BH Unit? Are unplanned readmissions inclusive of an inpatient BH admission at any hospital or only a re-admission to our hospital?

A. Please see the "Attribution Methodology Overview" section in the most recent version of the Databook for more information about the attribution methodology for QIP-NJ. Please note that individuals may be included in the measurement for a hospital, even if they are readmitted to another hospital, depending on the individual's attribution for QIP-NJ.

2. Hospital A does not have many individuals that fit the index admission criteria, so the number is not representative. What does this mean for hospitals that do not have many BH admissions?

A. Hospitals with denominators below 30 individuals on BH1 will have payment distributed across other measures in which they participate.

3. Changes to the measure mean a readmission within 48 hours of discharge is excluded. Do readmissions from day 3 to 30 apply?

A. Yes, readmissions must occur within 3 to 30 days after the index discharge date from the eligible index admission date that had the principal discharge diagnosis of a psychiatric disorder (Table BH01_00).

BH2

1. Please define in more specific terms who meets definition of "Mental Health Provider".

A. The Department recognizes that there are many types of health care practitioners/providers who can perform follow-up services that meet the criteria for the numerator in BH2 and BH4. "Mental Health Provider" is broadly defined as any provider (with the appropriate Place of Service (POS) code in accordance with the measure criteria) who delivers a mental health service as defined in the Mental Health Fee-for-Service (FFS) Program Provider Manual Version 4.9.0 (July 2021), which is available on the Department of Human Services, Division of Mental Health and Addiction Services' website.

However, since QIP-NJ pay-for-performance only uses final, paid Medicaid managed care claims to calculate a hospital's performance, the program defines Mental Health Providers as licensed providers with the appropriate Place of Service (POS) code delivering a mental health service as defined in the Mental Health Fee-for-Service (FFS) Program Provider Manual Version 4.9.0 (July 2021). Stand-alone interactions with unlicensed practitioners, such as peer specialists and recovery coaches who help to connect patients to care, are not considered follow-up services in and of themselves, and would not meet the numerator criteria for QIP-NJ measures unless paired with a service provided by a licensed provider. Despite the fact that services provided by unlicensed practitioners do not directly count toward performance, we encourage all hospitals to consider the additional benefit these practitioners provide to patients, which has been well-documented in the literature, and may impact future performance.

2. Please define "TCM".

A. TCM includes services provided to an individual with medical and/or psychosocial problems requiring moderate or high-complexity medical decision making. TCM services involve a transition of care from one of the following hospital settings: inpatient acute care hospital; inpatient psychiatric hospital; long-term care hospital; skilled nursing facility; hospital outpatient observation or partial hospitalization; partial hospitalization at a community mental health center."¹

3. Has DOH considered how COVID-19 impacts BH2? This measure is heavily impacted by COVID-19 pandemic in terms of the number of individuals who are not able to attend an in-person follow-up visit.

A. Please see response to question #2 in the Baseline Period section above. Also, please note that BH2 allows follow-up visits to be delivered via telehealth modalities.

BH3

1. Does this measure include all visits to the ED not specific to AOD?

A. No, the denominator only includes visits where there is a principal diagnosis of AOD abuse or dependence; please consult "Table BH03_DetailOID". This includes discharge from the ED (value set name "ED") with a principal diagnosis of AOD (value set name "AOD Abuse and Dependence") on or between July 1 and December 1 of the MY where the individual was 18 years of age through 64 years of age on the date of the visit.

2. In the VSC, tab "BH03_AODTxservices" denotes the service providers. What are the specific credentials related to the "Licensed SUD professionals authorized by state licensing board?"

A. Information on the credentials and licensure requirements may be viewed on the State of New Jersey DHS website at [Division of Mental Health and Addiction Services](#).

¹ [FAQ on Transitional Care Management \(TCM\) \(aafp.org\)](#)

BH3 & BH4

- 1. What happens to a BH individual seen in the ED who is then incarcerated without a follow-up visit?**
 - A. If there is no follow-up visit within 30 days after ED visit with a principal diagnosis of mental health, the individual is considered numerator non-compliant.

