Quality Improvement Program – New Jersey (QIP-NJ)
Frequency Asked Questions (FAQ)

Version v2.0 – Updated September 8, 2021

Introduction

The following FAQ document provides additional guidance and clarification to key partners and stakeholders relative to QIP-NJ. As the Department of Health (DOH) receives additional questions, this document will be updated as indicated by the version number and date in the footer. 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**". For information regarding QIP-NJ, please visit DOH's dedicated QIP-NJ website. In addition, general questions or comments regarding QIP-NJ may also be submitted to DOH via email at QIP-NJ@PCGUS.com.

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Glossary of Terms

Abbreviation	Definition
AMA-PCP	American Medical Association – Physician Consortium for Performance Improvement
AOD	Alcohol or Other Drugs
APR DRGs	All Patient Refined Diagnosis Related Groups
ASAM	American Society of Addiction Medicine
BH1-BH11	Behavioral Health Measures 1 - 11
BH	Behavioral Health
BTS	Breakthrough Series
CBOs	Community-Based Organizations
CCBHCs	Certified Community Behavioral Health Clinics
CMS	Center for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CQO	Chief Quality Officer
Databook	QIP-NJ Measure Specifications and Submission Guidelines
DHS	New Jersey Department of Human Services
DOB	Date of Birth
DOH	New Jersey Department of Health
DSRIP	New Jersey Delivery System Reform Incentive Payment
ED	Emergency Department
EHR	Electronic Health Record
FAQ	Frequently Asked Questions
FFS	Fee-for-Service
GME	Graduate Medical Education
HCPCS	Healthcare Common Procedure Coding System
ID	Identification Number
IT	Information Technology
LOI	Letter of Intent
M1-M9	Maternal Health Measures 1 - 9
MMC	Medicaid Managed Care
MMCO	Medicaid Managed Care Organization
MMIS	Medicaid Management Information System
MY	Measurement Year
NPI	National Provider Identifier
NCQA	National Committee for Quality Assurance
PACE	**Program of All-inclusive Care for the Elderly**
P4P	Pay-for-Performance
PCG	Public Consulting Group
Q&A	Question & Answer
QIP-NJ	Quality Improvement Program-New Jersey
QMC	Quality Measures Committee

RMP	Relative Medicaid Percentage
SFTP	QIP-NJ Secure File Transfer Portal
SMI	Severe Mental Illness
SUD	Substance Use Disorder
SVP	Senior Vice President
VSC	Value Set Compendium

General Information

1. **What is QIP-NJ?**
   A. QIP-NJ is a Medicaid P4P initiative administered by DOH in partnership with the DHS. It is focused on behavioral health (BH) and maternal health and open to all acute care hospitals in the New Jersey. QIP-NJ is the successor to DOH's NJ DSRIP Program.

2. **When did QIP-NJ start?**
   A. QIP-NJ began on July 1, 2021.

3. **Does QIP-NJ require federal approval from CMS?**
   A. Yes, QIP-NJ requires federal approval from CMS. For MY1, DOH received CMS approval on May 20, 2021 for both the BH and Maternal Health Performance-Based Section 438.6(c) Preprints, as well as the MY1 Targeted Bridge Payment Section 438.6(c) Preprint. Please note that DOH envisions QIP-NJ to be a multi-year program and, as a result, is actively working with CMS to secure necessary approvals for additional MYs. DOH will release more information as it becomes available.

4. **Does QIP-NJ focus on specific health care policy areas?**
   A. Yes, QIP-NJ focuses on advancing statewide quality improvements in maternal health and BH, in alignment with broader statewide policy initiatives such as the First Lady Office's Nurture NJ initiative and the broader goals of the Murphy Administration relative to BH outcomes. For purposes of QIP-NJ, BH is used as an umbrella term that includes both mental health and SUD services.

5. **What are the broad policy and/or quality improvement goals of QIP-NJ?**
   A. In QIP-NJ, participating hospitals will earn QIP-NJ incentive payments through the achievement of performance targets on state-selected quality measures that demonstrate:
      - Improvements in maternal care processes;
      - Reductions in maternal morbidity;
      - Improvements in connections to BH services; and
      - Reductions in potentially preventable utilization for the BH population.

6. **Can all NJ hospitals participate in QIP-NJ?**
   A. All acute care hospitals licensed in NJ that meet QIP-NJ program design requirements, as outlined in the Databook, are eligible to participate in QIP-NJ and earn incentive payments. Please note that only hospitals with Labor and Delivery units are eligible to participate in and earn incentive payments for the maternal health component of QIP-NJ.

7. **Does QIP-NJ have a formal application process?**
   A. No, QIP-NJ does not have a formal application process. However, DOH implemented a LOI process for MY1, which DOH intends to recur annually to confirm or decline participation for each MY. Please note, hospitals may participate in future MYs even if they do not participate in MY1 so long as the hospital submits all necessary data outlined in the LOI documents. For more information on the LOI process, please visit the "Participants & Stakeholders" section of the QIP-NJ website.

