

DIVISION OF MEDICAL ASSISTANCE  
AND HEALTH SERVICES

# QUALITY STRATEGY

(Updated June 12, 2014)

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## INTRODUCTION

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The New Jersey Department of Human Services (DHS) Division of Medical Assistance and Health Services (DMAHS) provides health service benefits to approximately 1.3 million individuals through various programs funded by State or a combination of State and federal monies. As of August 2013, about 90% of managed care eligible beneficiaries have received services through the managed care program.

New Jersey expanded its Medicaid program under the Affordable Care Act effective January 1, 2014. This allows New Jersey to cover childless adults and parents up to 133% of the federal poverty level (FPL). We anticipate that an additional 300,000 people will enroll in Medicaid and CHIP (Children's Health Improvement Plans).

Managed care promotes preventive care, provides care management services and enables clients to receive coordinated care from a network of diverse providers. The provisions in the managed care contract are aimed at ensuring that enrollees have access to high quality and equitable health care that is patient-centered, culturally competent, and cost-effective and promotes optimal health outcomes. Through collaborations in quality initiatives and monitoring compliance with requirements and standards, DMAHS works cooperatively with contracted Managed Care Organizations (MCOs) and other stakeholders to promote improvements in care.

In compliance with 42 CFR 438.202, the following New Jersey Quality Strategy incorporates the required activities for a comprehensive written strategy for monitoring, assessing and improving the quality of managed care services offered by all contracted New Jersey FamilyCare/Medicaid (NJFC)/M MCOs, as well as the State-contracted Dual Eligible Special Needs Plans (D-SNPs). Initially, Managed Long Term Services and Supports (MLTSS) will be offered to eligible members under the NJFC/M Contract. Planning for the implementation of D-SNP MLTSS with a target date of 2015 is underway. New Jersey will seek the input of enrollees, advocacy groups and other stakeholders in the development of the strategy through the Medical Assistance Advisory Committee (MAAC) and the Managed Long Term Services and Supports (MLTSS) Steering Committee and make it available for public comment before adopted. The MLTSS Steering Committee is comprised of 15 participants of the Medicaid Long Term Care Funding Advisory Council of New Jersey, managed care organizations and various consumers. The MAAC is comprised of beneficiaries, consumer advocates and providers and is open to the public at large. These committees serve as the mechanism by which the State obtains the input of the beneficiaries and other stakeholders in the development of the quality strategy, pursuant to 42 CFR 438.202(b).

<p><b>42 CFR 438.202 State Responsibilities</b></p>
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<p>Each State contracting with an MCO or PIHP must do the following:</p>
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<p>(b) Obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final.</p>
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The quality strategy ensures that the MCOs comply with all standards established by the NJ DMAHS that are consistent with 42 CFR 438. The State will conduct periodic reviews to evaluate the effectiveness of the quality strategy and update it as needed, whenever a significant change has been made, as well as provide regular reports on its implementation and effectiveness. For additional information regarding New Jersey DMAHS adherence to 42 CFR 438 et seq., refer to Appendix E.

Outreach and education about Medicaid managed care continues in all 21 counties through the State's contracted Health Benefits Coordinator (HBC). Members covered under the Children's Health Insurance Program (CHIP), as well as individuals with special needs and children in foster care are mandated to enroll in managed care.

All members, including NJFC/M, D-SNP and MLTSS, will receive written information regarding their appeal and fair hearing rights, upon enrollment into the MCO, and whenever they receive a denial of service or denial of authorization of service.

The New Jersey Comprehensive 1115 Medicaid Waiver was approved in October 2012. Implementation of the MLTSS Home and Community Based Services (HCBS) and Nursing Facility (NF) services for new MLTSS members will begin in July 2014. In February 2014, New Jersey has made the decision that all current nursing facility residents will remain in the fee-for-service program for life and all current special care nursing facility residents will remain in the fee-for-service program for two years. Special care nursing facilities are those that provide services to Ventilator, Traumatic Brain/Injury/Coma, Pediatric, HIV (AIDS), and Neurologically Impaired, young Adult/Huntington's Disease, and Behavioral Management patients.

Under this demonstration, New Jersey will operate a statewide health reform effort that will expand existing managed care programs to include managed long term services and supports (MLTSS) and expand home and community based services to some populations. The 1115 combines, under a single demonstration, authority for several existing Medicaid and CHIP waivers and demonstration programs, including:

- Two Section 1915(b) Managed Care waiver programs;
- Four 1915(c) Home and Community Based Services (HCBS) waivers; and
- Title XIX Medicaid and Title XXI CHIP section 1115 demonstrations.

The Comprehensive Waiver also provides additional 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 (SED), Persons with Autism Spectrum Disorder (ASD) and children with intellectual disabilities with co-occurring mental illness. These programs are administered by the Department of Children (DCF) and Families and the DHS Division of Developmental Disabilities (DDD) and the services are provided through Medicaid fee-for-service. A separate quality strategy will be developed for these populations while aligning with the principles outlined in this strategy.

The strategy supports and promotes compliance with Contract requirements that are consistent with federal and State standards. The quality strategy is examined at least annually and updated as needed based on findings and trends identified through the State's monitoring activities. All contracted MCOs fall under this Quality Strategy.

The strategy complements and aligns with New Jersey's quality strategies for its Programs of All-Inclusive Care for the Elderly (PACE) as well as programs that serve the developmentally disabled and intellectually disabled populations.

## **NEW JERSEY DMAHS QUALITY STRATEGY VISION**

The right care and supports, for every person, every time, in the appropriate setting that ensures members have access to quality, equitable, person-centered, culturally-competent and cost-effective care that results in optimal outcomes, including maximum independence and quality of life.

## **GOALS, VALUES AND GUIDING PRINCIPLES**

### **GOALS**

To implement our vision, New Jersey has focused on providing all of our members with quality care and services through increased access and appropriate, timely utilization of health care services. These goals guide the program in direction and scope.

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

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.

### **GUIDING VALUES OR PRINCIPLES**

- New Jersey seeks to achieve excellence through continuous quality improvement activities;
- The quality strategy affirms the importance of State oversight to ensure the delivery of high quality, person and family centered, cost effective care for older adults and people with disabilities;
- The quality strategy uses a multi-disciplinary, collaborative approach to identify, assess, measure and evaluate the access, timeliness, availability, level of care and clinical effectiveness of care and services to NJFC/M members;
- Members are supported in taking responsibility for their own health and health care, including the opportunity to self-direct care where appropriate;
- Members with institutional level of care needs have the right to choose the setting in which they will receive their services;

- Providers are accountable for delivering quality services and programs in compliance with federal and State law and regulations;
- Collaboration among community, State, professional, and advocacy groups creates opportunities to identify and initiate valuable quality improvement activities;
- Access to care and services will be equitable;
- Cultural sensitivity is an essential element in providing quality services to a diverse population and decreasing disparities;
- Forums for communication that promote an open exchange of ideas while maintaining privacy guidelines, are useful for the identification of issues and to indicate where quality improvement activities may be beneficial.

## QUALITY STRATEGY OVERSIGHT STRUCTURE

New Jersey has a consistent and coordinated framework via overarching interagency authority and oversight to deliver timely, appropriate quality health care across all populations, including those members needing MLTSS services. **While there are several State agencies involved in the administration of the HCBS, the DMAHS will maintain authority over the programs and will exercise the appropriate monitoring and oversight.**

### OFFICE OF QUALITY ASSURANCE AND THE EXTERNAL QUALITY REVIEW ORGANIZATION

The OQA meets biweekly with the Island Peer Review Organization (IPRO) as the External Quality Review Organization (EQRO) to discuss the status of the quality projects as well as any issues identified. The DMAHS OQA reviews quality and monitoring reports submitted by the MCOs and the EQRO. Managed Long Term Services and Supports (MLTSS) performance measures will be received and reviewed by Division of Aging Services (DoAS) and Division of Disability Services (DDS). Specifically, the DoAS will receive and review from the MCOs those MLTSS performance measures related to Level of Care (LOC) and the DDS will receive and review the self-direction data. The DoAS and the DDS will communicate their findings to the OQA-MLTSS unit.

### INTERNAL QUALITY COMMITTEE (IQC)

The Internal Quality Committee, consisting of the Medicaid Medical, Dental and Pharmacy Directors, Office of Managed Health Care (OMHC), Directors of OQA and OQA-MLTSS will meet on a monthly basis to discuss their analyses of the NJMF/M quality and monitoring reports received, including those related to MLTSS activities and critical incidents. OMHC, DoAS and DDS also will attend the monthly Quality Committee. **The Internal Quality Committee will recommend feedback to the MCOs and corrective actions will be requested when necessary.** On a quarterly basis, the Internal Quality Committee will make recommendations to the Interdivisional/Interdepartmental Quality Leadership Conference.

## INTERDIVISIONAL/INTERDEPARTMENTAL QUALITY LEADERSHIP CONFERENCE (IQLC)

The Quality Leadership Conference, consisting of DMAHS OQA; OQA-MLTSS unit; Office of the Chief of Operations; OMHC; DoAS; DDS; Division of Developmental Disabilities (DDD); Division of Mental Health and Addiction Services (DMHAS); and Department of Children and Families (DCF) will meet quarterly to review the findings and recommendations identified by the IQC during its review of the NJFC/M reports and projects, including those related to MLTSS. The Quality Leadership Conference will report its findings to the Director of Medicaid including a dashboard of metrics related to the quality and monitoring reports and projects, such as: Performance Measures, Quality Improvement Projects, Critical Incidents, MLTSS Measures and the status of any outstanding MCO corrective action plans. The Medicaid Director will advise the Quality Leadership Conference of any further action to be taken and in turn the Quality Leadership Conference will advise the Quality Committee.

The Quality Leadership Conference will provide an opportunity for dialogue, exchange of information, identification of best practices, discussion of strategies for continuous quality and performance improvement, development of remediation strategies and feedback to participating agencies and program staff.

## INVOLVEMENT OF STAKEHOLDERS IN QUALITY MANAGEMENT

The Medicaid Director will report pertinent information regarding NJFC/M quality and access issues, including those related to MLTSS, to the Medical Assistance Advisory Committee (MAAC) on a quarterly basis. With regard to MLTSS, the Director of the Division of Aging Services and the Director of Medical Assistance and Health Services will report on quality and access issues to the MLTSS Steering Committee.

## MCO INVOLVEMENT

Currently, DMAHS convenes various meetings with the MCOs that afford them the opportunity to discuss quality matters. These meetings include: Quarterly Medical Director's meeting; Managed Care Operations meeting; Care Management meeting; Quarterly Medicaid Director's meeting; MLTSS Steering Committee and the MAAC, as well as ad hoc teleconferences with the EQRO.

## MLTSS TRANSITION OVERSIGHT

Prior to the transition into the Comprehensive Waiver, DoAS will conduct pre-transition calls with the MCOs and the Care Management Agencies to ensure that their lines of communication are established and functioning. There will be a dedicated point person located at DoAS who will relay pertinent information to the OQA-MLTSS unit.

To ensure a smooth transition of members from the 1915C waivers to MLTSS under Managed Care and the expansion of Medicaid eligibility, the DMAHS OMHC, together with the OQA-MLTSS unit will convene a daily Quality Leadership conference call jointly with all of the health plans during the first two weeks after MLTSS go-live, during which time the MCOs will be asked to report concerns and corrective actions to ameliorate them.

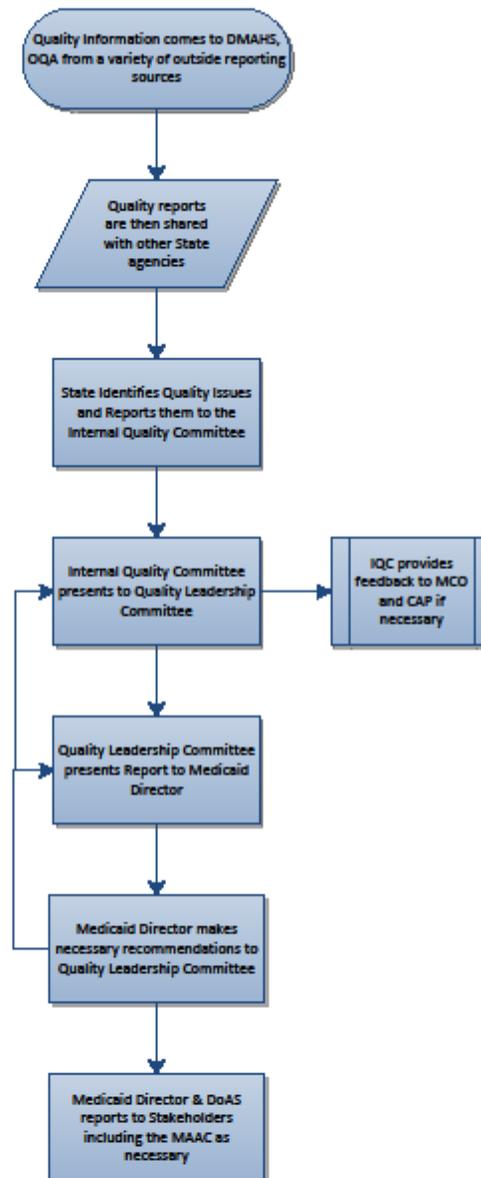
Thereafter, the State will assess the possibility of decreasing the frequency of meetings to biweekly during the remainder of the first 30 days of MLTSS implementation. The Quality Leadership

Conference will determine the schedule of conference calls beyond the first 30 days. The frequency of meetings during the second month will be based on the Conference's findings from the previous month.

#### COLLABORATION ON QUALITY WITH CMS

The State will participate in monthly monitoring calls with Centers for Medicare & Medicaid Services (CMS) to discuss any significant actual or anticipated issues affecting the Comprehensive Waiver.

## Quality Reporting Process



## OBJECTIVES

Healthy New Jersey 2020 is the NJ Department of Health (NJ DOH) health improvement plan and health promotion and disease prevention agenda for the decade. It is modeled after the federal Healthy People 2020 initiative and is the result of a multiyear process that reflects input from a diverse group of individuals and organizations. It seeks to attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; achieve health equity, eliminate disparities and improve health for all people; and promote quality of life, healthy development and healthy behaviors across all life stages.

In an effort to align our priorities with the NJ DOH Healthy New Jersey 2020, NJ DMAHS has established the following objectives to advance improvement in priority areas. New Jersey proposes to have the following rates, listed below, increase by 1-2 percentage points per year over 5 years. Please see Table 1 – Dashboards of Quality Strategy Objectives in the Improvement section.

Healthy NJ 2020 Topic	Objective	Data Source
Access	Children and Adolescent's Access to Primary Care	MCO HEDIS*
Access	Adults' Access to Preventive Care	MCO HEDIS
Birth Outcomes	In development by Office of Research	Office of Research Encounter Data
Childhood Immunizations	Childhood Immunizations Combination 3	MCO HEDIS
Obesity	BMI Assessment for Children and Adolescents	MCO HEDIS
Obesity	Adult BMI Assessment	MCO HEDIS
Diabetes	HbA1c Testing	MCO HEDIS
Diabetes	HbA1c control (<8.0%)	MCO HEDIS
Blood Pressure	Controlling High Blood Pressure	MCO HEDIS
Annual Preventive Dental Visits – by Dual, Disability, Other and Total Categories	Access to dental visits	MCO HEDIS
CAHPS (Utilization)	Percentage of respondents who responded “None” to question UT1. “In the last 6 months, how many times did you go to an emergency room to get health care for yourself?”	CAHPS *
CAHPS (Satisfaction)	Percentage of respondents who responded “Always” to composite questions Adult Q 4 & 6 that asked how often you got health care when needed care right away/an appointment with a doctor/clinic as soon as you thought you needed	CAHPS

	it.	
CAHPS (Satisfaction)	Percentage of respondents who responded “Always” to composite Child questions Q 4 & 6 that asked how often you got health care for your child when it was needed right away/an appointment with a doctor/clinic as soon as you thought your child needed it.	CAHPS
Care Management Audits	High/low range of MCOs final annual scores for: Identification, Outreach, Continuity of Care and Coordination of Services.	File Review
MLTSS measure	Hospital admissions of members using HCBS	MCO data
MLTSS measure	ER utilization of members using HCBS	MCO data
MLTSS measure	Nursing Facility (NF) Short stay admissions of members using HCBS	MCO data

\*Healthcare Effectiveness and Data Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) are nationally recognized tools to measure the quality of healthcare.

## HEALTH INFORMATION TECHNOLOGY

DMAHS recognizes the critical role of health information technology (HIT) as a transformation enabler. Current deficiencies in health system integration arising from information silos have impeded care coordination and resulted in duplication of services, medical errors and administrative inefficiencies. DMAHS continues to explore and implement initiatives that will promote health information exchange (HIE), adoption of interoperable electronic health records (EHR) and use of technology tools that will lead to improved program/population management and integrated chronic care management.

Key strategies in promoting quality improvement are the assessment and design of New Jersey’s Medicaid Information Technology Architecture (MITA) and the Master Client Index (MCI) Project. The MITA assessment is in progress. The MCI Project is currently under development. The MCI is the foundation for accurate data exchange between NJ Medicaid and its partner agencies. The three participating source systems for the MCI project are the NJ MMIS database, New Jersey Department of Health (DOH) Immunization Registry and the NJ DOH Lead Registry. The MCI will provide the identity management necessary to associate data that resides in Medicaid, Immunization and Blood Lead Screening databases for the same person where the person demographics lack 100% consistency with regard to format and content. The MCI is used to cross-reference client identifiers across each participating information system to uniquely identify each client, perform global searches and matching, consolidate duplicate client records, and create complete views of client information and share data easily across multiple facilities and information systems. DMAHS envisions that these initiatives will facilitate the flow of enrollee-centered health information to improve quality, patient safety and cost-effectiveness of health programs.

