Quality Improvement Program – New Jersey (QIP-NJ)
Introductory Webinar

Thursday, April 15, 2021 from 3pm-4pm

Introduction

The Department of Health (DOH) has produced the following Question and Answer (Q&A) document as a follow up to the *QIP-NJ Introductory Webinar*, held on Thursday, April 15, 2021 from 3:00 to 4:00 pm EST. The webinar's recording and presentation slides have also been made available on the QIP-NJ Resources webpage.

This Q&A document contains responses to questions asked during the live webinar. In developing these responses, duplicative questions were removed, and where appropriate remaining questions were grouped and slightly modified for clarity. If any webinar participants notice that a question asked during the presentation has not been addressed or addressed inadequately, please reach out to program administrators at QIP-NJ@pcgus.com.

The information provided in this Q&A document as well as all April 15, 2021 QIP-NJ Introductory Webinar materials reflect proposed program requirements and protocols from DOH and are subject to change pending official Centers for Medicare and Medicaid Services (CMS) approval.

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Program Policy

1. **What does the QIP-NJ stand for?**
    A. QIP-NJ is an acronym that stands for the Quality Improvement Program – New Jersey.
2. **Is there any possibility of a delay in the start due to the COVID-19 pandemic?**
    A. DOH does not anticipate any delays to the July 1, 2021 start date for QIP-NJ, due to the COVID-19 pandemic.
3. **Would a hospital have a choice in participating in either behavioral health (BH) and/or maternal health (MH) measures and how would that be initiated?**
    A. Yes, hospitals may choose to participate in QIP-NJ relative to the BH population, MH population, or both. However, only hospitals with labor and delivery units are eligible to participate in QIP-NJ relative to the MH population. DOH will be providing "Letter of Intent" materials in early May 2021, which will allow hospitals to indicate whether they intend to participate in one or both populations of focus for QIP-NJ.
4. **Can a hospital participate if they only see behavioral health patients in the Emergency Department (ED) versus inpatient?**
    A. Yes, we anticipate that all hospitals will have patients attributed based on BH utilization in the ED, even if a hospital does not provide BH inpatient or outpatient services specifically.
5. **Can you comment on hospitals and the expectations for community partnerships? Will formal agreements with community providers be required for hospitals to contract with?**
    A. DOH will not require or provide direction as to what business and/or contractual arrangements hospitals may wish to enter into with community providers relative to QIP-NJ. That said, DOH encourages collaboration between hospitals and community providers to support the coordination and increased quality of care for all patients.
6. **How and when do we submit the "Letter of Intent" materials?**
    A. DOH expects to release the "Letter of Intent" materials and guidance document in early May 2021. All acute care hospitals are required to complete and submit the "Letter of Intent", requiring the hospital confirm or decline participation in QIP-NJ as well as acknowledge and agree to conditions for program participation based on that selection. A hospital Chief Executive Officer (CEO), Chief Financial Officer (CFO) or Chief Quality Officer (CQO) signature will be required to be considered complete. The DOH expects the due date from hospitals to be mid-June 2021.
7. **Will attribution lists be available before the letter of intent is due?**
    A. Hospitals will receive their baseline attribution list prior to July 1, 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.

Hospital Eligibility

1. **Based on the attribution models, it seems there are some hospitals will not be eligible? Has your analysis found that to be true?**

A. All hospitals are eligible to participate in the BH portion of QIP-NJ, as all hospitals serve patients with BH diagnoses. Preliminary reviews of baseline attribution show that all hospitals will likely meet minimum denominator requirements for BH. Please note that hospitals that do not have a labor and delivery unit will not be eligible for the MH portion of the program.

Measure Specifications

1. **Where can I find the list of the QIP-NJ measures?**

   A. A draft of the QIP-NJ measures and their specifications can be found in the QIP-NJ Measure Specifications and Submission Guidelines (Databook), on the QIP-NJ website. Please note the final version of the document is forthcoming, pending CMS approval.

2. **When will you release the next QIP-NJ Databook version?**

   A. The next QIP-NJ Databook released will be the final version for Measurement Year 1 (MY1). DOH anticipates releasing the final version in early May.

3. **Some of the measures require certain billing codes (i.e., Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS)). Will hospitals be provided an appendix of these codes?**

   A. Yes, when the final QIP-NJ Databook is released, the Value Set Compendium (VSC) will also be released and include code sets (inclusive of CPT and HCPCS codes, if/as applicable) for the state-selected BH and MH quality measures.

4. **Can a follow-up BH visit from the ED be at a non-hospital facility and will that claim through Medicaid be counted that way?**

   A. Yes, claims at non-hospital facilities (e.g. outpatient clinics, substance use treatment centers, primary care practices) will count towards numerator compliance for BH quality measures BH2, BH3, BH4, BH5 & BH6.