8. Can hospitals choose which component(s) of QIP-NJ in which they want to participate, i.e., maternal health only, BH only, or both?

A. **Yes, during the annual LOI process, hospitals are able to indicate whether they would like to participate in one or both components of QIP-NJ. Hospitals are also able to indicate if they are declining participation in QIP-NJ altogether.** Please note that to participate in each component of QIP-NJ, hospitals must meet the denominator requirements, as specified in the Databook, for at least one measure for each population of focus.

9. Will incentive payments be available?

A. Funding will be available only for acute care hospitals, as specified by CMS. DOH acknowledges that success on many of the performance-based measures will require follow-up care and will be achieved in partnership with community-based providers. As a result, DOH strongly encourages hospital and community-based providers to begin discussions now about establishing partnerships and implementing strategies for effective follow-up care.

10. Will implementation of QIP-NJ be more complex than it was for the NJ DSRIP program?

A. No. NJ DSRIP program had a much broader population focus (eight areas) and more than 100 measures and evolved from having a data reporting focus to having a performance focus. By contrast, QIP-NJ will have a targeted focus on performance from the beginning with two distinct populations and fewer outcome measures (9 maternal health and 11 BH, respectively).

Eligibility & Participation

1. **Since QIP-NJ is a Medicaid P4P initiative, what Medicaid population(s) does it include?**
    A. QIP-NJ only includes those individuals enrolled in MMC as of the end of the specified MY. Please note that Medicaid FFS individuals are not included in QIP-NJ; however, individuals that start in Medicaid FFS but enroll in MMC before the end of the MY in question will be eligible for QIP-NJ. Please note that while only MMC-enrolled individuals will drive attribution, QIP-NJ includes FFS Medicaid claims for those MMC-enrolled individuals to be used in QIP-NJ performance calculation.

2. **What is MMC?**
    A. MMC is a health care delivery system via contracts made between NJ DHS and MMCOs. These MMCOs are paid a capitated rate for providing Medicaid-covered healthcare services to enrollees. There are currently five (5) MMCOs contracted to provide care in NJ: Aetna, Amerigroup NJ, Horizon NJ Health, United Healthcare Community Plan, and WellCare.

3. **Does QIP-NJ take into consideration presumptive eligibility for Medicaid?**
    A. Yes, however, if an individual has presumptive eligibility for Medicaid but is not enrolled in MMC by the close of the MY, then that individual will not be attributed to any hospital for purposes of QIP-NJ.

4. **What happens if an individual loses MMC coverage during the MY?**
    A. Individuals must be enrolled in MMC at the close of the MY (December 31st). For example, if an individual went off and on coverage several times throughout the MY (known as "churn") but ultimately was enrolled as of December 31st of the MY, then that individual will be included in attribution.

5. **Does QIP-NJ include charity care?**
    A. No, Charity Care Assistance is not included in QIP-NJ because it is not a Medicaid program. QIP-NJ only includes MMC enrollees.

6. **Are dually eligible individuals included in QIP-NJ?**
    A. **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.**

Attribution

1. **How will DOH assign MMC-enrolled individuals to participating hospitals in QIP-NJ?**
    A. DOH uses an attribution process to assign MMC-enrolled individuals to participating hospitals for inclusion in QIP-NJ performance calculations. Attribution will be analyzed retrospectively, at the end of the MY following three-months of claims runout, based on an MMC-enrolled individual's actual use of care during the MY. Please note that each MMC-enrolled individual will only be assigned to one (1) hospital and therefore only be included in the denominator for that hospital's performance measure calculations. For more specific information on the attribution process for the maternal health and BH populations, please see the corresponding sections below.

2. **Can MMC-enrolled individuals be attributed to both the maternal health and BH populations for QIP-NJ?**
    A. Yes, MMC-enrolled individuals can be attributed to both the maternal health and BH populations for QIP-NJ.

3. **When were QIP-NJ attribution lists made available to hospitals?**
    A. QIP-NJ attribution is retrospective. **Hospitals received their baseline attribution lists, which are used to determine performance targets for MY1, on July 26, 2021. 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.

4. **How is DOH generating the attribution lists?**
    A. The attribution data captures individuals who are enrolled in Managed Medicaid 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.

5. **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.

6. **Does QIP-NJ's attribution methodology fully align with current hospital billing practices for Medicaid, and, if not, what does that mean?**
    A. **No, not necessarily. For some participating hospitals, DOH recognizes that QIP-NJ design requirements may be different than what may be happening relative to coding and billing practices for purposes of Medicaid MCO payments. However, please note that this does not mean that hospitals are doing anything out of compliance with Medicaid billing practices/guidance, as it is possible to correctly bill for purposes of Medicaid payment but still not have all of the required data elements for purposes of the QIP-NJ attribution methodology. As a result, DOH will continue to release guidance and provide technical assistance to impacted hospitals to help guide affected hospitals in making decisions about adjustments to their respective billing practices to ensure claims include the necessary data**

elements for QIP-NJ per program design to allow for the appropriate linkages and capturing of individuals/services.

