



Quality Improvement Program - New Jersey (QIP-NJ)

Governing Document

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Prepared by Public Consulting Group

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I. Glossary of Terms

Term	Definition
BH	Behavioral Health
BTS	Breakthrough Series
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CQO	Chief Quality Officer
D-SNPs	Dual Eligible Special Needs Plans
Databook	QIP-NJ Measurement Specifications and Submission Guidelines
DHS	Department of Human Services
DOH	Department of Health
DSRIP	Delivery System Reform Incentive Payment
ED	Emergency Department
EHR	Electronic Health Record
FAQ	Frequently Asked Questions
FFS	Fee-for-Service
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinic Health
IHI	Institute for Healthcare Improvement
LOI	Letter of Intent
MCO	Managed Care Organization
MMC	Medicaid Managed Care
MMCOs	Medicaid Managed Care Organizations
MMIS	Medicaid Management Information System
MY	Measurement Year
NJ	New Jersey
PACE	Program of All-Inclusive Care for the Elderly
PCG	Public Consulting Group, Inc.
PDSA	Plan, Do, Study, Act
PPC	Postpartum Care
QIP-NJ	Quality Improvement Program – New Jersey
QMC	Quality Measures Committee
RMP	Relative Medicaid Percentage
SFTP	Secure File Transfer Portal
SFY	State Fiscal Year
SME	Subject Matter Expert
SUD	Substance Use Disorder

VP	Vice President
VSC	Databook Value Set Compendium

II. Introduction

The purpose of this Governing Document is to provide information regarding QIP-NJ and its program policies and processes. QIP-NJ was developed by NJ DOH with support from PCG and NJ DHS and approval from CMS. This document outlines the major components of the program as well as resources to aide participating hospitals in the program. For additional information, please visit the [QIP-NJ website](#) or, for specific questions, email QIP-NJ@pcgus.com.

III. Background & Overview

To support continued population health improvement across NJ following the conclusion of the DSRIP program¹ on June 30, 2020, DOH implemented QIP-NJ on July 1, 2021. QIP-NJ was originally proposed to run for five years, from July 1, 2020, through June 30, 2025. However, due to the impacts of COVID-19, DOH delayed the implementation of QIP-NJ by one year to July 1, 2021. As a result of this delay, CMS approved a time-limited directed payment to support the financial stability of acute care hospitals. The time-limited directed payment, known as the QIP-NJ “Bridge” payment, was approved by CMS on September 17, 2020, as a Section 438.6(c) Preprint and requires each of the state’s MMCOs to issue a per diem add-on payment to hospital inpatient claims across several proposed classes of providers. For more information regarding the QIP-NJ “Bridge” Payment, please see [NJ Hospital QIP-NJ "Bridge" Payment Memo](#).

QIP-NJ, submitted by DOH and DHS via a Section 438.6(c) Preprint, was approved by CMS on May 20, 2021. DOH envisions QIP-NJ to be a multiyear program and is actively working with CMS to renew the program for future years. QIP-NJ is being administered by DOH, in partnership with DHS, as a Medicaid pay-for-performance initiative open to all acute care hospitals in the state. The primary purpose of QIP-NJ is to advance quality improvements in acute care hospitals for their MMC population in the domains of BH and maternal health. Hospitals will earn QIP-NJ incentive payments through the achievement of performance targets on state-selected quality measures that demonstrate:

- Improvements in connections to BH services;
- Reductions in potentially preventable utilization for the BH population;
- Improvements in maternal care processes; and
- Reductions in maternal morbidity.

Figure 1 below shows the key activities and timeline for the baseline period (MY0) through MY2, and Figure 2 defines QIP-NJ’s MYs. Appendix A contains the complete timeline for QIP-NJ over the intended five-year program.

¹ QIP-NJ was developed as a successor program to the NJ DSRIP program. The NJ DSRIP program was one component of New Jersey’s Comprehensive Medicaid Waiver as approved by CMS. For more information regarding NJ DSRIP, please visit <https://dsrip.nj.gov/>.

Calendar Year:	2020												2021												2022											
Month:	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
Measurement Year (MY):	MY0 (Baseline)						MY1						MY2																							
Claims Run Out:																																				
Attribution (Chart & MMIS) Released:																																				
Non-Claims-Based Measures Submitted by Hospitals:																																				
Performance Results Released:																																				
Appeals Period:																																				
Final Payment Calculation:																																				
Final Payment																																				

Figure 1. QIP-NJ MY0-MY2 Timeline

Measurement Year (MY)	Dates
MY0 (Baseline)	July 1, 2020 – December 31, 2020
MY1	July 1, 2021 – December 31, 2021
MY2	January 1, 2022 – December 31, 2022
MY3	January 1, 2023 – December 31, 2023
MY4	January 1, 2024 – December 31, 2024
MY5	January 1, 2025 – December 31, 2025

Figure 2. QIP-NJ MYs

In addition to the QIP-NJ BH and Maternal Health Performance-Based Section 438.6(c) Preprints, DOH also submitted a targeted MY1 Bridge Payment 438.6(c) Preprint, for the period of July 1, 2021, through December 31, 2021. DOH is directing this one-time payment arrangement to help ensure that hospitals with a high RMP have funding for continued response and recovery resulting from the COVID-19 pandemic, as well as to promote better access to care for MMC individuals in light of the COVID-19 pandemic. For more information regarding the Targeted MY1 Bridge Payment Section 438.6(c) Preprint, please see [CMS Approval Announcement: QIP-NJ and Targeted MY1 Bridge Payment Preprints UPDATED 06/24/2021](#).