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## ASSESSMENT

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### A. QUALITY AND APPROPRIATENESS OF CARE AND SERVICES

#### EXTERNAL QUALITY REVIEW ACTIVITIES

DMAHS is responsible for ensuring that Medicaid MCOs meet quality and compliance standards. As part of this process and in accordance with the requirements of the Centers for Medicare & Medicaid Services (CMS), DMAHS currently contracts with Island Peer Review Organization (IPRO) as the External Quality Review Organization (EQRO) for DMAHS. In accordance with 42 CFR 438.358, IPRO performs the following activities on behalf of DMAHS:

##### Mandatory activities

- Validation of quality improvement projects (QIPs)
- Validation of performance measures (PMs)
- Review of MCO compliance with State standards for access to care structure and operations; and quality measurement and improvement (Assessment of MCO Operations)

##### Optional activities

- Conduct studies on quality that focus on a particular aspect of health services
- Conduct a care/case management audit
- Individual Case Review
- Development of New Jersey Performance Measures
- Encounter Data Validation

**42 CFR 438.358 Activities related to external quality review.**

- (a) General rule. The State, its agent that is not an MCO, PIHP, or an EQRO may perform the mandatory and optional EQR-related activities in this section.
- (b) Mandatory activities. For each MCO and PIHP, the EQR must use information from the following activities:
- (1) Validation of performance improvement projects required by the State to comply with requirements set forth in 438.240 (b) (1) and that were underway during the preceding 12 months.
  - (2) Validation of MCO or PIHP performance measures reported (as required by the State) or MCO or PIHP performance measure calculated by the State during the preceding 12 months to comply with requirements set forth in 438.240 (b)(2).
  - (3) A review, conducted within the previous 3-year period, to determine the MCO's or PIHP's compliance with standards (except with respect to standards under 438.240(b)(1) and (2), for the conduct of performance improvement projects and calculation of performance measures respectively) established by the State to comply with the requirements of 438.204(g).
- (c) Optional activities. The EQR may also use information derived during the preceding 12 months from following optional activities:
- (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 of performance improvement projects in addition to those conducted by an MCO or PIHP and validated by an EQRO.
- (5) Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services at a point in time.
- (d) Technical assistance. The EQRO may, at the State's direction, provide technical guidance to groups of MCOs or PIHPs that assist them in conducting activities related to the mandatory and optional activities that provide information for the EQR.

## Quality Technical Report

In compliance with 42 CFR 438.364, on an annual basis, the EQRO prepares a Quality Technical Report (QTR) that summarizes the findings of EQRO activities and provides a comprehensive, comparative analysis and review of progress and areas of concern as they relate to the quality, access and timeliness of care provided by the MCOs to enrollees. The report follows the Centers for Medicare and Medicaid Services (CMS) guidelines for Annual Technical Reports and includes: objectives; technical methods of data collection and analysis; description of data obtained and conclusions drawn from that data; assessment of strengths (best practices) and weaknesses (opportunities for improvement) regarding quality, timeliness and access to health care rendered to the NJFC/M members, including those enrolled in the MLTSS program; recommendations for improvement; and an assessment of how effectively the MCOs have addressed the recommendations made in the previous year. This information is available upon request to various stakeholders, including potential members, members, advocacy groups, as well as the general public, in any format necessary.

### **42 CFR 438.364**

- (a) Information that must be produced. The State must ensure that the EQR produces at least the following information:
  - (1) A detailed technical report that describes the manner in which the data from all activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and conclusions were drawn as to the timeliness, and access to the care furnished by the MCO. The report must also include the following for each activity conducted in accordance with 438.358:
    - (i) Objectives.
    - (ii) Technical methods of data collection and analysis.
    - (iii) Description of data obtained.
    - (iv) Conclusions drawn from the data.
  - (2) An assessment of each MCOs strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients.
  - (3) Recommendation for improving the quality of health care services furnished by each MCO.
  - (4) As the State determines methodologically appropriate, comparative information about all MCOs.
  - (5) An assessment of the degree to which each MCO has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's

EQR.

- (b) Availability of information. The State must provide copies of the information specified in paragraph (a) of this section, upon request, through print or electronic media, to interested parties such as participating health care providers, enrollee and potential enrollees of the MCO, recipient advocacy groups, and member of the general public. The State must make this information available in alternative formats for persons with sensory impairments, when requested.
- (c) Safeguarding patient identity. The information released under paragraph (b) of this section may not disclose the identity of any patient.

Clinical Standards/Guidelines

Per Goals 1 through 4, each year, contracted MCOs are required to submit an annual work plan that includes a schedule of clinical standards to be developed, medical care evaluations and other key quality assurance activities to be completed. The guidelines must meet the requirements of 42 CFR 438.236 for the management of selected diagnoses and basic health maintenance; be based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field; take into consideration the needs of the contractor's enrollees; and be updated in consultation with contracting health care professionals. All standards, protocols and guidelines are to be reviewed and updated periodically, as appropriate, and must be distributed to all providers and upon request to enrollees or potential enrollees. MCO decisions regarding utilization management, member education, coverage of services, etc. must be consistent with these guidelines. In addition, MCOs are required to have procedures for monitoring the quality and adequacy of medical care including assessing the use of distributed guidelines and assessing possible under-treatment/under-utilization of services.

Data on Race, Ethnicity and Primary Language

Per Goals 2 and 3, each MCO is provided with the race/ethnicity and the primary language spoken of their enrollees via the Plan Selection Form that is processed by the Health Benefits Coordinator (HBC). The Contract requires MCOs to have Member Services staff that includes individuals who speak English, Spanish and any other language that is spoken as a primary language by a population that exceeds five (5) percent of the MCO's enrollees or two hundred (200) enrollees in the contractor's plan, whichever is greater. Additionally, the MCO provider networks must include providers who can accommodate the different languages of the enrollees. If the language and/or cultural needs of an enrollee are known to the MCO and the MCO has not received information on the enrollee's selected Primary Care Physician (PCP), the MCO is expected to assign the enrollee to a PCP who is or has office staff who are linguistically and culturally competent to communicate with the enrollee or have the ability to interpret in the provision of health care services and related activities during the enrollee's office visits or contacts. Article 5.14 of the managed care contract details the requirements for the provision of culturally competent services.

**NJFC/Medicaid Managed Care Contract 5.14**

**CULTURAL AND LINGUISTIC NEEDS**

The contractor shall participate in the Department's Cultural and Linguistic Competency Task Force, and cooperate in a study to review the provision of culturally competent services. The

contractor shall address the relationship between culture, language, and health care outcomes through, at a minimum, the following Cultural and Linguistic Service requirements.

A. Physical and Communication Access. The contractor shall provide documentation regarding the availability of and access procedures for services which ensure physical and communication access to: providers and any contractor related services (e.g. office visits, and health fairs); customer service or physician office telephone assistance; and, interpreter, TDD/TT services for individuals who require them in order to communicate. Document availability of interpreter, TDD/TT services.

B. Twenty-four (24)-Hour Interpreter Access. The contractor shall provide twenty-four (24)-hour access to interpreter services for all enrollees including the deaf or hard of hearing at provider sites within the contractor's network, either through telephone language services or in-person interpreters to ensure that enrollees are able to communicate with the contractor and providers and receive covered benefits. The contractor shall identify and report the linguistic capability of interpreters or bilingual employed and contracted staff (clinical and non-clinical). The contractor shall provide professional interpreters when needed where technical, medical, or treatment information is to be discussed, or where use of a family member or friend as interpreter is inappropriate. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical. The contractor shall provide for training of its health care providers on the utilization of interpreters.

C. Interpreter Listing. Throughout the term of this contract, the contractor shall maintain a current list of interpreter agencies/interpreters who are "on call" to provide interpreter services.

D. Language Threshold. In addition to interpreter services, the contractor will provide other linguistic services to a population of enrollees if they exceed five (5) percent of those enrolled in the contractor's NJFC/M line of business or two hundred (200) enrollees in the contractor's plan, whichever is greater.

E. The contractor shall provide the following services to the enrollee groups identified in D above.

1. Key Points of Contact

- a. Medical/Dental: Advice and urgent care telephone, face to face encounters with providers
- b. Non-medical: Enrollee assistance, orientations, and appointments

2. Types of Services

- a. Translated signage
- b. Translated written materials
- c. Referrals to culturally and linguistically appropriate community services programs

F. Community Advisory Committee. Contractor shall implement and maintain community linkages through the formation of a Community Advisory Committee (CAC) with demonstrated participation of consumers (with representatives of each Medicaid/NJ FamilyCare eligibility category- See Article 5.2), community advocates, and traditional and safety net providers. The contractor shall ensure that the committee responsibilities include advisement on educational and operational issues affecting groups who speak a primary language other than English and cultural competency.

G. Group Needs Assessment. Contractor shall assess the linguistic and cultural needs of its enrollees who speak a primary language other than English. The findings of the assessment shall be submitted to DMAHS in the form of a plan entitled, "Cultural and Linguistic Services Plan" at the end of year one of the contract. In the plan, the contractor will summarize the

methodology, findings, and outline the proposed services to be implemented, the timeline for implementation with milestones, and the responsible individual. The contractor shall ensure implementation of the plan within six months after the beginning of year two of the contract. The contractor shall also identify the individual with overall responsibility for the activities to be conducted under the plan. The DMAHS approval of the plan is required prior to its implementation.

H. Policies and Procedures. The contractor shall address the special health care needs of all enrollees. The contractor shall incorporate in its policies and procedures the values of (1) honoring enrollees' beliefs, (2) being sensitive to cultural diversity, and (3) fostering respect for enrollees' cultural backgrounds. The contractor shall have specific policy statements on these topics and communicate them to providers and subcontractors.

I. Mainstreaming. The contractor shall be responsible for ensuring that its network providers do not intentionally segregate DMAHS enrollees from other persons receiving services. Examples of prohibited practices, based on race, color, creed, religion, sex, age, national origin, ancestry, marital status, sexual preference, income status, program membership or physical or mental disability, include, but may not be limited to, the following:

1. Denying or not providing to an enrollee any covered service or access to a facility.
2. Providing to an enrollee a similar covered service in a different manner or at a different time from that provided to other enrollees, other public or private patients or the public at large.
3. Subjecting an enrollee to segregation or separate treatment in any manner related to the receipt of any covered service.
4. Assigning times or places for the provision of services.
5. Closing a provider panel to DMAHS beneficiaries but not to other patients.

J. Resolution of Cultural Issues. The contractor shall investigate and resolve access and cultural sensitivity issues identified by contractor staff, State staff, providers, advocate organizations, and enrollees.

## QUALITY AND MONITORING IMPROVEMENT ACTIVITIES

### ASSESSMENT OF MCO OPERATIONS

Frequency: Annual

Description:

The EQRO conducts an annual assessment of MCO operations that includes a review of policies and procedures and their implementation. The assessment may comprise an offsite and onsite review to determine MCO compliance with State and federal Medicaid managed care regulations, including adherence to and effectiveness of individual MCO Quality Assurance Programs (QAP). The assessment is designed to validate, quantify and monitor the quality of each MCO's structure, processes and outcomes. The time period under review is the 12 months prior to the visit.

Each review element will be evaluated on a three-tiered scoring system. The finding of each element will be one of the following:

- Met – all requirements within the element are in full compliance

- Not Met – not all of the requirements within the element are in full compliance
- N/A – the requirement is not applicable to the MCO being reviewed

Year 1, considered the baseline year, involves a comprehensive review of all requirements for all MCOs. Any MCOs with a compliance rate under 85% must undergo a comprehensive review of all requirements in the succeeding year. MCOs with a compliance rate of 85% or better would be subject to only an interim review focusing on areas needing improvement; specifically, those review elements that were Not Met or Not Applicable during the comprehensive review. All MLTSS-related elements will be reviewed annually for the first several years after the implementation of the Comprehensive Waiver, however, to ensure program compliance before being considered eligible for interim review.

MCOs that perform well in Year 1, and therefore, have an interim review in Year 2 would have a full review in Year 3 regardless of the findings of the interim review. The MCOs that receive a full review in Year 2 and subsequently had a compliance rating of 85% or better would have an interim review in Year 3. MCOs that continue to receive a compliance rating below 85% would continue to have comprehensive reviews. MCOs have to provide a Corrective Action Plan (CAP) within 45 days of receiving the report to address elements that were not met in the Annual Assessment. The corrective actions are monitored by the OQA.

The annual assessment is separated into 13 sections by category, as follows:

- Access
- Quality Assessment and Performance Improvement Quality Management
- Committee Structure
- Programs for the 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

The review explores each MCO's operations in order to determine whether:

- Quality of care and services provided enrollees meet professionally recognized standards;
- Services are rendered in the appropriate setting and are accessible and timely;
- Services are appropriate for individual patient needs;
- Services are provided in accordance with MCO contract and federal and State requirements;
- There is a potential for under- or over-treatment and/or under- or over-utilization of services;
- There are disparities in the delivery of healthcare services.

The Annual Assessment of MCO Operations addresses Goals 1-4 and is designed to show trends, best practices, deficiencies, other areas of concern and opportunities for improvement covering all areas of the assessment. The analysis will reflect:

- An accurate and reliable description of the care delivered to NJFC/M clients;
- A clear identification of instances in which care can be improved and a baseline for future assessments to determine whether care has been improved;
- Priority attention to clinical conditions and health services delivery issues that have the greatest prevalence and incidence, potential for improving health outcomes and possible impact on care;
- Discussion of how the MCO is identifying and addressing disparities in health care outcomes; and
- A focus on how the MCO evaluates outcomes for its initiatives.

#### PERFORMANCE MEASURE VALIDATION

Frequency: Annual

Description:

As a part of the Annual Assessment, the EQRO validates the MCO performance measures in a manner consistent with the CMS protocol – Validating Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities. The review criteria are the requirements of the MCO contract, the CMS Protocol for Validating Performance Measures and NCQA Healthcare Effectiveness and Data Information Set (HEDIS) technical specifications. The performance measures are analyzed by the EQRO and the State to detect trends and deficiencies in healthcare services and to identify where quality improvement activities are needed to bring about positive change. MCOs are asked to submit a work plan within 45 days of request for any required HEDIS Measures that fall below the national average. Failure to submit an effective work plan may result in a Notice of Deficiency (NOD) and Request for Corrective Action Plan (CAP). Continued deficiency may result in a Notice of Intent to Sanction (NOIS) followed by a Notice of Sanction (NOS) if the MCO fails to appropriately remedy the issue. For more information regarding see the section of this document Level of Contract Compliance – Methods of Remediation that describes the process for issuing Sanctions. This activity is conducted to address Goals 1, 2 and 3.

HEDIS	2012 Combined MCO Average	2013 Combined MCO Average	2013 NCQA 50th Percentile	Core Set
<b>Childhood Immunization</b>				
Combination 2	70.61	70.49	76.89	Child
Combination 3	65.74	64.97	72.88	Child

<b>Immunizations for Adolescents</b>				
Combination 1	81.05	83.33	68.59	Child
Meningococcal	82.94	86.16	71.07	Child
Tdap/Td	90.00	88.50	85.19	Child
<b>Lead Screening in Children</b>	79.74	79.48	72.26	
<b>Well-Child Visits in the First 15 Months of Life 6 or More Visits</b>	66.83	66.74	65.16	Child
<b>Well-Child Visits in the Third, Fourth, Fifth and Six Years of Life</b>	78.97	78.48	72.26	Child
<b>Adolescent Well Child Care Visits</b>	57.76	62.33	48.18	Child
<b>Appropriate Testing for Children with Pharyngitis</b>	48.37	58.57	70.30	Child
<b>BMI assessment for children/adolescents</b>				
3-11 Years	51.10	51.60	52.88	Child
12-17 Years	53.49	47.80	53.66	Child
Total	51.87	50.40	52.31	Child
<b>Breast Cancer Screening</b>	52.80	52.73	51.32	Adult
<b>Cervical Cancer Screening</b>	64.82	64.23	66.42	Adult
<b>Chlamydia Screening</b>				
16-20 Years	49.52	47.38	53.80	Child
21-24 Years	59.91	55.61	64.58	Adult
Total	53.97	50.75	57.30	
<b>Use of Appropriate Medications for People With Asthma</b>				
5-11 Years	87.58	83.50	90.31	Child
12-18 Years	82.46	78.64	85.88	Child
19-50 Years	75.63	74.25	74.76	
51-64 Years	79.01	77.43	72.50	Adult
Total	82.95	79.84	84.70	Child/Adult
<b>Comprehensive Diabetes Care</b>				
HbA1c Testing	79.38	78.12	83.16	Adult
HbA1c Poor Control (>9.0%)	45.25	45.68	43.02	Adult
HbA1c Control (<8.0%)	46.36	45.41	48.57	Adult
HbA1c Control (<7.0%) for a Selected Population	34.15	35.54	34.76	Adult
Eye Exam	54.41	54.09	54.31	Adult
LDL-C Screening	78.48	78.50	76.28	Adult
LDL-C <100 mg/dL	34.91	33.29	34.89	Adult
Medical Attention for Nephropathy	76.21	74.53	79.23	Adult

Blood Pressure Controlled <140/80 mm Hg	34.29	36.99	38.89	Adult
Blood Pressure Controlled <140/90 mm Hg	56.83	58.99	61.03	Adult
<b>Prenatal and Post-Partum Care</b>				
Timeliness of Prenatal Care	83.44	83.95	85.88	Child
Postpartum Care	58.16	61.16	63.99	Child
Frequency of On-Going Prenatal (81+ Percent of Expected Prenatal Visits)	56.22	62.20	64.70	Child
<b>Follow-up for Children Prescribed ADHD Medication- Initial Phase</b>				
	31.25	32.27	39.76	Child
<b>Follow-up Care After Hospitalization for Mental Illness (DDD)</b>				
30 Day Follow-up	31.00	43.47	68.85	Child/Adult
7 Day Follow-up	14.66	22.80	44.66	Child/Adult
Adult BMI	-	65.41	72.09	Adult
Controlling High Blood Pressure	-	51.70	56.20	Adult
Annual Monitoring for Patients on Persistent Medications-Total	-	83.68	85.39	Adult
Ambulatory Care ER visits per 1,000 Member Months- Total Medicaid		55.30	65.65	Child/Adult
<b>Children's and Adolescents' Access to Primary Care- Total Medicaid</b>				
12 – 24 months	-	97.42	96.89	Child
25 months – 6 years	-	91.20	89.39	Child
7 – 11 years	-	93.24	90.88	Child
12 -19 years	-	91.55	89.58	Child
<b>New Jersey-Specific Performance Measures</b>				
Annual Preventive Dental Visits	-	-	-	Child
Adults' Access to Preventive Care	-	-	-	Adult

As New Jersey moves forward with various program requirements, (Comprehensive Waiver; Dual Eligible Special Needs Program (D-SNP); Children's Health Insurance Reauthorization Act (CHIPRA)), DMAHS is reviewing additional HEDIS measures including those found in the CHIPRA Pediatric Core Measurements and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults. Additionally, DMAHS has developed New Jersey-specific special needs

performance measures that have been included in the State Managed Care Contract. This will be done to address the health care needs of the expanding diversity of this population.

