

# Attachment 1: Quality and Monitoring Activities

New Jersey has a consistent and coordinated framework via overarching interagency authority and oversight to deliver timely, appropriate quality health care across all populations. The programs under the Comprehensive Demonstration are administered by various state agencies, however, the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) maintains authority over monitoring and oversight of the programs.

## Managed Care Quality and Monitoring

### *External Quality Review*

Pursuant to the requirements set forth in 42 CFR 438.350, NJ DMAHS contracts with an External Quality Review Organization (EQRO), IPRO, to conduct an independent review of quality outcomes, timeliness of, and access to the services included in the Managed Care Contract. IPRO and DMAHS work together to continuously improve NJ's quality strategy, increase accountability of Managed Care, and provide care to NJ beneficiaries.

IPRO performs the following CMS mandatory activities:

- Validation of Performance Improvement Projects (PIPs)
- Validation of Performance Measures
- Review of Compliance with Medicaid and CHIP Managed Care Regulations
- Validation of Network Adequacy<sup>1</sup>

In addition to the mandatory activities listed above, IPRO is engaged with optional activities including, but not limited to, focused studies, care management program audits, quality of care surveys, development of NJ-specific performance measures, and validation of encounter data.

The annual Quality Technical Report (QTR), produced by IPRO, summarizes all external quality review activities completed for the calendar year. The most recent QTR, spanning January through December 2020, captures annual assessment of Managed Care Organization (MCO) operations, validation of PIPs, focused quality studies, validation of performance measures, CAHPS surveys, Care Management audits and more. IPRO provided a summary of key findings,

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<sup>1</sup> Pending protocol under development by CMS

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as well as an evaluation of MCO strengths and weaknesses. For areas scored as not met, MCOs are required to submit Corrective Action Plans outlining their efforts to cure deficiencies.

### ***Monitoring of Quality and Access to Care***

In addition to EQR activities, DMAHS' Contracts with the MCOs set forth reporting requirements that allow for consistent monitoring of timely and quality access to care for NJ beneficiaries.

- Appeals and Grievances: MCOs are required to report data related to utilization management and non-utilization management appeals and grievances for the NJ FamilyCare program, including Managed Long Term Services and Supports (MLTSS).
- Childhood Lead Screening: MCOs are required to maintain a lead screening program. Annually, DMAHS evaluates the effectiveness of action plans and interventions MCOs submit in their efforts to improve lead screening rates.
- EPSDT Performance Standards: MCOs are expected to achieve minimum performance standards for EPSDT measures (well-child visits, childhood immunizations, etc.) Measures that fall below standards results in a refund of capitation paid.
- Performance-Based Contracting: MCOs that earn a 3.5 Star Rating based on HEDIS and CAHPS scores are eligible to receive performance payment incentives. Incentives are based on specific scores defined in the Managed Care Contract.
- Network and Geographical Access Files: MCOs are required to establish, maintain, and monitor at all times a network of appropriate providers that is sufficient to provide adequate and timely access to all services covered under the Managed Care Contract. Specific requirements related to appointment availability, provider ratios, and access standards are set forth in the Managed Care Contract. MCOs are required to submit network and geographical access files demonstrating compliance with these requirements.
- MCO Performance Reviews: DMAHS holds meetings with each MCO (on a rotating cycle) to review quality and performance across all functional areas and relative to other plans. The discussions are collaborative reviews of relevant metrics, trends, and actions pertinent to the MCO's core Medicaid, MLTSS, and FIDE-SNP operations. Each review highlights strengths, weaknesses, mixed results, and concerning findings.
- Provider Terminations: MCOs are required to notify DMAHS and Medicaid Fraud Division (MFD) of suspensions, termination, non-renewal of contact or voluntary withdrawal or any other form of non-participation of a provider or subcontractor from participation in the program on a weekly basis.

## **2020 Key Findings and Planned Monitoring Activities**

**Annual Assessment of MCO Operations:** Each MCO completed a partial audit with the NJ EQRO in 2020. The 2020 compliance scores ranged from 93% to 98%. Four of the five MCOs increased scores and one MCO maintained the prior year's score. Three review categories decreased from 2019 (Programs for Elderly and Disabled, Satisfaction, Enrollee Rights and Responsibilities) but were between 96% and 98%. Access had the lowest MCO average score of 77%, an increase of 8 percentage points from 2019. The EQRO's recommendations include improvements in access, appointment availability, performance improvement projects (PIPs), performance measure reporting, and resolution of grievances and appeals.