IV. Eligibility

All NJ acute care hospitals are eligible to participate in QIP-NJ. To be considered for payment, hospitals must submit a LOI for the respective MY and all appropriate data and performance measurement information required in the [Databook](#). Hospitals that do not submit this required information will not be eligible to earn payment for the respective MY, but participation in subsequent MYs may still be possible (see [Section IV.B Participation in Subsequent MYs](#)).

Hospitals must be able to satisfy the denominator reporting requirements of at least one measure per participating population (BH or Maternal Health populations) to remain eligible for payments associated with that population. If a hospital does not meet the minimum denominator requirement for any measures in the participating population, the hospital will be unable to participate or earn payment for that population for the specific MY; however, participation in subsequent MYs may still be possible (see [Section IV.B Participation in Subsequent MYs](#)). Please note that minimum denominator requirements will vary by measure and refer to the latest version of the [Databook](#):

- MMIS - Denominator with fewer than 30 will not be included in payment calculations
- Chart / EHR - Denominators with fewer than that which is identified by the applicable sampling table (30) will not be included in payment calculations.

When a hospital is eligible to participate for the population but does not meet the minimum denominator requirement for a particular measure, the measure must still be reported (for non-claims-based measures) but will be removed from performance payment consideration for the MY. Incentive payments attached to measures that have been removed will be reallocated across the hospital’s remaining measures for that population for a given MY. The measure will be reinstated for payment in the next MY for which the hospital meets the denominator requirement(s). The baseline for the measure will be the previous MY in which the denominator requirement was met. To earn payment on this measure, hospitals will be expected to meet the full performance target for the MY in addition to 50% of the gap from any previous MY in which they did not meet the minimum denominator requirement. Figure 3 below provides an example of this scenario.

MY	Denominator Population for Measure X	Payment Eligibility	Gap to Goal
MY0	30	Baseline Value for Hospital A	
MY1	29	Not Eligible for Payment – Measure X Omitted	5% from MY0
MY2	60	Eligible for Payment	12.5% from MY0

Figure 3. Payment Eligibility and Requirements for Previously Omitted Measure X

A. Letter of Intent

Annually, all NJ acute care hospitals will be required to complete the QIP-NJ LOI and actively confirm or decline participation in QIP-NJ for the current MY. As part of the LOI, hospitals will be required to agree to a set of program policies and conditions associated with their participation decision. The LOI must be signed by either a hospital CEO, CFO, or CQO. Although the LOI will be considered a formal indication of whether a hospital intends to participate in QIP-NJ, it is not a legally binding document. All LOI materials will be available on the QIP-NJ [Participants & Stakeholders](#) webpage.

B. Participation in Subsequent Measurement Years

Hospital participation in QIP-NJ is voluntary. Hospitals that withdraw from participation in a MY and choose to rejoin the program in a future MY, or elect to participate after MY1, will be required to submit performance data for DOH to determine hospital baselines and performance targets for periods preceding the MY(s) in which they are participating. The hospital must also submit a completed LOI to DOH confirming participation and agreeing to program requirements.

To earn incentive payments, hospitals are required to meet their own individual hospital target for each measure. Each MY, the gap between the baseline and statewide goal will increase. If a hospital does not participate in the previous MY, the current MY’s target will be adjusted to require the hospital close 50% of the remaining gap from the previous year in addition to the full gap for the new MY. For more information regarding the gap to goal methodology, please see [Section VII.B. Gap to Goal Methodology](#).

V. Attribution

Attribution is the process by which DOH will assign MMC enrolled individuals to each hospital for inclusion in performance calculation. Every individual is assigned to only one hospital and can then only be included in the denominator for that hospital's performance measure calculations. The denominator population is identified as a subset of these assigned individuals based upon meeting each measure's specific denominator criteria. Certain measures have specific requirements surrounding continuous enrollment during the performance period. Continuous enrollment means that individuals are enrolled in MMC with minimal gaps to keep them in the respective measurement cohorts.

QIP-NJ's attribution will be analyzed retrospectively, at the end of the MY, based on an individual's actual use of care during the MY. To be attributed to a hospital for measurement, an individual must be enrolled in a MMCO² by the end of the MY. If an individual has presumptive eligibility for Medicaid but is not enrolled in managed care by the close of the MY, that individual will not be attributed to any hospital. Only MMC enrolled individuals will drive attribution, but FFS Medicaid claims for those MMC enrolled individuals will be used in performance calculations. Dually eligible individuals who are enrolled in one of the five NJ MMCOs are included in QIP-NJ. However, dually eligible individuals enrolled in PACE, Medicaid Advantage, or Medicare but receiving Medicaid FFS are not included.

At the close of each MY, DOH will extract claims data for the attributable population, allowing for three months of claims run out. Attribution for the maternal health population will be determined by the hospital at which the birth occurs and enrollment in an MMCO on December 31st of the MY.

