New Jersey Division of Medical Assistance and Health Services

Quality Strategy

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Introduction

Executive Summary

The New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), administers New Jersey's Medicaid program and the Children's Health Insurance Program, which together are known as NJ FamilyCare. As of July 2021, DMAHS serves over 2 million low-to moderate- income adults and children, nearly 22% of New Jersey's residents, through these programs.

NJ FamilyCare provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, disabled, and individuals qualified for long-term care services. NJ FamilyCare's comprehensive health coverage provides a wide-range of services including: doctor visits, hospital services, prescription drugs, tests, vision care, mental health care, dental, home and community-based services, nursing home care and other healthcare services.

Most NJ FamilyCare beneficiaries are enrolled in managed care. With managed care, a health plan (also known as a Managed Care Organization or MCO) coordinates an individual's health care needs. As of July 2021, 96.9% of New Jersey's FamilyCare beneficiaries were enrolled in a managed care organization. Through managed care enrollment, Medicaid beneficiaries have expanded access to healthcare providers and care coordination, allowing for greater member choice.

MCOs provide a comprehensive package of preventive health services which, combined with the full range of Medicaid benefits, allows for the best healthcare possible.

New Jersey's Quality Strategy serves as a roadmap for ongoing improvements in care delivery and outcomes. Whether it be through new benefits and services, innovations, technology, or managed care accountability, New Jersey DMAHS is committed to serving Medicaid beneficiaries the best way possible. To demonstrate compliance with the Centers for Medicare and Medicaid (CMS) Quality Strategy Toolkit for States, NJ DMAHS has included a crosswalk titled **Appendix A: CMS Regulatory Crosswalk** that lists each required and recommended element and the corresponding page of the NJ DMAHS Quality Strategy that addresses that requirement/recommendation.

Background and Structure

History

The New Jersey Comprehensive 1115 Medicaid Waiver was approved in October 2012, consolidating authority for managed care system delivery. Among other things, the Comprehensive Demonstration created the Managed Long Term Services and Supports (MLTSS) program, which began operation in July 2014. On July 24, 2017, Centers for Medicare and Medicaid Services (CMS) approved a five year 1115 demonstration extension and renamed the demonstration to "New Jersey FamilyCare Comprehensive Demonstration." Under the current demonstration, New Jersey operates a statewide managed care program that combined and expanded upon several previously existing Medicaid and Children's Health Insurance Program (CHIP) waivers/demonstration programs, including:

- Two 1915(b) Managed Care Waiver programs
- Four 1915(c) HCBS waivers
- Title XIX Medicaid and Title XXI CHIP Section 1115 demonstrations

The Comprehensive Demonstration also provides additional authority for in-home community supports for individuals with intellectual and developmental disabilities as well as needed services and additional HCBS supports for children diagnosed with Serious Emotional Disturbance and children with intellectual disabilities with co-occurring mental illness. These programs are administered by the Department of Children and Families (DCF) and the DHS Division of Developmental Disabilities (DDD), and the services are provided through Medicaid managed care.

Under New Jersey's Comprehensive 1115 Demonstration, nearly all Medicaid and CHIP populations are required to receive benefits through managed care, with certain limited exceptions (examples include: individuals in a Program of All-inclusive Care for the Elderly (PACE) program and some individuals who were receiving long-term institutional care at the launch of MLTSS). As noted above, over 95% of NJ FamilyCare's beneficiaries are currently enrolled in a managed care organization. As of 2011, MCOs covered most of the Medicaid population – with the exception of some dual eligible beneficiaries – and covered most acute, primary, and specialty care services. In 2012, following federal approval to reform elements of its managed care system through a new Section 1115 comprehensive demonstration, NJ expanded managed care to include long-term services and supports. The MLTSS program launched in July 2014.

Subsequently, in January 2016, New Jersey's Dual Eligible Special Needs Plans (D-SNP) met the criteria to become designated by CMS as a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP). This enhanced the existing D-SNP to include FIDE SNP specific elements such as:

- Access to benefits within a single MCO under a Medicare Improvements for Patients and Providers Act (MIPPA) compliant, risk-based contract
- Coordination of service delivery of covered Medicare and Medicaid health and long-term care
- Provision of services using aligned care management and specialty care networks for high-risk beneficiaries
- Employment of policies and procedures approved by CMS and the State to coordinate or integrate enrollment, member materials, communications, grievance and appeals, and quality improvement

Effective October 1, 2018, the NJ FamilyCare managed health care benefit plan changed for Division of Developmentally Disabled (DDD) managed care enrollees, as well as for beneficiaries enrolled in Managed Long Term Services and Supports (MLTSS) or Fully Integrated Dual Eligible Special Needs Plans (FIDE SNP). With the exception of certain benefits, the updated plan includes most mental health and substance use disorder treatment benefits in order to better integrate behavioral and medical health care coverage through the member's MCO.

DMAHS Organization Structure

DMAHS upholds a strong organizational structure committed to the implementation and oversight of programs that serve NJ beneficiaries. A brief overview of the NJ DMAHS structure can be found in Figure 1.

Figure 1: DMAHS Organizational Structure

Department of Human Services

Division of Medical Assistance and Health Services (DMAHS)

Assistant Commissioner/Medicaid Director

Deputy Director	Medical Director	Chief Financial Officer	Office of Innovation	Legal & Regulatory Affairs	Operations	Chief Information Officer	Chief of Staff	Managed Care Operations	Managed Care Accountability
Leadership priorities	Clinical Review	Budget/ Finance	Policy development	Legal/ Regulatory	Eligibility operations	IT service center	Policy implementation	Member & provider relations	Access and availability
Customer experience & Quality control	Pharmacy, Dental	MCO/provider reimbursement	Health equity & delivery system reform	Recovery units	Health benefits vendor mgmt	IT vendor mgmt	HR engagement/ strategy	Contract management	Quality Assurance
External affairs & stakeholder collaboration	Clinical Ops/ Behavioral Health	Audit management	Reporting/ Analytics	MFD/MFCU liaison	County partnerships	Systems development/ mgmt	Facilities	Duals integration	Accountability measures

Assistant Commissioner and Executive Leadership Team

The DMAHS Assistant Commissioner/Medicaid Director is responsible for ensuring the organization achieves the established goals and vision set forth in the Quality Strategy. Along with the Executive Leadership Team and their key functional areas, the Medicaid Director develops and implements policies and procedures to support the delivery of quality services to Medicaid members in NJ.

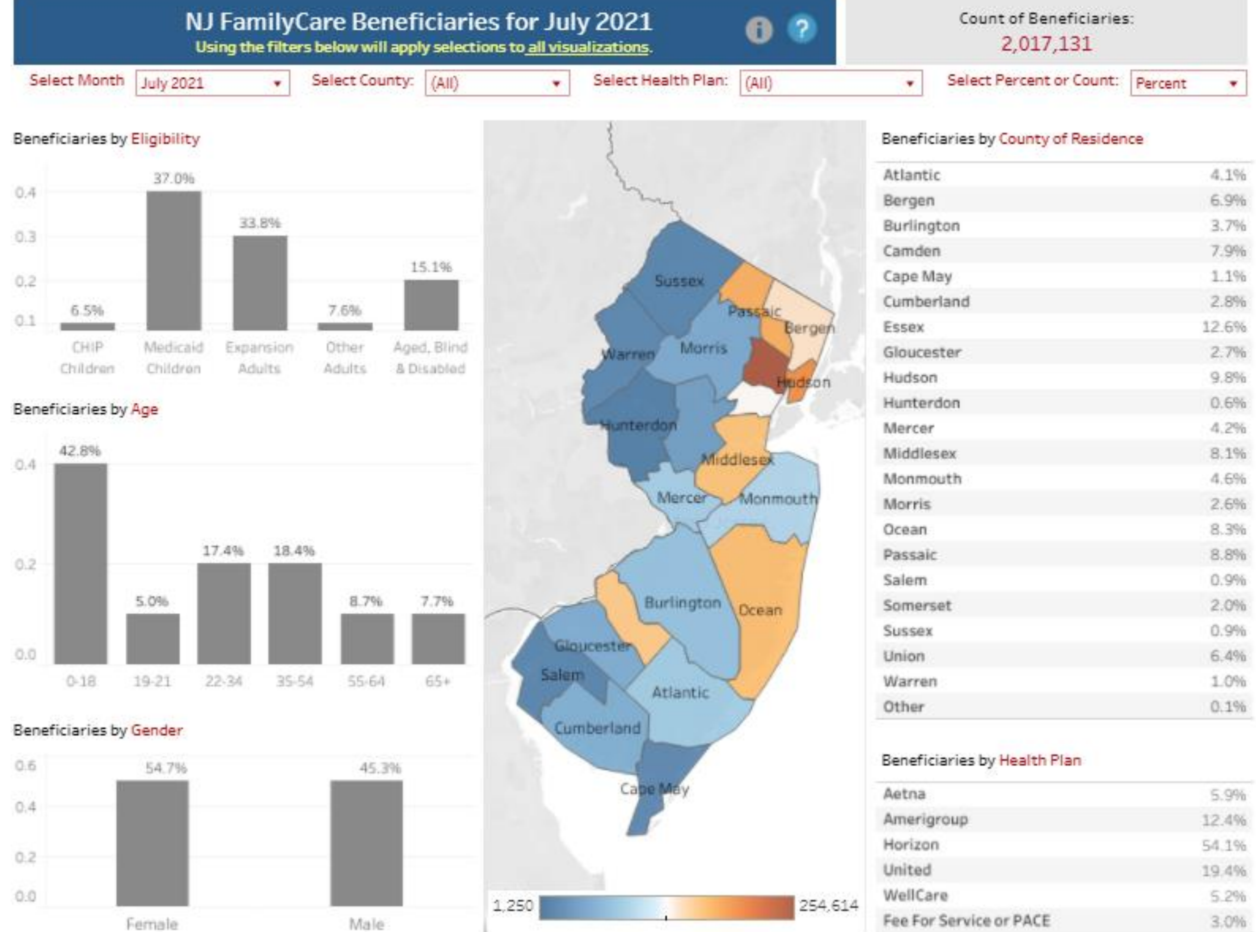
Medical Assistance Advisory Council (MAAC)

Federal law and State statute provides for the establishment of the Medical Assistance Advisory Council (MAAC). The MAAC's primary objective is to advise the Director of DMAHS, and to foster communication with the public. Invitations, agendas, meeting minutes, presentations, and audio recordings can all be found on the NJ DMAHS Website.

NJ FamilyCare Key Demographics

NJ FamilyCare operates in all counties of the State with the highest percentage of beneficiaries residing in Essex County. NJ FamilyCare serves children, pregnant women, aged, blind, disabled adults, childless couples, and more. Figure 2 displays the demographic data dashboard as of July 2021.

Figure 2: NJ FamilyCare Beneficiaries for July 2021



NJ Managed Care Organizations

Today, five (5) Managed Care Organizations (MCOs), participate in the NJ FamilyCare program:

- Aetna Better Health of New Jersey
- Amerigroup New Jersey, Inc.
- Horizon NJ Health
- United Healthcare Community Plan
- WellCare Health Plans of New Jersey, Inc.

97% of NJ beneficiaries are enrolled in managed care organizations. Details about each managed care organization are included on the DMAHS website, under NJ FamilyCare Health Plans. Additionally, DMAHS provides a link to NCQA's Health Plan Report Cards where all accreditation ratings are published.

Each Managed Care Organization also offers Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) for beneficiaries with Medicare and Medicaid.

Mission, Values, and Goals

Mission and Values

DMAHS is committed to upholding the core mission set forth by the Department of Human Services:

The Department of Human Services (DHS) is dedicated to providing quality services that consistently meet expectations with the goal to protect, assist, and empower economically disadvantaged individuals, families, and people with disabilities to achieve their maximal potential. We strive to ensure a seamless array of services through partnerships and collaborations with communities statewide. We seek to promote accountability, transparency, and quality in all that we do.

DMAHS maintains the following values while executing its mission:

- ***Serve people the best way possible*** through new benefits and services, by ensuring health equity, and through quality improvements across the program.
- ***Experiment with new ways to solve problems*** using innovation and new technology to consider bold and inclusive solutions.
- ***Focus on integrity and real outcomes*** to achieve operational accountability and compliance.

Guiding Principles

To deliver our mission and execute on our vision, NJ DMAHS has leveraged the Healthy New Jersey 2020 goals to serve as principles. Healthy New Jersey 2020 was developed by the NJ Department of Health (DOH) and serves as the State's health improvement plan and health promotion and disease agenda for the decade. It is modeled after the Federal Healthy People 2020 initiative and is the result of an ongoing process reflecting input from varied individuals and organizations.

Aims, Goals, and Objectives of the Quality Strategy

The Quality Strategy provides a structure for development, evaluation, and updating activities to reflect continuous improvements and stakeholder input. It establishes clear goals and measureable objectives to drive improvements in health care delivery, health outcomes, and satisfaction while aligning to the

CMS Quality Strategy aims. The table below serves as a crosswalk between CMS's Quality Strategy aims, NJ DMAHS goals, and NJ DMAHS Objectives. .

CMS Aims	NJ DMAHS Goals	NJ DMAHS Objectives
Better care	Serve people the best way possible through benefits, service delivery, quality, and equity	• Improve maternal/child health outcomes • Help members with physical, cognitive, or behavioral health challenges get better coordinated care • Support independence for all older adults and people with disabilities who need help with daily activities
Smarter spending	Experiment with new ways to solve problems through innovation, technology, and troubleshooting	• Monitor fiscal accountability and manage risk • Demonstrate new value-based models that drive outcomes • Use new systems and technologies to improve program operations
Healthier people, healthier communities	Focus on integrity and real outcomes through accountability, compliance, metrics, and management	• Address racial and ethnic disparities in quality of care and health outcomes • Hold operational partners accountable for ensuring a stable, accessible, and continuously improving program for our members and providers • Ensure program integrity and compliance with State and Federal requirements

DMAHS remains committed to evaluation of methodologies to assess progress with above goals – this includes the metrics to monitor results, performance targets, and accountability measures if not achieved. To monitor progress with identifying and evaluating metrics and performance , DMAHS developed a goal tracking table found in Appendix B. DMAHS updates this table as metrics change, performance improves, and priorities within the program shift.

Purpose and Scope

Purpose of the Quality Strategy

Consistent with the DHS mission and DMAHS values, the purpose of the Quality Strategy is to:

- Establish a quality improvement plan designed to develop and sustain an effective and efficient healthcare delivery system meeting the needs of those that we serve.
- Design a roadmap that continues to expand on assessment, measurement, and improvement opportunities for managed care organizations.
- Achieve program excellence and improve member satisfaction through meaningful quality improvement activities.
- Identify new and innovative ways to simplify and make healthcare more affordable.
- Promote person-centered healthcare, social services, and supports.

Scope of the Quality Strategy

Federal law requires New Jersey to draft and implement a written quality strategy for assessing and improving the quality of health care and services provided by its MCOs. New Jersey's Quality Strategy incorporates the activities set forth in federal law for a comprehensive strategy to monitor, assess, and

improve the quality of services offered under NJ FamilyCare. New Jersey's Quality Strategy is designed to be broad and all-encompassing and will address:

- All NJ FamilyCare beneficiaries in all demographic groups and service areas in which the MCOs are contracted to provide services.
- All services covered by the managed care organizations (as defined in the MCO contract), including but not limited to: preventative care, primary and specialty care, emergency services, prenatal care, dental services, pharmacy services, mental health/substance use disorder services, Managed Long Term Services and Supports, home care, and hospice.
- All aspects of care - including availability and accessibility, timeliness, and clinical effectiveness - of services covered by NJ Family Care.
- All aspects of MCO operations and performance, including but not limited to, quality management, utilization management, network and contracting, internal administrative processes related to service delivery and quality of care, delegated vendor oversight, and MLTSS.