7. **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 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.). **Through various channels, DOH requested that hospitals validate this information to ensure QIP-NJ utilized the appropriate Medicaid IDs and billing provider NPIs, as DOH recognizes that not all may be appropriate for populations of focus and/or types of services provided through QIP-NJ.**

8. **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.

9. **Will DOH release the total number of attributed individuals for the entire state so that hospitals can estimate their proportional share of QIP-NJ funding?**
    A: Yes, the statewide total number of MMC enrolled individuals attributed for the BH and maternal health components of QIP-NJ for the baseline period was provided to hospitals through the QIP-NJ SFTP on August 2, 2021, for MY1 and will continue to be provided to hospitals for future years of the program. This is information is provided to all participating hospitals for both historical context as well as to assist hospitals with projecting their share of total attribution for each MY.

Measure Selections & Updates

1. **How did DOH identify the state-selected quality measures for maternal health and BH for inclusion in QIP-NJ?**
    A. In developing and refining QIP-NJ quality measures, DOH engaged the following key partners and stakeholder groups:
        - QMC, convened in 2018 to support the design of QIP-NJ, which included determining the areas of focus (maternal health and BH), selecting measures, and reviewing the final measure specifications.
        - State-based experts in maternal health and BH to support the development of the measure specifications and identify appropriate statewide benchmarks based on national benchmarks, statewide data, and alignment with other state initiatives.
        - NJ hospitals, which were also given the opportunity to review the draft Databook and provide comments that were incorporated, as appropriate, into the final version of the Databook for MY1.

2. **What are "Measure Stewards" and how do they influence QIP-NJ program design and policies?**
    A. The QIP-NJ measure specifications, as outlined in the Databook for MY1, were determined based on nationally recognized "Measure Stewards", which are entities responsible for the maintenance of the measure(s) they develop. Examples include the NCQA, AMA-PCP, the Joint Commissions, CMS, the ASAM, and more.

    Please note that DOH has made various adjustments to some measure specifications to better align with the goals and populations of QIP-NJ, whenever possible, striving to maintain the integrity of the selected measure. To that end, where DOH made material deviations from Measure Steward specifications, the type/nature of those deviations, as well as the underlying rationale, have been specifically identified in the Databook for each measure.

3. **Will DOH continue to engage with the QMC and other stakeholders on an ongoing basis, relative to updating the Databook?**
    A. Yes, going forward, the Databook will be updated annually by DOH and shared prior to the start of each QIP-NJ MY using a process that will entail the following steps:
        - Reviewing any updates made to the measure specifications from the Measure Stewards, which generally occur in the fall of each year, and making appropriate changes to better align the measures with the goals of QIP-NJ.
        - Meeting with the identified QIP-NJ Hospital Technical Contacts who will review the Measure Stewards' measure specification updates and provide recommendations for inclusion in the Databook.
        - Convening the QMC to review the Measure Stewards' measure specifications updates and Technical Contact recommendations to DOH.

    DOH will carefully and closely review the QMC's recommendations and make a final decision regarding measure specification updates for each MY. **DOH has also incorporated smaller changes to the Databook based on ongoing feedback from the hospitals and stakeholders. When changes have been made to the measure specifications in the Databook, DOH has provided a change log to communicate these updates with participating hospitals.**

Maternal Health Measures

1. **For the maternal health component of QIP-NJ, what population is included?**
    A. The maternal health population includes all MMC-enrolled individuals who gave birth at a participating NJ hospital during the specified MY.

2. **How does the attribution process work for the maternal health population?**
    A. To be included in attribution for maternal health, an individual must be enrolled in MMC and have given birth at the NJ hospital during the MY. Please note that while there are no age limitations for the maternal population for attribution, there are age limitations in some of the individual measure criteria as outlined in the Databook for MY1.

3. **What if a hospital has very small number of attributed individuals? Is there a minimum threshold/denominator needed to participate in QIP-NJ for the maternal health measures?**
    A. To participate in the maternal health component of QIP-NJ, hospitals must have a minimum of 30 MMC-enrolled individuals in the denominator of at least one measure to receive incentive payments. For example, if a hospital has less than 30 births for the MY, then it will not be eligible to participate in the maternal health portion of QIP-NJ, as it will not have sufficient attribution to meet requirements of any measure. More detailed information about denominator requirements can be found in the Databook for MY1 on the QIP-NJ Documents & Resources webpage.

    Please note that participating hospitals must report on all measures, even those with fewer than the denominator requirements specified in the Databook for MY1. However, hospitals will only be paid on the set of maternal health measures for which it meets the denominator threshold requirements. For example, it is determined that Hospital A's funding is $1 million for the maternal health measures. Hospital A does not meet the denominator threshold requirement for M1. Therefore, instead of the $1 million being spread over the performance achieved on the seven (7) maternal health payment driving measures, it is spread over the achievements of six (6) measures.