Attribution of the BH population will be determined as follows:

- For individuals who have three or more outpatient BH claims during the MY, AND two or more outpatient BH claims with a single hospital, the individual will be attributed to the hospital with the majority (plurality)³ of the individual's outpatient BH claims.
- For individuals not attributed through the above, who have three or more outpatient physical health claims during the MY, AND two or more outpatient physical health claims with a single hospital, the individual will be attributed to the hospital with the majority of the individual's outpatient physical health claims.
- For individuals not attributed through the above, who have three or more ED claims during the MY, AND two or more ED claims with a single hospital, the individual will be attributed to the hospital with the majority of the individual's ED claims.
- For individuals not attributed through the above, if the individual has any inpatient claims (Maternity, Psychiatric or Med/Surgery), the individual will be attributed to the hospital with the majority of the individual's inpatient claims.
- If above criteria not met, the individual will not be attributed.

² The five MMCOs that currently participate are: Aetna, AMERIGROUP NJ, Horizon NJ Health, UnitedHealthcare NJ, and WellCare. If an individual is enrolled in either the HMO or D-SNP of any of these five health plans, they are considered eligible. Individuals enrolled in PACE, Medicare Advantage, and other commercial insurance plans are not eligible for QIP-NJ. For purposes of QIP-NJ, DOH is collecting applicable data pursuant to program requirements and reviewing enrollment files for all five NJ MMCOs (utilizing the DHS' eligibility data), inclusive of D-SNPs, to determine attribution eligibility.

³ Plurality is determined among hospitals eligible to have an enrollee attributed to them within that level of the attribution hierarchy through a gross count of claims within the level of the attribution hierarchy billed for the specific individual.

Where two hospitals have the same volume of claims in any category above, the most recent visit of that type will be used as a tiebreaker. Figure 4 below provides an example of an individual who meets diagnosis and utilization criteria within the measurement period for MY0 and is eligible for attribution to a QIP-NJ hospital. Both hospital B and hospital D have four (4) ED claims for this individual during MY0, and no provider was able to engage this individual in outpatient BH services. Since hospital B and hospital D have the same number of ED claims, the data of the most recent ED visit during the MY and the location must be confirmed. In this case, the last ED visit was on December 29, 2020, at hospital D's ED, so the individual will be attributed to hospital D.

Date (MY0)	Location			Visit Type	
	Hospital B	Hospital C	Hospital D	ED	Outpatient
07/25/2020	x			Y	N/A
08/03/2020	x			Y	N/A
09/16/2020			x	Y	N/A
09/30/2020		x		Y	N/A
10/19/2020	x			Y	N/A
11/10/2020		x		Y	N/A
11/21/2020	x			Y	N/A
12/02/2020			x	Y	N/A
12/13/2020			x	Y	N/A
12/29/2020			x	Y	N/A
TOTAL	4	2	4	10	0

Figure 4. Individual Attribution Tiebreaker Example

For more information regarding the attribution methodology and measure specific guidelines, please refer to the latest version of the [Databook](#) available on the QIP-NJ [Documents & Resources](#) webpage.

VI. Performance Measures

A. Quality Measures Committee

The QMC was established in 2018 to support DOH in the policy design and implementation of QIP-NJ. The QMC initially consisted of sixteen members across the health care industry, including state-based experts, subject matter experts, quality improvement and measurement experts, and hospital representatives. In developing QIP-NJ, QMC members met at least quarterly to determine the areas of focus, measure inclusion and specifications, and attribution methodology. QMC members were also asked to review measure policies and specifications within the draft and final versions of the [Databook](#).

Prior to the start of QIP-NJ, and in reviewing the current QIP-NJ QMC membership, DOH employed a data-driven approach to identify additional individuals from several NJ acute care hospitals and/or hospital systems to join the QMC to by taking into consideration various data points and demographic factors including, but not limited to, region, size, type of organization, volume of services (ED, outpatient BH, births, etc.), etc., with the ultimate goal being to ensure a greater diversity of representation from numerous perspectives. The future role of the QMC will include reviewing measure steward measure updates, reviewing Hospital Technical Contact suggested updates, and providing feedback to DOH on the inclusion and updates of QIP-NJ measures.

B. QIP-NJ Hospital Technical Contacts

In Spring 2021, hospitals and health systems identified representatives to serve as Technical Contacts for QIP-NJ. The identified QIP-NJ Hospital Technical Contacts for each hospital are subject-matter experts in their hospital's coding, billing, and/or population health analytics practices and systems. Through a series of Technical Contact forums, DOH gathered and continues to gather hospital feedback on hospital billing, coding, and population health analytic practices to further efforts in ensuring alignment, wherever possible, between QIP-NJ measurement guidance and current coding, billing, and population health analytics practices. DOH recognizes that coding and billing practices vary between hospitals and, as such, can have a material impact on quality measure calculations.

As a result, a key role of the Technical Contacts will be to assist with identifying any variances, mitigating any potential gaps/challenges, increasing accuracy of QIP-NJ measure calculations, and reviewing the measure stewards' measure specification updates and providing recommendations for inclusion in future [Databook](#) releases. The Technical Contact forums are expected to be held at least quarterly, depending on current QIP-NJ activities.

C. Selected Measures

1. Behavioral Health Measures

Eleven (11) BH measures were selected for inclusion in QIP-NJ for MY1 and performance on nine of the eleven measures impact payment. Hospitals must submit data to support the calculation of the five non-claims-based measures to be eligible to receive funding for the BH component of QIP-NJ⁴.