Development, Review, and Evaluation

The goals, interventions, and activities described in this Quality Strategy are designed to ensure members have access to quality, equitable, person-centered, and cost-effective services. As required by 42 CFR §438.340(c), development, evaluation, and revisions related to this strategy are outlined below.

Development of the Quality Strategy

The Quality Strategy is developed using internal and external stakeholder feedback and is considered a living document, reflective of the ongoing improvement of the NJ FamilyCare program. The Quality Strategy draws upon shared goals and priorities across programs, as well as the specific and unique objectives designed to meet the needs of the specific and unique populations DMAHS serves. Following extensive internal discussion and review by DMAHS executive staff and their functional teams, the Quality Strategy was posted for public comment.

External stakeholder engagement

Stakeholder engagement is a critical part of the ongoing NJ FamilyCare quality program development and monitoring, NJ DMAHS engages with internal and external key stakeholders representing payers, providers, members, advocates, associations, other State agencies, and other subject matter experts. NJ FamilyCare's active stakeholders include (but are not limited to):

- Medical Assistance Advisory Council members and participants
- Perinatal Episode of Care workgroup
- Electronic Visit Verification Steering Committee and stakeholder workgroups
- Doula workgroup
- Medicaid/Aging community partnership
- Autism workgroup
- Health care provider associations
- Advocates for people with disabilities
- Legal advocates
- New Jersey Association of Health Plans (NJAHP)

Review and Update of the Quality Strategy

NJ DMAHS conducts an annual review of the Quality Strategy. Updates to the strategy are made, at a minimum, every three (3) years or whenever a significant change occurs. DMAHS will solicit input from both internal and external stakeholders as part of the triennial update process.

In accordance with 42 CFR §438.340(b)(10), NJ defines a "significant change" as:

- material changes to the structure of the NJ FamilyCare program or to quality management practices within the department
- substantive changes to quality standards or requirements resulting from regulatory change or legislation at the state or federal level
- significant changes in membership demographics, provider networks, or benefits as defined by NJ DMAHS

NJ DMAHS will work collaboratively with CMS to ensure that the Quality Strategy meets all requirements set forth in 42 CFR §438.340. The most recent version of the Quality Strategy will be available on the NJ FamilyCare website.

Evaluating the Effectiveness of the Quality Strategy

NJ DMAHS will regularly evaluate the effectiveness of the Quality Strategy to ensure that it continues to meet its aims and objectives through ongoing activities within the Division. These activities include (but are not limited to):

- Biannual review of the Managed Care Contract to determine if contract requirements align with aims and objectives outlined above
- Annual review of EQRO reports to measure compliance with the Managed Care Contract
- MCO accountability reviews highlighting strengths and weakness compared to past performance and to other MCOs
- Routine monitoring of performance indicators and data collected by DMAHS and/or submitted by the MCOs (i.e. member and provider inquiries, HEDIS, CAHPS, NCI-AD, grievances and appeals)

As NJ DMAHS completes the above review activities, opportunities for new or modified reports may be identified to ensure access to high quality and cost-effective services that fosters the health and independence of those we serve.

Quality Assessment and Performance Improvement

As part of the managed care program, DMAHS uses different mechanisms to assess the quality and appropriateness of care provided to managed care members.

1) Contract Management: The NJ Managed Care Contract includes extensive quality provisions and performance metrics across a number of areas, such as network adequacy, care management, operational logistics, etc.
2) Data collection and analysis: New Jersey regularly collects and reviews data from managed care plans to compare results across MCOs, against national benchmarks, and relative to prior program performance. Examples of reports/data include: Healthcare Effectiveness Data and Information Set (HEDIS) quality metrics, Consumer Assessment of Healthcare Providers and

Systems (CAHPS) measures, performance measures (NJ specific and MLTSS), MLTSS National Care Indicators – Aging and Disability (NCI-AD), Adult and Child core-set measures, etc.

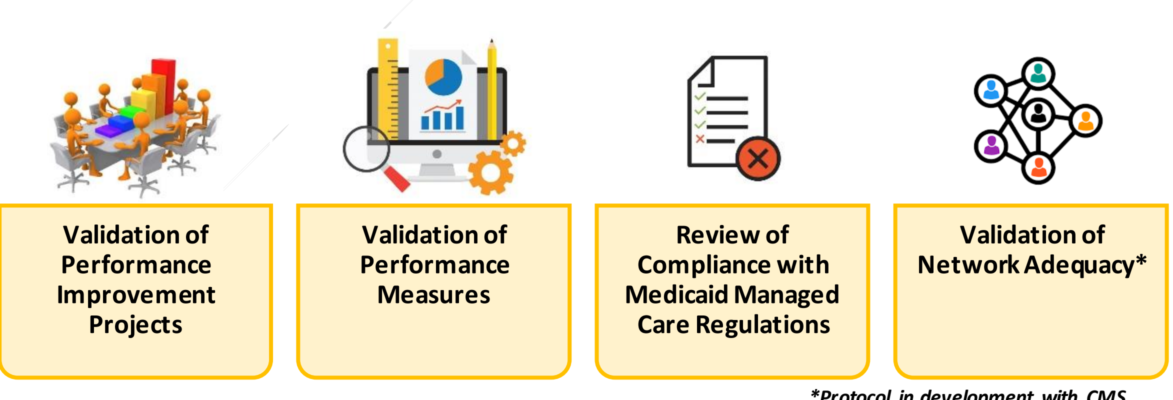
3) External Quality Review Organization (EQRO): Through the Annual Assessment process, the EQRO assesses each MCO's operations to determine compliance with the Managed Care Contract. The EQRO also reviews and validates performance measure methodology. Detailed activities of the EQRO can be found within the Quality Strategy.
4) Quality Assessment and Performance Improvement (QAPI) Program: DMAHS requires that all MCOs implement and maintain a QAPI program that is capable of producing, concurrent, and retrospective analyses. The written description of the program, submitted to NJ DMAHS and/or the EQRO annually, must address both the quality of clinical care and quality of non-clinical aspects of service. MCOs must include enrollee rights and responsibilities in the QAPI – Standard X of the Managed Contract outlines specific requirements such as enrollee rights to be treated with dignity, privacy, and respect. MCOs are required to ensure the QAPI program objectively and systematically monitors and evaluates the quality and appropriateness of care to enrollees. In accordance with 42 CFR §438.330, MCOs use their QAPI programs to perform ongoing quality assessments, monitor overutilization and underutilization of services, and assess appropriateness of care furnished to members. Requirements of the QAPI program are further defined in the Managed Care Contract.

External Quality Review

NJ DMAHS currently contracts with Island Peer Review Organization (IPRO) as the EQRO to monitor Managed Care quality and compliance standards. In accordance with 42 CFR §438.350, IPRO performs the following activities on behalf of DMAHS.

Mandatory Activities:

To evaluate the quality and timeliness of, and access to, the services covered under the Managed Care Contract, DMAHS has contracted with IPRO to conduct the following mandatory external quality review activities:



Validation of performance improvement projects: Performance improvement projects (PIPs) are studies that MCOs conduct to evaluate and improve processes of care based on identified barriers. PIPs should follow rigorous methodology that will allow for the identification of interventions that seek to improve care. Ideally, PIPs are cyclical in that they test for change on a small scale, learn from each test, refine the change based on lessons learned, and implement the change on a broader scale. The EQRO assesses

each PIP for compliance with the relevant review categories. The EQRO's validation determines if the PIPs are designed to achieve improvement in nonclinical and clinical care. Information specific to the NJ PIPs is discussed below in the Quality Strategy.

Validation of performance measures**:** As part of the EQRO responsibilities, IPRO validates the methodology used to calculate Core Medicaid, FIDE SNP and MLTSS performance measures.

Review of Compliance with Medicaid Managed Care Regulations**:** During the Annual Assessment of MCO Operations, the EQRO validates, quantifies, and monitors the quality of each MCO's structure, processes, and the outcome of its operations.

Validation of Network Adequacy: While CMS develops requirements and protocols for validation of network adequacy, NJ DMAHS completes a series of analyses, quarterly, to monitor managed care network adequacy. Strengths, weaknesses, and concerning findings are shared with MCOs during performance accountability reviews. Included in these analyses are:

- Geographic Access: standards for applicable provider types and average distance/time to the nearest servicing provider.
- Capacity: provider-to-member ratios as defined by the Managed Care Contract.
- Appointment availability: procedures and policies ensure access to services within the timeframes defined by the Managed Care Contract.

Optional activities:
Below are optional activities that IPRO leads. More information and findings for these activities can be found in **Appendix E: 2020 EQRO Quality Technical Report (QTR)**. Additional details related to specific optional activities in NJ are found further below in the Quality Strategy.

- Conduct focus studies on particular aspects of health services
- Conduct care/case management audits
- Individual case reviews
- Development of NJ-specific Performance Measures
- Encounter data validation
- Calculation of additional performance measures
- Administration or validation of Quality of Care surveys

MCO Annual Assessment:
The MCO Annual Assessment determines MCO compliance with the NJ FamilyCare Managed Care Contract requirements, including FIDE SNP MIPPA Contract, and with the State and federal regulations in accordance with requirements of 42 CFR 438.204(g). Areas review included, but are not limited to:

- Access
- QAPI
- Quality Management
- Efforts to Reduce HealthCare Disparities
- Committee Structure
- Programs for Elderly and Disabled
- Provider Training and Performance
- Satisfaction
- Enrollee Rights and Responsibilities
- Care Management and Continuity of Care

- Credentialing and Recredentialing
- Utilization Management
- Administration and Operations
- Management Information Systems

NJ DMAHS requires an annual assessment audit cycle: 2 consecutive years of partial audits followed by 1 year of a full audit. The annual assessments consist of pre-offsite reviews of documentation provided by each MCO as evidence of compliance with the standards. IPRO developed a State specific guide – the Annual Assessment of MCO Operations Review Submission Guide – to assist with submission of appropriate documentation. This guide closely follows the NJ FamilyCare Managed Care Contract. Following the document review, IPRO conducts interviews with key members of each MCO team to further clarify any questions that arose during the off-site review. Any MCO that scores less than 85% in the partial audit (percentages are calculated by the elements met versus not met over total evaluated elements) is subject to a full audit the following year. MCOs must submit a Corrective Action Plan (CAP) for any elements that have received a Not Met. A summary of comparative results is included in IPRO's QTR.

Care Management Audits:
As part of the optional activities and in additional to the annual assessment described below IPRO conducts care management audits for the Core Medicaid, FIDE SNP, MLTSS HCBS and MLTSS Nursing Facility population to evaluate the effectiveness of the contractually required care management programs. For each of the care management audits, IPRO uses eligibility data to identify a statistically sound sample size for each MCO. IPRO reviewers conduct file reviews prepared by each MCO. Areas that fall below defined benchmarks for the audit require Corrective Action Plans.

In compliance with 42 CFR §438.364, the EQRO prepares a Quality Technical Report (QTR), annually, for the activities related to the Core Medicaid population, the MLTSS population, and the FIDE SNP population. The QTR follows CMS guidelines for Annual Technical Reports; it includes objectives, methods of data collection and analysis, description and conclusions drawn from the data obtained, and an assessment of strengths and weaknesses across the NJ FamilyCare program. Annual QTRs are made available on DMAHS' website.

Performance Improvement Projects (PIPs)

NJ DMAHS requires MCOs to participate in PIPs – DMAHS works closely with MCOS and the EQRO to define PIP subjects. PIPs are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

New Performance Improvement Project Proposal: MCOs must submit to DMAHS and/or its EQRO a written description of the PIP the MCO proposes to begin the first quarter of the following calendar year.

Performance Improvement Project Progress Reporting: Twice yearly, MCOs must produce a progress report for each active PIP. Each submission must follow template guidelines set forth by DMAHS and the EQRO. Each submission is validated and reviewed by the EQRO; following the review, the EQRO submits a written recommendation to the MCO.

Performance Improvement Project Lifecycle: Implementation of the project must begin within the first quarter of the year following project review. The lifecycle must be based on the project's measurement periodicity, such that, there are at least two consecutive measurement periods where the project may demonstrate statistically significant improvement over the baseline, achieve the stated and approved performance goal, exhibit sustainability, and be operational within the organization.

Termination of a PIP: In the event that a project fails to achieve statistically significant improvement, the MCO may submit a written request to DMAHS and/or its EQRO at the direction of the State, to terminate the project. The request must demonstrate: 1) why the project was unable to result in significant improvement, sustained over time; 2) the MCO's efforts to resolve project barriers; and 3) an explanation of why these barriers were not addressed during the original proposal.

IPRO provides detailed feedback to the MCOs on PIP report submissions and PIP updates. In the event IPRO finds that the MCO is not meeting the requirements/benchmarks, the MCO receives a Not Met rating during the annual assessment and is required to submit a Corrective Action Plan (CAP) for DMAHS approval. Currently, NJ MCOs are engaged in at least one non-clinical PIP, one clinical PIP, and at least one MLTSS-specific PIP. Listing of active PIPs and interventions can be found in Appendix F.

Establishing Quality Metrics and Performance Targets

NJ DMAHS uses nationally recognized measure sets, wherever appropriate and possible, to measure clinical quality, access, and utilization management for the NJ FamilyCare program, including the MLTSS population. The Managed Care Contract requires MCOs to submit the below performance measures specified by the State annually, at a minimum. The State retains the right to add, delete, or revise performance measures.

- HEDIS measures as outlined by NCQA (including specific measures for FIDE SNP monitoring)
- NJ-specific Performance Measures, including MLTSS-specific measures
- Adult and Child Core Set measures as outlined by CMS
- CMS-416 for Annual Oral Health

A list of measures can be found in **Appendix D.**

HEDIS 2020 (MY2019)

DMAHS' EQRO validates HEDIS performance measures in a manner consistent with CMS protocols. In the Quality Technical Report (QTR), the EQRO provides analyses highlighting trends and deficiencies across the program. MCOs are required to submit a work plan within forty-five (45) days of their annual HEDIS submission for any measure falling below the State-defined benchmark. NJ DMAHS is implementing processes and requirements to report all CMS Child Core Set measures and Adult Behavioral Health Core Set measures by 2024.

DMAHS uses a combination of these metrics to monitor MCO performance and improvement. DMAHS publishes metrics on the NJ FamilyCare Analytics Dashboard – measures included are prioritized for continuous improvement and selected based on the needs of the populations served. NJ includes HEDIS measures and scores under preventative and follow-up care, assessments, screenings, immunizations,

and medication monitoring. In a second dashboard, NJ publically displays CAHPS Health Plan Overall Satisfaction ratings.

DMAHS sets the following benchmarks for MCOs:

- HEDIS Performance Measures: Performance measures that align with NJ's goals and objectives and fall below the NCQA 50th percentile require MCO work plans
- Core Set measures: A work plan may be requested of the MCOs if the performance does not reflect the minimal acceptable service level.
- CAHPS: Overall ratings and composite scores below the NCQA 50th percentile require MCO work plans.
- NJ Specific Performance Measures: Performance measures that align with NJ's goals and objectives and do not reflect the minimal acceptable service level require MCO work plans.
- Annual Assessment of MCO Operations: Any categories reviewed by the NJ EQRO that result in a Not Met finding require an MCO corrective action plan with detailed interventions and plans for monitoring to cure the deficiency.
- Core Care Management Audits: Performance below 85% or elements scored Not Met require MCO work plans and/or corrective action plans with detailed interventions and plans for monitoring until the deficiency is cured.
- MLTSS Care Management Audits: Performance below 86% require MCO corrective action plans with detailed interventions and plans for monitoring until the deficiency is cured. Each sub-element scored under 86% requires a corrective action.

Preventing and Reducing Disparities

As part of the required QAPI activities listed in the Managed Care Contract, MCOs are to submit a program to identify, evaluate, and reduce healthcare disparities within the MCOs by subgroups including but not limited to: gender, race, ethnicity, primarily language, geographic location, and disability status. MCOs must ensure the program includes a barrier analysis and action plan to address the disparities identified, implementation of the action plan, and ongoing evaluation of the effectiveness of the plan. MCOs are evaluated on compliance with QAPI standards during the Annual Assessment, further detailed below.