All elements scored as a "Not Met" by IPRO require a Corrective Action Plan (CAP) to monitor efforts to cure deficiencies listed. Today, CAPs are reviewed by the EQRO and DMAHS prior to being accepted. DMAHS is looking to enhance the CAP monitoring process to increase oversight of planned interventions to address deficiencies with the MCOs. In an effort to complete a more comprehensive and focused audit, Care Management elements that were previously reviewed during the Annual Assessment of MCO Operations were pulled and added to the respective Core Medicaid and MLTSS Care Management chart audits.

**Core Medicaid Performance Measures and CMS Core Set Measures:** NJ's EQRO validated Core Medicaid Performance Measures, New Jersey State-Specific Measures, CMS Core Set Measures, and MLTSS Performance Measures. Overall, Core Medicaid Performance Measures remained relatively constant between MY 2018 and MY 2019 (with a <5 percentage point change year over year) for most measures. There were significant increases in some measures and no significant declines.

Within the 2020 Core Set measures, two MCOs improved rates for developmental screening (DEC-CH).

Performance Measures that align with New Jersey's goals and objectives and fall below the NCQA 50<sup>th</sup> percentile require MCO work plans. Select Core Set measures below established benchmarks also require MCO work plans.

**MLTSS Performance Measure Validation:** IPRO conducted annual validation of all MLTSS performance measures which included review of source code (where applicable), claims data files, and documentation of methodologies. IPRO met with each MCO to review submissions and request modifications, if necessary. Results from the validation process from the July 2018-June 2019 measurement period can be found in the QTR.

Performance Measure 13 is designed to measure how often MLTSS home and community based services are delivered in accordance with the plan of care, including the type, scope, amount, frequency, and duration.

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Overall compliance rate across all MCOs was 36.7%, an increase of 4.3 percentage points from the prior year. All but one MCO demonstrated improved compliance – the highest increase in rates was 12.1 percentage points. Of the 477 members in the denominator across all plans, 175 received, on average, 95% of the planned service amount for all services documented in the plan of care. 2020 was the first year DMAHS required a CAP to focus MCO efforts on improving service delivery rates.

To improve monitoring, DMAHS is reviewing methods to supplement performance measures that monitor the delivery of MLTSS services to MCO increase oversight and accountability.

**Performance Improvement Projects:** Overall, through the challenges of 2020 with COVID-19, the EQRO recognized growth within each MCO for their performance improvement projects (PIPs). For the collaborative project – MCO Adolescent Risk Behaviors and Depression Collaborative – MCOs became more engaged, bringing more new questions, ideas, and suggestions for improvement. 2020's largest opportunity for improvement was related to COVID-19 impact and how to adequately capture data in spite of office closures. Through this barrier, telehealth emerged as the new platform to see and care for members.

**Care Management Audits:** IPRO conducted Care Management audits for Division of Developmental Disabilities (DDD), Division of Child Protection and Permanency (DCP&P) and MLTSS programs. CAPs are required for all areas scored non-compliant.

Four metrics were evaluated for the Core Medicaid audit for the DDD and DCP&P population: outreach, preventive services, continuity of care, and coordination of services. 3 of 5 MCOs scored above 90% in 4 of the 8 categories. 1 of 5 MCOs scored at or above 90% in 6 of 8 categories. 1 of 5 MCOs scored above 90% in 5 of 8 categories. Overall, preventive services and continuity of care remained the more common areas of opportunities for most plans.

IPRO also conducted Care Management audits for the MLTSS HCBS population. Categories for the HCBS audit include: Assessment, Outreach, Face to Face visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. IPRO also calculated rates for performance measures specific to the plan of care development through this audit. Gaps in Care/Critical Incidents remained a strength across all plans with the lowest score being 92.6%. Opportunities remain in different categories for each plan. All categories/performance measures scoring below 86% require a CAP with detailed monitoring actions.

The most recent QTR is available [here](#).