Measure #	Measure Type	Measure Name and NQF #	Payment Method
BH1	MMIS (Claims)	30 Day All-Cause Unplanned Readmission Following Psychiatric Inpatient Hospitalization, Based on NQF #2860	P4P
BH2	MMIS (Claims)	Follow-Up After Hospitalization for Mental Illness – 30-Days Post-Discharge, Based on NQF #0576	P4P
BH3	MMIS (Claims)	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (30 day), Based on NQF #3488	P4P
BH4	MMIS (Claims)	Follow-Up After ED Visit for Mental Illness (30 day), Based on NQF #3489	P4P
BH5	MMIS (Claims)	Initiation of Alcohol and Other Drug Abuse or Dependence Treatment, Based on NQF #0004	P4P
BH6	MMIS (Claims)	Engagement in Alcohol and Other Drug Abuse or Dependence Treatment, Based on NQF #0004	P4P
BH7	Chart/EHR (Non-claims based)	Preventative Care and Screening: Screening for Depression and Follow-Up Plan, Based on NQF #0418	P4P
BH8	Chart/EHR (Non-claims based)	Substance Use Screening and Intervention Composite, Based on NQF #2597	P4P

⁴ Data to support the calculation of instrument-based measures must be submitted to earn payment, but performance on these measures will not impact payment.

BH9	Chart/EHR (Non-claims based)	Timely Transmission of Transition Record (BH), Based on NQF #0648	P4P
BH10	Instrument (Non-claims based)	3-Item Care Transitions Measure, Based on NQF #0228	N/A
BH11	Instrument (Non-claims based)	Use of a Standardized Screening Tool for Social Determinants of Health (4 Domains)	N/A

Figure 5. QIP-NJ BH Measures

2. Maternal Health Measures

Nine (9) maternal health measures were selected for inclusion in QIP-NJ MY1 and performance on seven of the nine measures impact hospital payment. Hospitals must submit data to support the calculation of the six non-claims-based measures to be eligible to receive funding for the maternal health component of QIP-NJ⁵.

Measure #	Measure Type	Measure Name and NQF #	Payment Method
M1	MMIS	Severe Maternal Morbidity	P4P
M2	Chart/EHR	PC-02 Cesarean Birth, Based on NQF #0471	P4P
M3	Chart/EHR	Maternal Depression Screening, Based on NQF #1401	P4P
M4	MMIS	Postpartum Care, Based on NQF #1517	P4P
M5	MMIS	Treatment of SUD in Pregnant Women (Initiation of Alcohol and Other Drug Treatment), Based on NQF #0004	P4P
M6	Chart/EHR	Timely Transmission of the Transition Record (Maternal Health), Based on NQF #0648	P4P
M7	Chart/EHR	Treatment of Severe Hypertension	P4P
M8	Instrument	3-Item Care Transitions Measure, Based on NQF #0228	N/A
M9	Instrument	Use of a Standardized Screening Tool for Social Determinants of Health (5 Domains)	N/A

Figure 6. QIP-NJ Maternal Health Measures

3. Measure Updates

Measures will be reviewed annually by the QIP-NJ Hospital Technical Contacts, QMC, and DOH to determine the following:

- Alignment with the measure steward;
- Adjustment of statewide targets;
- Poor hospital performance or low denominators; and
- Inclusion of new measures.

⁵ Data to support the calculation of instrument-based measures must be submitted to earn payment, but performance on these measures will not impact payment.

Measure updates will be included in the latest version of the [Databook](#). A change log and redline version of the Databook will also be uploaded to identify updates made from the previous version.

VII. Performance Calculations

A. Baseline Determination

QIP-NJ performance measure baselines are determined based on an individual hospital’s performance on a measure in the baseline period (MY0), which is the six-month period of July 1, 2020 – December 31, 2020.

B. Gap to Goal Methodology

Each QIP-NJ measure has an identified statewide goal included in the [Databook](#). The statewide goal is the final program aim for each measure. The statewide goals were determined by reviewing national and statewide benchmarks and performance, engaging state-based and quality improvement experts, and aligning with other state initiatives. The statewide goals for the five-year program have been approved by CMS for MY1 and are envisioned to be the goals for the duration of QIP-NJ. Nevertheless, as part of our quality assurance process and in an effort to ensure hospitals are continually working towards systemic improvements relative to our various state-selected measures, DOH reserves the right to adjust the statewide targets based on actual hospital performance and to ensure alignment with the broader policy goals and initiatives put forward by NJ Leadership, subject to CMS approval.

Each year, hospitals will be required to close the gap between their current performance and the statewide goal by a specified amount to earn payment. DOH has identified uniform annual percentage of the gap between the statewide goal and baseline performance that individual hospitals must achieve on each measure. Figure 7 shows the 5-year gap closure scale which would end with the hospital meeting the statewide goal for the measure at the end of the five-year program.