In addition to the above, DMAHS is evaluating enhanced mechanisms to use MCO data/reports to identify, evaluate, and plan to reduce – to the extent possible – healthcare disparities. Currently, DMAHS collects member level detail files from MCOs for select performance measures. DMAHS quality teams are engaged in ongoing data analysis activities to evaluate trends amongst these measures. Similarly, DMAHS is reviewing new mechanisms for identification or evaluation of healthcare disparities including the expansion of member level detail files from MCOs.

Additionally, NJ plans to use the upcoming 1115 renewal as one of the policy levers to advance Medicaid priorities. Included in the 1115 renewal is a focus on serving NJ communities the best way possible by:

- Addressing known gaps and improving quality of care in maternal and child health
- Expanding health equity analyses to support better access and outcomes for communities of color and people with disabilities, while also seeking to improve the experience of other historically marginalized groups where data may not be available for analysis (e.g. LGBTQ identity)

New and ongoing initiatives in the demonstration aim to promote health equity and reduce disparities with, for example, extended postpartum coverage, housing-related services, community health workers, regional health hubs, enhanced provider partnerships, improved care management, and whole person care. DMAHS will support these initiatives with a renewed organizational focus on health equity and outcomes. NJ plans to use both quantitative and qualitative measures in evaluating programs to consider the impact on improving access and outcomes based on race/ethnicity, immigration status, disability, LGBTQ identity, geographic location, socioeconomic status, and additional intersecting factors known to impact a person's experience with the healthcare system.

Grievance and Appeals

All MCOs are required to make their grievance and appeal procedures available to all enrollees, or, where applicable, an authorized person, or permit a provider to act on behalf of an enrollee (with written consent). All grievance and appeal procedures must be in accordance with 42 CFR 438 subpart F.

MCOs are contractually required to submit utilization and non-utilization grievance and appeal data (including MLTSS members) on a quarterly basis using a format defined by DMAHS. Categories on the reporting template have been standardized to mirror the categories used by the New Jersey Department of Banking and Insurance (DOBI). MCO systems are required to support monitoring and tracking of all grievances and appeals from receipt to disposition. Submissions undergo DMAHS review for accuracy and completeness – findings are trended and shared with MCOs during ongoing MCO Performance Accountability Reviews.

In addition to grievance and appeal reporting, DMAHS tracks other complaints such as provider inquiries, hotline concerns, and Director Referrals. DMAHS requires MCO follow-up until resolution and trends data quarterly to highlight MCO or program concerns.

Non-Duplication of Mandatory Activities

Upon review of the conditions for exercising the non-duplication option for completing EQRO compliance reviews (42 CFR §438.360), NJ DMAHS has decided not to exercise this option for MCO Annual Assessments, Performance Improvement Projects, or validation of performance measures.

State Standards for Access and Operations

All NJ MCOs are required to maintain standards set forth in the Managed Care Contract for access to care including availability of services, assurance of adequate capacity of services, coordination and continuity of care, and coverage and authorization of services (42 CFR §438.206-208). NJ DMAHS has monitoring practices in place to ensure MCOs remain compliant with these requirements.

Availability of Services

In accordance with 42 CFR §438.206, all NJ MCOs must establish, maintain, and monitor at all times a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate and timely access to all services covered under the Managed Care Contract. Access standards include medically necessary services to be available to members 24 hours a day, 7 days a week. General provisions of the contract require that the provider network:

- Consist of traditional providers for primary and specialty care, other approved non-physician primary care providers, physician specialist, non-physician practitioners, hospitals, FQHCs,

nursing facilities, residential setting providers, home and community based providers, other essential community providers/safety-net providers, and ancillary providers.

- Be reviewed and approved by DMAHS.
- Include, at a minimum, sufficient number of available and physically accessible physician and non-physician providers of health care to cover all services in the amount, duration, and scope included in the benefits package under NJ Family Care.
- Include providers who can accommodate different languages of the enrollees, including bilingual capability for any language which is the primary language of five (5) percent or more of the enrolled DMAHS population.

The Managed Care Contract requires that MCOs provide female enrollees direct access to a women's health specialist to provide routine and preventative health care services. This will be in addition to the enrollee's designated PCP if that PCP is not a women's health specialist.

MCOs must also have policies and procedures in place for members to receive information on how to obtain a second opinion. NJ DMAHS requires that enrollees may receive second opinions within the network, or outside the network at no cost. The Managed Care Contract defines appointment availability maximum wait times. For example, waiting time in office must be less than 45 minutes. Additionally, MCOs are required to meet the following appointment standards by type of care:

Emergency Services: Immediately upon presentation at a service or delivery site

Urgent Care (including Speciality): Within 24 hours of referral or member request

Routine Care: Within 28 days including, but not limited to, well/preventative care appointments

Baseline physicals: Within 180 calendar days of enrollment for new adult enrollees, within 90 days of enrollment for new children enrollees and/or adults enrolled in DDD

Prenatal Care: Within 3 weeks of a positive pregnancy test (home or lab), 3 days within identification of high-risk, 7 days for requests within the first and second trimester, 3 days for requests within the third trimester

Lab and radiology: Within 3 weeks for routine appointments, within 48 hours for urgent care

Dental: Within 48 hours for emergency services, within 3 days of referral for urgent care, within 30 days for routine non-symptomatic

Mental Health/SUD: Immediately upon presentation at site for emergency, within 24 hours of request for urgent, within 30 days for routine

Cultural Competencies

In addition to the QAPI requirements detailed above, the Managed Contract requires MCOs to address the relationship between culture, language, and health care outcomes through, at a minimum, the following cultural and linguistic service requirements:

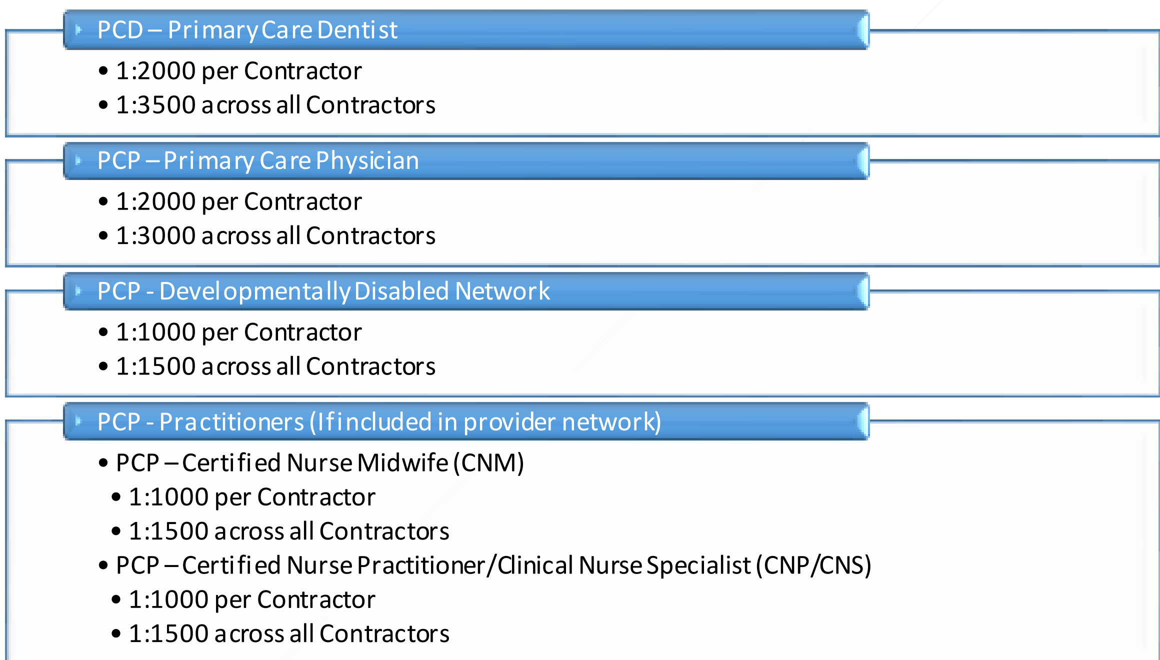
- Physical and communication access: provide documentation regarding availability of and access procedures for services which require physical and communication access to: providers, customer service or physician office telephone assistance, and interpreter TDD/TT to those that require them to communicate.
- 24 hour interpreter access free of charge to ensure the beneficiary can communicate with the MCO and providers to receive covered benefits.
- Interpreter listing: maintain a current list of interpreter agencies or oral interpreters who are “on call” to provide services.

- Language thresholds: provide linguistic services if population exceeds 5% or 200 of those enrolled, whichever is greater.
- Community Advisory Committee (CAC): Implement and maintain community linkages through the form of a CAC with demonstrated participation of consumers, community advocates, and traditional safety net providers.
- Group Needs Assessment: MCOs must assess the linguistic and cultural needs.
- Policies and Procedures that address the special healthcare needs of enrollees.
- Mainstreaming: MCOs must ensure network providers do not intentionally segregate DMAHS enrollees from other persons receiving services.
- Resolution of cultural issues.

Assurances of Adequate Capacity and Services

Provider Compliance and Ratios

NJ DMAHS requires MCOs to maintain certain provider ratios (number of provider per member) at each MCO, as well as cumulatively across all MCOs:



Geographic Access and Travel Time Standards

MCOs must maintain networks that comply with the geographic access standards set forth by DMAHS through the Managed Care Contract and in accordance with NJAC 11:26-6 et seq.

- 90% of the enrollees must be within six (6) miles of two (2) Pharmacies, two (2) PCPs and two (2) Primary Care Dentists (PCD) in an urban setting
- 85% of the enrollees must be within fifteen (15) miles of two (2) Pharmacies, two (2) PCPs and two (2) PCDs in a non-urban setting
- Include at least one (1) laboratory and one (1) licensed acute care hospital within their network that provides licensed medical-surgical, pediatric, obstetrical, and critical care services in each county or adjacent counties, and which is no greater than 15 miles or 30 minutes driving time, whichever is less, from 90% of members within the county or in adjacent counties

- Two (2) specialists (specialty types are defined in the Managed Care Contract) within 45 miles or one (1) hour driving time, whichever is less for 90% of members within county or approved sub-county

DMAHS requires MCOs network adequacy reports, quarterly. These reports include monitoring of sufficient physician and non-physician providers to service members, geographical access to physicians and hospitals in accordance with the requirements set forth by the Contract, evidence of contracts with Federally Qualified Health Centers (FQHCs), etc. NJ continues to modify requirements in an effort to improve oversight of access and availability of services. Recently, DMAHS updated geographical access reporting requirements to better reflect provider availability: As of July 2021, MCOs must submit a second geographical access report that is limited to contract providers that have at least $600 in paid claims or greater than 10 paid claims in the previous year. As improvements continue, DMAHS is focused on requiring quality data submissions, aligning to State and legislative priorities, and most importantly, closing gaps to ensure access and availability of services to NJ beneficiaries.

MLTSS Network Requirements
MCOs must contract with a sufficient number of nursing facilities (NFs), specialty care nursing facilities (SCNFs), assisted living facilities, and community alternative residential settings in order to have adequate capacity to meet the needs of MLTSS members. They must also have adequate HCBS provider capacity to meet the needs of each MLTSS member receiving HCBS services. At a minimum, MCOs must contract with at least two (2) providers for each HCBS, other than community-based residential alternatives, to cover each county. For HCBS provided in a member's place of residence, the provider does not need to be located in the county of the member's residence, but must be willing and able to serve residents of that county.

To ensure the adequacy and sufficiency of its MLTSS provider network, DMAHS requires MCOs develop, maintain, and submit annually a network development plan. It includes:
- Summary of NF provider network, by county
- Summary of HCBS provider network by service and county
- Demonstration of monitoring activities to ensure that access standards for MLTSS are met
- Demonstration of the MCO's ongoing activities to track/trend all instances where a member does not receive MLTSS services due to inadequate provider capacity
- Report of HCBS network deficiencies, by service and county, along with interventions/timetables to address deficiencies
- Efforts to develop a network of new and enhance existing community-based residential alternatives, including recruitment activities and ongoing capacity building
- Ongoing activities for HCBS provider development and expansion, taking into consideration identified provider capacity, network deficiencies, and service delivery issues and future needs relating to growth in membership and long term needs

Good Faith Negotiations
NJ DMAHS allows MCOs to submit a request for waivers should they not meet defined provider network access and availability standards. The approval for waivers is on a case-by-case basis and reflective of DMAHS's desire to support member choice. Waivers must be supported by evidence that the MCO has engaged or attempted to engage providers in good faith to negotiate contracts. If a waiver is approved,

member access for that provider type will be monitored and findings will be included in the managed care program assessment report as required by 42 CFR §438.66.

Coordination and Continuity of Care

In an effort to continuously improve coordination of service and continuity of care for our beneficiaries, NJ DMAHS requires MCOs to review other sources of coverage to coordinate services. Additionally, specific requirements are in place to prevent duplication of services such as, but not limited to, cooperation with school districts to prevent duplication of services for children with special needs, or limits on private duty nursing services overlapping with personal care assistance (PCA) or self-direction. DMAHS does allow MCOs to monitor and approve variable PDN/PCA services, within MLTSS, as needed on a case-by-case basis. The MLTSS Service Dictionary, as part of the Contract, includes service limitations for each benefit under the MLTSS program in an effort to avoid duplication of services.

For new enrollees, MCOs must honor and pay for on-going services established prior to enrollment with the MCO in an effort to maintain continuity of care until an initial assessment is completed. Policies and procedures related to transfer of MLTSS members between MCOs, such as requirements to continue services on member care plans, transition of discharge planning, and transfer of clinical assessments and records are outlined in detail in the MCO Contract.

In accordance with §438.208(b)(1), NJ requires that each MCO provide the enrollee with the opportunity to select a PCP. If no selection is made, the MCO will assign a PCP within 10 calendar days of enrollment.

Coverage and Authorization of Services

NJ DMAHS requires that all MCOs provide, or arrange to have provided, comprehensive, preventative, diagnostic, and therapeutic healthcare and MLTSS services that the NJ FamilyCare enrollees are entitled to receive. MCOs must demonstrate that beneficiaries have access to all covered services in an amount, duration, and scope as established by the Medicaid/NJ FamilyCare program, in accordance with medical necessity and without any predetermined limits, unless specifically stated. Medical necessity is further defined in the Managed Care Contract.

MCOs and their providers are expected to furnish all covered services required to maintain or improve health in a manner that maximizes coordination and integration of services, aligns with professionally recognized standards of quality, and encompasses all health care services for which payment is made.

Each MCO must have a Utilization Management plan that addresses all parts of the New Jersey QAPI standards. The MCO must also develop and maintain prior authorization policies and procedures with mechanisms to ensure consistent application of criteria for authorization decisions. As part of the utilization management requirements, NJ DMAHS does not allow MCOs to arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition. NJ also prohibits compensation to those conducting utilization reviews based on any method that encourages rendering of an adverse determination. The Contract specifies timeframes and requirements for specific types of determinations as seen in **Figure 3: Determination timeframes**, below.

Figure 3: Determination timeframes

Routine Determinations

Decisions shall be made and a notice via phone or writing within 14 calendar days of receipt of necessary information sufficient to make decision

Urgent Determinations

Decisions shall be made within 24 hours of receipt of necessary information but no later than 72 hours after receipt of request of service

Adverse Determinations

A physician with appropriate clinical experience in treating the enrollee's condition or disease and/or a physician peer reviewer shall make the final determination. The member or provider acting on behalf of the member shall receive written notice within two business days of said determination. The Notice of Action shall meet the requirements of 42 CRF 438.210

Enrollees with Special Needs

As defined in the Managed Care Contract, for adults, special needs include complex/chronic medical conditions requiring specialized health care services and persons with physical, mental, substance use disorder, and/or developmental disabilities. Children with special health care needs are defined as those that may have or are suspected of having serious or chronic physical, developmental, behavioral, or emotional conditions (short-term, intermittent, persistent, or terminal), who manifest some degree of delay or disability in one or more of the following areas: communication, cognition, mobility, self-direction, and self-care.