## QUALITY IMPROVEMENT PROJECTS

Frequency: Annual

Description:

Pursuant to 42 CFR 438.240(b)(1) and (d), Quality Improvement Projects (QIPs) are structured long term quality improvement activities that are intended to improve services; care or health outcomes in a particular area of health care and include:

- Project topic, including: rationale, objectives, baseline and benchmark data and goal;
- Methodology, including: population description, indicators, sampling methodology, baseline and re-measurement periods and data collection procedures;
- Interventions, including: description, target of the intervention and barriers;
- Results, including: number of cases in the project, re-measurement rates for indicators and statistical test results; and
- Conclusions, including: whether objectives were met, explanations and synopsis of the major findings, limitations, barrier and next steps.

The EQRO reviews the quality improvement projects (QIPs) designed by the MCOs as required by the Contract. The EQRO will monitor, advise and validate the development, implementation and evaluation of each MCO's QIPs utilizing the three activities specified in the CMS protocol, Validating Performance Improvement Projects (PIPs): 1) assess the MCO's methodology for conducting the QIP; 2) verify actual QIP study findings; and 3) evaluate overall validity and reliability of study results. This activity addresses Goals 1, 2 and 3.

Currently, the State is initiating a QIP around obesity. This topic was chosen because obesity is thought to be the root cause of many disease processes and aligns with the Healthy New Jersey 2020.

### **42 CFR 438.240 Quality Assessment and performance improvement program.**

(a) General rules.

- (1) The State must require, through its contracts, that each MCO and PIHP have an ongoing quality assessment and performance improvement program for the services it furnishes to it enrollees.
- (2) CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by State in their contracts with MCOs and PIHPs.

(b) Basic elements of MCO and PIHP quality assessment and performance improvement

programs. At a minimum, the State must require that each MCO and PIHP comply with the following requirements:

(1) Conduct performance improvement projects as described in paragraph (d) of this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollees satisfaction.

**42 CFR 438.240 (d)**

(d) Performance improvement projects.

(1) MCOs and PIHPs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas, and that involve the following:

- (i) Measurement of performance using objective quality indicators.
- (ii) Implementation of system interventions to achieve improvement in quality.
- (iii) Evaluation of the effectiveness of the interventions.
- (iv) Planning and initiation of activities for increasing or sustaining improvement.

(2) Each MCO and PIHP must report the status and results of each project to the State as requested. Including those that incorporate the requirements of 438,240(a)(2). Each performance improvement project must be complete in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

**QUALITY ACTIVITIES**

The Offices of Quality Assurance (OQA), OQA-MLTSS and the Dual Integration unit of the OMHC are units comprised of health professionals and program specialists who oversee various quality monitoring and improvement functions. The OQA is responsible for the oversight of the NJFC/M monitoring. The OQA-MLTSS is responsible for the oversight of the MLTSS monitoring. The Dual Integration unit of the OMHC is responsible for the oversight of the DSNP monitoring. The various monitoring reports and activities are listed below. Failure to submit any of the reports or participate in any of the activities listed below may result in a Notice of Deficiency (NOD) and Request for CAP. Continued deficiency may result in a Notice of Intent to Sanction (NOIS) followed by a Notice of Sanction (NOS) if the MCO fails to appropriately remedy the issue. For more information regarding see the section of this document Level of Contract Compliance – Methods of Remediation that describes the process for issuing Sanctions.

Frequency	Report	NJFC/M (including MLTSS)	MLTSS	DSNP
Annual	Assessment of MCO Operations	X	X	X
Annual	Performance Measure Validation	X	X	X

Annual	Quality Improvement Projects	X		X
Annual	Work Plan for Quality Assessment and Performance Improvement (QAPI) Activities	X		X
Annual	Annual Report on Quality Assurance Activities	X		X
Annual	After Hour Physician Availability Study	X		
Annual	Appointment Availability Study	X		
Annual	Twenty-Four Hour Access Report	X		
Annual	Focused Studies	X		
Annual	Care/Case Management Audit	X	X	
Annual	MCO Provider Lead Screening Rates	X		
Annual	CAHPS (Consumer Assessment of Healthcare Provider's and Systems)	X		X
Annual	Satisfaction Survey of Participating Providers	X		
Annual	Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Rates	X		
Annual	EQRO Technical Report	X		
Annual	Managed Care Program Quality Report	X		
Annual	Annual Executive Summary of Critical Incidents		X	
Semi-Annually	Documentation of Ongoing Internal Quality Assurance Activities	X		X
Semi-Annual	Follow-up of Lead Burdened Children	X		
Quarterly	Provider Network File	X		X
Quarterly	Geo-Access	X		X
Quarterly	Grievance and Appeals	X		X
Quarterly	Member and Provider Complaints	X		X
Quarterly	Ratio of Prior Authorizations Denied to	X		X

	Requested			
Quarterly	Survey of New Enrollees	X		
Quarterly	MLTSS Critical Incident Report		X	
Monthly	Medical/Dental Spot Checks	X		

## MONITORING OF MCO QUALITY ASSURANCE REPORTS

The Contract requires the MCOs to submit the following reports that are reviewed by the OQA staff. This review activity addresses Goals 1-4. Failure to submit any of the reports or participate in any of the activities listed below may result in a Notice of Deficiency (NOD) and Request for CAP. Continued deficiency may result in a Notice of Intent to Sanction (NOIS) followed by a Notice of Sanction (NOS) if the MCO fails to appropriately remedy the issue. For more information regarding see the section of this document Level of Contract Compliance – Methods of Remediation that describes the process for issuing Sanctions.

### 1. Work Plan for QAPI Activities

Frequency: Annual

Description:

MCOs develop and submit annually a work plan of expected accomplishments which includes a schedule of clinical standards to be developed, medical care evaluations to be completed and other key quality assurance activities. The QAPIs must be based on CMS guidelines.

### 2. Annual Report on Quality Assurance Activities

Frequency: Annual

Description:

MCOs prepare and submit on an annual basis a report of quality assurance activities which demonstrate the MCO's accomplishments, compliance and/or deficiencies in meeting its previous year's work plan and should include studies, subsequent actions and aggregate data on utilization and clinical quality of medical care rendered.

### 3. Documentation of Ongoing Internal Quality Assurance Activities

Frequency: Semi-annual

Description:

MCOs are required to submit, on a semi-annual basis, documentation of its ongoing internal quality assurance activities with its medical professionals and other staff. This includes, but is not limited to, agendas of quality assurance meetings and attendance sheets with attendee signatures.

## NETWORK ADEQUACY ASSURANCE

### 1. Provider Network File Monitoring

Frequency: Quarterly

Description:

Per Goals 1 and 2, MCO provider networks are analyzed quarterly to ascertain compliance with Contract standards. New methods utilizing National Provider Identification (NPI) numbers are being implemented to ensure the accurate assessment of provider networks with regard to how participating providers actually are serving in the networks and where services are being rendered.

PCPs and Primary Care Dentists (PCDs) are evaluated by county on enrollment capacity requirements and ratios in combination with geographic accessibility analysis. The evaluation of specialty and institutional services utilizes a geographic access-based methodology. These evaluations require the MCOs to establish, maintain and monitor, at all times, a network of appropriate providers that is in full compliance with 42 CFR 438.206 and N.J.A.C. 11:24-6 et seq., supported by written agreements and sufficient to provide adequate access to all services covered under the NJFC/M contract. Deficiencies may result in a NOD and Request for CAP. Continued deficiency may result in a Notice of Intent to Sanction (NOIS) followed by a Notice of Sanction (NOS) if the MCO fails to appropriately remedy the issue. For more information regarding see the section of this document Level of Contract Compliance – Methods of Remediation that describes the process for issuing Sanctions.

**N.J.A.C. 11:24-6.2** requires that the MCOs must maintain primary, specialty, ancillary and institutional services sufficient to meet the health care service needs of its members. New Jersey DMAHS adheres to the NJ Department of Banking and Insurance requirement that the MCOs must have a policy assuring access to the specialists listed below within 45 miles or one hour driving time, whichever is less for 90% of its members within each county or approved service area: Cardiologist; Dermatologist; Endocrinologist; ENT; General Surgeon; Neurologist; Obstetrician/gynecologist; Oncologist; Ophthalmologist; Orthopedist; Oral Surgeon; Psychiatrist and Urologist. For specialists not identified, the MCO must have a policy for assuring access to such specialists within 45 miles or one hour driving time, whichever is less, of 90% of members within each county or approved sub-county area.

## 1. Geo-Access Reports

Frequency: Quarterly

Description:

Per Goals 1 through 3, MCOs are required to submit a Geographical Accessibility Availability Analysis Report. These reports are developed utilizing a geographical mapping tool to monitor MCO compliance with Provider Network Requirements for PCPs/PCDs and Acute Care Hospitals in urban and non-urban counties in which the MCO services. The analysis must meet specific access and mileage standards based on member location and distance to these providers. The MCO is required to submit reports on Adult PCPs that include Internal Medicine, Family and/or General Practice; Pediatric PCPs which include Family Practice, General Practice, Pediatricians; Primary Care Dentists (PCDs) and Acute Care Hospitals and 13 additional provider specialties identified in N.J.A.C. 11:24-6.2 (see above). The MCO must ensure the enrollees, including those with special health care needs, have timely and appropriate access to any specialist for any medically necessary services. For the New Jersey DMAHS definition of medically necessary services, refer to Appendix A. The OQA reviews the reports and requests additional information or a Corrective Action Plan (CAP) as appropriate.

### **NJFC/Medicaid Managed Care Contract 4.8.8**

Geographic Access. The contractor shall maintain networks that comply with the geographic access standards in accordance with N.J.A.C. 11:24-6 et seq. and with this contract for PCPs, primary care dentists and hospitals. The following lists guidelines for urban geographic access for the DMAHS population.

1. Beneficiary children who reside within 6 miles of 2 PCPs whose specialty is Family Practice, General Practice or Pediatrics or 2 CNPs/CNSs; within 2 miles of 1 PCP whose specialty is Family Practice, General Practice or Pediatrics or 1 CNP or 1 CNS
2. Beneficiary adults who reside within 6 miles of 2 PCPs whose specialty is Family Practice, General Practice or Internal Medicine or 2 CNPs or 2 CNSs; within 2 miles of 1 PCP whose specialty is Family Practice, General Practice or Internal Medicine or 1 CNP or 1 CNS
3. Beneficiaries who reside within 6 miles of 2 providers of general dentistry services; within 2 miles of 1 provider of general dentistry services
4. Beneficiaries who reside within 15 miles of acute care hospital.
5. Beneficiaries with desired access and average distance to 1, 2 or more providers
6. Beneficiaries without desired access and average distance to 1, 2 or more providers

Access Standards

1. 90% of the enrollees must be within 6 miles of 2 PCPs and 2 PCDs in an urban setting
2. 85% of the enrollees must be within 15 miles of 2 PCPs and 2 PCDs in a non-urban setting
3. Covering physicians must be within 15 miles in urban areas and 25 miles in non-urban areas.

Travel Time Standards

The contractor shall adhere to the 30 minute standard, i.e., enrollees will not live more than 30 minutes away from their PCPs, PCDs or CNPs/CNSs. The following guidelines shall be used in determining travel time.

1. Normal conditions/primary roads - 20 miles

2. Rural or mountainous areas/secondary routes - 20 miles
3. Flat areas or areas connected by interstate highways - 25 miles
4. Metropolitan areas such as Newark, Camden, Trenton, Paterson, Jersey City - 30 minutes travel time by public transportation or no more than 6 miles from PCP
5. Other medical service providers must also be geographically accessible to the enrollees.
6. Exception: Social Security's Supplemental Insurance program (SSI) or New Jersey Care-Aged, Blind or Disabled (ABD) enrollees and clients of DDD may choose to see network providers outside of their county of residence.

Conditions for Granting Exceptions to the 1:2000 Ratio Limit for Primary Care Physicians

1. A physician must demonstrate increased office hours and must maintain (and be present for) a minimum of 20 hours per week in each county.
2. In private practice settings where a physician employs or directly works with nurse practitioners who can provide patient care within the scope of their practices, the capacity may be increased to 1 PCP FTE to 3500 enrollees. The PCP must be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances will a PCP relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCP.
3. In private practice settings where a primary care physician employs or is assisted by other licensed, but non-participating physicians, the capacity may be increased to 1 PCP FTE to 3500 enrollees.
4. In clinic practice settings where a PCP provides direct personal supervision of medical residents with a New Jersey license to practice medicine in good standing with State Board of Medical Examiners, the capacity may be increased with the following ratios: 1 PCP to 2000 enrollees; 1 licensed medical resident per 1100 enrollees. The PCP must be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances will a PCP relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCP.
5. Each provider (physician or nurse practitioner) must provide a minimum of 15 minutes of patient care per patient encounter and be able to provide four visits per year per enrollee.
6. The contractor shall submit for prior approval by DMAHS a detailed description of the PCP's delivery system to accommodate an increased patient load, work flow, professional relationships, work schedules, coverage arrangements, and 24 hour access system.
7. The contractor shall provide information on total patient load across all plans, private patients, Medicaid fee-for-service patients, other.
8. The contractor shall adhere to the access standards required in the contractor's contract with the Department.
9. There will be no substantiated complaints or demonstrated evidence of access barriers due to an increased patient load.
10. The Department will make the final decision on the appropriateness of increasing the ratio limits and what the limit will be.

Conditions for Granting Exceptions to the 1:2000 Ratio Limit for Primary Care Dentists.

1. A PCD must provide a minimum of 20 hours per week per county.
2. In clinic practice settings where a PCD provides direct personal supervision of dental residents who have a temporary permit from the State Board of Dentistry in good standing and also dental students, the capacity may be increased with the following ratios: 1 PCD to 2000 enrollees per contractor; 1 dental resident per 1000 enrollees per contractor; 1 FTE dental student per 300 enrollees per contractor. The PCD shall be immediately available for

consultation, supervision or to take over treatment as needed. Under no circumstances shall a PCD relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCD.

3. In private practice settings where a PCD employs or is assisted by other licensed, but non-participating dentists, the capacity may be increased to 1 PCD FTE to 3500 enrollees.

4. In private practice settings where a PCD employs dental hygienists or is assisted by dental assistants, the capacity may be increased to 1 PCD to 3500 enrollees. The PCD shall be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances shall a PCD relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCD.

5. Each PCD shall provide a minimum of 15 minutes of patient care per patient encounter.

6. The contractor shall submit for prior approval by the DMAHS a detailed description of the PCD's delivery system to accommodate an increased patient load, work flow, professional relationships, work schedules, coverage arrangements, and 24 hour access system.

7. The contractor shall provide information on total patient load across all plans, private patients, Medicaid fee-for-service patients, other.

8. The contractor shall adhere to the access/appointment availability standards required in the contractor's contract with the Department.

9. There must be no substantiated complaints or demonstrated evidence of access barriers due to an increased patient load.

10. The contractor shall monitor the providers and practices granted an exception every other month to assure the continued employment of an adequate number and type of auxiliary personnel described in 4.8.8.L.4, to warrant continuation of the exception.