4. **How many maternal health measures are included in QIP-NJ?**
    A. There are nine (9) maternal health measures in QIP-NJ, which are as follows:

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

For more information, please see the Databook and VSC for MY1 on the QIP-NJ Documents & Resources webpage.

5. **Are all the maternal health measures used for determining a hospital's QIP-NJ performance payment?**
   A. No, only the first seven (7) of the nine (9) measures (i.e., M1 – M7) determine a hospital's QIP-NJ performance payment. While hospitals are still required to submit data to support the calculation of M8 and M9, performance on those two measures will not impact performance payments. Please note that hospitals must submit data to support the calculation of the six (6) non-claims-based measures (i.e., M2, M3, M6, M7, M8, and M9) to be eligible to receive funding for the maternal health component of QIP-NJ.

Behavioral Health (BH) Measures

1. **For the BH component of QIP-NJ, what population is included?**
    A. The BH population includes all MMC-enrolled individuals, age 18 and older, with a primary BH diagnosis (SMI based on 2019 CMS definition, and/or AOD disorder).

2. **How does the attribution process work for the BH population?**
    A. In addition to meeting the requirements in question #1 above, the individual must have also received either one (1) inpatient or two (2) outpatient BH services during the MY in question to be eligible for BH attribution. Once an individual meets all these criteria (age, primary diagnosis, and 1 inpatient/2 outpatient BH services), the individual is then attributed to a single hospital using QIP-NJ's attribution algorithm based on a hierarchy of types of services, as follows:
        1. Outpatient BH: If an individual has three (3) or more outpatient BH claims in the MY and two (2) or more outpatient BH claims with a single hospital, the individual will be attributed to the hospital with the majority of the outpatient BH claims. Please note that outpatient BH is specific to non-ED services in the attribution hierarchy.
        2. Outpatient physical health (which includes primary care, family medicine, urgent care, etc.): If an individual has three (3) or more outpatient physical health claims during the MY and two (2) or more of those claims were with a single hospital, then the individual will be attributed to the hospital with the majority of outpatient physical health claims for that individual.
        3. ED: If an individual has three (3) or more ED claims during the MY and two (2) or more of those ED claims were with a single hospital, then the individual will be attributed to the hospital responsible for the majority of those claims.
        4. Inpatient: If an individual has any inpatient claims (including maternity, psychiatric or medical/surgical, etc.), then the individual will be attributed to the hospital responsible for the majority of those inpatient claims.

    Please note that in the case of "ties", i.e., where an individual has the same service volume with more than one hospital in any given step of the hierarchy, then as a "tie breaker", the individual will be attributed to the hospital where they had the most recent visit in that step of the algorithm (e.g., if there is a "tie" at step 2 for outpatient physical health, then you would break the tie at that point versus moving to step 3 for the ED). For more information, please review the Databook for MY1 on the QIP-NJ Documents & Resources webpage.

3. **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 ID(s) as the hospital, or is included in the claims extraction criteria for subsidies (e.g. charity care, GME payments, QIP-NJ, etc.).

4. **Overall, what entities will qualify for attribution, given that some hospitals have separate outpatient facilities?**

A. DOH will be looking at institutional claims and hospital identifiers that include the hospitals Medicaid ID and billing provider NPIs. Independent clinics will need to have their billing provide NPI connected with associated hospital Medicaid IDs.

5. **What if a hospital has very small number of attributed individuals? Is there a minimum threshold/denominator needed to participate in QIP-NJ for the BH measures?**
    A. To participate in the behavioral health measure set, hospitals must have a minimum of 30 MMC-enrolled individuals in the denominator of at least one measure to receive incentive payments. More detailed information about denominator requirements can be found in the Databook for MY1 on the QIP-NJ Documents & Resources webpage. Please note that participating hospitals must report on all measures, even those with fewer than the denominator requirements specified in the Databook for MY1. However, hospitals will only be paid on the set of BH measures for which it meets the denominator threshold requirements.

6. **Given that BH attribution requires outpatient visits, what happens if hospitals do not have a large outpatient BH practice?**
    A. BH attribution is primarily based on outpatient visits; however, for MMC-enrolled individuals with fewer than three (3) outpatient visits with a hospital during the MY, they may be attributed based on ED utilization. More detailed information can be found in the Databook for MY1 on the QIP-NJ Documents & Resources webpage.

7. **Can hospitals participate if they only see BH individuals in the ED versus inpatient?**
    A. Yes, DOH anticipates that all hospitals will have individuals attributed based on BH utilization in the ED, even if a hospital does not provide BH inpatient or outpatient services specifically.