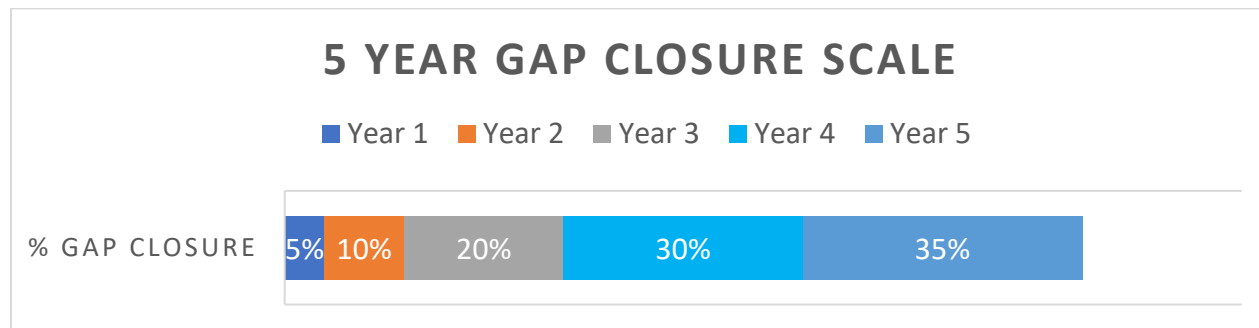


Figure 7. QIP-NJ 5 Year Gap Closure

Each year, DOH will determine the hospital target, or the hospital-specific aim for each measure, based on the hospital’s baseline or prior year performance of each measure. Figure 8 below shows an example of how Hospital E has an improvement target of 61% for MY1 given a 20% difference between its baseline and the statewide goal.

Calculation Step	Calculation Definition	Calculation %
Baseline for Measure Y	Hospital’s performance on Measure Y during baseline period.	60%

Statewide Goal for Measure Y	Final QIP-NJ aim for Measure Y.	80%
Hospital A Measure Y Gap	Subtract hospital baseline from statewide goal.	20%
Program-wide MY1 Gap Closure Goal	Uniform annual percentage that hospital must achieve for MY1.	5%
Hospital E MY1 Improvement Target	Multiply hospital gap by the MY1 gap closure goal.	1%
Hospital E MY1 Target Performance	Add hospital baseline to their improvement target for MY1.	61%

Figure 8. 'Hospital E' Gap to Goal Calculation Example

Each MY, the expected improvement amount between a hospital’s baseline to statewide goal will increase as indicated in Figure 7. The annual readjustment will happen in full, if a hospital meets performance targets, or partially, if hospitals fail to meet targets. Each year, hospital’s performance on a measure becomes the new baseline to calculate the gap to goal.

If a hospital does not meet its performance goal in a given MY, the next year’s target will be adjusted to require the hospital to close 50% of the gap from the previous year, in addition to the full gap for the measurement year. For example, in Figure 9 below, Hospital F did not meet its MY1’s target of closing the gap by 3%. Therefore, Hospital F’s MY2’s goal would be adjusted to include the 6% MY2 improvement target plus 50% of MY1’s 3% target, or 1.5%. This results in an MY2 improvement goal of 7.5% for Hospital B (rounded in this illustration to 8%).

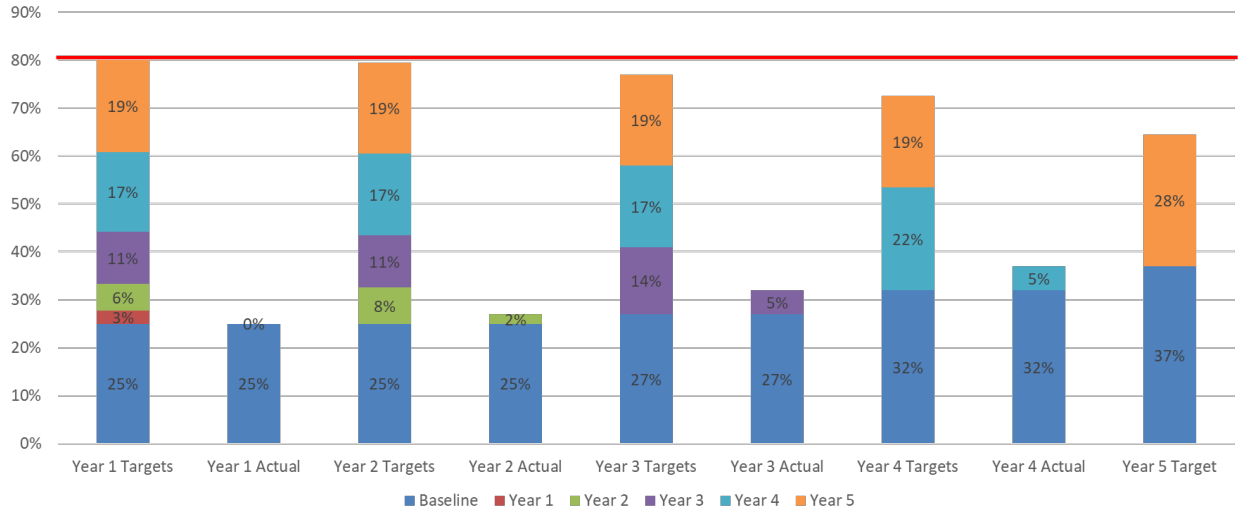


Figure 9. 'Hospital F' MY2 Target Setting

Once hospitals meet or exceed the statewide goal, so long as they remain at or above the statewide goal in subsequent MYs, hospitals will earn payment even if their performance declined one MY to the next. For example, the statewide goal for measure Z is 80%. In MY1, Hospital G exceeds the goal at 95% and, therefore earns payment. In MY2, Hospital G’s performance declines to 90%. However, since this is still above the statewide goal of 80% for measure Z, Hospital G earns payment in MY2.