11. The contractor shall submit reports to the DMAHS, bi-monthly, of the additions, deletions or any other change of auxiliary personnel; and include the names, license numbers, functions and work schedules of each currently employed auxiliary staff.

12. The Department will make the final decision on the appropriateness of increasing the ratio limits and what the limit will be.

## 1. Medical and Dental Spot Checks

Frequency: Monthly

Description:

Per Goals 1 and 2, the Monthly Provider Spot Checks report is contractually required of each MCO. These reports are conducted by the MCO to verify the accuracy of its provider network file and to monitor its providers for actual participation in the network. The MCO must survey at least fifty percent (50%) of its specialty provider network, fifty percent (50%) of its PCP provider network, fifty percent (50%) of its OB/GYN providers and fifty percent (50%) of its dental network per county annually. Each monthly survey should be county-specific with all counties in which the MCO operates surveyed at least annually.

The survey questionnaire is designed to verify provider name, including correct spelling, practice type/specialty, address, phone number, MCO participation status, office hours and open/closed panel. The survey also queries the ability to accommodate special needs members.

The results of the provider spot check survey report must be month/county specific and include documentation of the corrective actions taken by the MCO as a result of the spot checks.

The OQA reviews the MCO reports for compliance and identifies any deficiencies in the Provider Spot Checks reporting specifications and/or the provider network file and network participation. The MCO is notified by the OQA of any deficiencies and corrective action is taken by the MCO.

## 2. MCO/Health Care Facility (Hospital)/Provider Group Termination

Frequency: Ad-hoc

Description:

The termination of a provider group or facility from an MCO's network may have significant impact on the care received by enrolled beneficiaries. To assure a smooth transition and prevent disruptions in care, the OQA monitors and works with the MCO.

In the event that an MCO is acquired by another MCO, the OQA will closely monitor and coordinate communication between both MCOs to ensure continuity of care for the members impacted by the transition. This activity addresses Goals 1, 2 and 3.

## 3. After-Hour Physician Availability Study

Frequency: Annual

Description:

MCOs conduct this study annually in order to monitor availability and accessibility to primary care providers. This study is designed to determine a provider's availability for telephone consultation after regular business hours. MCOs are to survey no less than (twenty-five percent) 25% of their PCP network and submit a report of the results along with the plan to address any unacceptable results (as detailed in the MCO Contract). The OQA staff review these reports and compare them with previous findings to assess the effectiveness of the corrective actions. Failure to submit an effective CAP may result in a Notice of Deficiency (NOD) and Request for CAP. Continued deficiency may result in a Notice of Intent to Sanction (NOIS) followed by a Notice of Sanction (NOS) if the MCO fails to appropriately remedy the issue. For more information regarding see the section of this document Level of Contract Compliance – Methods of Remediation that describes the process for issuing Sanctions. This activity addresses Goals 1 and 2.

## 4. Appointment Availability Study

Frequency: Annual

Description:

Per Goals 1 and 2, MCOs conduct an annual review of appointment availability and submit a report to the OQA. This report must 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. The OQA approves the methodology for this review in advance. The MCO must assess the impact of appointment waiting times on the health status of enrollees with special needs. Below is a table showing the contractually required maximum wait times for various types of appointments.

Type of Appointment	Maximum Wait Time
Emergency Services	Immediately upon presentation at a service delivery site
Urgent Care	Within twenty-four (24) hours. An urgent, symptomatic visit is an encounter with a health care provider associated with the presentation of medical signs that require immediate attention, but are not life-threatening
Symptomatic Acute Care	Within seventy-two (72) hours. A non-urgent, symptomatic office
Routine Care	Within twenty-eight (28) days. Shall not be limited to well/preventive care appointments such as annual gynecological examinations or pediatric and adult immunization visits
Specialist Referrals	Within four (4) weeks or shorter as medically indicated. A specialty referral visit is an encounter with a medical specialist that is required by the enrollee's medical condition as determined by the enrollee's Primary Care Provider (PCP). Emergency appointments must be provided within 24 hours of referral
Urgent Specialty Care	Within twenty-four (24) hours of referral
Baseline Physicals for New Adult Enrollees	Within one hundred-eighty (180) calendar days of initial enrollment.
Baseline Physicals for New Children Enrollees and Adult Clients of DDD	Within ninety (90) days of initial enrollment, or in accordance with EPSDT guidelines
Type of Appointment	Maximum Wait Time
Prenatal Care. Enrollees shall be seen within the following timeframes: <ul style="list-style-type: none"> <li>• Positive pregnancy test (home or laboratory)</li> <li>• Identification of high-risk</li> <li>• Request in first and second trimester</li> </ul>	<ul style="list-style-type: none"> <li>• Three (3) weeks</li> <li>• Three (3) days</li> <li>• Seven (7) days</li> </ul>

<ul style="list-style-type: none"> <li>• First request in third trimester</li> </ul>	<ul style="list-style-type: none"> <li>• Three (3) days</li> </ul>
Routine Physicals	Within four (4) weeks for routine physicals needed for school, camp, work or similar
Lab and Radiology Services	Three weeks for routine appointments; forty-eight (48) hours for urgent care
Waiting Time in Office	Less than 45 minutes
Initial Pediatric Appointments	Within three months of enrollment
Dental Appointment	
1. Emergency	No later than 48 hours or earlier as the condition warrants, of injury to sound natural teeth and surrounding tissue and follow-up treatment by dental provider
2. Urgent	Within 3 days of referral
3. Routine non-symptomatic	Within 30 days
MH/SA Appointment	
1. Emergency	Upon presentation
2. Urgent	Within 24 hours of request
3. Routine	Within 10 days of request
SSI and ABD elderly and disabled	Each such member shall be contacted by the MCO within 45 days of enrollment and offered an appointment date according to the needs of the member, except when the member has been identified through the enrollment process as having special needs shall be contacted within 10 business days of enrollment and offered an expedited appointment

5. 24 Hour Access Report

Frequency: Annual

Description

Per Goals 1 and 2, MCOs submit an annual report describing its 24-hour access procedures for enrollees. The report must include the names and addresses of any answering services that the MCO uses to provide 24-hour access.

UTILIZATION, QUALITY AND APPROPRIATENESS OF CARE

1. Focused Studies

Frequency: Annual

Description:

The State-contracted external quality review organization, conducts focused quality studies that provide detailed reviews and assessments of aspects of healthcare for defined clinical and non-clinical areas with the intent to improve quality of care and outcomes. The studies may utilize medical records, care/case management notes and administrative data. Where possible, the focused studies will utilize HEDIS measurements, EPSDT standards, guidelines and requirements of the following entities: New Jersey Department of Health; Centers for Disease Control; National Institutes of Health; National Committee for Quality Assurance; American Diabetes Association; The Joint Commission; American Pain Society; American Society of Anesthesiologists; American Geriatrics Society; American Medical Association; U.S. Public Health Service; World Health Organization; and Interdisciplinary Council on Developmental and Learning Disorders. This activity addresses Goals 1 -3.

2. Care/Case Management Audits

Frequency: Annual

Description:

The OQA monitors MCO care management through Focused Chart Audits conducted by the EQRO on behalf of the OQA. The records are evaluated for timely outreach, including early identification of special needs populations (DDD, Division of Child Protection and Permanency (DCP&P) and MLTSS); completion of an initial health screening, designed to quickly identify members who are in need of care management (except DCP&P, DDD and MLTSS members); a needs assessment and care plan if appropriate; different levels of care management; preventive services, like BMI percentile/value; care of lead-burdened children; adherence to lead screening protocols; establishment of appropriate linkages within and outside the MCO; continuity of care; coordination of services; and discharge planning following hospitalization. Currently, DMAHS is working with their EQRO to develop MLTSS-related elements to be included in the Care/Case Management tool to ensure the timely identification and appropriate assessment of the needs of the this population. The anticipated timeframe for implementation of this tool is July 2015.

Benchmarks have been established to determine MCO compliance with the NJFC/M Contract care management requirements. A performance standard of at least 60-80% is required. Depending on the repetition and/or severity of the deficiency, a Notice of Deficiency (NOD), Notice of Intent to Sanction (NOIS) or Notice of Sanction (NOS) may be issued. If a NOD is issued, the MCO must produce a Corrective Action Plan to correct any deficiencies. The effectiveness of the CAP will be evaluated at the next audit. This activity addresses Goals 1 – 3.

3. Individual Quality of Care Reviews

Frequency: As needed

Description:

The OQA may receive inquiries or referrals that indicate quality of care issues related to access, care coordination, patterns of care and/or the type of care provided. In such cases, the EQRO reviews the charts in question and the OQA reviews pertinent information and takes action to remediate the issue and prevent recurrence. This activity addresses Goals 1 -3.

#### 4. Follow-up of Lead-Burdened Children

Frequency: Semi-annual

Description:

To ensure that lead-burdened children receive appropriate follow-up care, a bi-annual review of a sample of MCO lead case management records is performed by the OQA staff. The New Jersey Medicaid Lead Screening Database (NJ MLSD) is also updated twice a year to facilitate the identification of children in need of lead tests and follow-up care. This activity addresses Goals 1 and 2.

#### 5. MCO Provider Lead Screening Rates

Frequency: Annual

Description:

MCOs are required to notify and educate Primary Care Providers (PCPs) who have a lead screening rate of less than 80% for two consecutive six-month periods. The OQA reviews documentation provided by the MCO on their efforts to educate these providers and how impediments to the screening are addressed annually. This activity addresses Goals 1 and 2.

#### 6. MCO Care for Persons with Disabilities and the Elderly and Initiatives for the Aged

Frequency: Annual

Description:

The MCO Quality Department must promote improved clinical outcomes and enhanced quality of life for elderly enrollees and enrollees with disabilities. This must include: oversight of quality of life indicators, such as: degree of personal autonomy; provision of services and supports that assist people in exercising medical and social choices; self-direction of care to the greatest extent appropriate; and maximum use of natural support networks. Additionally, the MCO must review: persistent or significant complaints; quality assurance policies and procedures to ensure that they adequately address the needs of this population; and utilization of services, including any adverse or unexpected outcomes. Annually, using professional standards of practice, the MCO must: develop written policies and procedures for assessing the quality of complex healthcare/care management; ensure MCO compliance with the American with Disabilities Act; institute effective health

management protocols for the elderly and disabled enrollees; and test methods to identify and collect quality measurements, including treatment efficacy related to elderly and disabled populations.

Annually, using professional standards of practice, the MCOs are required to implement initiatives tailored for the aged members through the development of programs and protocols approved by New Jersey DMAHS. Specifically, the MCOs must develop programs for the elderly that include: pneumococcal and influenza vaccines; programs for preventive cancer screenings; COPD, diabetes, heart disease, depression; cognitive impairments; and initiatives to prevent long term institutionalization; abuse and neglect. These initiatives must include: development, distribution and measurement of PCP compliance with practice guidelines; educational outreach to members and providers; and access to ambulatory and homebound. If deficiencies or issues are identified by the EQRO, the MCO has 45 days from the date of notification to take appropriate action and document the remedial action.

The MCOs are required to monitor and evaluate enrollee outcomes at least annually in the following areas: aspiration pneumonia; injuries; fractures and contusions, decubiti and seizure management. Compliance with these required activities is reviewed by the EQRO during the Annual Assessment of MCO Operations. This activity addresses Goals 1 and 2.

## DATA ANALYSIS

### 1. Grievance and Appeals

Frequency: Quarterly

Description:

MCOs are contractually required to submit electronically, using a predefined reporting format, utilization management (UM) and non-UM enrollee complaints, grievance/appeal requests and provider complaints, grievances/appeals and dispositions on a quarterly basis. The reports include information for the reporting quarter and all open cases to date and indicate the enrollee's name, NJFC/M ID number, date of birth, age, eligibility, category of complaint, as well as the date of the complaints, grievance/appeal, resolution and date of resolution. Complaint, grievance and appeal categories have been standardized to mirror the categories used by the Department of Banking and Insurance (DOBI). Additional managed long term services and supports categories will be added to the existing member UM, and non-UM reports and provider reports to ensure that these issues are tracked and trended correctly, so that appropriate action can be taken by the State when necessary. The data is archived in database format with basic descriptive statistics generated by reporting period. Individual grievances are monitored by OQA and OQA-MLTSS for appropriate and timely resolutions. Work plans addressing any outliers will be requested of MCOs as necessary. This activity addresses Goals 1, 2 and 4.

### 2. Member and Provider Complaints

Frequency: Quarterly

Description:

The OQA and OQA-MLTSS addresses member complaints and provider access to care issues that are received as Director Referrals, written correspondence, NJFC/M Hotline complaints and telephone inquiries. Member and provider complaints regarding access and quality are tracked in a database that is queried on a quarterly basis with descriptive results detailed in a report each quarter. Analysis of patterns and trends is conducted by the OQA. In April 2009, the OQA in conjunction with the Office of Information Systems (OIS) implemented a new database to track and trend complaints received by the OQA. This database also has the capability to identify which complaints have been made by MLTSS members, special needs members, duals and those impacted by the managed care transition. This activity addresses Goals 1, 2 and 4.

### 3. Ratio of Prior Authorizations Denied to Requested

Frequency: Quarterly

Description:

MCOs are required to submit this report on a quarterly basis. The OQA staff evaluates high percentages of denials based on the number of authorizations requested for areas that stand out as unusual. The MCO is required to provide an explanation for these outliers. Any unacceptable explanations may result in a NOD and request for Corrective Action Plan (CAP) may be issued to the MCO. As of the first quarter of 2009, the report was changed to reflect more accurately the total number of Prior Authorizations (PA) “resolved,” not only those denied, as was previously reported. Failure to submit an effective work plan may result in a Notice of Deficiency (NOD) and Request for Corrective Action Plan (CAP). Continued deficiency may result in a Notice of Intent to Sanction (NOIS) followed by a Notice of Sanction (NOS) if the MCO fails to appropriately remedy the issue. For more information regarding see the section of this document Level of Contract Compliance – Methods of Remediation that describes the process for issuing Sanctions. This activity addresses Goals 1, 2 and 4.

## SATISFACTION SURVEYS

### 1. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Frequency: Annual

Description:

The contracted vendor conducts the core Medicaid adult and child Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey allows the State to determine the Medicaid

managed care populations' perceived satisfaction with the care they are receiving from their MCOs. It measures whether these beneficiaries are getting useful and accurate information from their health plan; whether the MCO is meeting their health care needs; whether medical services are being utilized; and ease of access to services. Based on the CAHPS Health Plan Survey Report, each MCO submits a CAP to address the areas which would benefit from improvements. This activity addresses Goal 4.

## 2. Survey of New Enrollees

Frequency: Quarterly

Description:

The MCOs are required to survey new enrollees quarterly to determine enrollees understanding of the MCO's processes and available services. If there are any gaps in understanding, the enrollee is re-educated by the MCO. Additionally, the MCOs use a language line if there is a language barrier. The reports are reviewed on an Ad Hoc basis. This activity addresses Goal 4.

## 3. Satisfaction Survey of Participating Providers

Frequency: Annual

Description:

Each MCO must conduct an annual satisfaction survey using a statistically valid sample of its participating providers who serve the DMAHS managed care enrollees and submit a copy of the survey instrument and methodology to DMAHS. It must include at a minimum: questions that address provider opinions of the impact of the referral, prior authorization and provider processes on behalf of his/her practice/services; reimbursement methodologies; and care management assistance from the contractor. Additionally, the written report must include any corrective actions that need to be taken by the MCO as a result of the findings, timeframe in which the corrective action will be taken by the MCO and the recommended changes as needed for subsequent use. This activity addresses Goals 1 and 2.

## PERFORMANCE MEASUREMENT

### 1. Early Periodic Screening, Diagnosis and Treatment (EPSDT)

Frequency: Annual

Description:

The managed care contract has set a performance standard for the delivery of EPSDT services. Encounter data, lead screening data and HEDIS rates are used in ascertaining compliance to the standard. Under-performance results in the issuance of a Notice of Sanction (NOS) and request for a CAP. This activity addresses Goals 1 and 2.

## 2. External Quality Review Organization (EQRO) Reports

Frequency: Annual

Description:

Quality Technical Report (QTR): Utilizing the results of existing reports, the EQRO conducts a comprehensive analysis and review of progress and areas of concern as they relate to the quality, access and timeliness of care to NJFC/M enrollees. The MCOs must submit CAPs for any patterns of deficiency that have not already been addressed earlier in the year when OQA had received the individual reports. The report follows the Centers for Medicare and Medicaid Services (CMS) guidelines for Annual Technical Reports.

This annual report includes information from the current calendar year and prior 12-month period. The findings of the comprehensive analysis along with relevant benchmarks and best practices guide recommendations for improvement. This activity addresses Goals 1 and 2.

## MONITORING OF TRANSITIONED MEMBERS INTO MANAGED CARE

From July 1, 2011, through October, 1, 2011, approximately 150,000 Fee-for-Service beneficiaries were transitioned into the Managed Care program. These included the ABD/DDD population and the dual eligible not already enrolled, individuals who were previously exempted from managed care and those enrolled in waiver programs. The transition was accomplished in several enrollment tiers over a four month period and resulted in Contract changes, including two new plan benefit services: Medical Day Care (MDC) and Personal Care Assistant (PCA) coverage for Plan A members; and the Managed Care Organizations' (MCOs) coverage for most drugs for all enrollees, including DDD members. Atypical antipsychotic and anticonvulsant drugs ordered by a provider must be covered by the MCO. Formulary and prior authorization requirements apply only when the initial medication treatment plan has been changed by the prescriber.