BH5 & BH6

- 1. Is inpatient BH considered under the umbrella of AOD? Is it measuring every individual through the hospital?**
 - A. If the Index Episode was an inpatient discharge (or an ED/observation visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the member is compliant. For BH5 & BH6, Extended Stay Psychiatric Hospitals (Provider Type Code = 64) are excluded from the denominator.
- 2. Initiation of treatment must start by day 14; however, many treatment programs have waiting lists that are beyond 14 days. Has this been considered?**
 - A. Yes, DOH is aware of the waiting lists; however, it is expected that hospitals come up with innovative solutions to address this challenge as part of the overall quality and health outcome improvement goals of QIP-NJ.
- 3. Can the “different” providers still be within the same departments (for example, a visit with a prescriber and a visit with a clinician in the same department)?**
 - A. Two engagement visits can be on the same date of service; however, they must be with different Billing Provider NPIs to count as two distinct events.
- 4. What is the “Intake Period” for measure BH5? The Intake Period was defined explicitly in the “Definitions” section of the M5 version of the measure, but BH5 does not have a “Definitions” section.**
 - A. The intake period (MY0 and MY1) for BH5 is July 1 – November 14th. This was erroneously omitted from the “Definitions” section for BH5 and has been modified in [Databook v1.2](#).

BH7

- 1. Can you add telehealth visits as an exclusion since the depression screening would not be administered due to time constraints?**
 - A. At this time, DOH will not be adding telehealth as an exclusion for BH7. DOH believes providers may make individualized decisions to allow these tools to be delivered through telehealth modalities.
- 2. Is this an outpatient measure only? I want to confirm that hospitalized inpatient BH visits are not to be included in this measure.**
 - A. This measure includes ED and outpatient services.

3. Is the PHQ2 considered an approved screening tool? If not, would DOH consider PHQ2 an approved screening tool if a positive screen is followed by PHQ9?

A. Yes, PHQ2 is an approved screening tool; this has been amended in [Databook v1.2](#).

4. What is considered “active” for a disorder?

A. Unless a diagnosis is documented as being in remission, it is considered active.

5. How do hospitals determine place of service on their internal data?

A. DOH recommends hospitals work with their internal technical liaison(s) to understand the associated system(s) and relevant data elements that house clinical and other pertinent information.

6. Could you provide additional guidance around the best method to determine the outpatient setting classification in the hospital?

A. The expectation is the depression screening will occur at minimum once per member per outpatient setting per year; further, screens should be performed if deemed necessary per the patient’s needs and consistent with the clinical staff in the setting.

At a minimum level, staff-assisted depression care supports consist of clinical staff (e.g., nurse, physician assistant) who may advise physicians of screening results and who can facilitate and coordinate referrals to mental health treatment. Therefore, unless a patient is exhibiting mental duress in a particular specialty setting (e.g., podiatrist, ophthalmologist), screening under these conditions is not considered medically necessary.

7. Is DOH considering approval of the C-SSRS tool for BH7?

A. C-SSRS has been added to the list of approved tools for BH7 and M3.

8. What do hospitals do if there are multiple entries for the same individual?

A. Based upon feedback from hospitals and further internal review, the updated guidance is that hospitals no longer must report every ED and outpatient encounter that would qualify an individual for this measure. Where a hospital chooses to limit their submission to a single encounter, DOH advises that hospitals prioritize ED visits over Outpatient visits for this measure. Hospitals may choose to report all encounters, or the first encounter for which patients received a positive screen, whichever is less burdensome for the hospital reporting team. If patients do not have a positive screen in the MY, then report the first encounter patients have a negative screen. If patients do not have a negative screen in the MY, then report the first eligible encounter patients have in the MY.

9. Is there a requirement to use a specific screening tool for depression? Can DOH provide examples?

A. Yes, the “Approved depression screening tools” may be found under the Numerator section of BH7. For more information regarding this process, please refer to questions 3 and 4 under “Non-Claims Based Measures”.

10. Where are the two-digit codes for the depression screening tools?

- A. The two-digit codes are found in the Databook section “Data File Layout and Submission Requirements”, Variable Description = Screening Tool Used. Each tool administered needs to be captured in a separate row, and reported in the latest Standard Reporting Template available on the QIP-NJ website.