5. **Can you elaborate on the community partners for BH with how that impacts the hospitals? If patients do not follow-up in 30 days when appointments are given to them at discharge, does that penalize the hospital?**

   A. DOH encourages hospitals to develop robust and meaningful connections to care with community-based partners, inclusive of effective follow-up strategies to ensure patients return for appointments in community-based settings, as it is expected that this will help foster increased quality of care for all patients. Hospitals are ultimately responsible for meeting or exceeding QIP-NJ performance targets. As a result, where patients are referred to community partners for follow-up, there must be a final, adjudicated Medicaid claim to confirm delivery of the service (e.g., BH quality measures BH2, BH3, BH4, BH5 & BH6).

6. **Is there any type of skill level needed to follow-up with BH or MH (i.e., psych nurse, maternal health nurse, or personal)?**

   A. Please refer to the soon-to-be released VSC for the appropriate billing codes to support BH quality measures BH2, BH3, BH4, BH5 & BH6.

Measure Submissions

1. **When are the training sessions for data submission?**

A. Non-claims-based (chart-based) measure reporting guidance is forthcoming in the final version of the QIP-NJ Databook and a series of informational webinars. DOH will release this guidance at a later date and announce scheduling for data submission training.

2. For the non-claims-based measures, how will the hospitals be submitting the data to DOH?

A. Hospitals will have two options to submit this information, and may choose whatever option best suites their internal infrastructure and needs, as follows:

- Option 1: Use a template developed by DOH where the hospital manually enters performance results and any additional patient information required to confirm those results.
- Option 2: Use a flat file submission following specific guidelines and instructions included in the final version of the QIP-NJ Databook and a series of informational webinars. DOH anticipates that hospitals will be required complete this process annually.

3. Is there a fee for the data collection tool?

A. No, there is no fee for receiving the data collection tool developed by DOH and used by hospitals to submit QIP-NJ non-claims-based measures. However, hospitals are responsible for any costs associated with chart abstraction and completing the tool.

Performance & Funding Targets

1. If a hospital exceeds its year 1 target by an amount that is greater than its year 2 target, what then becomes the hospital's year 2 target? Does it remain the original year 2 target?

A. If a hospital meets or exceeds the performance target (gap closure) for MY2 in MY1, the hospital will receive payment for MY1 but it would not change the performance target for MY2. To receive payment for MY2, the hospital would need to continue to meet or exceed the performance target for MY2. For example, the MY1 target is 5%, but Hospital A exceeds the target at 20%. The MY2 target is 10%. In this case, Hospital A must still achieve a 10% gap closure (up to the statewide target) above their MY1 performance to earn payment for MY2.

2. What dollar amounts are attributable to MH and BH? Can you walk through the funding allocation after the 70/30 split? Any other weighting involved? When will hospitals have a sense of the dollar volume per facility that they are attempting to achieve?

A. Under DOH's proposal, 70% of total QIP-NJ funding is allocated to behavioral health and 30% is allocated to maternal health. Hospitals will be eligible for a portion of the total funding available for the population of focus based on their attribution within that population of focus. Hospitals will receive their Measurement Year 1 attribution after the close of the measurement year and subsequent three-month claims runout. Hospitals may project their potential funding based on baseline attribution, which they will receive prior to July 1, 2021.

3. If there is no estimated target funding, how will a hospital know how much money they can dedicate to quality improvement in these clinical service areas?

A. Please see response above for question #2.

4. Will there be a separate pool of funding dedicated to the top Medicaid providers in the state, or is it all performance based?

A. DOH has submitted a request to CMS to provide a separate non-performance-based pool of funding to hospitals with a high Relative Medicaid Percentage (RMP), which is still pending approval. As a result, DOH cannot provide additional details at this time.

Payment

1. **Are Medicaid Managed Care Organizations (MMCOs) still going to be responsible for delivering payment?**

   A. Yes, MMCOs will be responsible for delivering payment to hospitals once per year. DOH submitted a Section 438.6(c) Preprint to CMS, which would allow the State to make a state-directed payment to MMCOs. As noted elsewhere in this document, QIP-NJ is pending CMS approval.

2. **How will payments, if any, be distributed to partners?**

   A. DOH, via MMCOs, will only make payments to hospitals. Once funds are earned, there are no conditions regarding how hospitals use or distribute the funds. However, DOH encourages hospitals to use the earned funds to continue to develop and further quality improvement efforts, which could include paying partners for their support relative to QIP-NJ throughout the measurement year.

Attribution

Overview

1. **Can patients be attributed to both the MH and BH populations?**

   A. Yes, patients can be attributed to both the MH and BH populations.

2. **What if a hospital has very small number of attributed patients? Is there a minimum threshold needed to participate?**

   A. To participate in the behavioral health measure set, hospitals must have a minimum of 30 patients in the denominator of at least one measure to receive payment in the BHportion of QIP-NJ. To participate in the MH measure set, hospitals must have a minimum of 30 patients in the denominator of at least one measure to receive payment in the MH portion of QIP-NJ. Please see the DRAFT Databook for the denominator requirements. For example, if a hospital has less than 30 births for the measurement period, it will not be eligible to participate in the MH portion of QIP-NJ, as they will not have sufficient attribution to meet requirements of any measure.