Prior to the transition, the OQA planned and implemented a blueprint that was used as a means of written communication between DMAHS and each of the MCOs. The blueprint provided the venue for DMAHS to list their expectations and for the MCOs to describe their plans to provide accessible, appropriate and timely quality health care to the members impacted by the transition.

The complaints and inquiry phone lines were made available for any member or advocate who had an issue with access or quality of care. The same day that the pertinent information was received by the OQA, the MCO was notified with request to resolve the issue. The MCO started working on the resolution the same day as it was received. If a recurring issue was identified, the OQA worked

with the MCO to identify and fix the root cause. The timeframe for resolution varied, depending on the complexity of the complaint. The OQA continues to look for ways to enhance the complaint tracking system, including tracking the complaints of dual eligibles.

Currently, the NJFC/M contract, which includes MLTSS population, requires the MCOs to gather data in a number of areas that directly impact dual eligibles: initiatives for the elderly that require the ongoing development of programs and protocols including a program to ensure provision of a pneumococcal vaccine and influenza immunizations; a program to ensure the provision of preventive cancer screenings; specific programs for the care of the enrollees identified with congestive heart failure, chronic obstructive pulmonary disease, diabetes, hypertension and depression; and a program to prevent unnecessary or inappropriate nursing facility admissions. These initiatives have been long-standing contract requirements that pre-date the MLTSS and will continue. The NJFC/M contract, including the MLTSS population, requires MCOs to monitor and evaluate enrollee outcomes at least annually in the following areas: aspiration pneumonia; injuries; fractures and contusions, decubiti and seizure management. This activity addresses Goals 1, 2 and 3.

## **COMPREHENSIVE WAIVER**

### **MANAGED LONG TERM SERVICES AND SUPPORTS**

The New Jersey Comprehensive 1115 Medicaid Waiver was approved by CMS in October 2012. Implementation of the Home and Community Based Services (HCBS) and Nursing Facility (NF) services for “new-to-NF” members will begin July 2014. Current NF residents will remain fee-for-service for the lifetime of their stay. Current special care NF (SCNF) residents will remain in fee-for-service for two years. (SCNFs are NFs offering a higher level of acuity of care). Preparation and planning for the administration of Managed Long Term Services and Supports (MLTSS) were addressed through a steering committee and four work groups (Assuring Access; Assessment to Appeals; Provider Transition; and Quality and Monitoring). New Jersey’s overall goal for MLTSS is to provide quality long term services and supports to individuals of all ages in the most integrated, appropriate setting. The State will build a cost-effective; and therefore, sustainable system to accomplish this goal.

New Jersey convened an MLTSS Steering Committee that was comprised of 15 participants of the Medicaid Long Term Care Funding Advisory Council of New Jersey, managed care organizations and various consumers. The Medicaid Long Term Care Funding Council was established to monitor, assess and advise the commissioner on legislative matters and develop recommendations for a program to recruit and train a stable workforce of home care providers, including recommendations for changes to provider reimbursement under Medicaid home and community based care programs. The steering committee and the four work groups met over a three month period with various stakeholders to gather information to formulate recommendations. The work groups met at least bi-monthly and built a framework for discussion and learning. Stakeholders discussed best practices and information was shared with all work groups on a secure project site. The Center for Health Care Strategies (CHCS) offered technical support and Mercer Government

Human Services Consulting (Mercer) provided ongoing policy and program development support. The following principles were developed by the steering committee and work groups:

- Home and Community Based Services (HCBS) is the preferred service delivery method for people receiving MLTSS;
- Consumer choice and participation in selecting service providers and living settings, to the maximum extent feasible, should be a priority of New Jersey's MLTSS; and
- Participation of all stakeholders is essential in the planning and implementation of MLTSS.

Additionally, the State has contracted with Mercer to facilitate an MLTSS work group to develop a standardized MLTSS Care Management framework. The work group identified and discussed the necessary steps to achieve an effective system of providing MLTSS care management. Once the standard framework was established, the State included stakeholders in the process to develop implementation strategies and refine contract language requirements. The State MLTSS work group continues to meet and consists of Mercer, DMAHS, Division of Developmental Disabilities, Division of Mental Health and Addiction Services (DMHAS), Division of Aging Services (DOAS), and Division of Disability Services (DDS) staff.

#### MLTSS - NURSING FACILITY LEVEL OF CARE ASSESSMENT

When there is a reasonable indication that a member may need MLTSS, a Nursing Facility (NF) level of care (LOC) assessment must be conducted with the standardized functional assessment tool, "NJ Choice". For members newly enrolled in managed care, the State must conduct the LOC assessment; for all members already enrolled in managed care, the MCO must conduct the LOC assessment and forward it to the State for final approval for any member meeting Nursing Facility Level of Care. The timeframe for completing the LOC is within 30 days of the receipt of the referral. At least annually, all enrollees receiving MLTSS must be reevaluated by the MCO with final approval by the State. The MCO must not alter the fundamental nature of the NJ Choice tool when accommodating it to their electronic/database needs. The implementation of this activity addresses Goals 1-4.

#### MLTSS - PLAN OF CARE

All members receiving MLTSS (either HCBS or NF services), must have a plan of care (PoC) developed by the MCO that will demonstrate a person-centered, individualized, on-going strategy that focuses on the member's abilities, needs and preferences. It must take into consideration, the member's current and historical bio-psycho-social and medical needs as well as their level of functioning and support systems. The PoC must emphasize HCBS settings, maximizing health and safety. A back up plan must be developed and incorporated into the PoC to ensure that needed services will continue in the event that regular service providers are temporarily unavailable. During the development of the first PoC and its subsequent reviews and updates, the member will be informed of the services available, as well as their rights and responsibilities; and how to recognize and report abuse, neglect and exploitation. Additionally, areas around person-centered processes such as choice of living arrangement (community or nursing facility); self-direction; and setting person-centered goals will be addressed with the member during the PoC and a written copy of the

topics discussed and choices made will be given to the member. The MLTSS work group is developing timelines for quarterly plan of care reviews and when face-to-face meeting will be done in the home setting or at a location and time of the member's choice. The initial PoC and subsequent PoC reviews will be monitored through care management audits to ensure that the member's assessed needs are addressed in type, scope, amount and frequency. The implementation of this activity addresses Goals 1-4.

#### MLTSS - SELF-DIRECTION

Members who choose self-direction will have the opportunity to have choice and control over how PCA and Home Based Supportive Care services are provided and who provides them. The services that the member receives through self-direction must be included in the calculations of the member's budget and must reflect the plan for purchasing these needed services. The State-contracted Fiduciary Intermediary (FI) will help self-direct members with the financial aspects of the program. The FI handles all payroll responsibilities for participants and acts as a bookkeeping service.

Self-direction is voluntary and members may participate in or withdraw from self-direction at any time. Also, a member may be involuntarily disenrolled from the self-direction program if continued participation would not permit the member's health, safety or welfare needs to be met or the member consistently demonstrates the inability to self-direct. The implementation of this activity addresses Goals 3-4.

#### MLTSS - COST LIMITATIONS

Members receiving MLTSS will receive cost-effective placement that most often will be in the community environment. Typically, the cost limits will be aligned with the estimated cost associated with their nursing facility level of care assessment. Exceptions to the cost limit provision include: an enrollee is transitioning from institutional care to community-based services; an enrollee experiences a change in health condition that is expected to last no longer than six months; or an enrollee has unique needs for which the State determines an exception must be made to accommodate such needs. MCO fiscal reports demonstrating the expenditures for Home and Community Based Services and Nursing Facility services, per enrollee for MLTSS during a 12 month period as percentages of total MLTSS must be submitted annually to the State. The State also requires complete Medicaid Financial Reports from each MCO detailing HCBS and NF costs as required by the contract, as well as, monthly income statements by category of aid detailing: medical expenses, IBNR estimates, member months, and PMPM costs by category of service. Should costs exceed limits as authorized by the State, discussions will take place between the State and the MCOs regarding contract costing, IBNR estimates, care management reviews, and actual vs. planned utilization to remediate the issue.

#### MLTSS - MEMBER REPRESENTATIVE

Each contracted MCO will designate a full-time MLTSS Member Representative who will be responsible for the internal representation of member's interests that include such things as: input

into planning and delivery of long term services; participation in quality activities; assistance with program monitoring and evaluation; and provision of education to members, families and providers on issues related to the MLTSS program. Additionally, the MLTSS Member Representative will assist the MLTSS members in navigating the MCO's system, including: helping members understand and use the MCO's system; being a resource for the members; providing information; making referrals to appropriate MCO staff members; and facilitating resolution of any issues. The MLTSS Member Representative will make recommendations to the MCO of any changes needed to improve the MCO's system for members receiving MLTSS and participate as an ex officio member of the MCO's Consumer Advisory Committee.

## MLTSS - PROVIDER NETWORKS

This demonstration will allow services to be delivered in the most integrated manner that offers the greatest selection of choice in settings of care; giving MLTSS members the flexibility to move from nursing facility to community placement. The MLTSS program offers its members accessible, on-going, conflict-free care management, coordination of care and assistance to meet their physical, behavioral, social and functional needs and has built-in monitoring to ensure that any assessed needs are met in type, scope, amount and frequency. In this way, the MLTSS members will have the opportunity to actively participate in their community and workforce to the greatest extent possible.

To ensure a successful shift in setting of care, New Jersey will monitor the MCOs' MLTSS provider networks and credentialing processes for adequacy and quality to make certain that the MLTSS members in the community have timely access to qualified providers in the appropriate settings. Access to a robust ancillary network, that can deliver such services as home modification or meal services, must be developed by July 1, 2014, and monitored in a manner similar to the current medical provider network. All MLTSS providers must be credentialed in accordance with 42 CFR 438.214. In the case of non-licensed or non-certified providers, the MCOs must develop credentialing mechanisms to address this requirement. HMOs must submit strategies to develop an adequate workforce providing MLTSS and describe the nature of their associated partnerships, including a process for implementing criminal background checks for all prospective employees/providers with direct physical access to members. See Article 4.6.1.C of the NJFC/M Contract below. Moreover, MCOs must develop back up plans for community services like "meals on wheels", etc. to avoid a gap in service to our most vulnerable population for these vital services.

NJFC/Medicaid Managed Care Contract 4.6.1.C.

For MLTSS providers the Contractor shall:

- a. Have a credentialing/re-credentialing process meeting the requirements at 42 CFR 438.214, the requirements above, and the credentialing/re-credentialing requirements in Appendix B.4.14 Standard IX for each provider type or service available under MLTSS, including non-licensed/non-certified providers.
- b. Ensure that all providers who provide direct support and/or services to MLTSS Members have policies and procedures to demonstrate compliance with State requirements to have a pre-employment criminal history check and/or background investigation on all staff Members.
- c. Develop and implement a process to ensure all contracted providers conduct criminal background checks on all prospective employees/providers with direct physical access to MLTSS Members.
- i. Have a credentialing/re-credentialing process meeting the requirements at 42 CFR 438.214, the

- requirements above, and the credentialing/re-credentialing requirements in Appendix B.4.14 Standard IX for each provider type or service available under MLTSS, including non-licensed/non-certified providers.
- ii. Ensure all providers who provide direct support and/or services to MLTSS members comply with State requirements to have a pre-employment criminal history check and/or background investigation on all staff members. MLTSS providers or those who provide services to MLTSS members who are required by state law or regulation to have criminal history background checks shall provide proof of the completion of the CHRI during credentialing process.
  - iii. At minimum, have a re-credentialing process for HCBS providers that shall include verification of continued licensure and/or certification (as applicable) and compliance with policies and procedures identified during credentialing, including criminal history background checks (CHRI).
  - iv. At minimum verify monthly that each HCBS provider has not been excluded from participation in the Medicare or Medicaid or NJFamilyCare programs.
  - v. Develop and implement a policy and procedure, approved by the Office of Managed Health Care, to require all contracted community based providers to certify in writing that they conduct effective, accurate and economical background checks on all prospective employees/providers expected to have direct physical access to MLTSS members. Providers who are required to have CHRI checks done as a condition of licensure by the State of NJ and are in good standing and submit documentation to the Contractor of same updated annually or in accord with the time frame established in governing statutes or regulations, shall be determined to have met the requirements for CHRI.
  - vi. Ensure that providers who are non-licensed or non-credentialed or who do not have a governing statute to conduct CHRI background checks must undergo state CHRI through the NJ State Police using the Universal Fingerprint form for Personal Record Review.
  - vii. Have policies and procedures that ensure that no provider shall be permitted to provide any HCBS service with direct physical access to an MLTSS member until appropriate proofs and documentation are submitted to the Contractor. This documentation shall be provided to the Contractor at credentialing and/or re-credentialing.
  - viii. Requirements for frequency of updates, disqualifying offenses and rehabilitation to be adapted from law/regulation.
  - ix. Shall not permit any providers or their employees or subcontractors to render direct support and/or services to MLTSS members absent such proof.
  - x. Shall not be responsible for conducting CHRI checks, but are required to maintain documentary proof that CHRI checks are done in compliance with State rule and the NJ FamilyCare MCO contract.
  - xi. Follow state protocols for addressing exception requests for providers/their employees who fail a CHRI within state/federal law or statute.

Additionally, the MCOs and the State will establish and conduct universal MLTSS provider training, including written materials for nursing facilities, assisted living and HCBS providers to address, at a minimum: the credentialing processes; service authorizations; continuity of care; community resources; options counseling; claims processes; cultural competency; and the responsibility of nursing facility and assisted living providers in the collection of patient payment liability and room and board. The MCOs will conduct provider training with all new MLTSS providers and on an ongoing basis as needed.

## MLTSS - INTERAGENCY AUTHORITY AND OVERSIGHT

New Jersey has a consistent and coordinated framework via overarching interagency authority and oversight to deliver timely, appropriate quality health care across all populations, including those members needing MLTSS services. **While there are several State agencies involved in the administration of the HCBS, the DMAHS will maintain authority over the programs and will exercise the appropriate monitoring and oversight.** The State will establish evidenced-based metrics that can be benchmarked whenever possible and will promote best practices and quality improvement. Data must be collected in a way that will facilitate its sharing across all agencies responsible for the Medicaid population and to external stakeholders. New Jersey currently has quality measures related to the medical model; however, Measurement Year 2 community-social measures must be developed to track and trend the safety and welfare of our members as well their degree of choice and satisfaction.

## MLTSS - EQRO AND STATE QUALITY MONITORING ACTIVITIES

In addition to the existing NJFC/M Managed Care Contract requirements, an MLTSS set of reporting requirements are developed and included in the Contract. As a result, the External Quality Review Organization (EQRO) will conduct one, unified set of mandatory external quality review activities outlined in 42 CFR438.358, including the Annual Assessment of Operations, Performance Measures and Quality Improvement Projects (QIPs), that will review the quality of the NJFC/M plan and the requirements of the MLTSS program.

The State is currently in consultation with its EQRO to develop a comprehensive set of MLTSS elements to add to the Annual Assessment as well as appropriate Performance Measures and QIPs. The Annual Assessment of Operations and the Performance Measures are a way of assessing the MCO's quality of care. The QIPs are a means to bring about improvement. The State's rationale is to assess the performance measure results first to identify where the QIPs would have the greatest impact on improvement. In this way the MCOs, in consultation with the EQRO, will apply quality strategies based on data driven, cause/barrier analysis; using continual monitoring and modify interventions when warranted. This will provide a method to track and trend each MCO's progress with improving the members' health and level of functioning. The Annual Assessment of MCO Operations will be conducted in 2015.

Likewise, the MCOs will submit all quality reports to the State for review and approval; incorporating MLTSS requirements into the existing quality reports (E.g. Annual Quality Assessment and Performance Improvement (QAPI); quarterly grievance and appeals reports, etc.) as well as any new MLTSS-specific requirements. The MCOs will be held to the requirements described in 42 CFR 438 Subpart D et seq. regarding the availability of services, adequate capacity of services, coordination and continuity of care, coverage and authorization of services. For additional information regarding 42 CFR 438 Subpart D. et seq., refer to Appendix E. The implementation of these activities addresses Goals 1-4.

## MLTSS-SPECIFIC ACTIVITIES

New Jersey’s approach to quality assessment and improvement for the entire Medicaid managed care population is to use nationally recognized quality measures whenever possible and to establish performance benchmarks. At this time, however, there are no nationally recognized measures specifically designed for the MLTSS population. Instead, the State is developing MLTSS-specific measures and is consulting with its EQRO in the development of some modified HEDIS measures to include the MLTSS population. Since HEDIS uses a full year of data from the previous year, the earliest that the MLTSS-specific measures could be obtained would be HEDIS 2016 (using 2015 data). This activity will address Goals 1-3.

Annually, Consumer Assessment of Health Providers and Systems (CAHPS) surveys are conducted to assess the level of member satisfaction for available Medicaid services. At this time, a sample of the general population of Medicaid members and CHIPRA (Children’s Health Insurance Program Reauthorization Act of 2009) members are surveyed using CAHPS. Additionally, the State is planning to use a Division of Aging Services survey to outreach the MLTSS population. In the future, the State may examine the feasibility of using an MLTSS-specific survey. This activity will address Goal 4.