VIII. Payment Calculations & Distribution

A. Payment Calculation

To earn payment, hospitals are required to meet the individual hospital target for each measure as described in the previous section. QIP-NJ incentive payments are earned by hospitals that have met their performance targets on a measure-by-measure basis for the MY. 70% of total available QIP-NJ funding will be distributed based on performance on the BH measures while 30% will be distributed for performance on the maternal health measures. All QIP-NJ funds will be distributed to hospitals that achieve performance targets via the program’s redistribution methodology ([Section VIII.C. Redistribution Methodology](#)).

Each MY, DOH will generate a list of MMC-enrolled individuals attributed to each hospital during the MY to determine individual hospital payment. DOH will then calculate, for each hospital, their proportion of attributed individuals in comparison to the entire QIP-NJ eligible population. This proportion will determine the eligible share of total program incentive payments for each hospital. Funding targets will not be shared with hospitals prior to the start of MY as funding targets are determined by the hospital’s delivery of services for the attributed population during the MY. Figure 10 provides an example of determining a hospital’s share of QIP-NJ payments.

Calculation Step	BH	Maternal Health
<i>Hospital H Eligibility:</i>	Yes	Yes
<i>Funding Available to Hospital H All Measure Targets Met:</i>	\$3,000,000	\$1,000,000
<i># of P4P Measures for which Gap-to-Goal Closed:</i>	6 measures	4 measures
<i>Payment Eligibility*:</i>	6/9 measures	4/7 measures
<i>Non-claims-based Measures Submitted by Hospital H:</i>	Yes	Yes
<i>Payment Earned* (without redistribution):</i>	\$2,000,000	\$571,429

Figure 10. ‘Hospital H’ Payment Calculation Example

*Unearned funds will be distributed through the redistribution policy as described [Section VIII.C. Redistribution Methodology](#) below.

B. Appeals Process

After claims-based measures have been calculated by DOH, and chart-based measures have been submitted by hospitals, DOH will calculate individual hospital performance results and publish an appeals guidance document and workbook to the QIP-NJ [Participants & Stakeholders](#) webpage. Appeals guidance documents and workbooks will be updated annually.

DOH will calculate hospital performance results within approximately thirty days of the hospital non-claims-based measure submission due date and release the results to hospitals via the [QIP-NJ SFTP](#). Hospitals will have fourteen (14) calendar days to review results and submit appeals and appropriate supporting documentation. Only computational and systemic reporting errors may be appealed; disputes related to DOH and CMS approved QIP-NJ protocols, program policy, formula designs, or measure

baselines, are not appealable. Additionally, hospitals cannot appeal results based on claims or non-claims-based data submitted incorrectly.

After hospitals have submitted appeals, DOH will review hospital submitted appeals and supporting documentation. Approximately, fifteen days after the appeals due date, DOH will post appeal results and communications to the [QIP-NJ SFTP](#).

C. Redistribution Methodology

All QIP-NJ funds will be distributed to hospitals that achieve performance targets via the program's redistribution methodology. Following the conclusion of the appeals process, hospitals failing to meet all performance targets will leave a portion of program funds undistributed. DOH will take these undistributed funds and will distribute them across a subset of the QIP-NJ performance measures that will be determined at the discretion of DOH to promote an equitable distribution of funds. The funds are then redistributed to hospitals that have met or exceeded performance targets on the DOH selected QIP-NJ measures, proportional to the hospital's share of attribution.

For example, if it is determined that there are three million dollars in undistributed funds that will be redistributed based on performance on the measure BH1, 30 Day All-Cause Unplanned Readmission Following Psychiatric Inpatient Hospitalization, the three million dollars would be divided amongst the hospitals that met their individual target for the BH1 measure, based on their share of attribution within the group of hospitals who also met their targets for BH1. See Figure 11 below for an illustrative description of the redistribution methodology.