11. For BH7, how should hospitals prioritize UB revenue codes when there are multiple per individual?

- A. If there are multiple UB revenue codes per patient encounter, hospitals need only report one eligible code. If there are multiple eligible encounters for a patient in the MY with different revenue codes, for example, if a patient had an outpatient visit and then had an ED visit a month later, the hospital should report the first encounter for which patients received a positive screen as outlined in above. Please refer to question 8 in this section for more information.

12. Does the primary physician need to sign off the transmission record prior to transmission?

- A. The clinical workflow is at the discretion of the hospital implementing the measure. The state is not collecting any data regarding physician signoff, only information as to whether the record has been transmitted.

13. For patients where the record was not transmitted at all, should we still submit a numerator record with a blank date?

- A. No, you do not need to report numerator non-compliant records for these measures.

14. Since we can look at more than the primary dx, is there a limit to the amount of diagnosis rows we can report per patient?

- A. No, you may report as many diagnoses as you see fit. As long as there is a diagnosis within the measurement period, that is what our team will be validate when calculating performance.

BH8**1. Is this an outpatient measure only?**

- A. This measure includes outpatient and ED.

2. Do observation visits qualify for the setting of care (clarify POS values/billing code source)?

- A. Please refer to Table BH08: NJ Place of Service Value Set for the value sets associated with this measure. An ED visit resulting in an observational stay should be excluded.

3. The numerator consists of individuals seen at least once within 12 months and who received at least one intervention for all positive screening results -- is this limited to outpatient settings?

- A. The screening may take place in the ED or the outpatient setting.

4. For BH8, based on the measure specifications patients may be screened outside of the MY. Should the results in the standard reporting template include the qualifying numerator encounter, which may fall outside the MY?

- A. It should include the qualifying numerator encounter in which a patient was screened. DOH understands that some screenings may fall outside of the MY for baseline.

5. For BH8, could you clarify the exclusionary criteria?

- A. There are several exclusionary criteria for BH8 including:
- Documentation of medical reason(s) for not screening
 - Use of opioids for chronic pain management (Medical notation that a pain contract agreement exists in the patient record)
 - Limited life expectancy or hospice
 - ED visits that result in an observation stay

The respective value sets are reflected in Table BH08_01.

6. If choosing to use the sampling methodology for BH8, are those individuals diagnosed with existing alcohol/substance disorders excluded from the sample?

- A. No, those individuals diagnosed with existing alcohol/substance disorders are not excluded from sampling.

7. For BH8, we will be utilizing the NIDA Quick Screen, which does not have a score, do we leave this field blank on the submission file?

- A. The requirement for BH8 is to report the tool name, raw score, result of screening (positive, negative or indeterminate) and if result is positive, the follow-up plan. For the NIDA Quick Screen, the expectation is that if the answer is negative, screening is complete and should be reported as negative. If the answer is affirmative to prescription or illegal drugs, the NIDA-Modified ASSIST which asks more detailed questions about drug use should be administered. PCG will validate the scores internally against the scales for each of the respective tools authorized for the measure.

8. For measure BH8, if screening does not cover all the items in the measure, can it still be reported? What is required for hospitals that are not using a DOH-approved screening tool?

- A. Screening must cover all components of the measure to count towards performance. Hospitals can report zero for the measure and indicate in the submission comments that a DOH-approved tool was not used.

9. What UB revenue codes should we use for BH8?

- A. Hospitals should use the same revenue codes that are indicated on BH7 for BH8. This has been updated in v.1.4 of the Value Set Compendium.

10. The threshold for intervention may be hospital specific. Can you provide guidance on how DOH intends to validate the need for an intervention with varying thresholds for intervention?

- A. The QIP-NJ team recognizes that different scores may be used by each facility to indicate a positive screening. We have indicated in the appendix of the Standard Reporting Template Guidance Document what we anticipate those scores will be. If your facility uses a threshold differing from what is provided in the guidance document, please let the QIP-NJ team know and it will be taken under review.