3. **Is the minimum threshold attribution of 30 patients in the denominator a prerequisite for the hospital to have to report on that measure?**

   A. Hospitals must report on all measures, even those with fewer than the denominator requirements specified in the DRAFT Databook. However, hospitals will only be paid on the set of measures within the MH or BH portion of the program for which it meets the denominator threshold requirements. For example, it is determined that a Hospital A's funding is $1 million for the MH measures. Hospital A does not meet the denominator threshold requirement for MH measure 1 (M1). Therefore, instead of the $1 million being spread over the performance achieved on the 9 MH measures, it is spread over the achievement of 8.

4. **What happens if a patient loses Managed Medicaid Care (MMC) coverage during the MY?**

A. Patients must be enrolled in MMC at the close of the MY (December 31st). For example, if a patient went off and on coverage several times throughout the year (churn) but ultimately was enrolled as of December 31st of the MY, they are included in attribution.

5. How do we get notified what patients are attributed to our hospital?

A. QIP-NJ attribution is retrospective. Hospitals will receive an attribution roster that will include patient information (i.e., name, date of birth (DOB), etc.) following a three-month claims run out period for the MY.

6. Will you release the total number of attributed patients for the State so that hospitals can estimate their target funding?

A. Yes, DOH will provide the total attributed members for BH and MH for the baseline period, to assist hospitals in estimating their expected share of total funding.

7. If enrollment in MMC is low, how can we anticipate whether the incentive payment is sufficient compensation for the reporting effort?

A. Hospitals should carefully consider the budget impact of participation in QIP-NJ with their leadership team prior to submitting their "Letter of Intent" by the mid-June deadline.

8. Is there any concern about using last year's data as a baseline given that hospital admissions were extremely low because of the COVID-19 pandemic?

A. The current COVID-19 pandemic had unprecedented impacts on care patterns during the final three quarters of 2019 which continue today. DOH fully appreciates the uniqueness of this ongoing crisis and will be working with industry and policy experts to understand and implement ways to mitigate the impacts of these material variances on program performance measurement methods.

9. If a patient is not in MMC at the time of the Index admission, but is enrolled days 1-30 after discharge from the index admission will they still be included for the follow-up portions of the measure?

A. Yes, if this patient enrolls in MMC by the end of the measurement year (December 31st), then their fee-for-service (FFS) Medicaid claims from earlier in the measurement year would be included in performance measurement.

Attribution Lists

10. Is there a timeline for when hospitals will receive the baseline attribution list?

A. Hospitals will receive their baseline attribution list prior to July 1, 2021. An exact date is not available at this time.

11. When will hospitals receive its MY attribution list?

A. Hospitals will receive MY1 attribution lists following the close of the measurement year and subsequent three-month claims runout period.

12. How are hospitals receiving attribution lists if attribution happens retrospectively?

A. Hospitals will receive an attribution list that will include patient information (i.e., names, DOB, etc.) following the three-month claims run out period after the close of the MY.

13. Will hospitals receive names of attributed patients before or after payments are made? Will there be a process to validate that the attribution list reflects hospital's actual visits with those patients?

A. Hospitals will receive the names of attributed patients before payments are calculated and made. Attribution lists will be validated prior to distribution.

Behavioral Health

14. BH attribution requires outpatient visits. What if a hospital does not have a large outpatient behavioral health practice? What role do partners play in this, if any?

A. BH attribution is primarily based on outpatient visits; however, for patients with fewer than three (3) outpatient visits with a hospital during the measurement year, they may be attributed based on ED utilization. See the DRAFT Databook for more detail. Partnerships (e.g. primary care providers, Federally Qualified Health Centers (FQHCs), community health centers) with non-hospital entities will not impact attribution.

15. Can you please explain "Outpatient Physical Health" on the Attribution slides #32-33?

A. Outpatient physical health refers to physical health services (e.g., primary care, family medicine, urgent care, etc.) provided by hospitals in an outpatient clinic setting.

16. Is outpatient for BH inclusive of ED visits?

A. No, outpatient BH is specific to non-ED services in the attribution hierarchy.

17. Does a hospital owned outpatient facility count as an outpatient visit for attribution?

A. Yes, but only if the outpatient facility bills under the same Medicaid Provider ID as the hospital, or is included in the claims extraction criteria for subsidies (e.g. charity care, Graduate Medical Education (GME) payments, QIP-NJ).

18. Does attribution include inpatients that are not BH or MH? Such as patients that are inpatients but become behavioral patients?

A. Patients are eligible for attribution if they have a primary BH (Severe Mental illness (SMI) or Alcohol and Other Drugs (AOD)) diagnosis and one (1) inpatient service or two (2) outpatient BH services during the MY. Patient eligibility for attribution is considered independently from specific hospital attribution, so a patient may be attributed to a hospital where they received services prior to meeting the patient eligibility requirement for attribution.

Learning Collaborative

1. How many individuals per hospital can join collaborative?

A. There is no limit on the number of individuals per hospital that can join their hospital's improvement team as part of the QIP-NJ Learning Collaborative.

Program Support

1. Will this session be recorded? Will we get a copy of the slides for this webinar?

A. Yes, all QIP-NJ webinars will be recorded. Additionally, all recordings, slides, and Q&A documents will be posted to the QIP-NJ Resources webpage within about a week of the scheduled webinar.