The Managed Care Contract sets forth requirements for identification and service delivery for those who have or are at risk of having special needs. The MCOs are required to maintain a complete history of enrollee information, which includes information related to health care for enrollees with special needs. Additionally, the MCOs must complete timely Comprehensive Needs Assessments (CNAs), develop care plans that address service needs, ensure services are rendered in a timely manner, and are equal in quality and accessibility. In addition to confirming service appropriateness and delivery, MCOs are expected to incorporate the following into their policies and procedures: the values of 1) honoring enrollees' beliefs, 2) being sensitive to cultural diversity, and 3) fostering respect for enrollees' cultural backgrounds.

As it relates to network and access, MCOs must ensure enrollees with special needs have access to all medically necessary services, with special attention to dental services. Networks are required to include providers who are trained and experienced in treating individuals with special needs. MCOs are responsible for initial and ongoing provider training and communications as it relates to special needs, as well.

Standards for Structure and Operations

Contracts between NJ DMAHS and MCOs set forth requirements for Managed Care organizational structure and operations. The contract sets forth requirements in the following areas:

- Provider selection and credentialing
- Member information
- Confidentiality
- Enrollment and Disenrollment
- Subcontractual relationships and delegation

Provider Selection and Credentialing

NJ QAPI standards, defined in the MCO Contract, require a credentialing process that follows a systematic and timely approach to the collection and verification of providers' professional qualifications and the assessment of whether the provider meets professional competence and conduct criteria. Per section 4.6.1 of the Contract, before any provider/subcontractor may become a part of the MCO's network, that provider/subcontractor must be credentialed by the MCO. MCOs, at a minimum, should have written policies and procedures, consistent with NCQA standards and State requirements, to address these provisions required within the QAPI credentialing standards. As part of these provisions, MCOs must have a process and criteria for credentialing and recredentialing.

As part of the non-discrimination requirements set forth by the Managed Care Contract, MCOs cannot discriminate against any provider that services high-risk populations or specializes in conditions that require costly treatment.

Member information

As part of the general requirements under enrollee education and information, DMAHS sets forth requirements related to material shared with enrollees:

- Written material must be shared and approved by NJ DMAHS prior to distribution
- Font size must not be less than 12 point
- Available in the prevalent (5% or greater of population) non-English languages in each service area of operation
- Oral interpretation services available free of charge
- Electronic material must be readily accessible, in a format that can be saved and printed, consistent with applicable content and language specified in 42 CFR 438.10

Each member enrollee shall receive a bilingual (English/Spanish) member handbook, as well as a copy of their identification card. The handbook must be written in a fifth-grade reading level or at an appropriate reading level for enrollees with special needs. It must be available upon request in other languages, and alternate formats (e.g. large print, Braille, etc.)

Confidentiality

Each MCO's system functions and capabilities must include the ability to protect patient confidentiality through the use of masked identifiers and other safeguards, as needed. All provider contracts must protect the rights of enrollees and comply with applicable State and Federal laws, including confidentiality. All information, records, data, and data elements are protected from unauthorized disclosure. Access to this information shall be physically secured and safeguarded.

Enrollment and Disenrollment

Each MCO is required to comply with the enrollment and disenrollment requirements and limitations set forth in §438.56. In an effort to achieve simplicity and a streamlined process, NJ posts eligibility requirements to the NJ FamilyCare website. Enrollment application processes can be completed online and allows for saving partially completed applications, viewing submitted applications, and receiving future Medicaid alerts electronically. For those that have questions or need additional help, the NJ FamilyCare phone number is available.

NJ captures race and ethnicity directly on the NJ FamilyCare application – responses are recoded by individual applicant. NJ collects language at a household level and is specific to the language preferred for written material, such as letters. This information is passed to the applicable Managed Care Organization through the 834 enrollment file.

Once determined eligible, NJ FamilyCare enrollees must choose an MCO – a list of MCOs and covering service areas is available on the website. Those that do not choose an MCO will be auto assigned and may initiate disenrollment/transfer to another MCO if they meet one of the good cause reasons defined by the Managed Care Contract. The Contract also includes specifics related to disenrollment from a MCO including, but not limited to non-discrimination, non-coercion, notification of rights, transfer of records, and coverage.

Subcontractual Relationships and Delegation

NJ DMAHS allows MCOs to enter into subcontracts to carry out the terms of the Contract. However, in doing so, each MCO is held accountable for:

- Submitting all subcontracts to DMAHS for approval prior to implementation
- Including provisions set forth by the Managed Care Contract (B.7.2) in all subcontracts
- Monitoring performance on an ongoing basis to ensure compliance with the MCO Contract
- Not ceding or transferring some or all of the financial risk to the subcontractor
- Ensuring licensing by Department of Banking and Insurance (DOBI)
- Ensuring compliance with requirements under 42 CFR 438.3 and 438.230

Clinical Practice Guidelines

MCOs are required to adopt evidence-based practices to ensure consistent application of proven strategies to promote the highest quality of care and services for all populations. They are also required to disseminate evidence-based guidelines to providers and, upon request, enrollees and potential enrollees. Clinical practice guidelines must address chronic condition management (i.e.: asthma, diabetes, depression), disease prevention strategies, and care modalities for special populations, such as those with traumatic brain injury, and physical and intellectual disabilities.

Additionally, DMAHS requires annual, evidence-based protocol education to all Care Managers and Medical Director Staff assigned to manage specific populations such as pediatric, geriatric, or those with a diagnosis of Traumatic Brain Injury. Training programs should be designed to engage staff and ensure knowledge retention through the use and application of adult learner strategies. At a minimum, MCOs' methodology for providing evidence-based disease prevention must include:

- Direct provision of evidence-based disease prevention programs for members or Care Manager referral and linkage to local providers of such programs.

- Guidelines for member referral.
- Training of Care Management staff to ensure working knowledge of evidence-based disease prevention programs and MCO's guidelines for assessment and referral.
- Embedding information about evidence-based programs in provider and member training initiatives.
- Use of an automated tracking mechanism to monitor beneficiary referral to and completion of disease prevention programs.
- Outreach to the DMAHS' Office of the Medical Director to support coordination with DHS for evidence-based disease prevention.

NJ DMAHS uses an array of MCO reporting requirements as mechanisms to ensure compliance with standards in the Contract – a comprehensive list of reporting requirements can be found in **Appendix C: Managed Care Organizations Reporting Requirements**.

Improvements and Interventions

New Jersey engages in continuous quality improvement efforts through clinical and non-clinical intervention strategies designed to advance quality of care. They are intended to be dynamic to meet the needs of the NJ FamilyCare program and beneficiaries.

Directed Payment Programs

Many of these interventions are funded through Directed Payments (DPs) Programs, under 42 CFR 438.6(c), and are designed to help Managed Care Organizations achieve delivery system, payment reform, and performance improvement.

Uniform increase for publicly owned Nursing Facilities

DMAHS has implemented a uniform percent increase for services provided under Class II (publicly owned) nursing facilities with more than 500 licensed beds. The increase will be passed to the appropriate nursing facility providers through NJ Managed Care Organizations. At least 90% of these nursing home residents' population are enrolled in Medicaid. The increase is intended to maintain access to this critical safety net nursing home facilities while bolstering resources for them -- especially during the public health emergency (PHE).

Inpatient Hospital Service

In order to provide additional resources to hospitals in economically challenged communities, in serving their large Medicaid populations for inpatient hospital services, New Jersey established a pool of funds for the hospitals in each county, based on available resources. These DPs represent a per diem add-on payment managed through the NJ MCOs to provide additional support to all hospital inpatient claims across three classes of hospitals (State Public Hospital, County Public Hospital, and Private Acute Care Hospitals). The goal of this DP is to ensure access to care for Medicaid managed care beneficiaries, particularly in light of the PHE.

Medicaid Access to Physician Services (MAPS)

The MAPS program is designed to preserve and promote timely and appropriate access to medical services for Medicaid beneficiaries and underserved populations through setting minimum rates for professional services provided by qualified providers affiliated with schools of medicine or dentistry. The defined provider class is critical to ensuring that Medicaid managed care beneficiaries throughout the

state have access to necessary primary and specialty services including Breast Cancer Screening (BCS-AD), Cervical Cancer Screening (CCS-AD), Preventative Dental Services (PDENT-CH).

Adult Medical Day Care
NJ increased the per diem rate for Adult Medical Day Care providers. These DPs, managed through the MCOs, ensures that Adult Medical Day Care services are available for those who need them. The increased rate allows Adult Medical Day Care facilities to increase or maintain workforce and achieve the common goal of improving access to home and community based services.

Pay-for-Performance

NJ incentivizes managed care partners and providers to continue interventions that improve the quality of the program. Examples of performance payments are described below.

Quality Improvement Program-New Jersey (QIP-NJ)

To support continued population health improvement across NJ, DMAHS partnered with NJ DOH to develop a hospital performance initiative, QIP-NJ, to advance statewide quality in maternal health and behavioral health. Participating acute care hospitals receive incentive payments through the achievement of performance targets that demonstrate:

- Improvements in maternal health processes
- Reductions in maternal morbidity
- Improvements in connections to behavioral health services
- Reductions in potentially preventable utilization for the behavioral health population

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Incentive Payment

DMAHS requires MCOs to pay an increased fee to providers for each EPSDT screening examination. This incentive motivates providers to conduct age-appropriate screenings which can lead to early awareness of childhood health conditions and support better health outcomes. EPSDT screenings must reflect the age of the child and be provided according to the American Academy of Pediatrics/Bright Futures published recommendation, or when considered medically necessary. MCOs are reimbursed for this increased fee through monthly capitation payments.

Performance Based Contracting Program

NJ DMAHS monitors all performance payments regularly to ensure that measures remain appropriate for focus. Performance pool payments are used to leverage competitive dynamics and incentivize managed care performance in achieving State defined benchmarks. To be eligible, MCOs must be NCQA Accredited and earn a 3.5 star rating based on HEDIS and CAHPS reporting, as determined by NCQA.

As part of the performance payment pool, each eligible MCO currently may receive a financial incentive for each successfully attained benchmark in the following measures:

- pre-term birth rate <9.25%
- pre-natal care timeliness $\geq$ NCQA 75th percentile
- post-partum care timeliness $\geq$ NCQA 75th percentile
- hemoglobin A1c (HbA1c) scores less than 8 $\geq$ NCQA 75th percentile
- body mass index (BMI) documentation for children and adolescents $\geq$ NCQA 75th percentile

MCOs that meet 3 of the 5 benchmarks above qualify for a high performance incentive payment. The payment pool is divided equally amongst qualifying MCOs.

Specific to the MLTSS Home and Community Based performance payment, bonus payments will be awarded to those MCOs that score highest in care management performance metrics. Data is collected and scored by the EQRO annually. Performance based measures described above are subject to change based upon the goals of the Division. For the MLTSS bonus payment, MCOs are scored in:

- Timely plans of care established upon enrollment into MLTSS
- Plans of Care aligned with member needs based on clinical assessments
- Plans of Care developed using person-centered principles
- Evidence of member training to identify and report critical incidents
- Evidence of care management reviews and resolution of gaps in care

Intermediate Sanctions

Per 42 CFR §438.700 (subpart I), DMAHS has established intermediate sanctions that it may impose if it makes any of the determinations below. Determinations may be made on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

- ❖ If DMAHS determines that an MCO acts or fails to act as follows:
    - Failure to substantially provide medically necessary services to enrollees
    - Imposition of excess co-payments, premiums, or charges on enrollees
    - Discrimination among enrollees on the basis of health status or need for services
    - Misrepresentation or falsify information submitted to DMAHS or CMS
    - Misrepresentation or falsify information to enrollees, members, or providers
    - Fails to comply with requirements for physician incentive plans
- ❖ If DMAHS determines that an MCO has distributed marketing materials, directly or indirectly, that have not been approved by the State or that contain false or materially misleading information
- ❖ If DMAHS determines that the MCO has violated requirements of the Social Security Act

DMAHS uses a progressive disciplinary approach, further outlined in the Managed Care Contract and below, to address MCO noncompliance and deficiencies. DMAHS determines disciplinary action based on the nature and severity of the violation – in some instances, disciplinary action may not follow the linear progression outlined below.

Corrective Action Plan (CAP)

MCOs are required to submit and implement Corrective Action Plans (CAPs) for activities resulting in noncompliance as identified by DMAHS. Per 7.16.J of the Managed Care Contract, CAPs must be submitted within ten (10) business days of notification or within a timeframe otherwise determined by DMAHS. Failure to submit timely or acceptable plans may result in monetary damages.

Notice of Deficiency (NOD)

Should DMAHS determine noncompliance with program standards, performance standards or terms of the Contract, it will issue a formal Notice of Deficiency (NO D). Within the NOD, DMAHS will request a written Corrective Action Plan with timeframes to cure the deficiency, if one is not already in place. DMAHS may also request additional documentation such as policies, procedures, or evidence of

improvements. If the MCO fails to cure the deficiency as ordered, DMAHS reserves the right to exercise liquidated damages and/or administrative sanction options described below.

Liquidated Damages (LD)

As described in section 7.16 of the Managed Care Contract, DMAHS may impose liquidated damages as a disciplinary action. LDs may also be issued should the MCO not produce/deliver timely and accurate reports (7.16.3-4). NJ outlines specific LDs in the Managed Care Contract related to issues with financial reporting, encounter data, and timely payment to providers. NJ adds or modifies LDs through biannual contract amendments, as necessary.

Administrative Sanctions

DMAHS holds the right to exercise any of the administrative sanctions listed in the Managed Care Contract should the MCO fail to correct a deficiency in the manner identified or in the timeframe noted in the written notice. The type of action taken shall be in relation to the nature and severity of the deficiency. Examples of administrative sanctions include, but are not limited to:

- Suspend enrollment of beneficiaries into the Contractor's plan;
- Notify enrollees of Contractor non-performance and permit enrollees to transfer to another MCO without cause;
- Reduce or eliminate marketing and/or community event participation;
- Terminate the Contract (under provisions of Article 7);
- Cease auto-assignment of new enrollees;
- Refuse to renew the Contract;
- Impose and maintain temporary management during the period in which improvements are to be made to correct violations;
- Refer the matter, as appropriate, to other State or Federal agencies for further action;

Managed Care Performance Accountability Reviews

As a mechanism to maintain transparency with managed care partners while holding them accountable for continuous improvements to quality, NJ DMAHS holds monthly MCO accountability reviews on a rotating schedule. Each review is preceded by an extensive, internal DMAHS discussion of that MCO's contract compliance, interdisciplinary performance metrics, and open action plans. Each review covers relevant metrics or trends pertinent to the Core Medicaid, MLTSS, and FIDE SNP operations. DMAHS uses these meetings to highlight strengths, opportunities for improvement, and concerning findings. Repeat findings or concerning trends may result in actions listed above.

Health Information Technology

NJ's health information systems and technology initiatives support the overall execution and review of the Quality Strategy. Inefficiencies in health system integrations can create information silos and impede care coordination. NJ is engaged in specific initiatives, such as improvements to the Integrated Eligibility System, to streamline member enrollment and eligibility renewal. Similarly, DMAHS is continuing initiatives under Health Information Technology for Economic and Clinical Health (HITECH), such as promoting investments to enhance the quality of data exchange between providers and improve the operational processes in the MMIS and the overall Medicaid Enterprise Systems.