11. Is BH8 like BH9 where the primary dx must be behavioral for the episode to count towards performance?

- A. An individual does not need a primary diagnosis of substance abuse to be considered denominator compliant for this measure.

12. What RES_VAL do you use for the NIDA tool?

- A. 01 for INCL_T, L for RES_VAL and 95528-6 for CODE_VAL.

BH9

1. Is this measure limited to psychiatric individuals hospitalized on a Psychiatric Unit or does the measure include medical individuals treated for psychiatric illnesses in consultation? Does this include discharges from both medical units as well as BH Inpatient units?

- A. Please refer to Tables BH09M06_01a and Table BH09M06_01b for the value sets associated with this measure. Inpatient setting discharge is defined by bill type (BH09M06_01a) for an individual of the hospital's attributed BH population.

2. Can the transmission be to a PCP, Psych., Home Care, or Therapist?

- A. It may be a physician or other health care professional designated for follow-up care of the individual.

3. Is there a place for discharge disposition on the standard reporting template?

- A. To record discharge dispositions on the STANDARD REPORTING TEMPLATE for BH9, hospitals should report the RES_VAL field as "D" for discharge status and then fill in the CODE_VAL field with the respective 2-digit number. To report the transmission date, hospitals should report the RES_VAL field as "Z" for Other and then fill in the CODE_VAL field with the date in which the transition record was sent.

4. For internal transfers (defined as transfers to other hospitals within the network), do these patients count as exclusions?

- A. No, patients are not excluded when transferring between facilities, even when those patients are within the same network. See "BH09: Sample Individual #1: Profile" in the SRT Guidance for more detail on which data elements should be submitted.

5. For BH9, do hospitals need to do all four rows as seen in the Standard Reporting Template guidelines document? When is it appropriate to stop recording qualifying elements?

- A. BH9 requires several data elements to qualify for the measure, which will be documented as separate rows on the Standard Reporting Template. For the denominator, there needs to be an

ICD-10 diagnosis code, a Bill Type code, and a patient discharge status code (discharge disposition). The discharge date may be included on the same line as one of the three aforementioned elements. The numerator needs only one row, which will indicate the date of transmission. For the numerator row, the RES_VAL will be recorded as “Z” and the CODE_VAL will be the transmission date.

6. DOH references the Type of Bill. Is this on the UB-04?

A. Type of bill codes are four-digit alphanumeric codes that specify different pieces of information on claim form UB-04 or form CMS-1450. They are recorded in box 4 on line 1 of the UB-04.

7. For the timely transmission of transition record, CMS has a more rigorous requirement that transition records must be transmitted electronically. If our hospital is faxing over transition records, that is acceptable?

A. Yes, this is acceptable and meets the measure as outlined in the BH9 measure specification in the Databook. The QIP-NJ team is aware of the criteria set by CMS and if the measure steward updates the specifications to remove this modality in the future, the QIP-NJ team might decide, in a future MY, to limit the types of transmission that are allowed.

8. The BH diagnosis does not have to be during the encounter just during the measurement period?

A. For the purpose of this measure, the individual should have a principal mental health or AOD diagnosis for the encounter.

BH10

1. For BH10, what surveys are accepted for this measure?

A. Hospitals may submit HCAHPS, ECHO, or CTM-3 scores for BH10, and may submit HCAHPS or CTM-3 for M8. The scores should be reported at the patient level in the CTMS_S field on the Standard Reporting Template. If the CTM-3 is incorporated into another survey, the hospital will denote this using the CTMS_I field on the Standard Reporting Template. The CTMS_I field inquires if the survey is standalone or combined with another test.

2. For BH10, is there any consideration for psychosis or level of capability for individuals to complete the survey?

A. Depending on the instrument used by the hospital, there may be individual populations excluded from participation. HCAHPS excludes individuals discharged from psychiatric inpatient admissions, but not individuals whose principal diagnosis is Medical, Surgical or Maternity Care with psychiatric co-morbidities. The ECHO survey is appropriate for use with psychiatric individuals; however, DOH recognizes it is not widely used by hospitals at this time.