8. **Will CCBHCs be required to report their clients' hospitalizations although they will not be submitting data to DOH?**
    A. No, community providers' data will be obtained from the MMIS. However, hospitals may need more information from community providers. In addition, the real exchange of data will be achieved as part of providing high-quality, coordinated clinical care.

9. **How many BH measures are included in QIP-NJ?**
    A. There are eleven (11) BH measures in QIP-NJ, which are as follows:

Measure #	Measure Type	Measure Name and NQF #
BH1	MMIS	Measure BH1: 30 Day All-Cause Unplanned Readmission Following Psychiatric Inpatient Hospitalization 1, Based on NQF #2860
BH2	MMIS	Follow-up After Hospitalization for Mental Illness (FUH) – 30-Days Post-Discharge, Based on NQF #0576
BH3	MMIS	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) (30 day), Based on NQF #3488
BH4	MMIS	Follow-Up After Emergency Department Visit for Mental Illness (FUM) (30 day), Based on NQF #3489
BH5	MMIS	Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET – I), Based on NQF #0004
BH6	MMIS	Engagement in Alcohol and Other Drug Abuse or Dependence Treatment (IET – E), Based on NQF #0004
BH7	Chart/EHR	Preventative Care and Screening: Screening for Depression and Follow-Up (PDS), Based on NQF #0418
BH8	Chart/EHR	Substance Use Screening and Intervention Composite, Based on NQF #2597
BH9	Chart/EHR	Timely Transmission of Transition Record (Behavioral Health), Based on NQF #0648
BH10	Instrument	3-Item Care Transitions Measure (CTM-3), Based on NQF #0228
BH11	Instrument	Use of a Standardized Screening Tool for Social Determinants of Health

For more information, please see the Databook and VSC for MY1 on the QIP-NJ Documents & Resources webpage.

10. Are all of the BH measures used to determine a hospital's QIP-NJ performance payment?

A. No, only the first nine (9) of the eleven (11) measures (i.e., BH1 – BH9) determine a hospital's QIP-NJ performance payment. While hospitals are still required to submit data to support the calculation of BH10 and BH11, performance on those two measures will not impact performance payments. Please note that hospitals must submit data to support the calculation of the five (5) non-claims-based measures (i.e., BH7, BH8, BH9, BH10, and BH10) to be eligible to receive funding for the BH component of QIP-NJ.

Measurement & Payment Calculations

1. **How do hospitals earn incentive payments for meeting performance targets on state-selected quality measures in QIP-NJ?**
    A. QIP-NJ incentive payments will only be earned through hospitals achieving their performance targets on state-selected measures in BH, maternal health, or both. To earn incentive payments, hospitals are required to submit accurate and sufficient data for a suite of non-claims-based measures each MY. Please note that it is possible for hospitals to meet this requirement for only the maternal health or BH measures, in which case those hospitals would only be eligible to earn funding associated with the set of measures that were reported on completely. Furthermore, failure to submit the necessary, annual non-claims-based data will preclude the hospital from earning incentive payments in that MY. The hospital may become eligible to earn future QIP-NJ incentive payments in subsequent MYs so long as the hospital submits all necessary data to support the analysis of the non-claims-based measures in that MY.

2. **Relative to meeting performance targets on state-selected quality measures, how will DOH assess and measure hospital performance?**
    A. Hospital performance targets will be created by DOH using a gap-to-goal methodology. At a high-level, hospitals will be required to close the gap between the hospital's individual baseline and the statewide goal, identified in the Databook, by a set percentage each MY. For more detailed information on the gap-to-goal methodology, please see the Databook and VSC for MY1 on the QIP-NJ Documents & Resources webpage.

3. **For purposes of QIP-NJ and relative to the gap-to-goal methodology, what does DOH mean when it refers to a "statewide goal"?**
    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.

4. **For purposes of QIP-NJ and its gap-to-goal methodology, what does DOH mean when it refers to a "hospital baseline"?**
    A. "Hospital baseline" refers to a hospital's performance on the measures during the baseline period, which is the six-month period of July 1, 2020 through December 31, 2020.

5. **For purposes of QIP-NJ and its gap-to-goal methodology, what does DOH mean when it refers to a "hospital target"?**
    A. "Hospital target" refers to the hospital-specific aim for each measure that is updated every year, which is determined using the individual hospital's baseline data and a set percentage of the statewide goal.

6. **Can you provide more details regarding the gap-to-goal methodology and how hospitals earn incentive payments?**
    A. At a high level, to earn incentive payments, hospitals are required to meet their own individual hospital target for each measure. For example, assume in MY1 a hospital is required to close 5% of the gap between their baseline and the statewide goal. If the hospital's baseline is 60% and the statewide target is 80% on a particular measure, the hospital must improve their performance by 1% to reach a goal of 61% for MY1. Each MY, the gap between the baseline and statewide goal will increase. 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 close 50% of the gap from the previous year in addition to the full gap for the MY. For more detailed information on the gap-to-goal methodology, please see the Databook for MY1 or the webinar materials from the April 15, 2021 QIP-NJ Introductory Webinar on the on the QIP-NJ Documents & Resources webpage.