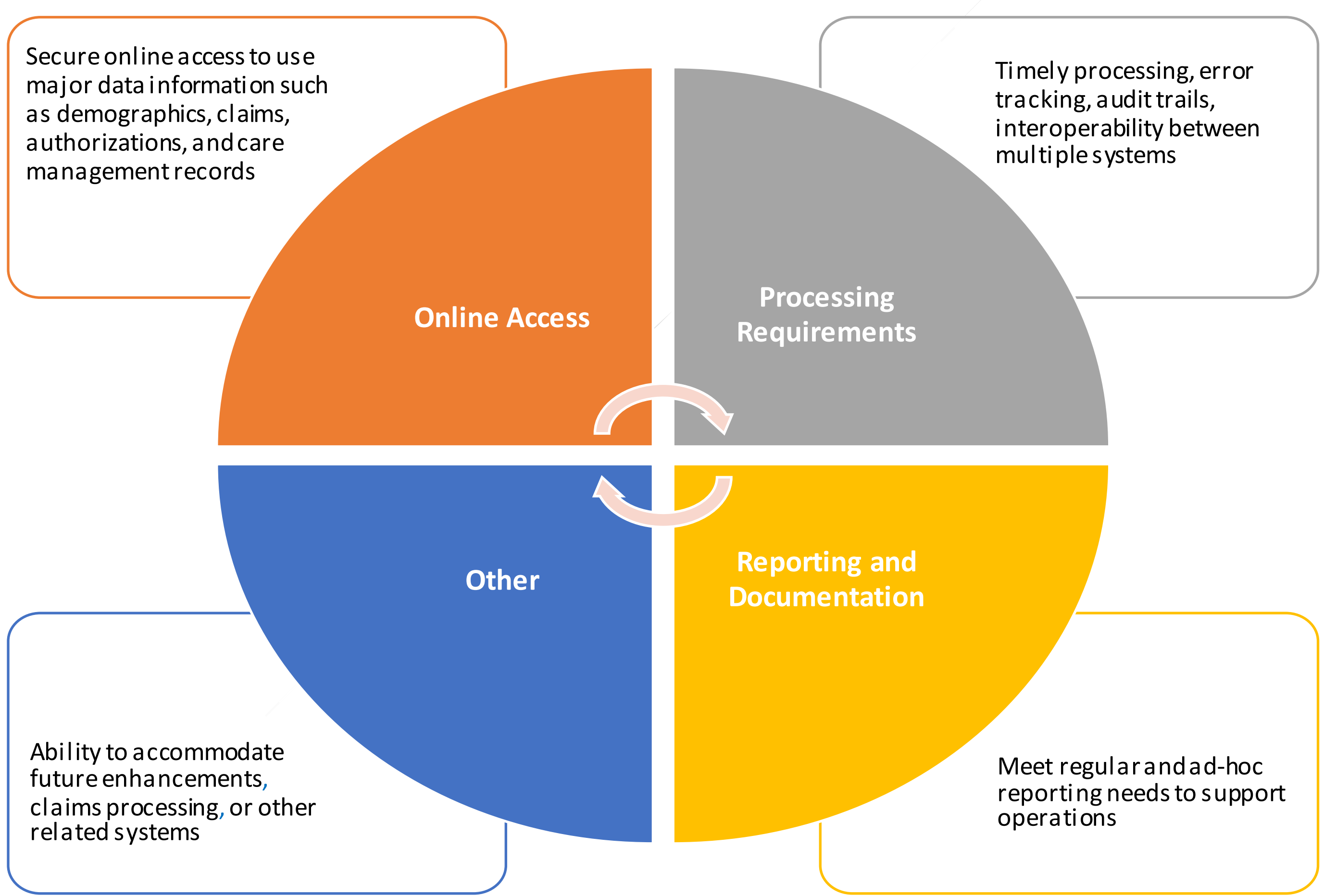
Electronic Visit Verification (EVV)

Section 12006 of the Twenty First Century Cures Act and CMS mandated that EVV be required for all personal care services by January 1, 2020. DMAHS received approval for a good faith exemption to the January 2020 mandate – New Jersey's EVV system went live on January 1, 2021. EVV is an example of technology enhancements designed to improve program integrity – personal care visits are required to be tracked and verified to ensure beneficiaries are receiving the care they need. Over time, this system will support provider quality reviews and MCO accountability for service delivery.

MCO Health Information Systems

As required by the Contract, an MCO's health information system must be sophisticated enough to meet current requirements, and respond to future requirements, set forth by the Contract. MCOs with more than one system must have the ability to integrate systems effectively and efficiently to provide for combined reporting, and to support required processing functions. Requirements can be categorized into four types, as seen in figure 5 below.

Figure 5: Health Information Systems Managed Care Requirements



Conclusions and Opportunities

NJ remains committed to ongoing development, monitoring, and evaluating of a comprehensive Quality Strategy aimed to improve the quality of care for NJ FamilyCare members. As the program continues to embrace CMS's triple aim – better care, smarter spending, and healthier communities – DMAHS

recognizes the opportunities that remain. Ongoing review and revisions of the NJ Quality Strategy continue to be a real-time, iterative process with internal and external stakeholder engagement.

Appendix A: CMS Regulatory Crosswalk

The following chart lists the required and recommended elements for the State Quality Strategy and corresponding sections in the NJ DMAHS Quality Strategy which address each element.

Section I: Introduction

Table 1—Introduction

Regulatory Reference	Description	Page
Optional	Include a brief history of the state's Medicaid and CHIP managed care programs.	3
Optional	Include an overview of the quality management structure that is in place at the state level. For example, how is the leadership team structured, are there any quality task forces, an MCO collaborative, etc.?	4
Optional	Include general information about the state's decision to contract with MCOs/PIHPs (e.g., to address issues of cost, quality, and/or access). Include the reasons why the state believes the use of a managed care system will positively impact the quality of care delivered in Medicaid and CHIP.	6
Optional	Include a description of the goals and objectives of the state's managed care program. This description should include priorities, strategic partnerships, and quantifiable performance driven objectives. These objectives should reflect the state's priorities and areas of concern for the population covered by the MCO/PIHP contracts.	15
§438.340	Include a description of the formal process used to develop the quality strategy	9
§438.340	Include a description of how the state obtained the input of beneficiaries and other stakeholders in the development of the quality strategy.	10
§438.340(c)(1)	Include a description of how the state made (or plans to make) the quality strategy available for public comment before adopting it in final.	9
§438.340(c)(2)(i)	Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).	10
§438.340(b)(11) and (c)(3)(ii)	Include a timeline for modifying or updating the quality strategy. If this is based on an assessment of "significant change," include the state's definition of "significant change".	10

Section II: Assessment

Table 2—Assessment

Regulatory Reference	Description	Page
§438.330(3)(b)(4)	Summarize state procedures that assess the quality and appropriateness of care and services furnished to all Medicaid members under the MCO and PIHP contracts, and to individuals with special health care needs.	21, 22
§438.330(e)(b)(4)	Include the state's definition of special health care needs.	22
§438.340(b)(6)	Detail the methods or procedures the state uses to identify the race, ethnicity, and primary language spoken of each Medicaid member. States must provide this information to the MCO and PIHP for each Medicaid member at the time of enrollment.	24

Optional	Document any efforts or initiatives that the state or MCO/PIHP has engaged in to reduce disparities in healthcare.	11

Table 3—National Performance Measures

Regulatory Reference	Description	Page
§438.330(c)(1)(i)	Include a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders.	15
Optional	Indicate whether the state plans to voluntarily collect any of the CMS core performance measures for children and adults in Medicaid/CHIP If so, identify state targets/goals for any of the core measures selected by the state for voluntary reporting.	NA

Table 4—Monitoring and Compliance

Regulatory Reference	Description	Page
§438.66	Detail procedures that account for the regular monitoring and evaluation of MCO and PIHP compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards). Some examples of mechanisms that may be used for monitoring include, but are not limited to: • Member or provider surveys • HEDIS results • Report Cards or profiles • Required MCO/PIHP reporting of performance measures • Required MCO/PIHP reporting on PIPs • Grievance/Appeal logs	13, 14, 15

Table 5—External Quality Review (EQR)

Regulatory Reference	Description	Page
§438.350(a)	Include a description of the state's arrangements for an annual, external independent quality review of the quality, access, and timeliness of the services covered under each MCO and PIHP contract. Identify what entity will perform the EQR and for what period of time	11
Optional	Identify what, if any, optional EQR activities the state has contracted with its External Quality Review Organization (EQRO) to perform. The five optional activities include: 1. Validation of encounter data reported by an MCO or PIHP 2. Administration or validation of consumer or provider surveys of quality of care 3. Calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO 4. Conduct PIPs in addition to those conducted by an MCO or PIHP and validated by an EQRO	11

	5. Conduct studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.	
§438.350(c)	Identify the standards for which the EQR will use information from Medicare or private accreditation reviews. This must include an explanation of the rationale for why the Medicare or private accreditation standards are duplicative to those in 42 CFR §438.204(g).	16
438.360(a)(2)	If applicable, for MCOs or PIHPs serving only dual eligible, identify the mandatory activities for which the state has exercised the non-duplication option under §438.360(c) and include an explanation of the rationale for why the activities are duplicative to those under §438.358(b)(1) and (b)(2).	16

Section III: State Standards

Table 6—State Standards

Regulatory Reference	Description	Page
	§438.206 Availability of Services	
§438.206(b)(1)	Maintains and monitors a network of appropriate providers	17
§438.206(b)(2)	Female members have direct access to a women's health specialist	17
§438.206(b)(3)	Provides for a second opinion from a qualified healthcare professional	17
§438.206(b)(4)	Adequate and timely coverage of services not available in network	17
§438.206(b)(5)	Out-of-network providers coordinate with the MCO or PIHP with respect to payment	17
§438.206(b)(6)	Credential all providers as required by §438.214	23
§438.206(c)(1)(i)	Providers meet state standards for timely access to care and services	17
§438.206(c)(1)(ii)	Network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service	17
§438.206(c)(1)(iii)	Services included in the contract available 24 hours a day, 7 days a week	17
§438.206(c)(1)(iv)-(vi)	Mechanisms to ensure compliance by providers	
§438.206(c)(2)	Culturally competent services to all members	18, 22
	§ 438.207 Assurances of Adequate Capacity and Services	
§438.207(a)	Assurances and documentation of capacity to serve expected enrollment	19
§438.207(b)(1)	Offer an appropriate range of preventive, primary care, and specialty services	19
§438.207(b)(2)	Maintain network sufficient in number, mix, and geographic distribution	19
	§ 438.208 Coordination and Continuity of Care	
§438.208(b)(1)	Each member has an ongoing source of primary care appropriate to his or her needs	21
§438.208(b)(2)	All services that the member receives are coordinated with the services the member receives from any other MCO/PIHP	21
§438.208(b)(4)	Share with other MCOs, PIHPs, and PAHPs serving the member with special health care needs the results of its identification and assessment to prevent duplication of services	21

§438.208(b)(6)	Protect member privacy when coordinating care	21, 23
§438.208(c)(1)	State mechanisms to identify persons with special health care needs	22
§438.208(c)(2)	Mechanisms to assess members with special health care needs by appropriate healthcare professionals	22
§438.208(c)(3)	If applicable, treatment plans developed by the member's primary care provider with member participation, and in consultation with any specialists caring for the member; approved in a timely manner; and in accord with applicable state standards	22
§438.208(c)(4)	Direct access to specialists for members with special health care needs	22
	§ 438.210 Coverage and Authorization of Services	
§438.210(a)(1)	Identify, define, and specify the amount, duration, and scope of each service	21
§438.210(a)(2)	Services are furnished in an amount, duration, and scope that is no less than the those furnished to beneficiaries under fee-for-service Medicaid	21
§438.210(a)(3)(i)	Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished	21
§438.210(a)(3)(ii)	No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition	21
§438.210(a)(4)(i)	Each MCO/PIHP may place appropriate limits on a service, such as medical necessity	21
§438.210(C)(5)	Specify what constitutes “medically necessary services”	21
§438.210(D)(b)(1)	Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services	21
§438.210(D)(b)(2)(i)	Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	21
§438.210(D)(b)(d)	Any decision to deny or reduce services is made by an appropriate healthcare professional	22
§438.210(D)(b)(d)	Each MCO/PIHP must notify the requesting provider, and give the member written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested Page 49 §438.210(d) Provide for the authorization decisions and notices as set	22
§438.210(e)	Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services	21

Table 7—Structure and Operation Standards

Regulatory Reference	Description	Page
	§438.214 Provider Selection	
§438.214(a)	Written policies and procedures for selection and retention of providers	23
§438.214(b)(1)	Uniform credentialing and recredentialing policy that each MCO/PIHP must follow	23
§438.214(b)(2)	Documented processes for credentialing and recredentialing that each MCO/PIHP must follow	23

§438.214(c)	Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment	23
§438.214(d)	MCOs/PIHPs may not employ or contract with providers excluded from Federal healthcare programs	23
	§438.10 Member Information	
§438.10	Incorporate member information requirements of §438.10	23
	§438.224 Confidentiality	
§438.224	Individually identifiable health information is disclosed in accordance with Federal privacy requirements	23
	§438.56 Enrollment and Disenrollment	
§438.56	Each MCO/PIHP contract complies with the enrollment and disenrollment requirements and limitations set forth in §438.56	24
	§438.228 Grievance Systems	
§438.228(a)	Grievance systems meet the requirements of Part 438, subpart F	16
§438.228(b)	If applicable, random state reviews of notice of action delegation to ensure notification of members in a timely manner	16
	§438.230 Subcontractual Relationships and Delegation	
§438.230(b)(1)	Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities	24
§438.230(b)(1)	Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform	24
§438.230(c)(1)(i)	Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	24
§438.230(c)(1)(iii)	Monitoring of subcontractor performance on an ongoing basis	24
§438.230(c)(1)(iii)	Corrective action for identified deficiencies or areas for improvement	24
	§ 438.236 Practice Guidelines	
§438.236(b)	Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field; 2) consider the needs of members; 3) are adopted in consultation with contracting healthcare professionals; and 4) are reviewed and updated periodically, as appropriate.	24
§438.236(c)	Dissemination of practice guidelines to all providers, and upon request, to members	24
	§ 438.330 Quality Assessment and Performance Improvement Program	
§438.330(a)(3)	Each MCO and PIHP must have an ongoing quality assessment and performance improvement program	10
§438.330(b)(1)	Each MCO and PIHP must conduct PIPs List out PIPs in the quality strategy	13, 14
§438.330(b)(2)	Each MCO and PIHP must submit performance measurement data as specified by the state	12, 15
	List out performance measures in the quality strategy	42
§438.330(b)(3) overutilization of services	Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services	11

§438.330(b)(4)	Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to members with SHCN	22
§438.330(e)	Annual review by the state of each quality assessment and performance improvement program. If the state requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy.	11
§ 438.242 Health Information Systems		
§438.242(a)	Each MCO and PIHP must maintain a health information system that can collect, analyze, integrate, and report data	28
§438.242(b)(2)	Each MCO and PIHP must collect data on member and provider characteristics and on services furnished to members	28
§438.242(b)(2)	Each MCO and PIHP must ensure data received is accurate and complete	28

Section IV: Improvement and Interventions

Table 8—Improvement and Interventions

Regulatory Reference	Description	Page
Optional	Describe, based on the results of assessment activities, how the state will attempt to improve the quality of care delivered by MCOs and PIHPs through interventions such as, but not limited to: Cross-state agency collaborative; Pay-for-performance or VBP initiatives; Accreditation requirements; Grants; Disease management programs; Changes in benefits for members; Provider network expansion, etc.	25, 26
Optional	Describe how the state's planned interventions tie to each specific goal and objective of the quality strategy.	-

Table 9—Intermediate Sanctions

Regulatory Reference	Description	Page
§438.340(b)(7)	For MCOs, detail how the state will appropriately use intermediate sanctions that meet the requirements of 42 C.F.R. Part 438, subpart I.	26, 27
Optional	Specify the state's methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems.	-

Table 10— Health Information Technology

Regulatory Reference	Description	Page
§438.340	Detail how the state's information system supports initial and ongoing operation and review of the state's quality strategy.	28
Optional	Include any HIT initiatives that will support the objectives of the state's quality strategy	-

Section V: Delivery System Reforms

Table 11—Delivery System Reforms

Regulatory Reference	Description	Page
Optional	Describe the reasons for incorporating this population/service into managed care. Include a definition of this population and methods of identifying members in this population.	-
Optional	List any performance measures applicable to this population/service, as well as the reasons for collecting these performance measures.	-
Optional	List any PIPs that are tailored to this population/service. This should include a description of the interventions associated with the PIPs.	-
Optional	Address any assurances required in the state's Special Terms and Conditions (STCs), if applicable.	-

Section VI: Conclusions and Opportunities

Table 12— Conclusions and Opportunities

Regulatory Reference	Description	Page
Optional	Identify any successes that the state considers to be best or promising practices.	-
Optional	Include a discussion of the ongoing challenges the state faces in improving the quality of care for beneficiaries	-
Optional	Include a discussion of challenges or opportunities with data collection systems, such as registries, claims or enrollment reporting systems, pay-for-performance tracking or profiling systems, electronic health record (EHR) information exchange, regional health information technology collaborative, telemedicine initiatives, grants that support state HIT/EHR development or enhancement, etc.	-
Optional	Include a discussion of challenges or opportunities with data collection systems, such as registries, claims or enrollment reporting systems, pay-for-performance tracking or profiling systems, electronic health record (EHR) information exchange, regional health information technology collaborative, telemedicine initiatives, grants that support state HIT/EHR development or enhancement, etc.	-

Appendix B: Goals Tracking Table

This section of the appendix highlights DMAHS goal tracking and monitoring – this tracking table is regularly modified as DMAHS adjusts priorities, enhances measures and specifications, and revises targets to improve quality across the NJ FamilyCare program. This table is not comprehensive of all objectives and measures.