3. Is the sample size requirement based on surveys returned or surveys mailed? How do hospitals know what the minimum survey population size is without knowing their attribution size?

- A. Hospitals should send as many surveys as possible, given that the common experience is that the response rate is very low. DOH will provide attribution lists which will help hospitals identify their survey population size. Additionally, DOH has decided to allow electronic submissions for surveys; this has been amended in [Databook v1.2](#).

4. Hospital A participates in HCAHPS – is this an acceptable alternative to using the CTM-3?

- A. DOH will allow hospitals to submit HCAHPS data or data from the ECHO Survey for BH individuals for BH10, and/or HCAHPS data for M8 (“CTM-3”). Data to support this measure should be reported in fields DMODE, CTMS_I, CTMS_E, and CTMS_S.

5. Some patients receive a Press Ganey survey instead of an HCAHPS survey. Should patients who receive a Press Ganey survey be included in the sample for this measure?

- A. Only results from HCAHPS, ECHO or CTM-3 questions will be deemed numerator compliant for this measure.

6. For BH10/M8, what is the numerator and denominator for this measure based on?

- A. The numerator is the hospital level sum of scores for all eligible sampled patients.. The denominator includes the number of eligible sampled adult patients discharged from a general acute care hospital. The result is the average score per patient in the denominator.

The 3-item CTM is comprised of the following questions (Qs):

1. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I left.
2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
3. When I left the hospital, I clearly understood the purpose for taking each of my medications.

There are 4 response options for Q1 and Q2: Strongly Disagree = 1, Disagree = 2, Agree = 3, Strongly Agree = 4 There are 5 response options for Q3: Strongly Disagree = 1, Disagree = 2, Agree = 3, Strongly Agree = 4, I was not given any medication when I left the hospital = 5.

7. If a hospital performed anonymous BH surveys during the baseline period & unable to filter survey responses in any way, is the report for that hospital then a 0 numerator?

- A. Yes. If results are being de-identified by your partner, you need to work with your partner to get the identified data. Indicate that no survey data is available for the baseline period in the sampling instruction tab under submission comments.

8. For hospitals that are not currently doing the CTM-3 survey. Is the expectation that they will start to administer this survey in future years? Since this metric is not tied to any \$, our hospitals are focusing resources on other metrics first. Will hospitals be penalized for reporting 0 for this metric?

- A. DOH recommends that all hospitals work to meet the requirements of this measure as soon as possible. A design components of this program is that if a hospital does not report data on non-claims based measures, there is the potential to lose out on payment for all measures. We will accept 0 for baseline, but our expectation is that moving forward there will be a tool in place.

- 9. Voicing concerns related to a double randomization for organizations using HCAHPS, CMS guidelines are being followed. This concern was also reported during Baseline reporting.**
- A. If you are not surveying your patient population separately, we want you to follow CMS guidelines. This program is not intended to be a barrier to following CMS guidelines. Where possible, we want to defer to CMS guidelines for HCAHPS.

BH11

- 1. What is the target population--- Inpatient/hospitalized individuals OR outpatient?**

A. This is for outpatient or ED.
- 2. What is the administration timeframe?**

A. The administration timeframe is while the individual is in the facility.
- 3. For BH11, do hospitals have to list every eligible screening for each patient or do patients only need one eligible screening listed?**

A. For baseline, only one eligible screening for each patient during the MY is required. Please note this may depend on the specific MY.
- 4. For BH11, how should the SDOH be scored? Does there have to be screening in every domain for a patient to be numerator compliant?**

A. Yes, questions must be asked within each of the four domains to determine if an individual is deemed to be at risk in any one of the domains.
- 5. For BH11, should hospitals provide a total score for that service date or for the entire period or report the highest value for all of the domains?**

A. Hospitals should report the scores from the most recent intervention. Required scores include the composite score in each domain as well as the SDOH Total score.
- 6. If the SDOH screening occurs in the PCP office (or in a Community Provider Office) within the measurement period, does that count to meet the metric? Or does the SDOH screening need to be in the ER setting?**

A. Yes, if screening is performed in a PCP office or Community Provider Office within the measurement period, and the hospital has access to the required data elements from the screening tool, it is numerator compliant.
- 7. If a patient belongs to both the MH and BH programs, can we use the PRA for BH11? Or should we add a comment on the S file as to why the PRAPARE was not administered for the BH program?**

A. If you have only seen them in context of Maternity but they are in BH roster, it seems clinically appropriate. Please let us know of this in the comments.