The appropriate quality monitoring and improvement activities required by the NJFC/M Contract, as well as the following MLTSS-specific reports will be necessary to address MLTSS requisites in Year 1 of the comprehensive waiver. The State is researching quality of life measures to be included in Year 2 and beyond. The implementation of these monitoring activities will address Goals 1-4.

## MLTSS Measures

Measures to Begin Year 1

		Measure	Method	Frequency	Data Source	Who Calculates	STC
	<b>Participant Access Measures</b>						
	<b>LOC</b>						
1	Number of members receiving HCBS and NF services just prior to implementation	Number of members receiving HCBS and NF services just prior to implementation	Division of Aging will run report	Once	Division of Aging will provide the report to DMAHS	Division of Aging Services	X
2	LOC conducted prior to enrollment into MLTSS	Numerator, denominator and % of new MLTSS enrollees in MCO with LOC evaluation prior to receipt of services	Division of Aging will run report	Monthly initially (State automated system not in place).	Division of Aging will provide the report to DMAHS	Division of Aging Services	X
3	LOC: members who were referred for LOC who were determined to have met NF LOC by	Numerator, denominator and % of members referred for LOC who OCCO determined met NF	Division of Aging will run report	Monthly	Division of Aging will provide the report to DMAHS	Division of Aging Services	

	OCCO	LOC					
4	Timeliness of LOC	Numerator, denominator and % of MLTSS members who received an evaluation for LOC determination within 30 days of referral	Division of Aging will run report	Monthly	Division of Aging will provide the report to DMAHS	Division of Aging Services	
5	Timeliness of LOC re-determination	Numerator, denominator and % of MLTSS members who received LOC within 12 months of initial/subsequent LOC determination	Division of Aging will run report	Monthly	Division of Aging will provide the report to DMAHS	Division of Aging Services	X
6	Options Counseling	Numerator, denominator and % of MLTSS members who received options counseling	Division of Aging will review individual NJ Choice Tool results for evidence of members being offered Options Counseling and will run report	Monthly	Division of Aging will provide the report to DMAHS	Division of Aging Services	X
7	Members are offered choice between institutional and HCBS	Numerator, denominator and % of MLTSS members who indicated that they were offered a choice between institutional and HCBS	Division of Aging will review individual NJ Choice Tool results for evidence of members being offered choice between NF and HCBS and will run report	Monthly	Division of Aging will provide the report to DMAHS	Division of Aging Services	X
	<b>Participant-Centered Service Planning and Delivery</b>						
	<b>POC</b>						
8	POCs established	Numerator,	Record	Quarterly by	DoAS reviews	DoAS in	X

	within required timeframe	denominator and % of care plans for MLTSS members that are developed within 30 days of enrollment into MLTSS	review of sample of member care plans	DoAS as a part MLTSS Quality Strategy Annually by EQRO as part of Care Management Audit	MCO electronic records and provides the report to DMAHS EQRO reviews member charts	collaboration with DMAHS DMAHS/ EQRO	
9	POC reviewed annually within 30 days of members anniversary and as necessary	Numerator, denominator and % of care plans for MLTSS members that are reviewed annually, at a minimum, or more frequently, as appropriate	Record of a sample of member care plans	Annually by EQRO as part of Care Management Audit	EQRO reviews member charts	DMAHS/ EQRO	X
10	POCs are aligned with member needs based on the results of the NJ Choice tool and CNA in type, scope, amount and frequency.	Numerator, denominator and % of MLTSS members whose services and supports aligned with assessed need, including health and safety	Record review of sample of member care plans	Quarterly by DoAS as a part of MLTSS Quality Strategy or by MCO  Verified Annually by EQRO as part of Care Management Audit	DoAS reviews MCO electronic records or by MCO and provides a report to DMAHS EQRO reviews member charts	DoAS in collaboration with DMAHS  DMAHS/ EQRO	X
11	POC are developed using person-center principles	Numerator, denominator and % of POC for MLTSS members that are developed in accordance with the member's unique needs, expressed preferences and decisions concerning their life in the community	Record review of sample of member care plans	Quarterly by DoAS as a part of MLTSS Quality Strategy or by MCO  Verified Annually by EQRO as part of Care Management Audit	DoAS reviews MCO electronic records or by MCO and provides a report to DMAHS EQRO reviews member charts	DoAS in collaboration with DMAHS  DMAHS/ EQRO	X
12	POCs include a back-up plan	Numerator, denominator and % of MLTSS members receiving HCBS services who have a POC that includes a back-up plan	Record review of member sample of member care plans	Quarterly by DoAS as a part of MLTSS Quality Strategy or by MCO  Annually by	DoAS reviews MCO electronic records or by MCO and provides a report to DMAHS	DMAHS/ EQRO	X

				EQRO as part of Care Management Audit	EQRO reviews member charts		
13	Services are delivered in accordance with POC including the type, scope, amount and frequency.	Numerator, denominator and % of POCs for MLTSS members in which the services and supports are delivered in type, scope, amount and frequency	Record review of sample of member care plans	Quarterly by DoAS as a part of MLTSS Quality Strategy or by MCO  Verified Annually by EQRO as part Care Management Audit	DoAS reviews MCO electronic records or by MCO and provides a report to DMAHS  EQRO reviews member charts	DMAHS/ EQRO	X
<b>Provider Capacity and Capabilities</b>							
<b>PROVIDER NETWORK</b>							
14	Member Access to MLTSS services	Compliance with provider network standards. MCO network has adequate number and type of participating traditional and non-traditional providers	State review of MCO network submission	Quarterly and Annually	State reviews MCO provider file data and geo access	DMAHS/ EQRO	X
15	MCO MLTSS providers are credentialed/re-credentialed timely	Compliance with credentialing and re-credentialing requirements	Review of sample of provider records	Annually by EQRO as part of Annual Assessment	EQRO reviews credentialing/recredentialing files	DMAHS/ EQRO	X
<b>Participant Safeguards</b>							
<b>Critical Incident Management System</b>							
16	Training on identifying/reporting Critical Incidents	Numerator, denominator and % of MLTSS members (or family members/ authorized representative) receive information/ education at least annually on how to identify and report abuse, neglect and exploitation	Record review of sample of member care plans	Annually by EQRO as part of Care Management Audit	EQRO reviews member charts	DMAHS/ EQRO	X
17	Timeliness of Critical Incident reporting (Electronically within one business	Numerator, denominator and % of CIs re: MLTSS members reported on a timely basis.	State review of Critical Incident report	Daily, as necessary	MCO submits individual critical incident information	DMAHS	X

	day.)	(Electronically within one business day of learning of the CI)					
18	Quarterly and Annual Critical Incident reporting	Quarterly: numerator, denominator and % of Critical incidents re: MLTSS members by incident type. Annually: Summary of incidents occurring during the calendar year and MCO interventions.	State review of critical incident report and Summary	Quarterly and Annually (summary)	MCO submits quarterly critical incident report and annual summary	TBD	X
	<b>Participant Rights and Responsibilities</b>						
	<b>Complaints, Grievance and Appeals</b>						
19	Timelines	Numerator, denominator and % of complaints, grievances and appeals re: MLTSS members that are addressed within appropriate timeframes	State reviews the CTR and Table 3 A	Quarterly	State reviews CTR (state complaint) database and MCO-submitted Table 3A report	DMAHS	X
	<b>Measuring effectiveness of MLTSS activities</b>						
20	Total number of MLTSS members receiving MLTSS services. (This includes HCBS and NF members).	Total number of MLTSS members receiving any HCBS and/or NF services during each 12 month period.	State reviews report	Quarterly  Annually	MCO submits report  MCO submits annual summary of results and interventions	DMAHS	X
21	MLTSS Members transitioned from NF to Community	Numerator, Denominator and % of MLTSS members who transitioned from NF to the community.	State reviews report	Quarterly and Annually	MCO submits report	DMAHS	X
22	New MLTSS members admitted to NF during 12 month period	Numerator, Denominator and % of new MLTSS members admitted to NFs during 12 month period.	State review report	Annually	MCO submits report	DMAHS	X
23	MLTSS Members transitioned from	Numerator, Denominator and %	State reviews	Quarterly and Annually	MCO submits report	DMAHS	

	NF to Community who returned to the NF within 90 days	of MLTSS members transitioning from NF to community who returned to the NF within 90 days.	report				
24	MLTSS Members transitioned from the Community to the NF for greater than 180 days	Numerator, Denominator and % of HCBS members transitioning from the community to the NF for a stay of greater than 180 days.	State reviews report	Quarterly and Annually	MCO submits report	DMAHS	X
25	HCBS Members transitioned from the Community to NF for less than or equal to 180 days (Short Stay)	Numerator, denominator and % of HCBS members transitioning from the community to NF for a stay of less than or equal to 180 days. (NF Short Stay)	State reviews report	Quarterly and Annually	MCO submits report	DMAHS	X
26	HCBS Members admitted to Hospital- each instance of Hospitalization (not unique members)	Numerator, denominator and % of HCBS members who were admitted to the Hospital	State reviews report	Quarterly and Annually	MCO submits report	DMAHS	X
27	NF Members admitted to Hospital- each instance of Hospitalization (not unique members)	Numerator, denominator and % of NF members who were admitted to the Hospital	State reviews report	Quarterly and Annually	MCO submits report beginning 3 <sup>rd</sup> Quarter 2014	DMAHS	
28	HCBS Members re-admitted to Hospital- each instance of re-Hospitalization within 30 days of last hospitalization (not unique members)	Numerator, denominator and % of HCBS members who were re-admitted to the Hospital within 30 days of last hospitalization	State reviews report	Quarterly and Annually	MCO submits report	DMAHS	
29	NF Members re-admitted to Hospital- each instance of re-Hospitalization within 30 days of last hospitalization (not unique members)	Numerator, denominator and % of NF members who were re-admitted to the Hospital within 30 days of last hospitalization	State reviews report	Quarterly and Annually	MCO submits report beginning 3 <sup>rd</sup> Quarter 2014	DMAHS	
30	HCBS Members with ER utilization-each instance of ER utilization- not	Numerator, denominator and % of HCBS members who had ER utilization	State reviews report	Quarterly and Annually	MCO submits report	DMAHS	X

	unique members						
31	NF Members with ER utilization-each instance of ER utilization- not unique members	Numerator, denominator and % of NF members who had ER utilization	State reviews report	Quarterly and Annually	MCO submits report beginning 3rd Quarter 2014	DMAHS	
32	Self-Direction	Numerator, denominator and % of MLTSS members opting to use self direction	State reviews report	Annually	TBD	DDS	X
33	HCBS members receiving only PCA services (out of all the possible MLTSS services available to them)	Numerator, denominator and % of HCBS members receiving only PCA services within last 6 months (out of all the possible MLTSS services available to them)	State reviews report	Semi Annually	MCO submits report	DMAHS	
34	HCBS members receiving only Medical Day Care services (out of all the possible MLTSS services available to them)	Numerator, denominator and % of HCBS members receiving only Medical Day Care services within last 6 months (Out of all the possible MLTSS services available to them)  Report by Adult; Pediatric; and Total	State reviews report	Semi Annually	MCO submits report	DMAHS	
35	Percentage of MLTSS members in HCBS setting with follow-up after hospitalization for mental illness  HCBS members 7 day follow-up	Numerator, denominator and % of MLTSS members in HCBS setting who receive follow up within 7 days of hospitalization for mental illness. (For selected DSM V Diagnoses: 295, 296, 297, 298, 299, 300, 301, 302, 307, 308, 309, 311, 312, 313, 314)	State reviews report	Annually	MCO submits report	DMAHS	
36	Percentage of MLTSS members in HCBS setting with follow-up after hospitalization for mental illness  HCBS members	Numerator, denominator and % of MLTSS members in HCBS setting who receive follow up within 30 days of hospitalization for mental illness. (For	State reviews report	Annually	MCO submits report	DMAHS	

	30 day follow-up	selected DSM V Diagnoses: 295, 296, 297, 298, 299, 300, 301, 302, 307, 308, 309, 311, 312, 313, 314)					
37	Percentage of MLTSS members in NF setting with follow-up after hospitalization for mental illness  NF members 7 day follow-up	Numerator, denominator and % of MLTSS members in NF setting who receive follow up within 7 days of hospitalization for mental illness. (For selected DSM V Diagnoses: 295, 296, 297, 298, 299, 300, 301, 302, 307, 308, 309, 311, 312, 313, 314)	State reviews report	Annually	MCO submits report	DMAHS	
38	Percentage of MLTSS members in NF with follow-up after hospitalization for mental illness  NF members 30 day follow-up	Numerator, denominator and % of MLTSS members in NF setting who receive follow up within 30 days of hospitalization for mental illness. (For selected DSM V Diagnoses: 295, 296, 297, 298, 299, 300, 301, 302, 307, 308, 309, 311, 312, 313, 314)	State reviews report	Annually	MCO submits report	DMAHS	
39	Number of MLTSS members in HCBS setting with selective behavioral health diagnoses.	Numerator, denominator and % of MLTSS members in HCBS setting with selective mental health and substance abuse disorder diagnoses: 292,295, 296, 297, 298, 299, 300, 301, 302, 303, 304,305, 307, 308, 309, 311, 312, 313, 314.	State reviews report	Annually	MCO submits report	DMAHS	
40	Number of MLTSS members in NF setting with selective behavioral health diagnoses.	Numerator, denominator and % of MLTSS members in NF setting with selective mental health and substance abuse disorder diagnoses: 292,295, 296, 297, 298, 299, 300, 301, 302, 303,	State reviews report	Annually	MCO submits report	DMAHS	

		304,305, 307, 308, 309, 311, 312, 313, 314..					
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Quality of Life Measures to begin Year 2

	Participant Satisfaction	Measure	Method	Frequency	Data Source	Who Calculates

CRITICAL INCIDENT REPORTING

Critical Incident Management Principles

1. All adults and children receiving MLTSS and Home and Community Based Services should be able to enjoy a quality of life that is free of abuse, neglect and exploitation.
2. Responsible staff should receive initial and ongoing training to be competent to respond to, report and document incidents, in a timely and accurate manner.
3. Consumers, legal representatives and guardians must be made aware of and have available incident reporting processes.
4. Any individual, who in good faith, reports an incident or makes an allegation of abuse, neglect or exploitation will be free from any form of retaliation.
5. Quality starts with those who work most closely with persons receiving services.

New Jersey Statute and Regulation

New Jersey State statute and regulations require reporting abuse, neglect and exploitation. Additionally, New Jersey enacted “Danielle’s Law” that requires a member of the staff at facilities for persons with developmental disabilities or persons with traumatic brain injury; or a member of the staff at a public or private agency, who in either case works directly with persons with developmental disabilities or traumatic brain injury, shall be required to call the 911 emergency telephone service for assistance in the event of a life-threatening emergency at the facility or the public or private agency, and to report that call to the State. MCOs must take steps to educate MLTSS members, their family members, if applicable and providers about how to identify and report abuse, neglect and exploitation, as well as, make their contracted providers aware of their legal responsibility to do so. See New Jersey regulations and Statute listed below.

**N.J.S.A. § 52:27D-409. Report of suspected abuse, neglect, exploitation**

a. (1) A health care professional, law enforcement officer, firefighter, paramedic or emergency medical technician who has reasonable cause to believe that a vulnerable adult is the subject of abuse, neglect or exploitation shall report the information to the county adult protective services provider.

(2) Any other person who has reasonable cause to believe that a vulnerable adult is the subject of abuse, neglect or exploitation may report the information to the county adult protective services provider.

b. The report, if possible, shall contain the name and address of the vulnerable adult; the name and address of the caretaker, if any; the nature and possible extent of the vulnerable adult's injury or condition as a result of abuse, neglect or exploitation; and any other information that the person reporting believes may be helpful.

c. A person who reports information pursuant to this act, or provides information concerning the abuse of a vulnerable adult to the county adult protective services provider, or testifies at a grand jury, judicial or administrative proceeding resulting from the report, is immune from civil and criminal liability arising from the report, information, or testimony, unless the person acts in bad faith or with malicious purpose.

d. An employer or any other person shall not take any discriminatory or retaliatory action against an individual who reports abuse, neglect or exploitation pursuant to this act. An employer or any other person shall not discharge, demote or reduce the salary of an employee because the employee reported information in good faith pursuant to this act. A person who violates this subsection is liable for a fine of up to \$ 1,000.

e. A county adult protective services provider and its employees are immune from criminal and civil liability when acting in the performance of their official duties, unless their conduct is outside the scope of their employment, or constitutes a crime, actual fraud, actual malice, or willful misconduct.

L. 1993, c. 249, § 4; amended 2009, c. 276, § 2, eff. Apr. 17, 2010.

#### **N.J.A.C. § 8:36-5.10 Reportable events**

(a) The facility shall notify the Department immediately by telephone at (609) 633-9034 or (609) 392-2020 after business hours, followed within 72 hours by written confirmation, of the following:

1. Termination of employment of the administrator, and the name and qualifications of his or her replacement;
2. Any elopements; and
3. **Any suspected cases of resident abuse or exploitation, which have been reported to the State of New Jersey Office of the Ombudsman for the Institutionalized Elderly.**

(b) The written notification to the Department, as required by (a) above, shall be forwarded by the facility to the following address:

Director  
Long-Term Care Licensing and Certification Unit  
New Jersey Department of Health EPSDT

PO Box 367  
Trenton, NJ 08625-0367

#### **N.J.A.C. § 8:43F-3.3 Administrative policies and procedures**

(a) If a health care facility licensed by the Department provides adult day health services in addition to other health care services, the facility shall adhere to the rules in this chapter and to the

rules for licensure of facilities providing the other health care services.