DMAHS Goal	DMAHS Objective	Measure Name	Measure Specification	Target
CMS Aim #1: Better Care				
Goal #1: Serve people the best way possible through benefits, service delivery, quality, and equity	1.1: Improve maternal/child health outcomes	Prenatal and Postpartum Care	HEDIS PPC	NCQA 75th percentile
		Perinatal Risk Assessment (PRA) completion	N/A	Annual increase against baseline
		Well Child Visits	HEDIS W30, HEDIS WCV	NCQA 75th percentile
		Pediatric Dental Quality	CMS-416, NJ State Specific Measures	55% for NJ Specific
	1.2: Help members with physical, cognitive, or behavioral health challenges get better coordinated care	Core Medicaid Care Management Audits	EQRO	85%
		Autism service utilization	Measures in development	TBD
	1.3: Support independence for all older adults and people with disabilities who need help with daily activities	MLTSS Care Management Audits	EQRO	86%
		HCBS Unstaffed Cases/ Workforce Challenges	MCO Accountability Reporting	0% of cases >30 days
		Nursing Facility Transition/Diversion Reporting	MLTSS Performance Measures	≥ 246 transitions per month; ≤ 18 admissions to NF per month
CMS Aim #2: Smarter Spending				
Goal #2: Experiment with new ways to solve problems through innovation, technology, and troubleshooting	2.1: Monitor fiscal accountability and manage risk	Minimum Loss Ratio (CMS Final Managed Care Rule)	DMAHS Finance	85% (non-MLTSS), 90% (MLTSS)
	2.2: Demonstrate new value-based models that drive outcomes	Perinatal Episode of Care Payment Metrics	Measures in development	
		MCO Primary Care Home Models	Measures in development	TBD
		COVID-19 Vaccine Incentives	MCO Reporting	90th percentile among State Medicaid programs
	2.3: Use new systems and technologies to improve program operations	Eligibility Redeterminations – *measures under development*	CMS Reporting	TBD
		MMIS provider module –	*Measures in development*	TBD

		Electronic Visit Verification (EVV) Compliance	DMAHS Managed Care Reporting	100%
CMS Aim 3: Healthier people, healthier communities				
Goal #3: Focus on integrity and real outcomes through accountability, compliance, metrics, and management	3.1: Address racial and ethnic disparities in quality of care and health outcomes	Breast Cancer Screening	HEDIS BCS	NCQA 75th percentile
		COVID-19 Vaccination Rates	MCO Reporting	90th percentile among State Medicaid programs
		Cervical Cancer Screening	HEDIS CCS	NCQA 75th percentile
	3.2: Hold operational partners accountable for ensuring a stable, accessible, and continuously improving program for our members and providers	Network Adequacy Reporting	DMAHS Accountability	under redevelopment
		MCO 1:1 performance accountability series	DMAHS Accountability	Case specific
		Operational Partner Scorecards	Measures in Development	TBD
	3.3: Ensure program integrity and compliance with State and Federal requirements	T-MSIS data quality	DMAHS IT	Gold status by Jan 2022 Blue status by Jan 2023
		Medicaid Provider Revalidation	DMAHS/Gainwell	Achieve and maintain full compliance

Appendix C: Managed Care Reporting Requirements

This section of the appendix includes examples of Managed Care reporting requirements as they relate to the Quality Strategy. This list is not comprehensive and is subject to changes.

REPORT TITLE	DESCRIPTION	FREQUENCY
Availability of Services §438.206 §438.207		
Provider Network Files	• Report of all providers in MCO's network • Demonstrate compliance with provider network requirements	Quarterly
MLTSS Provider Network Files	• Report of al MLTSS providers in MCO's network • Demonstrate compliance with MLTSS network requirements	Quarterly
Insure Kids Now/CHIPRA Dental Network File		Quarterly
MLTSS Network Development Plan	• Plan to demonstrate adequacy and sufficiency of MLTSS network • Track and trend deficiencies • Provide evidence of efforts to cure deficiencies	Annual
Geographic Accessibility	• Evidence of maintain networks that comply with DMAHS geoaccess standards	Quarterly
Changes in large provider groups, IPAs, subnetworks		Adhoc
Provider Network Requirements Policies and Procedures		Adhoc
Providers using electronic health records	• Utilization of EHR technology	Quarterly
Provider spot check	• Verify the accuracy of MCO provider network file	Monthly
Claims inactivity report	• Identify providers in network without evidence of serving members via claim activity	Quarterly
Provider termination reports	• report of providers and/or subcontractors who have been terminated or withdrew from the MCO's respective provider network and the reason(s) for such terminations and withdrawals	Ad Hoc
Encounter data	• Electronic Submission of Encounter Data - Utilization and Medical Expenditure Summary	Monthly
	•	

REPORT TITLE	DESCRIPTION	FREQUENCY
Assurances of adequate capacity of services §438.207		
Medicaid enrollment by PCP	• Electronic submission of Medicaid enrollment by PCP	Quarterly
MLTSS Telephone Statistics	• Monthly and quarterly call phone statistics including calls received, calls abandoned, calls answered within 30 seconds, average speed of answer	Monthly, Quarterly
24 hour access report	• Evidence of 24 hour access to primary care physicians and dentists	Annual
Appointment availability studies	• List the average time that enrollees wait for appointments to be scheduled in each of the following categories: baseline physical, routine, specialty, and urgent care appointments. DMAHS must approve the methodology for this review	Annual
	•	

REPORT TITLE	DESCRIPTION	FREQUENCY
Coordination and Continuity of Care §438.208		
Staffing positions and Organizational Charts	• Material detailing individuals at each position, vacancies, status of filling positions, staff changes, and restructuring of organization	Annual
Care Management Program Description and Evaluation	• Monthly and quarterly call phone statistics including calls received, calls abandoned, calls answered within 30 seconds, average speed of answer	Annual
Coverage and Authorization of Services §438.210		
Summary of Contractor Initiated TPL Recovery Actions		Quarterly
Pharmacy Prior Authorization/Denial		Quarterly
Prior Authorization Process for Mental Health Prescriptions		Adhoc
REPORT TITLE	**DESCRIPTION**	**FREQUENCY**
Enrollment and Disenrollment §438.56		
MLTSS Voluntary Withdrawal Form		Weekly
Participant Involuntary Disenrollment Form		Weekly
REPORT TITLE	**DESCRIPTION**	**FREQUENCY**
Grievance Systems §438.228		
System & Procedure for the Receipt/Adjudication of Complaints and Grievances by Enrollee		Annual/OQA AdHoc
Provider Grievances, Appeals, and Inquiries		Quarterly
UM and non-UM Member Grievances and Appeals		Quarterly
REPORT TITLE	**DESCRIPTION**	**FREQUENCY**
Subcontractual Relationships and Delegation §438.230		
Written Request and Plan for Active Oversight to Delegate/Subcontract QAPI Activities	• All subcontracts must be reviewed and approved by DMAHS prior to execution.	Adhoc
Lists of Names, Addresses, Ownership, Control Information of Participating Providers and Subcontractors		Annual
All subcontracts	• All subcontracts must be reviewed and approved by DMAHS prior to execution	As needed
REPORT TITLE	**DESCRIPTION**	**FREQUENCY**
Practice Guidelines §438.236		
Provider Manual, Provider Quick Reference Guide and Updates	•	Annual
REPORT TITLE	**DESCRIPTION**	**FREQUENCY**

REPORT TITLE	DESCRIPTION	FREQUENCY
Quality Assessment and Performance Improvement (QAPI) §438.330		
QAPI Work Plan	• Work plan of expected QAPI accomplishments	Annual
QAPI Evaluation Prior Year	• Evaluation of prior year's QAPI work plan – accomplishments, compliance, deficiencies	Annual
QAPI Documentation	• Documentation of all QAPI activities conducted throughout the year	Annual
REPORT TITLE	**DESCRIPTION**	**FREQUENCY**
Health Information Systems §438.242		
Encounter Data - Utilization and Medical Expenditure Summary		Monthly
Pharmacy encounter data		Monthly
Claim lag reports		Quarterly
Claim inactivity reports		Quarterly
Claims paid under MAPS program		Quarterly
Invoice Identifying the Additional Enhanced Payments for Qualifying Physicians		Quarterly
Additional Capitation Funds Distribution Plan, Payment for Increased Access to Physician Services Reports		Quarterly
Electronic Submission of FQHC Payments		Quarterly
REPORT TITLE	**DESCRIPTION**	**FREQUENCY**
Delivery System Reforms		
New Quality Improvement Project Proposal	• A written description of the PIP the MCO proposes to conduct	Adhoc
Quality Improvement Project Progress Report	• Twice yearly, the MCO must produce a progress report for each current PIP project	Semi-Annual
Final Report on Sustainable Quality Improvement Project	• Upon completion of a PIP, a final written report must be submitted that includes a detailed narrative of the overall project.	Adhoc

Appendix D: Performance Measures

The following chart details some of the performance measures collected to measure and monitor Managed Care quality. DMAHS receives all HEDIS measures annually – the below are measures that DMAHS is currently monitoring, closely. This list may not be comprehensive of all reported/collected measures.

Measure	Steward
Healthcare Effectiveness Data and Information (HEDIS)	
Childhood Immunization (CIS)	NCQA
Lead Screening in Children (LSC)	NCQA
Well-Child Visits in the First 30 Months of Life (W30)	NCQA
Well-Child Visits)	NCQA
Breast Cancer Screening (BCS)	NCQA
Cervical Cancer Screening (CCS)	NCQA
Comprehensive Diabetes Care (CDC)	NCQA
Controlling High Blood Pressure (CBP)	NCQA
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NCQA
Statin Therapy for Patients with Cardiovascular Disease (SPC)	NCQA
Prenatal and Postpartum Care (PPC)	NCQA
Immunizations For Adolescents (IMA)	NCQA
Appropriate Testing for Pharyngitis (CWP)	NCQA
Appropriate Treatment for Upper Respiratory Infection (URI)	NCQA
Chlamydia Screening (CHL)	NCQA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	NCQA
Adult BMI Assessment (ABA)	NCQA
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	NCQA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	NCQA
Antidepressant Medication Management (AMM)	NCQA
Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	NCQA
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)	NCQA
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	NCQA
Children and Adolescents' Access to Primary Care Practitioners (CAP)	NCQA
Adults' Access to Preventive/Ambulatory Health Services (AAP)	NCQA
Asthma Medication Ratio (AMR)	NCQA
FIDE SNP HEDIS Monitoring	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	NCQA
Pharmacotherapy Management of COPD Exacerbation (PCE)	NCQA

Pharmacotherapy Management of COPD Exacerbation (PCE)	NCQA
Osteoporosis Management in Women Who Had a Fracture (OMW)	NCQA
Antidepressant Medication Management (AMM)	NCQA
Follow-up After Hospitalization for Mental Illness (FUH)	NCQA
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)2	NCQA
Use of High-Risk Medications in the Elderly (DAE)	NCQA
Plan All-Cause Readmissions (PCR) 2,3,5	NCQA
Core Set and NJ Specific measures	
Annual Dental Visit (ADV)	NCQA
Use of Opioids at High Dosage (HDO)	NCQA
Use of Opioids From Multiple Providers (UOP)	NCQA
Risk of Continued Opioid Use (COU)	NCQA
Plan All-Cause Readmissions (PCR)	NCQA
Ambulatory Care - Outpatient Visits per Thousand Member Months (AMB)	NCQA
Ambulatory Care - Emergency Room Visits per Thousand Member Months (AMB)	NCQA
Preventive Dental Visit	NJ DMAHS
Developmental Screening	OHSU
Diabetes Short-Term Complications Admission (PQI01) - Admissions per 100,000 Member Months	AHRQ
Contraceptive Care - Postpartum Women	OPA
Contraceptive Care - All Women	OPA

The following chart details performance measures collected to measure and monitor MCO quality and effectiveness for the MLTSS program. This list may not be comprehensive of all reported/collected measures.

PM #	Performance Measure Description	Reported by	Frequency
PM 03	Nursing Facility Level of Care Assessments conducted by the MCO determined to be "Not Authorized"	DoAS	quarterly
PM 04	Timeliness of Nursing Facility Level of Care Assessment by MCO	MCO	monthly
PM 04a	Timeliness of Nursing Facility Level of Care Assessment by OCCO/ADRC	DoAS	monthly
PM 05	Timeliness of Nursing Facility Level of Care Re-determinations	DoAS	quarterly
PM 07	Members offered a choice between Institutional and HCBS Settings	DoAS	monthly
PM 08	Plans of Care established within 45 days of MLTSS enrollment	EQRO	annually
PM 09	Plans of Care reassessment for MLTSS members conducted within 30 days of annual level of care re-determination	EQRO	annually
PM 09a	Plans of Care amended based on change of member condition	EQRO	annually
PM 10	Plans of Care are aligned with members needs based on the results of the NJ Choice assessment	EQRO	annually

PM 11	Plans of Care developed using Person-Centered Principles	EQRO	annually
PM 12	MLTSS Home and Community Based Services (HCBS) Plans of Care that include a back-up plan	EQRO	annually
PM 13	MLTSS HCBS services are delivered in accordance with the Plan of Care, including the type, scope, amount, frequency, and duration	EQRO	annually
PM 16	MCO member training on identifying/reporting Critical Incidents	EQRO	annually
PM 17	Timeliness of Critical Incident written reporting within 2 business days	DoAS	monthly
PM 17a	Timeliness of Critical Incident reporting (verbally within 1 business day) for media and unexpected death incidents	DoAS	monthly
PM 18	Critical Incident Reporting	MCO	quarterly and annually
PM 19	Tables 3A/3B - Appeals and Grievances for MLTSS members	MCO	quarterly
PM 20	MLTSS Members receiving MLTSS services	MCO	quarterly and annually
PM 21	MLTSS Members who Transitioned from NF to the Community	MCO	quarterly and annually
PM 23	MLTSS NF to HCBS Transitions who returned to NF within 90 days	MCO	quarterly and annually
PM 26/27	Acute Inpatient Utilization by MLTSS Members (HEDIS IPU)	MCO	quarterly and annually
PM 28/29	All Cause Readmissions of MLTSS Members to Hospital within 30 Days (HEDIS PCR)	MCO	quarterly and annually
PM 30/31	Emergency Department Utilization by MLTSS Members (HEDIS AMB)	MCO	quarterly and annually
PM 33/34/41	MLTSS Services used by MLTSS HCBS Members - PCA and/or Medical Day only	MCO	quarterly and annually
PM 36/38	Follow-Up after Mental Health Hospitalization for MLTSS Members (HEDIS FUH)	MCO	quarterly and annually
PM 42/43	Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence for MLTSS Members (HEDIS FUA)	MCO	quarterly and annually
PM 44/45	Follow-Up after Emergency Department Visit for Mental Illness for MLTSS Members (HEDIS FUM)	MCO	quarterly and annually
PM 46	MLTSS HCBS Members not receiving MLTSS HCBS, PCA or Medical Day Services	MCO	quarterly and annually
PM 47	Post-hospital Institutional Care for MLTSS HCBS Members	MCO	annually
PM 48/49	Hospitalization for MLTSS Members with Potentially Preventable Complications (HEDIS HPC)	MCO	annually
PM 50/51	Follow-Up After Emergency Department Visit for MLTSS Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)	MCO	annually
PM 52/53	Care for Older Adults for MLTSS Members (HEDIS COA)	MCO	annually

PM 54	New MLTSS members with MLTSS services initiated within 120 days of enrollment	MCO	annually

Appendix E: EQRO Annual Technical Report

Below is a copy of the latest External Quality Review (EQR) Annual Technical Report.