## Department of Children and Families, Children's System of Care: Quality and Monitoring

New Jersey's Department of Children and Families (DCF), Children's System of Care (CSOC) provides a single point of access for service and supports for youth under the age of 21 with emotional and behavioral health care challenges and their families; youth with developmental

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and intellectual disabilities and their families; and youth with substance use challenges and their families. CSOC provides oversight and management of two programs in the demonstration; the Children's Support Services Serious Emotional Disturbance Program (SED), and the Intellectual Disabilities/Developmental Disabilities Program for youth that may have co-occurring mental health diagnoses (ID/DD). CSOC undertakes a range of quality and monitoring activities related to demonstration programs, which are described in greater detail below.

### ***Quality Management Unit Comprehensive Annual Audit***

The Division of Medical Assistance and Health Services' (DMAHS) Quality Management Unit (QMU) conducts an annual comprehensive audit on demonstration services, which includes CSOC's SED and ID/DD programs. QMU monitors compliance in the following performance measure areas: service plan, level of care, qualified providers, health and welfare, and financial accountability. At the conclusion of the audit, the QMU informs CSOC of the outcomes and will require a Plan of Correction (POC) if any of the assurances fall below a compliance rate 86%. CSOC supports QMU by offering annual training on our electronic record, securing access to the requested records and clarifying conflicting findings as needed.

### ***Qualified Providers***

CSOC's has developed a network of providers that have been qualified to deliver services as defined by CSOC and the demonstration. Each of these providers are required to meet qualifications specified by DCF and may have either responded to a Request for Proposal or Qualification (RFP/Q). Additionally, any provider that is contracted with CSOC agrees to uphold identified deliverables, including staff trained in the standards set by DCF and CSOC. Service line manager responsibilities include reviewing information regarding the service network and its performance/functioning/level of quality, including individual provider and system utilization and performance data and identifying and managing training and technical assistance needs and resources to support service quality and adherence to program standards.

If the provider is not meeting the requirements, CSOC will provide outreach and assistance assure that each provider is holding to the standards set forth. If CSOC requires a provider to make an adjustments within a program, a corrective action plan may be created. Areas that may be addressed include regulation requirement and program deliverables.

If a corrective action plan is required, CSOC will monitor the plan to ensure that the provider complies. In cases of continuous non-compliance, CSOC may terminate their contractual agreement with the provider. If this action occurs, CSOC will ensure that a transition plan is implemented for continuation of care.

### ***Unusual Incident Reporting***

New Jersey Administrative Order 2:05 Addendum establishes policy for the reporting of unusual incidents affecting the health, safety and welfare of DCF's service recipients.

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DCF manages these reports through its unusual incident reporting systems. Within these system, incidents are categorized in order to determine the severity of a situation, which parties the incident should be communicated to, and the timeframe in which DCF should be notified of the incident. The CSOC Unusual Incident Reporting (UIR) Coordinator conducts a review of each report and distributes it to CSOC staff identified for monitoring and/or follow up as needed, including coordination with DCF's offices of licensing, contracting, and institutional abuse investigations unit.

### **Division of Developmental Disabilities Community Care Program and Support Program Audits**

#### ***Quality Management Unit Comprehensive Annual Audit***

The Quality Management Unit (QMU), under the Department of Human Services Division of Medical Assistance and Health Services Office of Preventative Health Services, conducts an annual audit of both DDD programs utilizing a review of a statistically significant sample of beneficiaries. QMU monitors compliance in the following performance measure areas: service plan, level of care, qualified providers, health and welfare, and financial accountability. Each performance area with a finding below 86% requires a corrective action plan by DDD. DDD is also expected to address systemic concerns (compliance rate below 86%) as well as review and correct individual findings; as appropriate.

#### ***External Audits***

The Department of Human Services, Division of Medical Assistance and Health Services currently contracts with the independent accounting firm Mercadien, P.C., Certified Public Accountants to conduct an annual compliance review of selected provider agencies receiving Medicaid reimbursement under the DDD programs within the New Jersey FamilyCare Comprehensive Demonstration. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services is responsible for establishing and maintaining effective internal control over the provider agencies' compliance with requirements of Community Care and Supports Program policies and procedures manuals. Annually, an engagement letter is drafted that outlines the agreed upon procedures to be performed. The procedures vary each year, but typically include the following performance measures: level of care metrics, access and eligibility metrics, service plan metrics, staff qualification and training metrics, billing, and payment metrics. At the completion of the engagement an agreed-upon procedures report is written reporting on all procedures performed and any noncompliance exceptions noted.