7. **If a hospital exceeds its MY1 target by an amount that is greater than its MY2 target, what then becomes the hospital's MY2 target? Does it remain the original MY2 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.

8. **For reporting the non-claims-based or chart/EHR measures, can hospitals use sampling methodology rather than reporting on all MMC-enrolled individuals served?**
    A. Yes, hospitals may use the Databook's outlined sampling methodology rather than report on all individuals served. The measures that are eligible for sampling are:
        - BH Measure Set: BH7, BH8, BH9, BH10, BH11
        - Maternal Health Measure Set: M2, M3, M6, M7, M8, M9

    Sampling may be permitted based upon the volume of attributed individuals. 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. For maternal health, sampling is determined by the total number of attributed individuals admitted to the hospital for labor and delivery during the MY.

    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:

    - **Step 1: 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.**
    - **Step 2: Search chart/EHR systems to identify numerator events for all members in the eligible population.**
    - **Step 3: 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.**

- **Step 4: Exclude from the eligible population, members from step 3 for whom system data identified an exclusion to the service or procedure being measured.**

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.

9. **What happens when hospitals fail to meet performance targets?**
   A. For each QIP-NJ MY, all QIP-NJ funds will be fully distributed to hospitals that achieve performance targets through DOH's redistribution methodology. The redistribution methodology takes undistributed funds (i.e., those from hospitals failing to meet performance targets) and redistributes them to hospitals across a portfolio of QIP-NJ performance measures that will be determined at the discretion of DOH to promote an equitable distribution of funds.

10. **Some of the QIP-NJ quality measures require certain billing codes (i.e., CPT or HCPCS). Will participating hospitals be provided an appendix of these codes?**
    A. Yes, the VSC, which is included with the Databook, includes code sets (inclusive of CPT and HCPCS codes, if/as applicable) for the state-selected maternal health and BH quality measures.

11. **For the required data and information submission for non-claims-based measures, are there any specific timelines that hospitals should be tracking?**
    A. **Yes, by September 30, 2021,** hospitals will be required to submit baseline data (for the baseline period of July 1, 2020 through December 31, 2020) for chart-based measures. This data will be used to determine baseline and create hospital specific MY1 performance targets. Moreover, hospitals will be expected to submit final, chart-based measure information after the three-month claims run out following the end of each MY. This data will be used to determine performance in each measure and payment earned for the MY in question.

12. **For the required data and information submission for non-claims-based measures, how does DOH expect this information to be submitted and will there be a fee?**
    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 the Standard Reporting Template (SRT) developed by DOH where the hospital manually enters performance results and any additional individual information required to confirm those results.
       - Option 2: Use a flat file submission following SRT guidelines and instructions included in the final version of the QIP-NJ Databook and a series of information webinars (Technical Contact Forums 1-3). DOH anticipates that hospitals will be required to complete this process annually.

    Please note that 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 hospital chart abstraction and completing the tool.

13. Does QIP-NJ include an appeals process for performance results and payment calculation?

A. **Yes, there will be a formal process for appeals. 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. 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.**

Hospital Funding & Payments

1. **What is the QIP-NJ budget and funding breakdown attributable to the maternal health and BH components of QIP-NJ, and how will this funding be allocated to hospitals?**
    A. Approximately $168 million is allocated to MY1 of QIP-NJ. Of that $168 million, 30% is allocated to maternal health and 70% is allocated to BH. Please note that DOH envisions QIP-NJ to be a multi-year program and, as a result, is actively working with CMS to secure necessary approvals for additional MYs.

    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 MY1 attribution after the close of the MY and subsequent three-month claims runout. Hospitals may project their potential funding based on individual hospital baseline attribution and statewide totals for baseline attribution.

2. **Relative to QIP-NJ, will there be a separate pool of funding dedicated to the top Medicaid providers in the state, or will all funding be tied to performance on QIP-NJ quality measures?**
    A. In addition to the QIP-NJ BH and Maternal Health Performance-Based Section 438.6(c) Preprints, DOH also submitted the 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 (totaling approximately $42 million) 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. Under this authority, DOH, in partnership with DHS, will require each of the state's MMCOs to issue a per diem add-on payment to all hospital inpatient claims across three classes of providers: (1) State Public Hospitals, (2) County Public Hospitals, and (3) Private Acute Care Hospitals in top quartile for RMP.

    Please note that the funding is planned to be divided between the three classes as an add on to the negotiated rates for inpatient services between the provider classes and MMCOs. The total dollars to be distributed across the three classes will be a set amount, but because total utilization cannot be known until the close of the period, the exact dollar increase per bed day will be calculated after the close of the period.

3. **As part of QIP-NJ, does DOH anticipate hospitals needing to submit financial data, information, or budgets?**
    A. No, at this time, DOH will not require hospitals to submit any such information.