Medicaid and MLTSS Quality Report 2021

Appendix F: Performance Improvement Projects

MCO	Topic	Key Interventions*
Aetna Better Health NJ	**EPSDT focused PIP**	• *Project proposal is in development*
	MCO Adolescent Risk Behaviors and Depression Collaborative	• Complete person-to-person outreach campaigns while in the provider setting to encourage adherence with adolescent well-care (AWC) visits • Implement state approved AWC incentive program and track adherence by provider • Provide training and guidance to participating providers specifying areas of priority for targeted performance improvement • EPSDT mailers sent to all eligible members encouraging timely well child visits
	Improving PCP Access and Availability (Non-Clinical – Core Medicaid)	• Provide targeted PCPs with a monthly roster identifying new members for future outreach to promote scheduling a baseline appointment • Provide targeted PCPs a monthly list of members evaluated in the ER with a LANE diagnosis for future follow-up by the PCP to establish a relationship and schedule an annual visit • Identify members assigned to a PCP practice without claims to educate on the importance of regular visits for preventive care • Distribute an educational flyer to members educating on the appropriate use of the ER
	Reduction in ER and IP Utilization Through Enhanced Chronic Disease Management	• All HCBS members who meet the eligibility criteria will also have a condition specific assessment completed at each face to face visit and disease specific plan person-centered plan of care created • All members with an IP stay will have a completed follow up visit with their PCP, or specialist within 30 days of notification of discharge
Amerigroup	**EPSDT focused PIP**	• *Project proposal is in development*
	MCO Adolescent Risk Behaviors and Depression Collaborative	• Educate providers quarterly on the importance of privacy to elicit honest responses to risk behavior screenings • Distribute sample screening tools to providers quarterly during educational visits • Distribute scorecards to providers containing the results of the medical record review • Educate the providers on the 5 risk behaviors and referral resources following a positive screening
	Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members (Non-Clinical – Core Medicaid)	• Provide online education to identified providers regarding the utilization of the Telehealth option – to increase office hours • Quarterly meeting with identified providers for education and discussion of barriers – of appointment availability • Monitoring the number of PCP visits for providers who received education and barrier discussions • Triannual text messaging to attributed members who have not had a PCP visit

MCO	Project	Interventions
	Prevention of Falls in the Managed Long Term Services and Supports (MLTSS) Population	• Educate member and staff by providing fall prevention information semi-annually to nursing facility and assisting living settings • Require Fall Risk Assessment completion quarterly for HCBS members • Provide assistive device demonstration and request return-demonstration for members prescribed an assistive device
	Decreasing Gaps In Care In Managed Long Term Services and Supports (MLTSS)	• Telephonic outreach to members at risk for food insecurity (reported by NJ Choice assessment BMI) • Targeted outreach to members identified as needing meals through Plan of Care to ensure member has chosen a provider/meal order • Telephonic outreach and education regarding the importance of well visits and flu vaccinations and assistance with scheduling appointments by a dedicated Amerigroup associate to members prior to and during each flu season • Provide a list of members with gaps in flu vaccinations to identified provider groups.
Horizon NJ Health	**EPSDT focused PIP**	• *Project proposal is in development*
	MCO Adolescent Risk Behaviors and Depression Collaborative	• Mailer to the parents of eligible members stressing the importance of an annual visit and gap list to providers for those who were sent the mailer • Initial meeting with providers to discuss practice-related barriers and consequent remediation plans, and providing quarterly "touchpoint" meetings to monitor progress • Provide participating groups with education on the importance of utilizing a standardized screening tool and follow up with quarterly "touchpoint" meetings to monitor progress
	Increasing PCP Access and Availability for Members with Low Acuity, Core Medicaid Membership Non-Emergent ED Visits (Non-Clinical –Core Medicaid)	• Mail annual educational materials and biannual visit reminders to any member evaluated in the ED for a LANE ED visit and has not had a PCP visit within the last 12 months • Quarterly "touchpoint" meetings with providers and practice staff to discuss progress and barriers – to annual and follow-up visits • Monthly list sent to providers identifying members with a LANE ED visit that have not been seen by the provider within 12 months
	Reducing Admissions, Readmissions and Gaps in Services For Members With Congestive Heart Failure in the Horizon NJ Health MLTSS Medicaid Population	• Educational materials on CHF triggers and symptoms (green light/red light) will be reviewed with the member by MLTSS Care Manager during Face to Face visits • MLTSS Care Manager will conduct Outreach within 3 business days of an inpatient hospital discharge, including reminder/assistance in setting up post facility follow-up visit with member's PCP/Specialist • MLTSS Care Manager will conduct a 30 day pledge post hospital which includes a face to face visit within 10 business days and telephonic outreach weekly • HDM providers with authorizations to service an MLTSS member with CHF who was discharged after an inpatient hospitalization will be contacted by the MLTSS care management team to inquire about member receipt of HDM/meals meeting dietary restrictions
	EPSDT focused PIP	• *Project proposal is in development*

UnitedHealthCare	**MCO Adolescent Risk Behaviors and Depression Collaborative**	• Monthly telephonic outreach to members scheduled for an AWC visit stressing the importance of adolescent health screenings and confidentiality during the visit • Quarterly provider visits to offer staff support and guidance specifying areas of priority for targeted performance improvement
	Decrease Emergency Room Utilization (Non-Clinical – Core Medicaid)	• Contact eligible members who had an avoidable ED visit to discuss barriers to a PCP appointment and educate on appropriate ED usage • Assist in scheduling an annual physical appointment for members who had an avoidable ED visit – in the past quarter and are overdue • Work with identified practices to increase and monitor urgent appointment availability
	Improving Influenza and Pneumococcal Immunization Rates in the Managed Long Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) Population	• Care Manager completes a follow up call to MLTSS/HCBS member that had a Flu/Pneumococcal vaccination education during the F2F visit • Coordination/facilitating removing barriers to accessibility for flu vaccination during the face to face on site visit by coordinating activities/arrangement (i.e. locating vaccine site, arranging transportation, and/or scheduling PCP office visit • Care Manager completes a follow up call to MLTSS/HCBS member that received coordination of care for Flu vaccination during the F2F visit. visit to clarify and reinforce vaccination education • Coordination /facilitating removing barriers to accessibility for pneumococcal vaccination during the face to face on site visit coordinating activities/arrangement (i.e. locating vaccine site, arranging transportation, and/or scheduling PCP office visit
WellCare	**EPSDT focused PIP**	• *Project proposal is in development*
	MCO Adolescent Risk Behaviors and Depression Collaborative	• Conduct 3rd and 4th quarter provider visits to monitor provider documentation and clinical response to positive screenings • Providers to document in the medical record when educational materials on risk behaviors are distributed to adolescent members/families • Targeted practice sites to be monitored for provider practice change.
	Medicaid Primary Care Physician Access and Availability (Non-Clinical – Core Medicaid)	• Distribute educational material to eligible members on the appropriate usage of the ER • Implement provider outreach to update their demographic profile • Inform providers of members utilizing care in settings other than their office and educate them on access and availability standards
	Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis	• Member Visits by Care Management for the purpose of education of early signs and symptoms of Sepsis • Provide education and educational material (fact sheet) to members/ caregivers/PCA to members who had a history of sepsis • Members presenting with pressure ulcers will be provided education and educational materials (fact sheet) • Provide catheter care-sepsis- education and catheter care – sepsis fact sheet.

All interventions in MCO PIP are not listed here

Appendix G: Effectiveness Evaluation

Per the managed care regulations (42 CFR §438.340), in addition to a Quality Strategy, Medicaid State agencies that contract with Managed Care Organizations include evaluation of effectiveness of the Quality Strategy within the previous three (3) years. This section outlines the evaluation of the Quality Strategy for 2019-2022.

Quality Strategy Goals and Objectives

As stated in the previous NJ Quality Strategy, NJ focused on providing beneficiaries with the quality care and services through increased access and appropriate and timely utilization of healthcare services. Specific NJ DMAHS goals included:

Goal 1: To improve timely, appropriate access to primary, preventive, and long-term services and supports for adults.
Goal 2: To improve the quality of care and services.
Goal 3: To promote person-centered health care and social services and supports.
Goal 4: To assure member satisfaction with services and improve quality of life.

Consistent with the DHS mission, the purpose of the Quality Strategy was to:

- Drive continuous quality improvements with managed care partners
- Ensure high quality, person-centered, and cost-effective care for NJ beneficiaries
- Develop a multi-disciplinary approach to identify, assess, and measure the access, timeliness, availability, and quality of care

A variety of data sources are used to measure the effectiveness of goals listed. COVID-19 and the Public Health Emergency (PHE) impacted availability of some data and/or impacted progress with meeting objectives.

Results

Overall, the Quality Strategy represents an opportunity to measure and improve the quality of the NJ FamilyCare program. In the prior Strategy, NJ did not make a distinction between goals and objectives, making the evaluation process challenging. The updated Quality Strategy includes objectives, methods of measurement, and targets when appropriate.

Goal 1: To improve timely, appropriate access to primary, preventive, and long-term services and supports for adults.

As evidenced in the annual Quality Technical report, there have been the following improvements in performance between MY 2018 through MY 2019:

- Adolescent Well-Care Visits (AWC) improved by 5.05 percentage points.
- Prenatal and Postpartum Care (PPC)
  - Postpartum Care improved by 15.64 percentage points
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC):
  - BMI percentile 12-17 Years improved by 11.64 percentage points.
  - BMI percentile - Total improved by 7.20 percentage points.
  - Counseling for Nutrition - 12-17 Years improved by 6.07 percentage points.

    - Counseling for Physical Activity - 12-17 Years improved by 7.93 percentage points.
- Adult BMI Assessment (ABA) improved by 7.83 percentage points.
- Follow Up Care for Children Prescribed ADHD Medication (ADD)
    - Continuation and Maintenance Phase improved by 6.64 percentage points.
- Follow-Up After Hospitalization for Mental Illness (FUH)
    - 18-64 Years – 30-Day Follow-Up improved by 8.64 percentage points.
    - 18-64 Years – 7-Day Follow-Up improved by 8.39 percentage points.
    - Total – 30-Day Follow-Up improved by 5.85 percentage points.
    - Total – 7-Day Follow-Up improved by 6.91 percentage points.
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)
    - 18-64 Years – 7-Day Follow-Up improved by 6.61 percentage points.
    - Total - 7-Day Follow-Up improved by 6.12 percentage points.
- Risk of Continued Opioid Use (COU) 65+ Years - >= 15 days covered improved (decreased) by 12.36 percentage points.

Goal 2: To improve the quality of care and services.
MCOs engaged in different quality activities alongside the Division and the EQRO in an effort to improve quality of care and services across the NJ FamilyCare program.

Focus studies: DMAHS requested the EQRO develop a clinical focused study on maternal mortality in 2019. The study aimed to investigate pregnancy associated and pregnancy-related deaths in the NJ Medicaid population. The study results and conclusions were available by August 2021 – of note, because of the small number of cases in the study, only 40 enrollee charts were included in the population. Some restrictions to formal analyses are described further below.

- Study findings revealed that medical and behavioral risk factors were present in the majority of the cases – 78.1% of the cases in the study had one or more chronic medical conditions, 62.5% of cases had a history of mental health conditions excluding depression, and 59.4% of cases had a history of depression.
- The Study findings revealed that only 6.3% of cases had any documentation of postpartum care even though most (78.1%) of the deaths occurred more than 60 days after the termination of pregnancy.
- Prenatal care with adequate documentation to determine dates of care was noted for 56.3% of the cases that were reviewed for pregnancy related care. The overall rate for some evidence of prenatal care was 81.3%.

Restrictions include:

- The small number of cases limits ability to conduct formal analyses and extrapolate findings.
- Reliance on medical and MCO records – as with any study involving chart review – may contribute to information bias; documentation of diagnoses, and receipt of services are subject to human error.
- There may be services received that are not documented and there may also be documentation of services and diagnoses that don't accurately reflect the patient's condition or what occurred.
- Determinations regarding whether cases were pregnancy related or pregnancy associated were based on clinical judgments informed by the documents provided.

Performance Improvement Projects (PIPs): In an effort to evaluate and improve processes of care on identified barriers, each MCO has been engaged in a number of PIPs during the monitoring period. PIP

topics by MCO can be found in Appendix F of this Quality Strategy. NJ's EQRO, IPRO, is responsible for validating and scoring each PIP. IPRO notes strengths and opportunities in the Annual Technical Report (ATR). Each MCO was scored on PIP compliance during its respective Annual Assessment of Managed Care Operations. Below are PIP scores, by MCO, as scored by NJ's EQRO:

Aetna Better Health NJ				
PIP Topic	**Year 1**	**Year 2**	**Sustainability**	**Final Report**
Improving Developmental Screening and Referral Rates to Early Intervention for Children	71.9%	50.0%	61.8%	N/A
MCO Adolescent Risk Behaviors and Depression Collaborative	62.5%	65.4%	N/A	N/A
Non-Clinical Improving Access and Availability	N/A	N/A	N/A	N/A
Decreasing Gaps in Care in Managed Long Term Services and Supports	62.5%	76.9%	N/A	N/A

≥ 85% met; 60-84% partial met (corrective action plan)

Amerigroup New Jersey				
PIP Topic	**Year 1**	**Year 2**	**Sustainability**	**Final Report**
Reduction of the Amerigroup Preterm Birth Rate by 5%[1]		62.5%	62.5%	60.0%
Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services For Members < 3 Years Old	59.0%	81.3%	76.5%	N/A
MCO Adolescent Risk Behaviors and Depression Collaborative	62.5%	69.2%	N/A	N/A
Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members	N/A	N/A	N/A	N/A
Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population	79.2%	69.2%	N/A	N/A
Decreasing Gaps in Care in Managed Long Term Services and Supports (MLTSS)	62.5%	65.4%	N/A	N/A

≥ 85% met; 60-84% partial met (corrective action plan)

[1] The shaded columns represent scoring completed on a different review template, and therefore comparisons cannot be made for these components

Horizon NJ Health				
PIP Topic	**Year 1**	**Year 2**	**Sustainability**	**Final Report**
Developmental Screening and Early Intervention in Young Children	90.6%	90.6%	91.2%	N/A
MCO Adolescent Risk Behaviors and Depression Collaborative	100%	100%	N/A	N/A
Increasing PCP Access and Availability for Members with low acuity, non-emergent ED visits	N/A	N/A	N/A	N/A
Reducing Admissions, Readmissions and Gaps in Service for Members with Congestive Heart Failure in the Horizon MLTSS Home and Community Based Setting population	100%	84.6%	N/A	N/A

≥ 85% met; 60-84% partial met (corrective action plan)

UnitedHealthCare Community Plan

PIP Topic	Year 1	Year 2	Sustainability	Final Report
Early Intervention for Children in Lead Case Management (Age Birth to 2.99 Years Old)	75.0%	90.6%	100%	N/A
MCO Adolescent Risk Behaviors and Depression Collaborative	75.0%	100%	N/A	N/A
Decrease Emergency Room Utilization	N/A	N/A	N/A	N/A
Improving Influenza and Pneumococcal Immunization Rates in the MLTSS Home and Community Based Services (HCBS) Population	79.2%	80.8%	N/A	N/A

≥ 85% met; 60-84% partial met (corrective action plan)

WellCare				
PIP Topic	**Year 1**	**Year 2**	**Sustainability**	**Final Report**
Improving the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age	90.6%	100%	88.2%	N/A
MCO Adolescent Risk Behaviors and Depression Collaborative	87.5%	88.5%	N/A	N/A
Medicaid Primary Care Physician Access and Availability	N/A	N/A	N/A	N/A
Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis	87.5%	100%	N/A	N/A

≥ 85% met; 60-84% partial met (corrective action plan)

Goal 3: To promote person-centered health care and social services and supports.
NJ has remained focused on person-centered care – individuals that are empowered to take charge of their own health will have better health outcomes.