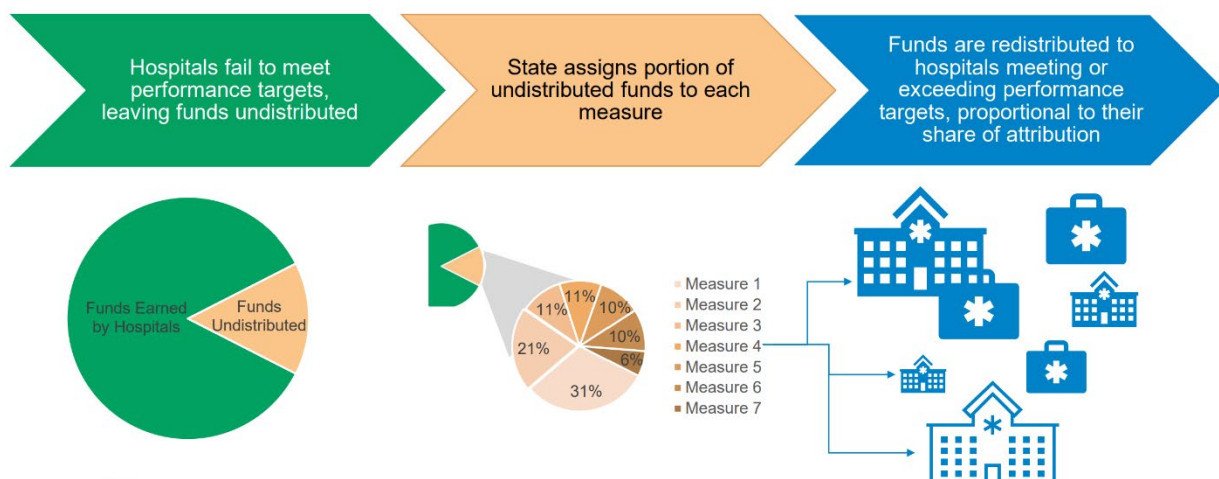


Figure 11. QIP-NJ Redistribution Methodology

D. Medicaid Managed Care Organization Payment Distribution

QIP-NJ's Section 438.6(c) Preprints permit DOH to make a state-directed payment to MMCOs. Once measures and payments are calculated by DOH and DHS, funds will be distributed to MMCOs who are then required to distribute the payment to hospitals within thirty (30) days. Payments will be disbursed once per year. Refer to [Appendix A: QIP-NJ Timeline](#) for more information.

IX. Learning Collaborative

A. Design

The Learning Collaborative (the “Collaborative”) is an opportunity for hospitals to receive education about evidence-based practices and improvement coaching for frontline teams as well as to participate in a forum for peer-to-peer learning. The overarching goal of the Collaborative is to help hospitals accelerate work already underway, begin to tackle new challenges, and plan for meaningful progress over time. The Collaborative is based on the BTS Collaborative learning model, created by IHI. The Collaborative will consist of two focus areas: BH and maternal health.

Participation in the Collaborative is voluntary for all QIP-NJ hospitals. The design relies on iterative cycles of testing, adapting, and implementing evidence-based strategies as outlined in the Change Packages for each Collaborative focus area. The Collaborative will include real time data collection, reporting and reviewing, personalized coaching from improvement advisors, and implementation of rapid cycle, small tests of change through PDSA cycles. The process will begin with a pre-work and one-on-one coaching time for participating teams. The Collaborative will center around three Learning Sessions throughout the course of the year with Action Periods between each session. Action Periods will allow time for teams to test changes in practice and identify how to apply or adapt best practices to their local environment.

1. Learning Sessions

Learning Sessions will aid teams in gaining new knowledge from state and national experts on best practices. Each Learning Session will consist of plenary presentations, workshops, storyboard rounding or presentations, and team development sessions.

2. Action Periods

Action Periods, which will occur between each Learning Session, will allow teams to test changes in practice and put in motion what they have learned from the Learning Sessions. There are several support structures for the Action Periods, including:

1. Monthly group coaching sessions;
2. Monthly data reporting; and
3. Listserv for peer collaboration.

The monthly data reported by participating hospitals will be anonymized and used in ongoing coaching sessions for discussion. A Listserv will provide a platform for participating teams to continue communication with each other as well as with Collaborative faculty.

Improvement advisors will lead Coaching Sessions and guide each Collaborative. In the ongoing monthly coaching sessions, hospital teams will complete and report data on PSDA cycles. These sessions will also allow different hospital teams to learn from each other in a peer-to-peer learning environment. Coaching will come from an improvement advisor facilitator. The Collaborative Leadership Team, which consists of DOH and PCG, will assist with the monthly data reporting requirements and will provide ongoing guidance as needed.

3. One-on-One Coaching Sessions

Onboarding coaching will allow improvement advisors to work one-on-one with each team to prepare them for successful participation in the Collaborative. Throughout the Collaborative, teams will be able to sign up for additional one-on-one coaching sessions to address the specific challenges they are facing while testing changes in practice.

B. Learning Collaborative Documents

For each Collaborative, there will be a set of core documents posted to the [Learning Collaborative](#) webpage that hospitals can utilize both before and during the Collaborative.

1. Change Package

The Change Package contains a set of evidence-based or expert recommended improvement strategies that hospitals can implement to improve QIP-NJ measure performance. This document will provide an overview of the detailed changes that hospitals can expect from Collaborative participation as well as the measures intended to support the improvement process.

2. Learning Collaborative Charter

The Learning Collaborative Charter provides the rationale and program details for each Learning Collaborative. Throughout this document, there is information about the proposed Collaborative measures, framework for improvement, benefits and eligibility of participation, and Collaborative design. The Charter is the most detailed Collaborative document and describes the expectations of participation from all parties involved in the Collaborative.

C. Behavioral Health Learning Collaborative

The BH Learning Collaborative will begin in the fall of 2021. The aim of the BH Collaborative is to increase follow-up visits for individuals with mental health or SUD diagnoses within 30 days of discharge. By the end of the BH Collaborative, in September 2022, the goal is to have participating teams achieve a 25% follow-up visit rate for SUD-related visits, and a 75% follow-up visit rate for mental health related visits. The focus for the BH Collaborative was selected by DOH in consultation with a panel of experts including state policy experts, addiction medicine and emergency psychiatry clinicians, consumer experience and harm reduction experts, and social workers.

D. Maternal Health Learning Collaborative

The Maternal Health Learning Collaborative will launch in the summer of 2022 and more information will be available on the [Learning Collaborative](#) website closer to the start date.