8. **For patients with a 1 or 2 in SDOH_E, do we report them as M_Element N or E?**
 - A. They should report as M_ELEMENT N not E. They will be deemed numerator non-compliant.
9. **If resources were provided for an identified risk, would that be reported as Referral Made or Other?**
 - A. Giving information like a pamphlet should be listed as “other” and indicated in the submission comments that materials were provided. That does not count as a referral.
10. **If we get data from FHI for PRA, but it is not in the patient’s chart, is it still acceptable to use for data submission?**
 - A. Yes, there is no requirement that the data come from the chart, but we do expect that it comes from a completed PRA, and the data be patient specific and not de-identified.

M1

1. **Is it possible to use only the potentially preventable components on the SMM list such as NTSV C-section rate, eclampsia, acute renal failure, etc. (provided they are not present on admission) and disregard the items beyond their control as clinicians?**
 - A. Based on feedback from the state-based experts in maternal health, DOH has been guided to not modify measure specifications from the measure steward. Please note, the statewide target for this measure is 25.2/1000 delivery hospitalizations including transfusions with the goal of achieving this by MY5.
2. **Has DOH considered the COVID-19 impact on the baseline period for this measure?**
 - A. DOH has added COVID-19 to exclusions (Table M01_02).
3. **Which measure rate is being used? Would DOH consider excluding blood transfusions?**
 - A. This rate is based upon the NJ Maternal Report Card data (2016) and should be interpreted as 25.2 per 1,000 delivery hospitalizations including transfusions. In consultation with the QMC, DOH, and subject-matter experts in maternal health, the measure will include blood transfusions to align with State and national initiatives.

M2

1. **The file format wants us to report previous live birth(s). Since hospitals are only using file format to report denominator, not denominator exclusions, and the answers will always be “Y” since all denominators must be live birth singleton, do we need this for future reporting?**
 - A. Yes, report denominator for only those individuals where the birth is nulliparous. DOH will review, and update the template, as necessary, annually.
2. **Hospitals are reporting baseline post-July 2021. Hospitals did not have the measure details for codes until May 2021. M2 wants hospitals to use the codes to report vertex. Hospital A will start coding**

vertex presentation in charts for July 2021 reporting MY1. Since Hospital A does not usually code a chart for vertex, can Hospital A use the documentation for just MY0 to report those individuals in the denominator (otherwise Hospital A will be at 0 for denominator)?

A. DOH has taken this matter into consideration and has agreed that an option will be made available to indicate a binary response (Y/N) for vertex presentation. This has been amended in Databook v1.2.

3. How do you report a patient which is excluded due to being in a clinical trial? Also, how to do you report a patient which is excluded because it is non-nulliparous?

A. We do not have a code set to identify clinical trial status. Patients excluded due to clinical trial status should be reported using M_ELEMT = E, and a comment should be added under submission comments on the Sampling_Instructions tab with the clinical trial information.

4. If the patient was admitted on 12/31/2021 but the delivery was on 01/01/2022 at 2 am. Should this patient be reported in the 2022 submission?

A. Delivery occurred in 2022 year, so that patient should be included in MY2 attribution.

5. The submission for M02 should essentially only list Cesarean births?

A. No, your denominator will include nulliparous individuals who deliver a live term singleton newborn, in vertex position with greater than 37 weeks completed. The numerator is individuals having an ICD-10-PCS Procedure Code for a Cesarean delivery.

M3

1. Can hospitals continue to use EPDS Screening Tool?

A. Yes. This an acceptable screening tool for measure M3.

2. Is there a requirement to use a specific screening tool for depression? Can DOH provide examples?

B. Yes, the “Approved depression screening tools” may be found under the Numerator section of BH7. If you would like to use a tool not listed, please submit it to QIP-NJ@pcgus.com immediately for DOH review and approval. For more information regarding this process, please refer to question 3 under “Non-Claims Based Measures”.