4. **Under QIP-NJ, are MMCOs going to be responsible for remitting payment to participating hospitals?**
    A. Yes, MMCOs will be responsible for delivering payment to hospitals once per year. DOH's CMS-approved Section 438.6(c) Preprint allows the state to make a state-directed payment to MMCOs. Please note that 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 MY.

Learning Collaboratives

1. What are the Learning Collaborative opportunities offered through QIP-NJ?

A. To support hospitals participating in QIP-NJ, DOH, in partnership with PCG, has designed data-driven Learning Collaboratives. The QIP-NJ Learning Collaboratives will be based on a proven model from the Institute for Healthcare Improvement, called the BTS Collaborative. Success within QIP-NJ will require a multi-faceted approach involving the entire system of maternal health care and/or BH care, as applicable; accordingly, the Learning Collaboratives will focus on targeted areas and metrics to test changes for improvements in care processes and outcomes for the QIP-NJ maternal and BH populations. **Designed as a multi-year initiative, QIP-NJ began on July 1, 2021, with a BH-focused Learning Collaborative scheduled to begin on September 22nd, 2021, and a maternal health-focused Learning Collaborative projected to begin in the summer of 2022.** For more information, please visit the QIP-NJ Learning Collaboratives webpage, and review helpful resources including the Learning Collaborative charter, information sheet, change package, and upcoming learning session dates.

2. Are hospitals required to participate in the QIP-NJ Learning Collaborative?

A. **No, while DOH requests that all NJ acute care hospital EDs submit a Participation Interest Form before the commencement of each Learning Collaborative,** participation in either Learning Collaborative is voluntary and not required for hospitals to earn incentive payments in QIP-NJ.

3. How many individuals per hospital can join the QIP-NJ Learning 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; however, DOH encourages hospitals to carefully consider the size and makeup of their selected quality improvement teams to ensure and maximize meaningful opportunities for participation.

4. What benefits are there from participating in the QIP-NJ Learning Collaborative?

A. DOH strongly encourages NJ acute care hospitals to participate in the QIP-NJ Learning Collaborative, which DOH believes will assist participating hospitals with achieving performance targets, sharing knowledge and best practices across hospitals to drive systemic changes, and supporting overall improvement in health outcomes for the state's Medicaid population in the areas of maternal health and BH. Specific benefits include, but are not limited to, the following:

- Targeted support to meet performance targets on some QIP-NJ P4P measures;
- Personalized coaching for frontline care team and hospital leadership from state and national clinical and improvement experts in the field;
- Increased quality improvement capacity across team members;
- Access to a peer learning network; and
- Continuing professional education credits.

5. What is expected from hospitals that choose to form improvement teams for the QIP-NJ Learning Collaborative?

A. To support hospital improvement teams getting the most out of their participation, each hospital electing to participate in the QIP-NJ Learning Collaborative is asked to perform several tasks and complete activities such as:

- Forming an interprofessional project team which would ideally include the following members:
  - Executive leader who will facilitate implementation of key system and cultural changes and help teams overcome administrative barriers;
  - Director, CQO or SVP of Quality;
  - Clinical champion and other clinical and administrative care team members;
  - Quality Improvement lead;
  - IT champion to configure and pull data from the EHR system;
  - Representatives from staff who support care in the target setting for the QIP-NJ populations
  - Representatives from key CBOs who support care for QIP-NJ populations
  - Representatives from other CBOs who can support effective transitions to appropriate services or other supports; and/or
  - Individual and chosen family representatives.
- Committing to improvement project team member participation in QIP-NJ Learning Collaborative events and activities and contribution to shared learning. Members of the improvement project team will work over the course of the twelve (12)-month Collaborative to test, adapt and implement strategies for targeted health care process improvement.
- Share key information back to other stakeholders within their team, hospital, or larger hospital system, including leadership, so that improvements can be fully implemented, sustained, and spread.
- Collect data and submit structured data reports to the QIP-NJ Learning Collaborative leadership monthly.

6. What is expected from the QIP-NJ Learning Collaborative leadership team?

A. To create an impactful, effective, and satisfying program for hospital teams, the Collaborative Leadership team from DOH and PCG will be expected to:

- Create an engaging curriculum with access to experts in the field;
- Provide training that enables teams to implement improvements towards the QIP-NJ Learning Collaborative's primary goal;
- Provide one-on-one and group coaching to teams to help teams overcome individual challenges during the implementation process;
- Disseminate best practices and effective strategies across the peer network based on the implementation experience of participating teams;
- Connect hospital teams to applicable state resources or aligned programs aiming to make improvements related to the QIP-NJ Learning Collaborative aim;
- Use the lessons learned from the QIP-NJ Learning Collaborative to impact future policy decisions; and

- Provide excellent participant support with timely replies to any question or issue communicated by a participating hospital quality improvement team.