(b) Except in an emergency, facilities shall not provide program services to individual participants for more than 12 consecutive hours during any calendar day of the year without prior written approval by the Department.

(c) The facility shall adhere to applicable Federal, State, and local laws, rules, regulations, and requirements.

(d) A policy and procedure manual(s) for the organization and operation of the facility shall be developed, implemented, and reviewed at intervals specified in the manual(s). Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility to representatives of the Department at all times. The manual(s) shall include at least the following:

1. A written statement of the program's philosophy and objectives and the services provided by the facility;

2. An organizational chart delineating the lines of authority, responsibility, and accountability for the administration and participant care services of the facility;

3. A description of mechanisms for referral of participants to other health care providers, in order to provide a continuum of care for the participant;

4. A description of the quality improvement program for participant care and staff performance;

5. Specification of the hours and days on which services are provided;

6. Policies and procedures for the maintenance of personnel records for each employee, including, at a minimum, the employee's name, previous employment, educational background, credentials, license number with effective date and date of expiration (if applicable), certification (if applicable), verification of credentials, records of physical examinations, job description, and evaluations of job performance;

7. Policies and procedures, including content and frequency, for physical examinations upon employment and subsequently for employees and for other persons providing direct care services to participants; and

8. Policies and procedures for complying with applicable statutes and protocols to report abuse or mistreatment of participants, elopement, sexual abuse, specified communicable disease, rabies, poisonings and unattended or suspicious deaths. These policies and procedures shall include, but not be limited to:

**i. The notification of any suspected case of participant abuse or exploitation that occurs during the participant's participation in adult day health services to the Office of the Ombudsperson for the Institutionalized Elderly in the Division of Elder Advocacy of the New Jersey Department of the Public Advocate, pursuant to N.J.S.A. 52:27G-7.1 et seq., if the participant is 60 years of age or older, and if less than 60 years of age, to the Assessment and Survey Unit in the Division of Health Facilities Evaluation and Licensing of the**

**Department;**

ii. The notification of any suspected case of participant abuse or exploitation that occurs outside of the participant's participation in adult day health services that is discovered by facility staff to Adult Protective Services, pursuant to N.J.S.A. 52:27D-46 et seq., if the participant is 60 years of age or older;

iii. The notification of any suspected case of abuse or exploitation to the New Jersey Department of Children and Families, Division of Youth and Family Services of a participant who is 16 or 17 years of age;

iv. The development of written protocols for the identification and the treatment of participants who are abused and/or neglected;

v. The provision at least annually of education and/or training programs to appropriate persons regarding the identification and reporting of diagnosed and/or suspected cases of sexual abuse; domestic violence; abuse of participants and the facility's policies and procedures; and

vi. Policies and procedures regarding communicable diseases, in accordance with N.J.A.C. 8:57.

(e) The policy and procedure manual(s) shall be available and accessible to all participants, staff, and the public.

(f) The facility shall have a written agreement for services not provided directly by the facility. The written agreement, or its equivalent, shall specify that the facility retain administrative responsibility for services rendered and shall require that services be provided in accordance with the rules in this chapter.

**N.J.A.C. § 8:43J-3.4 Administrative policies and procedures**

(a) If a health care facility licensed by the Department provides pediatric medical day care in addition to other health care services, the facility shall adhere to this chapter and to the applicable rules for licensure of facilities providing the other health care services.

(b) The facility shall adhere to applicable Federal, State and local laws.

(c) The facility shall develop, implement and review, at intervals specified therein, a policy and procedure manual for the organization and operation of the facility.

(d) Each review of the manual shall be documented and the manual(s) shall be available in the facility to representatives of the Department at all times.

(e) The manual shall address at least the following:

1. The program's philosophy and objectives and the services provided by the facility;

2. An organizational chart delineating the lines of authority, responsibility and accountability for the administration and child care services of the facility;
3. Specifications for each therapeutic intervention for use by all staff involved in the care of the children;
  - i. With respect to this requirement, the facility shall review the manual every six months to assure that the facilities procedures conform to prevailing and acceptable treatment practices.
4. The maintenance of an admission register listing children admitted by name with identifying information about each, the referral source, family contacts and emergency contacts;
5. The maintenance of a discharge register with final disposition and the discharge date;
6. The maintenance of a daily census record;
7. The maintenance of an accident and incident record;
8. The maintenance of an individual record for each child that contains:
  - i. Identifying data;
  - ii. All details of the referral and admission;
  - iii. Correspondence;
  - iv. Payer status; and
  - v. Medical history, signed and dated in ink by the health professional providing the service, which contains allergies, special precautions, an immunization record, the initial plan for care and updates, physician's orders, progress notes and medications dispensed;
9. Referral procedure to other health care providers in a manner that ensures the provision of a continuum of care for the child;
10. The conduct of an interdisciplinary review of each child's interdisciplinary plan of care every two months, which requires, at a minimum, that the facility share the interdisciplinary plan of care summary and recommendations with the primary health care provider, who shall approve or modify any changes in writing, and which requires the facility to give a copy of the interdisciplinary plan of care summary and recommendations to the child's parent;
11. Discharge procedures that require, at a minimum, that the facility conduct a conference involving pediatric medical day care facility staff, the child's parent and staff of other agencies involved in the child's care to discuss post-discharge care and follow-up and which require the facility to develop a written discharge summary and to enter it in the child's record within 10 business days following discharge;

12. A quality improvement program for child-care and staff performance;
13. Facility operation hours and days on which services are provided;
14. The maintenance of personnel records for each employee, which require, at a minimum, the employee's name, address, previous employment, educational background, credentials, license and/or certification and/or registration number, as applicable, with the effective date and date of expiration, and the results of the criminal background investigation;
15. The content and frequency of physical examinations, upon employment and subsequently, for employees and for other persons providing direct care services to children;
16. Procedures for follow-up of a child in the event that a child does not appear for services on scheduled days and for documentation of the follow-up in the child's medical record; and
- 17. Procedures for compliance with applicable statutes and protocols to report abuse or mistreatment of children, elopement, sexual abuse, specified communicable diseases, poisonings, birth defects and unattended or suspicious deaths, which shall address, at a minimum, the following:**
  - i. The notification of any suspected case of child abuse or exploitation to the New Jersey Department of Children and Families, Division of Youth and Family Services;**
  - ii. The development of written protocols for the identification and the treatment of children who are abused and/or neglected;
  - iii. The provision at least annually of education and/or training programs to appropriate persons regarding the identification and reporting of diagnosed and/or suspected cases of sexual abuse, domestic violence, child abuse and the facility's policies and procedures;
  - iv. Communicable disease reporting, in accordance with N.J.A.C. 8:57; and
  - v. Birth defect reporting, in accordance with N.J.A.C. 8:20.
- (f) The policy and procedure manual shall be available and accessible to children's parents, staff and the public.
- (g) The facility shall have a written agreement for services not directly provided by the facility.
  1. The written agreement, or its equivalent, shall specify that the facility retain administrative responsibility for services rendered and shall require that services be provided in accordance with this chapter.
- (h) Each facility shall maintain at least one bulletin board in a conspicuous location in the facility in an area accessible to the public upon which the facility shall place all notices this chapter requires to be posted.

## **Danielle's Law**

AN ACT concerning staff working with persons with developmental disabilities or traumatic brain injury and supplementing Titles 30 and 45 of the Revised Statutes.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

C.30:6D-5.1 Short title.

1. This act shall be known and may be cited as "Danielle's Law."

C.30:6D-5.2 Definitions relative to staff working with persons with developmental disabilities, traumatic brain injury.

2. As used in this act:

"Commissioner" means the Commissioner of Human Services.

"Department" means the Department of Human Services.

"Facility for persons with developmental disabilities" means a facility for persons with developmental disabilities as defined in section 3 of P.L.1977, c.82 (C.30:6D-3).

"Facility for persons with traumatic brain injury" means a facility for persons with traumatic brain injury that is operated by, or under contract with, the department.

"Life-threatening emergency" means a situation in which a prudent person could reasonably believe that immediate intervention is necessary to protect the life of a person receiving services at a facility for persons with developmental disabilities or a facility for persons with traumatic brain injury or from a public or private agency, or to protect the lives of other persons at the facility or agency, from an immediate threat or actual occurrence of a potentially fatal injury, impairment to bodily functions or dysfunction of a bodily organ or part.

"Public or private agency" means an entity under contract with, licensed by or working in collaboration with the department to provide services for persons with developmental disabilities or traumatic brain injury.

C.30:6D-5.3 Responsibilities of staff at facility for persons with developmental disabilities, traumatic brain injury.

3. a. A member of the staff at a facility for persons with developmental disabilities or a facility for persons with traumatic brain injury or a member of the staff at a public or private agency, who in either case works directly with persons with developmental disabilities or traumatic brain injury, shall be required to call the 911 emergency telephone service for assistance in the event of a life-threatening emergency at the facility or the public or private agency, and to report that call to the department, in accordance with policies and procedures established by regulation of the commissioner. The facility or the public or private agency, as applicable, and the department shall maintain a record of such calls under the policy to be established pursuant to this section.

b. The department shall ensure that appropriate training is provided to each member of the staff at a facility for persons with developmental disabilities or a facility for persons with traumatic brain injury or member of the staff at a public or private agency, who in either case works directly with persons with developmental disabilities or traumatic brain injury, to effectuate the purposes of subsection a. of this section.

C.30:6D-5.4 Violations, penalties.

4. A member of the staff at a facility for persons with developmental disabilities or a facility for persons with traumatic brain injury or a member of the staff at a public or private agency who violates the provisions of section 3 of this act shall be liable to a civil penalty of \$5,000 for the first offense, \$10,000 for the second offense, and \$25,000 for the third and each subsequent offense, to be sued for and collected in a summary proceeding by the commissioner pursuant to the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

C.30:6D-5.5 Record of violations.

5. The department shall maintain a record of violations of the provisions of section 3 of this act, which shall be included in the criteria that the department considers in making a decision on whether to renew the license of a facility or whether to renew a contract with a public or private agency, as applicable.

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C.45:1-21.3 Violation of the responsibility to make 911 call, forfeiture of license, authorization to practice.

6. A health care professional licensed or otherwise authorized to practice as a health care professional pursuant to Title 45 of the Revised Statutes who violates the provisions of section 3 of P.L.2003, c.191 (C.30:6D-5.3) shall, in addition to being liable to a civil penalty pursuant to section 4 of P.L.2003, c.191 (C.30:6D-5.4), be subject to revocation of that individual's professional license or other authorization to practice as a health care professional by the appropriate licensing board in the Division of Consumer Affairs in the Department of Law and Public Safety, after appropriate notice and opportunity for a hearing.

C.30:6D-5.6 Rules, regulations.

7. The Commissioner of Human Services, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations necessary to effectuate the purposes of this act.

8. This act shall take effect on the 180th day after enactment, but the Commissioner of Human Services may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act.

Approved October 26, 2003.

## Definitions of Reportable Incidents

### Abuse, Neglect and Exploitation

The New Jersey Office of the Ombudsman for the Institutionalized Elderly defines:

- *Abuse* as the willful infliction of pain, injury, mental anguish (by staff or other residents), unreasonable confinement or willful deprivation of services.
- *Exploitation* as resident's resources used for another person's profit or advantage.
- *Neglect* as failure to perform one's duties according to an accepted professional standard.
- *Missing Person* as a resident missing for more than two hours.

The Department of Children and Families defines:

- *Abuse* as the physical, sexual or emotional harm or risk of harm to a child under the age of 18 caused by a parent or other person who acts as a caregiver for the child.
- *Neglect* as occurring when a parent or caregiver fails to provide proper supervision for a child or adequate food, clothing, shelter, education or medical care although financially able or assisted to do so.

The Division of Developmental Disabilities defines:

- *Abuse* as any act or omission that deprives an individual of his or her rights or which has the potential to cause or causes actual physical injury or emotional harm or distress. Examples of abuse include, but are not limited to: acts that cause pain, cuts, bruises, loss of a body function; sexual abuse; temporary or permanent disfigurement, death; striking with a closed or open hand; pushing to the ground or shoving aggressively; twisting a limb; pulling hair; withholding food; forcing an individual to eat obnoxious substances; use of verbal or other communications to curse, vilify, degrade an individual or threaten an individual with physical injury. Planned use of behavioral intervention techniques which are part of an approved behavior modification plan or Individual Habilitation Plan are not abuse or neglect.
- *Exploitation* as any unjust or improper use of an individual or his or her resources for one's profit, advantage or gratification.
- *Neglect* as the failure of a paid or unpaid caregiver to provide for the care and safety of individuals under his or her supervision, or failure to provide and maintain proper and sufficient food, clothing, health care, shelter, and/or supervision.
- *Unexpected death* – death caused by accident or an unknown and unanticipated cause.
- *Natural/expected death*-A death caused by long term illness, diagnosed chronic medical condition or other natural/expected conditions resulting in death.

#### Other Categories of Incidents

- Environmental Hazard/Unsafe condition: An unsafe condition that creates an immediate threat to life or health of a consumer.
- Law Enforcement intervention: An arrest or detention of a person by a law enforcement agency, involvement of law enforcement in an incident or event, or placement of a person in a correctional facility.
- Emergency services: i.e., Admission to a hospital or psychiatric facility or the provision of emergency services to a consumer that result in medical care that is not anticipated for this consumer, and that would not routinely be provided by a primary care provider.
- Unable to contact – “Unable to contact” shall mean that an MLTSS member is absent without notification from any program or service offered under MLTSS and the provider is unable to identify the location of the member using contact information in the client file.
- Potential Medicaid Fraud – The intentional deception or misrepresentation that an individual knows or should know to be false or does not believe to be true and makes knowing the deception could result in some unauthorized benefit to himself or some other person(s); definition by the CMS.

#### Reportable Incidents

MCOs are required to develop and implement a critical incident reporting and management system to investigate, analyze and track critical incidents that occur in MLTSS settings. Critical incidents include but are not limited to:

- Missing person or Unable to Contact
- Unexpected death of a member;
- Missing person or Unable to Contact;
- Theft with law enforcement involvement;
- Severe injury or fall resulting in the need for medical treatment;
- Medical or psychiatric emergency, including suicide attempt;
- Medication error resulting in serious consequences;
- Inappropriate or unprofessional conduct by a provider/agency involving the member;
- Suspected or evidenced physical or mental Abuse, (including seclusion and restraints, both physical and chemical);
- Sexual abuse and/or suspected sexual abuse;
- Neglect/Mistreatment, including self-neglect, caregiver overwhelmed, environmental;
- Exploitation, including financial, theft, destruction of property;
- Failure of a member's back-up plan;
- Elopement/wandering from home or facility;
- Eviction/loss of home;
- Facility closure, with direct impact to member's health and welfare;
- The potential for media involvement;
- Cancellation of utilities;
- Natural disaster, with direct impact to member's health and welfare;
- Other, Explain:

## Reporting Guidelines

Any unexpected death or incident with media involvement or the potential for media involvement must be reported to the State by telephone the day the Contractor is notified; using the phone number listed on the Critical Incident Report, and an electronic report is to be submitted within one business day.

The Contractor shall submit a report to the State electronically regarding any critical incident listed in Article 9.10.1.D within one business day of detection or notification. Effective steps must be taken immediately to prevent further harm to or by the affected members.

In addition to reporting individual incidents electronically within one business day, on a quarterly basis, the MCOs must submit a report to the State in a format approved by the State, describing the critical incident by:

- Member Original Medicaid Identification Number;
- Date of occurrence;
- Date the MCO first became aware of the incident;
- Type of incident;

- Setting;
- Type of provider;
- Short description of the incident;
- Short description of the immediate actions taken to protect/halt or ameliorate the harm;
- Numerator/denominator and % of critical incidents by incident type; and
- Numerator/denominator and % of members impacted.

On an annual basis, the MCOs must submit to the State a summary reflecting their analysis of the critical incident trends, including a description of any policies/procedures that have been or will be changed/adopted to prevent similar incidents in the future; trainings held; and description provider corrective action plans requested. Critical incidents where there is a potential violation of criminal law must be reported to local law enforcement authorities. Also, critical incidents occurring in the NF setting should continue to be reported to the Department of Human Services (see contact information listed below).

### **Department of Health**

The Nursing Facilities, Assisted Living Facilities, Personal Care Assistants and Medical Day Care Centers are required to report immediately suspected abuse, neglect and exploitation of members to the New Jersey Department of Health at **(609) 633-8991 and (800) 792-9770 after business hours, followed by written confirmation within 48 hours.**

### **Adult Protective Services (APS)**

The MCOs are required to report, immediately, suspected abuse, neglect and exploitation of members who are adults to the State Adult Protective Services. **Contact information: (609) 341-5567, or write Division of Aging Services, P.O.Box 807, Trenton, NJ 08625-0807.**

### **Division of Children and Families Division of Child Protection and Permanency (DCF/DCP&P)**

Likewise, the MCOs are required to report, immediately, suspected abuse, neglect and exploitation of members who are children to the Department of Children and Families, Division of Child Protection and Permanency. **To report abuse or neglect, call 1-877-NJ ABUSE (652-2873).**

### **New Jersey Office of the Ombudsman**

The Ombudsman will accept complaints from any source regarding the welfare and civil rights of any elderly person, 60 years of age or older, receiving services from nursing facilities, assisted living facilities, residential health care facilities, residential class "C" boarding homes, developmental centers, state psychiatric hospitals and adult medical daycare centers. **To file a complaint, call toll free: 1-877-582-6995; or write the Office of the Ombudsman, P.O. Box 852, Trenton, NJ 08625-0852.**

### **Law Enforcement and other State Investigations:**

The MCOs, their staff and contracted providers are required to cooperate with any investigation conducted by the State or law enforcement authorities.