X. Program Resources

A. Databook & Supporting Materials

1. Databook

The [Databook](#) provides an overview of QIP-NJ's measures and measure specifications for the BH and maternal health performance measures. The Databook also provides information on the attribution methodology, reporting requirements, and performance and payment calculations.

The Databook will be reviewed and updated, as needed, annually. Each measure steward is responsible for the maintenance of the measure(s) they develop. DOH will evaluate the most recent finalized version made publicly available prior to October 15th of each calendar year. Additionally, DOH will meet with the QIP-NJ Hospital Technical Contacts and QMC and obtain feedback on the measures. As necessary, the Databook will be updated in a way which indicates whether a newer or older version of the measure specifications is to be followed and what additional changes may be relevant to QIP-NJ. DOH reserves the right to adjust elements of the measurement specifications and the statewide benchmark based on performance prior to the start of the next MY.

As changes are made to the Databook, the “Measures Change Log Summary” section will be updated to clarify major modifications between each release of the Databook and VSC. Major modifications are defined as those changes, including addition or deletion of value sets or pertinent clarifications.

2. Value Set Compendium

The [Databook](#) references tables and codes used to properly report the QIP-NJ measures. The [VSC](#) is a companion document to the Databook that contains all the value and code sets (e.g. CPT, HCPCS) referenced in the Databook.

3. Databook Frequently Asked Questions

The [Databook FAQ](#) is a companion document to the Databook and VSC. The FAQ document was created by compiling questions the DOH has received in the QIP-NJ inbox, webinars, and other forums. This document will be updated as new questions are submitted and new versions of the Databook and VSC are released.

B. Secure File Transfer Portal

The [QIP-NJ SFTP](#) is the secure website used by the DOH and participating QIP-NJ hospitals to securely share QIP-NJ files. PCG, the owner of QIP-NJ SFTP, is responsible for securely handling and storing sensitive participant and provider information in accordance with HIPAA including the HITECH Act amendments.

To request QIP-NJ SFTP access, prospective users must complete the [QIP-NJ Contact Information and Access Request Form](#). The QIP-NJ team will confirm access by providing the username and password via QIP-NJ@pcgus.com. Each hospital is limited to three users, with hospital systems receiving an additional two users. Participating users are recommended to be those uploading/downloading QIP-NJ files and completing non-claims-based measures submission. Hospitals will receive notification from QIP-NJ@pcgus.com when DOH has uploaded files to the SFTP and when DOH has received any files uploaded by hospitals.

For more information on QIP-NJ SFTP, please read the [QIP-NJ SFTP User Guide](#) available on the [QIP-NJ Participants & Stakeholders](#) website.

C. QIP-NJ Webinars

QIP-NJ webinars provide guidance to hospitals in preparation for programmatic milestones. Topics include interpretation of program polices, measure specifications, preparations for chart-based measure data submission, and interpretation of interim and annual performance results. Ongoing webinars will be held on an ad hoc basis and tied to key program updates.

Previous QIP-NJ Informational Webinars can be found on the QIP-NJ [Documents & Resources](#) webpage of the QIP-NJ website. Webinars are organized by date in a table which contains the title and date of the webinar, a brief overview of the webinar, and links to presentation materials including slides, recordings, and Q&A documents.

D. QIP-NJ Website

The QIP-NJ website is the centralized location for all information related to program implementation. There are five tabs located on this site: QIP-NJ Home, Dashboard, Participants & Stakeholders, Documents & Resources, and Learning Collaborative as described below.

- [“QIP-NJ Home”](#) page provides a general overview of QIP-NJ. Recent news and save the dates are also displayed under this tab. Contact information for QIP-NJ is shown here and can be found on the other webpages of the QIP-NJ website.
- [“Participants & Stakeholders”](#) page contains the schedule for informational webinars as well as materials requiring action from QIP-NJ hospitals. Participating hospitals can also find guidance and templates for the QIP-NJ LOI process to be conducted annually. A link to the [QIP-NJ SFTP](#) can also be found under this tab.
- [“Documents & Resources”](#) page consolidates QIP-NJ newsletters and guidance and protocol documents. Specifically, access to the latest QIP-NJ Databook and the VSC can be found here. There are also links important programmatic announcements including CMS approvals and overview policy documents.
- [“Learning Collaboratives”](#) page is the last webpage on the QIP-NJ website, and it provides a comprehensive overview of the QIP-NJ Learning Collaborative. Resources regarding Learning Collaborative schedules, handbook, and information sheets can be found here.
- [“Dashboard”](#) page is currently being developed and will hold a hospital specific log-in to view performance results and trends over time.

XI. Appendix A: QIP-NJ Timeline⁶

Calendar Year:	2020												2021												2022												2023												2024												2025												2026											
Month:	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
Measurement Year (MY):	MY0 (Baseline)												MY1												MY2												MY3												MY4												MY5												Post-MY5 (Program End)											
Claims Run Out:																																																																																				
Attribution (Chart & MMIS) Released:																																																																																				
Non-Claims-Based Measures Submitted by Hospitals:																																																																																				
Performance Results Released:																																																																																				
Appeals Period:																																																																																				
Final Payment Calculation:																																																																																				
Final Payment Distributed:																																																																																				

Legend	
MY0 (Baseline)	
MY1	
MY2	
MY3	
MY4	
MY5	
Post-MY5 (Program End)	

⁶ Please note that QIP-NJ MY2-MY5 are subject to CMS approval.