3. Where are the two-digit codes for the depression screening tools?

A. The two-digit codes are found in the section “Data File Layout and Submission Requirements”, Variable Description = Screening Tool Used. Each tool administered needs to be captured in a separate row and this template will be updated prior to the start of the program.

4. The file format has a field for exclusion reason. Since hospitals are only reporting denominators in the file, that field would not be applicable. What would hospitals enter there since none of the denominators in the reported data would have exclusions?

A. Yes, the hospital will be responsible for reporting only individuals eligible for inclusion in the denominator; this has been amended in the [Databook v1.2](#).

5. For M3, are there any exclusions besides hospice?

- A. Yes, additional exclusions for M3 include individuals that:
- Were transferred to another facility before or after delivery
 - Expired prior to discharge (Table M03_02)

Typically, these discharge statuses are found on the UB-04 claim (Form Locator 17, UB-04); however, may be in differing data elements in the chart/EHR.

M4

1. May this visit be conducted by any OBGYN or Primary Care Clinician (MD, DO, APC, Midwife)?

- A. Yes, the postpartum visit may be with a provider not affiliated with the hospital. The visit is also irrespective of provider type and based on services rendered. Please consult Table: M04_DetailOID.

M5

1. Is this only for individuals with AOD Diagnosis who have delivered? At time of delivery or any time in the MY?

- A. This is for individuals with an AOD diagnosis at any time in the MY.

M6

1. The doctors at Hospital A have access to the individual's entire EHR in the EHR platform; however, Hospital A does not currently transmit discharge summaries to the outpatient offices. Would Hospital A's status quo meet this measure?

- A. No, to meet this measure, the record must be transmitted to the PCP or health care professional designated. However, if the designated provider is a provider affiliated with your hospital, transmitting the record via the EHR platform is acceptable.

M7

1. Would an individual that has not had a hypertensive episode while in the hospital for birth, but sees a doctor for a follow up after childbirth on day 6 (BP >160/>110) be attributed to the hospital where the birth occurred even though the individual did not have the episode at the hospital?

- A. Yes, the individual would be attributed to the hospital where the delivery occurred; however, the individual will not be in the numerator or denominator for this measure because the episode did not occur at that hospital where the individual was attributed.

2. What does "new-onset" mean?

- A. New onset means the first instance of a high blood pressure reading within a facility on a given day. This only applies to episodes in the facility to which the individual is attributed.
- 3. This data is presently submitted to AIM; will QIP-NJ obtain the data from AIM submission or strictly from the EHR? Additionally, there were recent changes to the NJ PQC data portal that include exacerbation of chronic HTN. Will QIP-NJ be adopting those changes?**
- A. Hospitals will be required to submit data to support calculation of this measure to DOH through the proscribed process. QIP-NJ continues to work with the NJ PQC to maximize the alignment of measures across the two programs. Proposed modifications to measures will be reviewed by the QMC and QIP-NJ leadership team, prior to the start of each MY.
- 3. For M7, during a severe hypertension ED visit in which a patient is admitted for observation, would a hospital just report first instance of SHTN that occurred in the ED, or would hospitals report all instances of SHTN, even those that are recorded on inpatient claims?**
- A. Hospitals should report the first occurrence of SHTN. Hospitals should prioritize the SHTN instance that occurred in the ED. First-line agents should be administered within one hour of the second reading of SHTN.
- 4. How should we report a subset of patients who are in the denominator but received a 1st or 2nd line of medication before the 2nd blood pressure within the 15 to 60 minute gap. Clinically the best outcome for the patient was considered and a pre-eclamptic patient's blood pressure was controlled before the 2nd read was done.**
- A. Where the first line agent is administered prior to second reading, this will count as a numerator compliant encounter because this a clinical best practice.
- 5. Is a second reading required if the medication was administered after the first reading?**
- A. The expectation is that a second reading will be taken regardless of when the medication was administered.
- 6. How do we report those patients that have the correct gestational age, correct diagnosis code, but DO NOT have the required BP readings?**
- A. The expectation is that you take the two blood pressure readings and that they will be at least 15 minutes apart. Patients without blood pressure readings will be excluded from the denominator.
- 7. Does the 2nd BP reading have to be hypertensive too?**
- A. The expectation that there is a diagnosis and two readings that indicate a hypertensive episode, so yes. But that may not always be the case if the first line agent is administered prior to the second reading. If an antihypertensive is given after the 1st hypertensive reading, then hospitals should we report the 2nd BP reading taken within the 15 to 60 minutes as a normotensive value. If a patient does not have blood pressure readings that indicate a hypertensive episode, they will not be denominator compliant. If you report them, they will be excluded from the denominator.