7. How do interested hospitals join the QIP-NJ Learning Collaboratives?

A. The deadline for Participation Interest Form submission for the BH Learning Collaborative has passed, but hospitals interested in participating in the Maternal Health Learning Collaborative should look for updates closer to the anticipated start date of Summer 2022. More information can be found on the QIP-NJ Learning Collaborative webpage, by accessing the previous informational webinars found on the QIP-NJ Documents and Resources page or by contacting QIP-NJ@pcgus.com.

Program Support

1. **Where can I find more information about QIP-NJ?**
   A. Interested parties can find helpful information on DOH's QIP-NJ website, including past meeting materials, forms, and more. In addition, DOH releases a monthly QIP-NJ Newsletter, which is posted to the Document & Resources webpage of DOH's QIP-NJ website. If you do not currently receive the monthly QIP-NJ Newsletter, please complete the QIP-NJ Contact Information and Access Request Form to share your contact information or email us at QIP-NJ@pcgus.com, and the QIP-NJ team can add you to the distribution list.

2. **Will DOH make a QIP-NJ public-facing dashboard available?**
   A. Yes, the QIP-NJ Dashboard is currently under development, and will be available on the Dashboard webpage of the QIP-NJ website. Participating QIP-NJ hospitals will be notified when the QIP-NJ dashboard becomes available.

3. **Will DOH host a QIP-NJ SFTP?**
   A. Yes, the SFTP is available on the Participants & Stakeholders webpage of the QIP-NJ website. The SFTP can be used to securely upload or download QIP-NJ documents.

4. **Does DOH record and publicly make available prior meeting and webinar materials?**
   A. Yes, all previous QIP-NJ informational webinars are available on the Document & Resources webpage on DOH's QIP-NJ website, which include slide decks, webinar recordings, and Q&A documents.

5. **How do I share new and/or updated contact information with DOH so I receive the most up-to-date QIP-NJ information?**
   A. Interested parties should share new and/or updated contact information using DOH's web-based QIP-NJ Contact and Access Form, which is available on the QIP-NJ website.

6. **Will DOH be available to assist with questions about the QIP-NJ P4P measures?**
   A. Yes, DOH is always available to answer any questions about any aspect of QIP-NJ. You can contact the QIP-NJ team by sending an email to QIP-NJ@pcgus.com. In addition, DOH regularly hosts live webinars relative to key policy and/or programmatic areas, which are available on the QIP-NJ Documents & Resources webpage, so DOH encourages stakeholders to check back regularly for upcoming events! Additionally, DOH has published a series of pre-recorded webinars on each chart-based measure to provide additional technical assistance for hospitals interpreting the measure specifications, which are available on the QIP-NJ Documents & Resources webpage.

7. **Who can I contact if I have questions or concerns regarding QIP-NJ?**
   A. Interested parties can contact DOH by email at QIP-NJ@pcgus.com, or by phone through the QIP-NJ Service Desk at 1-833-598-6635.

Miscellaneous and Other Information

1. **Given the unprecedented nature of the COVID-19 pandemic and the possibility of future resurgence and increased hospitalizations due to variant strains and other factors, is there any possibility of an impact on MY1 of QIP-NJ or delay to the start of future MYs?**
    A. **DOH recognizes the unique and constantly evolving challenges posed by the ongoing COVID-19 pandemic and continues to closely monitor the situation; however, at this time, DOH does not anticipate any material impacts to MY1 or delays to the start of future MYs. As always, DOH will keep participating hospitals, as well as other interested parties, up to date as things continue to progress in this space, and issue updated guidance if/as needed.**

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?**
    A. 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 of identified material variances on QIP-NJ performance measurement methods.

3. **If a hospital's MMC enrollment/population is small, how should it anticipate whether the QIP-NJ incentive payments are sufficient compensation for the associated reporting effort?**
    A. **Hospitals should carefully consider the budget impact of participation in QIP-NJ with their leadership team before the LOI submission process each year.** For more information on the LOI process, please see the "General Information" section, question #7 above.

4. **What role do community-based partners/providers play relative to QIP-NJ?**
    A. DOH recognizes the value that NJ community-based partners and providers play in delivering high-quality, effective health care services to NJ residents. To this end, relative to QIP-NJ and its focus on quality improvement, DOH strongly encourages participating hospitals to develop new (as well as build upon existing) robust and meaningful connections to care with community-based partners. These connections are already and will continue to be critical to developing and implementing effective strategies to get individuals to return for appointments and receive clinically appropriate follow-up care in community-based settings, as well as assisting NJ acute care hospitals with meeting the performance targets in QIP-NJ.

5. **Relative to community-based partners/providers and hospital interaction, does DOH have any expectations and/or will it require formal agreements in this space?**
    A. DOH will not require and/or provide direction as to what business and/or contractual arrangements hospitals may wish to have with community providers for QIP-NJ. That said, DOH encourages collaboration between hospitals and community providers to support the coordination and increased quality of care for all individuals, as outlined in question #2 above.