- **Rebalancing of Medicaid long-term care**: In 2018, 61% of individuals received home and community based services rather than nursing home care – an increase from 29% in 2014.
  - From 2014 to 2019, there was a decline of almost 5% in total Medicaid nursing facility census; NJ's elderly population grew by more than 12% over the same time period.
  - Strong performance on key quality measures; above national averages on measures of physical and wellness exams, flu shots, dental visits, and vision exams.
- **Improved access to HCBS for adults with intellectual and developmental disabilities**: As of SFY 2020, approximately 10,950 individuals in the Supports Program and 11,730 individuals in the Community Care Program receive services, typically in a lower-intensity setting.
  - NJ implemented an expanded array of services for youth with an autism spectrum disorder (initially piloted through the demonstration and transitioned to State Plan).
  - Simplified and streamlined program administration under the Children's Support Services Program (CSSP), breaking down previously existing silos of care for youth with complex needs.
  - Continued quality performance improvement among DSRIP hospitals participating in asthma and diabetes quality projects.
  - Introduction of a flexible and comprehensive substance use disorder benefit within context of integrated behavioral health system.

Goal 4: To assure member satisfaction with services and improve quality of life: NJ has used nationally-recognized surveys, to understand and improve member satisfaction across the program.

- **Adult** Consumer Assessment of Healthcare Providers and Systems (CAHPS): NJ posts health plan overall satisfaction ratings on the NJ FamilyCare Analytics Dashboard.
    - Overall rating of healthcare has increased from 84% in 2018 to 88% in 2021.
    - Overall rating of health plan has increased from 84% in 2018 to 90% in 2021.
    - Overall rating of personal doctor has increased from 88% in 2018 to 93% in 2021.
    - Overall rating of specialists has remained steady since 2018 with a slight decline in 2019 – 90% in 2018, 89% in 2019, 91% in 2020 and 2021.
- **Child** Consumer Assessment of Healthcare Providers and Systems (CAHPS): NJ posts health plan overall satisfaction ratings on the NJ FamilyCare Analytics Dashboard.
    - Overall rating of healthcare has increased from 92% in 2018 to 94% in 2021.
    - Overall rating of health plan has remained steady since 2018 (92%) to 2021 (93%).
    - Overall rating of personal doctor has remained steady since 2018 to 2021 at 95%.
    - Overall rating of specialists has increased from 92% in 2018 to 95% in 2021.

- **National Core Indicators – Aging and Disabilities (NCI-AD):** New Jersey has participated in the NCI-AD survey since 2016; the survey collects valid and reliable person-reported data about the impact of LTSS programs on the quality of life and outcomes of older adults and adults with physical disabilities. Key results from the 2018-2019 survey are shared below.
    - Cross-state comparison: when comparing average scores to states with similar programs, NJ compared favorably in some categories and unfavorably in others:
        - NJ was above average in 17 categories, including the following notable items:
            - Would prefer to live somewhere else (risk-adjusted),
            - Felt they have an emergency plan in place,
            - Have a backup plan if their paid support staff do not show up,
            - Felt comfortable and supported enough to go home after being discharged from a hospital or rehabilitation facility in the past year,
            - Discussed their forgetting things more often than before with a doctor or nurse,
            - Had concerns about falling or being unstable and had somebody talk to them or work with them to reduce the risk,
            - Have access to healthy foods if they want them,
            - Understand what they take their prescription medicines for,
            - Paid support staff treat them with respect, and
            - Able to lock the doors to their room if they want to (if in group setting).
        - NJ scored below average in 7 areas including:
            - Able to choose their roommate (group setting only),
            - Able to get up and go to bed when they want,
            - Able to furnish and decorate their room however they want to (group setting only),
            - Receive information about their services in the language they prefer (if non-English), and
            - Can choose or change what kind of services they get.
    - NJ MCO Comparison: DMAHS also identified areas with wide ranges in MCO scores and areas that require improvement across the board.

- Where a wide range exists, DMAHS is working with MCOs to bring lower performing plans to higher levels while continuing to challenge higher performing plans to raise the bar. For example:
  - Percentage of people who are as active in their community as they would like to be – state average: 38%, MCO low: 28%, MCO high: 45%,
  - Percentage of people who receive information about their services in the language that they prefer (if non-English) all the time – sample average: 74%, MCO low: 48%, MCO high: 93%,
  - People's level of involvement in deciding what is in their service plan/plan of care – sample average: 73%, MCO low: 68%, MCO high: 88%.
- Where across the board improvement is needed, DMAHS is working with MCOs to identify best practices and improve performance overall. For example:
  - Percentage of people who like how they spend their time during the day – state average: 55%, MCO low: 53%, MCO high: 62%,
  - Percentage of people whose long-term services meet their current needs and goals, yes completely – sample average: 70%, MCO low: 63%, MCO high: 72%.

Appendix H: NJ Public Comment

DMAHS has included the recommendations and feedback received by stakeholders during NJ's public comment period. The NJ Quality Strategy was posted on the DMAHS website for 45 calendar days.

Organization	Area of Comment	Recommendation	DMAHS Response
New Jersey Family Planning League (NJFPL) Rachel Baum, President & CEO	Contraceptive Measures, pg. [44, 57, 58, 86, 87,]	In the postpartum contraception category (p. 87), DMAHS should consider combining the 15-20 category with 21-44, since the sample size for postpartum 15-20 year old individuals is likely quite small, and there are no national benchmarks for this age group. Considering the history of contraceptive coercion among underserved populations, particularly racial/ethnic minorities and low-income individuals, we are committed to supporting patient-centered contraceptive provision, while increasing access to the patient's preferred contraceptive method.	DMAHS would like to thank you for your recommendation. DMAHS will consider modifying age groups to better align with population size and national benchmarks during the next quality strategy review. Additionally, DMAHS will continue its focus on maternal health equity to improve access and health outcomes.
New Jersey Family Planning League Rachel Baum, President & CEO	Maternal Mortality, pg. [54]	DMAHS to consider including strategies for addressing and monitoring the factors that contribute to maternal mortality The Quality Strategy references the 2020 Maternal Mortality Focused study (p. 54). It may be helpful to incorporate findings from this study into the Quality Strategy, and for DMAHS to develop policies that align with those recommendations, as well as metrics to monitor improvement.	DMAHS would like to thank you for your recommendation. While the findings from the maternal mortality focus study are listed in the Quality Strategy, the small population of focus limited DMAHS's ability to extrapolate findings for broader policy/recommendations. DMAHS is using the focus study experience and leveraging the Department of Health's more broad-based data set to improve data analytics and interventions.
New Jersey Association of Mental Health and Addiction Agencies, Inc. Debra L. Wentz, Ph. D. President and CEO	Readability and length of document	"Unfortunately the 374 page document is not readily absorbed, which hinders a thorough review and comprehensive feedback. The Document also often lacks specifics in regards to measures that will be used, leaving	DMAHS would like to thank you for your recommendation. The document is indeed lengthy but the overall quality strategy is

		stakeholders unable to assess certain provisions at all."	summarized within the first 30 pages. That summary is followed by a number of appendices including a regulatory crosswalk, Managed Care Reporting Requirements, the EQRO Quality Technical Report, etc. The strategy is drafted in accordance with federal regulations (42 CFR §438.340) and CMS expectations (Medicaid and Children's Managed Care Quality Strategy Toolkit).
New Jersey Association of Mental Health and Addiction Agencies, Inc. Debra L. Wentz, Ph. D. President and CEO	Performance measures pg. [14]	Lack of specificity for the measures used leaving stakeholders unable to assess certain provisions at all.	DMAHS would like to thank you for your recommendation. Appendix D outlines additional performance measures used to monitor Managed Care quality. DMAHS aims to enhance program-related performance measures while supporting and sustaining quality improvements already in motion.
New Jersey Association of Mental Health and Addiction Agencies, Inc. Debra L. Wentz, Ph. D. President and CEO	Network Adequacy pg. [15, 16]	Improve on network adequacy for mental health and substance use treatment services and support for Medicaid members	DMAHS would like to thank you for your recommendation. DMAHS continues to work with MCOs and providers to expand access to quality health care services in accordance with 42 CFR §438.206.
New Jersey Association of Mental Health and Addiction Agencies, Inc. Debra L. Wentz, Ph. D. President and CEO	Health Equity Sanctions and Liquidated Damages pg. [14, 15, 16, 27, 28]	More specificity in the analysis of health equity analyses and a much stronger language regarding recommendations for improvement that are imperative and not suggestive, with consequences for lack of progress	DMAHS would like to thank you for your recommendation. DMAHS continues to work with NJ MCOs to expand health equity analyses to support better access and health outcomes for our communities.

			Through new and strengthened processes and trending, DMAHS is improving managed care accountability. DMAHS continues to strengthen MCO Contract language to include disciplinary actions for noncompliance and/or lack of progress.
ViiV Healthcare Stephen Novis Government Relations Director	HIV quality measures pg. [14, 21, 25]	DMAHS to align the departmental quality data goals to the national EHE effort and to the state's own "Strategic Plan to End the HIV Epidemic by 2025.[1] Therefore, ViiV urges DMAHS to build a data infrastructure that captures laboratory viral suppression data that will allow its five contracted Medicaid Managed Care Organization and fee-for-service programs to report on the HIV Viral Load (HVL) quality measure.	DMAHS would like to thank you for your recommendation. DMAHS aims to align quality goals to national efforts when appropriate and possible. DMAHS will review the request to build a data infrastructure to allow HIV Viral Load quality reporting in the future.
ViiV Healthcare Stephen Novis Government Relations Director	Reporting of HVL Measure pg. [14, 40, 47]	DMAHS should consider adopting claim-based quality measures that are built along the HIV Care Continuum framework of diagnosis, treatment, retained in care, and viral suppression. HIV quality measures are critical in elevating the importance of the care and treatment of people with HIV and for reducing the incidence of new HIV infections. "While the HVL measure is the ultimate outcome measure that signals high-quality HIV care, there are other measures along the HIV care continuum that can be adopted in the interim, as one way to improve and measure quality of HIV care in the state's Medicaid program. Because long term HIV care is strongly associated with vital suppression and optimal health outcomes for people with HIV, DMHAS should also consider measuring retention in care, which includes adherence and medical visits as part of its suit of quality measures."	DMAHS would like to thank you for your recommendation. DMAHS will review the recommendation to adopt claim-based quality measures to align HIV reporting to the HIV Care Continuum framework of diagnosis, treatment, retained in care, and viral suppression.
New Jersey Health Quality Institute	Data Collection Process	We encourage the Division to be more specific about how the data will collected, verified, and incorporated into ongoing work. As the largest	DMAHS would like to thank you for your recommendation. DMAHS

[1] A Strategic Plan to End the HIV Epidemic in New Jersey by 2025. NJ Department of Health. Page 3. Ending the HIV Epidemic in New Jersey Plan.pdf (nj.gov) (Accessed December 13, 2021)

Kate Shamzad, Director, Medicaid Policy Center		health care payer in the state, it is critical that the Division and its contracted MCOs accurately collect race, ethnicity, and language ("REaL") and disability data and use the REaL data to stratify reporting on all or as many as possible of the quality measures.	has started to collect member-level detail on certain performance measures from the MCOs. DMAHS partners with the EQRO to collect and validate large data sets. DMAHS will continue to expand on collection of this data to be able to complete data analysis across multiple quality measures.
New Jersey Health Quality Institute Kate Shamzad, Director, Medicaid Policy Center	Intermediate Sanctions	The Quality Strategy could be improved by including more specific enforcement steps, details regarding the basis and factors that will trigger specific corrective actions, and more details regarding the same for penalties for not meeting network adequacy requirements as set forth in the MCO contract.	DMAHS would like to thank you for your recommendation. The Managed Care Contract further describes when and how disciplinary actions are taken for noncompliance/lack of progress in improvement. With each contract review period, DMAHS continues to strengthen this language in an ongoing effort to improve collaboration and accountability with Managed Care partners.
New Jersey Health Quality Institute Kate Shamzad, Director, Medicaid Policy Center	Network adequacy	In addition, we would like to see a detailed plan and timeline for improving the network directories and credentialing process to ensure that the public information is accurate including information about whether providers are accepting new patients, the specific locations that a provider sees patients, and other critical consumer information that improves access to timely care and enables the Division to enforce its network adequacy requirements.	DMAHS would like to thank you for your recommendation. DMAHS continues to strengthen network adequacy standards in the Managed Care Contract. DMAHS has also improved data collection and methods to increase efficiency of analytical processes. DMAHS will continue efforts to improve access across the program by focusing on provider directory and credentialing process improvements.

New Jersey Health Quality Institute Kate Shamzad, Director, Medicaid Policy Center	Auto Assignment of MCO	We would encourage consideration for including the Quality Strategy and plan for auto-assignment to the MCO that has the highest quality ratings that are specific to the type of care the beneficiary may be utilizing - for example, pediatric preventative care measures or maternity outcomes.	DMAHS would like to thank you for your recommendation. DMAHS's proposed 1115 demonstration renewal includes alignment of auto-assignment to MCO performance.
New Jersey Health Quality Institute Kate Shamzad, Director, Medicaid Policy Center		We encourage the Division to raise the expected benchmark for many of the reported CMS Adult and Child Core Set measures and the HEDIS measures including but not limited to: adult and pediatric primary and preventive care, perinatal care, reproductive care, oral health care, and access to follow-up care after hospitalization or mental health issue.	DMAHS would like to thank you for your recommendation. DMAHS will review existing benchmarks for quality measures including review of past performance, comparison across all MCOs, and performance relative to national benchmarks.
New Jersey Health Quality Institute Kate Shamzad, Director, Medicaid Policy Center		We agree with the Division that timely prenatal and postpartum visits are good measures to include in the Quality Strategy. We suggest that the measures be stratified based on REaL data to show existing health inequities and to support focused quality improvement efforts. For example, California includes this in its quality strategy and proposed to decrease the disparities by 50% by 2025. In addition, we suggest that Maternal Depression Screening and care referrals be measured and focused on as mental health is a leading contributor to perinatal morbidity and mortality. California has a measure to improve its outcomes on this by 2025. The Perinatal Risk Assessment (PRA) tool, which is discussed in the Quality Strategy, should be measured for completion at two points during the perinatal period, but more importantly, should be tracked and reported for use to connect patients to services. This could be done as an electronic measure that is developed, tested, and then used during the 3-year period of the Quality Strategy.	DMAHS would like to thank you for your recommendation. DMAHS will incorporate recommendations received to strengthen health equity analyses, especially those related to maternal health.