- 8. Most often Magnesium sulfate is the drug of choice. Should we report them too?**
 - A. Magnesium Sulfate is considered a non-first line agent so you would report that in the ED_OTHTX field.

 - 9. How should the antihypertensive medication be reported?**
 - A. One row reported with RES_VAL as “N” for NDC code and a CODE_VAL of an NDC code in the FDA approved list in the CODE_VAL.

 - 10. Would the state be open to modifying the NDC character length from 9 to 11 as all other reporting done by the organization is done on the 11 digit code?**
 - A. Not at this time. The tables we pulled in from the FDA are formatted in 9 digit codes, so that is how we will be validating them.

 - 11. We are assisting many hospitals with their reporting of metrics for QIP. None of these hospitals have met the 30 cases in the denominator when reviewing their entire population of claims. I assume this is partly due to the shortened (6 months) of the period. Does QIP have a plan for how to handle this if few or possibly no hospitals have enough cases in this measure?**
 - A. A measure with less than 30 individuals in a denominator are excluded from payment. The total amount of funds the hospital is eligible for will be redistributed across measures within that same measure set (BH or maternal health) for that hospital. The total funds eligible to be earned will be the same for that hospital even with measures being excluded. Unless the hospital has no eligible measures, then funds will be redistributed to other hospitals.

 - 12. It appears possibly that very few if any hospitals in NJ will meet that denominator and therefore would QIP be looking into replacing this metric.**
 - A. The measure will not be removed. The expectation is that hospitals will continue to report even if they fall below 30.
-

M8

- 1. Hospital A participates in HCAHPS – is this an acceptable alternative to using the CTM-3?**
 - A. DOH will allow hospitals to submit HCAHPS data or data from the ECHO Survey for BH individuals for BH10, and/or HCAHPS data for M8 (“CTM-3”). A template will be provided for submission of HCAHPS/ECHO data.

- 2. Does this measure need to be counted for each discharge for an individual, or once per individual?**
 - A. Data should be submitted for each discharge for an individual. However, if the hospital is reporting their HCAHPS score for this measure, DOH will accept reporting in compliance with the HCAHPS standard.

- 3. For BH10/M8, what is the numerator and denominator for this measure based on?**
 - A. See answer for BH10 above.

M9

- 1. PRA is used in some outpatient settings by external providers. Does QIP-NJ recommend the screening take place in multiple settings?**
 - A. Yes, DOH recommends that screenings take place in multiple settings, including the hospital, if results of the screening completed in the outpatient setting are not readily available to the hospital.

- 2. Has DOH considered that M9 is already reported to the state for claims purposes? Can DOH leverage this information to ensure that portal (PRASPECT.org) data can meet our reporting requirements?**
 - A. Yes, DOH has taken this matter under advisement and is actively conducting an internal assessment to see what opportunities may exist for data exchange and greater cross-initiative alignment. At this time, hospitals will need to separately report for purposes of QIP-NJ; however, DOH will provide more information once a final approach has been identified.

- 3. Do hospitals have to incorporate the entire screening tool for it to count even if the hospital only needs to report on several questions?**
 - A. Yes. For M9, the validated Social Determinants of Health (SDOH) tools are the AAFP: Social Determinants of Health and the NJ Perinatal Risk Assessment (PRA), and hospitals should ensure all required domains within these tools are addressed. A full listing of the approved screening tools for each measure can be found in the most recent version of the Databook.