### **Managed Care contracted providers:**

The MCO-contracted providers are required to submit to their MCO a written investigative report regarding the critical incidents as soon as possible but no later than 30 days. The MCO must review

the provider's investigative report to ensure that the appropriate investigation was conducted and corrective actions were taken within the applicable timeframes.

## Investigations

The MCOs are responsible to conduct their own investigation and must have designated staff to conduct critical incident investigations who:

- are adequately trained in how to conduct a critical incident investigation;
- are not nor have been directly responsible for the authorization of care or care of the member (care management);
- have sufficient authority to obtain information from those involved; and
- have clinical expertise to evaluate the adequacy of care provided relevant to the critical incident.

The investigation must be completed within 30 days unless the findings or information necessary for completion of the investigation cannot be obtained within that time frame. In such cases, the investigation must be completed as soon as possible. The MCOs are responsible for identifying and addressing actual or potential quality of care and/or health and safety issues and ensuring that corrective actions are implemented. Note that the MCOs are not responsible for the investigation of critical incidents that occur in the NF setting; however, they must ensure that they are reported to the proper authority.

The MCOs must educate all staff members and contracted MLTSS providers who have any type of member contact, about how to recognize suspected/actual abuse, neglect or exploitation and how to report it and to whom. During the development of the MLTSS Plan of Care, the members must be counseled on how to recognize suspected/actual abuse, neglect or exploitation and how to report it and to whom and the member is asked to sign that they have received such counseling.

Additionally, the MCOs will be required, as part of its regular monitoring, to track Critical Incident trends internally and develop a system of "triggering off-cycle recredentialing" where a pattern has been identified with a particular provider to take appropriate action and notify the State of the MCO's findings. The implementation of these activities addresses Goals 2, 3 and 4. For the protocol for "unable to contact", please see Appendix B; for Contract information regarding critical incidents, please see Appendix D.

## **BEHAVIORAL HEALTH LONG TERM CARE SERVICES**

There are 100,000 patients discharged from hospitals to nursing facilities in New Jersey annually. All of these individuals and those moving from their home into a nursing facility require a Preadmission Screen and Resident Review (PASRR) Level 1 Screening for severe mental illness and or Intellectual Disabilities or Developmental Disabilities (I/DD). The individuals who screen positively for mental illness or (I/DD) require a Level 2 Screen. As of July 1, 2012, the MCO are responsible for the Level 1 Screening and the State (Division of Mental Health and Addiction Services for mental health

and Division of Developmental Disabilities for I/DD) will continue to conduct the Level 2 Screenings to determine the member's Long Term Care/Behavioral Health (LTC/BH) needs.

All LTC individuals must be assessed in collaboration with the member, the member's family and all others involved with the member's care, including other agencies or systems. The strengths and needs of the member will be evaluated to determine the types and levels of care needed. Services must be provided in a manner that respects the member's and the family's cultural heritage and makes use of the member's natural supports in the community.

As of July 1, 2014, New Jersey will utilize its contracted MCOs to manage all the Medicaid services including home and community based services (HCBS), Nursing Facilities (NF)(for members new to NF) and Behavioral Health (BH) services for those members who qualify for MLTSS level of care. The State will establish specific criteria for the provision and coordination of behavioral health services, to include services that are:

- Least restrictive;
- Most integrated setting; and
- Appropriate to their needs.

The contracted MCOs must establish a LTC BH Administrator who will be responsible for coordinating BH services:

- Across institutional and community settings;
- Collaborating with LTC and community providers; and the LTC case managers.

Additionally, the MCOs must have BH staff who, at a minimum, must have experience in behavioral health care and who will coordinate services with the BH LTC case managers for LTC, acute care and BH, including the ASO.

## **BEHAVIORAL HEALTH ASO**

Before the implementation of the Comprehensive Waiver, the DDD managed care members received their behavioral health services through the MCO in which they were enrolled. All other managed care members and Fee for Service (FFS) beneficiaries received their behavioral health services as a FFS carve-out. Formerly, determination of eligibility was completed by the Division of Developmental Disabilities for those with Intellectual and other Developmental Disabilities (I/DD) population.

As of January 1, 2013, the Division of Children's System of Care (CSOC) under the Department of Children and Families, determines eligibility for developmental services administered by their Administrative Service Organization (ASO), Perform Care. Children and adolescents up to age of 21 years with emotional, developmental and behavioral health care issues and their families may be eligible for services that include community-based, in-home, out-of-home residential and family support services.

Individuals with I/DD/MI who are 21 years and older and not enrolled in MLTSS will receive their behavioral health services under a DMAHS–contracted Administrative Services Organization (ASO). The Division of Developmental Disabilities (DDD) and various stakeholders were consulted for their input in the development of the RFP for the ASO. The ASO will be responsible for the management of all BH Medicaid covered services and most of the state only funded BH services. When the ASO goes live, it is expected that the ASO and the MCO will coordinate care for individual’s transitioning to and from MLTSS into the ASO.

As outlined in the Standard Terms and Conditions, the ASO will be responsible for the following functions: 24/7 call center, member services, screening and assessment, prior authorization, network management, utilization management, care management, care coordination, quality management, information technology, data submission and reporting requirements, financial management, development of care models and coordination with MCOs. The ASO will have quality and performance measures that are specific to BH and will be defined in the RFP and subsequent ASO contract.

In addition to the ASO, the Medicaid Comprehensive Waiver allows for the provision of Behavioral Health Homes (BHH). DMAHS in collaboration with the DMHAS is developing a State Plan Amendment to be able to provide BHH services. These services will be monitored and managed by DMHAS and DMAHS until the ASO goes live. Persons enrolled in MLTSS will be eligible for BHH services and there is expected coordination of care of individuals who are transitioning who are in a BHH and the MLTSS program.

All members in the MLTSS and D-SNP will receive their behavioral health services through the MCO in which they are enrolled. The implementation of these activities addresses Goals 1-3.

## **D-SNP**

In an effort to improve the integration and coordination of health care services, New Jersey has entered into a full benefit Dual Eligible Special Needs Plan (D-SNP), effective January 2012. This program combines all of the benefits to be rendered under one MCO.

### **D-SNP ELIGIBILITY**

In order to be considered eligible to enroll in the D-SNP Program, the potential member must meet the following criteria:

- Have full Medicaid coverage or full Medicaid coverage with Qualified Medicare Beneficiary eligibility (QMB Plus), Specified Low-Income Medicare Beneficiary (SLMB Plus), or Other Full Benefit dual eligibility;
- Show evidence of Part A and Part B coverage; or be enrolled in Medicare Part C coverage; concurrently enrolled in Part D;
- Reside in the service area defined in the D-SNP contract; and
- Enroll in the Contractor’s Medicare Advantage Product as defined in the D-SNP Contract.

Persons not eligible to enroll into the D-SNP program include:

- Individuals medically determined to have End Stage Renal Disease (ESRD) at the time of enrollment;
- Individuals who are only eligible for Specified Low-Income Medicare Beneficiary (SLMB) Qualified, Disabled and Working Individuals (QDWI), Qualified Individual-1 (QI-1) or Qualified Individual-2 (QI-2) and are not otherwise eligible for Medical Assistance;
- Individuals who become eligible for Medical Assistance only after spending down a portion of their income;
- Individuals who are residents of State-operated psychiatric facilities;
- Individuals residing in long term care facilities longer than Medicare covered limits or institutionalized in an inpatient psychiatric institution or intermediate care facility for the intellectually disabled;
- Individuals who are eligible for Medical Assistance who are under 65 years of age, have been screened for breast and/or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program and need treatment for breast or cervical cancer, and are not otherwise covered under creditable coverage as defined in the Federal Public Health Service Act (Program Status Code 295);
- Individuals who are presumptively eligible or in Medically Needy or PACE programs;
- Individuals in out-of-state placements.

## D-SNP NETWORKS

The contracted MCOs are offering a D-SNP and their provider networks are composed of providers who are participating in both the MCO's Medicaid and Medicare networks.

## D-SNP BENEFITS

D-SNP members will receive the same Medicaid and Medicare benefits covered under those capitated contracts, including care management and behavioral health services, as appropriate. There is no cost for joining a D-SNP. Members may choose their MCO as well as disenroll at any time. Aside from improved integration and coordination of health care services, other incentives of joining a D-SNP include no copays for prescriptions and incidentals such as passes to gyms.

## D-SNP Monitoring

Since the D-SNP program offers both Medicaid and Medicare benefits, it is administered through a separate contract. Therefore, the State must have its EQRO conduct a separate review of the CMS mandated quality activities. Mandatory EQRO D-SNP activities include: (1) an annual assessment of MCO operations to determine the MCO's compliance with federal CMS standards; (2) validation of performance improvement projects; and (3) validation of the MCO performance measures. Per 42 CFR 438.360-362, to avoid duplication of activities, CMS gives States the option of using the information obtained from the MCO's Medicare review or private accreditation review, provided

that certain conditions are met. Any standards that are used in the place of a Medicaid review must be at least as stringent as the Medicaid standard; must be included in the State's quality strategy, explaining its rationale for why the standards are duplicative; and must meet with CMS approval. Contingent upon the D-SNP MCOs achieving National Committee for Quality Assurance (NCQA) accreditation, New Jersey will seek CMS approval in exercising the option of using MCO information obtained from a Medicare or private accreditation review to avoid duplication of otherwise mandatory activities, and will comply with 42 CFR 438.360-362. Please see applicable federal regulations at the end of this section.

#### NON-DUPLICATION OF ACTIVITIES FOR ANNUAL ASSESSMENT OF MCO OPERATIONS

Once the D-SNP MCOs achieve accreditation and have met the conditions outlined in 42 CFR 438.360-362, the State will refer to a crosswalk of the deemable standards. At that time, New Jersey will apply Medicare/private accreditation information in its EQRO's review for all Annual Assessment of MCO Operations standards identified in the crosswalk as being "Met" or deemable. The MCOs will be required to provide to the EQRO all reports, findings and other results of their Medicare/private accreditation review to ensure that the applicable standards have, in fact, been met by the individual D-SNP MCO. In the meantime, the EQRO will conduct a full Annual Assessment of MCO Operations for each contracted D-SNP. This activity addresses Goals 1-4.

#### NON-DUPLICATION OF ACTIVITIES FOR PERFORMANCE MEASURES AND PERFORMANCE IMPROVEMENT PROJECTS

After reviewing 42 CFR 438.360 and 438.362 with CMS, it has been determined that New Jersey has not met the conditions to apply non-duplication of activity for performance improvement projects or validation of performance measures. Therefore, the New Jersey EQRO is conducting these activities and executing an effective program of external quality review. With the assistance and technical advice of its EQRO, New Jersey intends to comply with all CMS requirements, including the non-duplication of activities. This addresses Goals 1 – 4.

#### PERFORMANCE MEASURES SPECIFIC TO D-SNP

Currently, on an annual basis, the D-SNP MCOs must submit the following performance measures:

- Adult BMI Assessment
- Comprehensive Diabetes Care
- Colorectal Cancer Screening
- Glaucoma Screening in Older Adults
- Care for Older Adults
- Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)
- Pharmacotherapy Management of COPD Exacerbation
- Cholesterol Management for Patients With Cardiovascular Conditions

- Controlling High Blood Pressure annually
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Disease Modifying Anti-Rheumatic Therapy in Rheumatoid Arthritis
- Osteoporosis Management in Women Who Had a Fracture
- Antidepressant Medication Management
- Annual Monitoring for Patients on Persistent Medications
- Use of Appropriate Medications for People with Asthma
- Potentially Harmful Drug-Disease Interactions in the Elderly
- Use of High-Risk Medications in the Elderly
- Medication Reconciliation Post-Discharge
- Follow-up after Hospitalization for Mental Illness
- Chlamydia Screening
- Breast Cancer Screening annually
- Cervical Cancer Screening annually
- Adult's Access to Preventive/Ambulatory Health Services
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Call Abandonment
- Call Answer Timeliness
- Total Membership
- Frequency of Selected Procedures
- Inpatient Utilization – General Hospital/Acute Care
- Ambulatory Care
- Mental Health Utilization
- Identification of Alcohol and Other Drug Services
- Antibiotic Utilization
- Plan All-Cause Readmissions
- Board Certification
- Race/Ethnicity Diversity of Membership
- Language Diversity of Membership

This monitoring activity addresses 1 through 4.

#### QUALITY IMPROVEMENT PROJECTS SPECIFIC TO D-SNP

The EQRO will prepare a Quality Technical Report. Initially, New Jersey will require a D-SNP-specific QIP concerning Medication Reconciliation. After the D-SNP Performance Measures have been collected and analyzed, additional D-SNP QIPs may be added to the contract requirements. These quality activities address Goals 1, 2 and 3.

As the D-SNP program develops, NJ will add additional quality monitoring activities such as a work plan of QAPI activities, satisfaction surveys, provider network reports and grievances and appeals reports. The implementation of these activities will address Goals 1-4.

**Regulations regarding Non-Duplication of Mandatory Activities  
Annual Assessment of MCO Operations**

**42 CFR 438.360 Non-duplication of mandatory activities.**

- (a) General rule. To avoid duplication, the State may use, in place of a Medicaid review by the State, its agent or EQRO, information about the MCO obtained from a Medicare or private accreditation review to provide information otherwise obtained from the mandatory activities specifies in 438.358 if the conditions of paragraph (b) or paragraph (c) of this section are met.
- (b) MCOs reviewed by Medicare or private accrediting organizations. For information about an MCO compliance with one or more standards required under 438.204(g), (except with respect to standards under 438.240 (b)(1) and (2), for the conduct of performance improvement projects and calculation of performance measures respectively) the following conditions must be met:
- (1) The MCO is in compliance with standards established by CMS for Medicare+Choice or a national accrediting organization. The CMS or national accreditation standards established by the State to comply with 438.204(g) and the EQR-related activity under 438.358(b)(3).
  - (2) Compliance with the standards is determined either by –
    - (i) CMS or its contractor for Medicare; or
    - (ii) A private national accrediting organization that CMS has approved as applying standards at least as stringent as Medicare under the procedures in 422.158.
  - (3) The MCO provides to the State all the reports, findings, and other results of the Medicare or private accreditation review applicable to the standards provided for in 438.204(g); and the State provides the information to the EQRO.
  - (4) In its quality strategy, the State identifies the standards for which the EQR will use information from Medicare or private accreditation review, and explains its rationale for why the standards are duplicative.
- (c) Additional provisions for MCOs serving only dual eligible. The State may use information obtained from the Medicare program in place of information produced by the State, its agent or EQRO with respect to the mandatory activities specified in 438.358 (b) (1) and (b) (2) if the following conditions are met:
- (1) The MCO serves only individuals who receive both Medicare and Medicaid benefits.
  - (2) The Medicare review activities are substantially comparable to the State-specified mandatory activities in 438.358 (b)(1) and (b)(2).
  - (3) The MCO provides to the State all reports, findings, and other results of the Medicare review from the activities specified under 438.358 (b)(1) and (b)(2) and the State provides the information to the EQRO.
  - (4) In its quality strategy, the State identifies the mandatory activities for which it has exercised this option and explains its rationale for why these activities are duplicative.

**438.362 Exemption from external quality review.**

- (a) Basis for exemption. The State may exempt an MCO or PIHP from EQR if the following conditions are met:
- (1) The MCO or PIHP has a current Medicare contract under part C of title XVIII or under section 1876 of the Act, and a current Medicaid contract under section

1903(m) of the Act.

- (2) The two contracts cover all or part of the same geographic area within the State.
  - (3) The Medicaid contract has been in effect for at least 2 consecutive years before the effective date of the exemption and during those 2 years the MCO or PIHP has been subject to EQR under this part, and found to be performing acceptably with respect to the quality, timeliness, and access to health care services it provides to Medicaid recipients.
- (b) Information on exempted MCOs or PIHPs. When the State exercises this option, the State must obtain either of the following:
- (1) Information on Medicare review findings. Each year, the State must obtain from each MCO or PIHP that it exempts from EQR the most recent Medicare review findings reported on the MCO or PIHP including—
    - (i) All data, correspondence, information, and findings pertaining to the MCO's or PIHP's compliance with Medicare standards for access, quality assessment and performance improvement, health services, or delegation of these activities;
    - (ii) All measures of the MCO's or PIHP's performance; and
    - (iii) The findings and results of all performance improvement projects pertaining to Medicare enrollees.
  - (2) Medicare information from a private, national accrediting organization that CMS approves and recognizes for Medicare+Choice deeming. (i) If an exempted MCO or PIHP has been reviewed by a private accrediting organization, the State must require the MCO or PIHP to provide the State with a copy of all findings pertaining to its most recent accreditation review if that review has been used for either of the following purposes:
    - (A) To fulfill certain requirements for Medicare external review under subpart D of part 422 of this chapter.
    - (B) To deem compliance with Medicare requirements, as provided in §422.156 of this chapter.
  - (ii) These findings must include, but need not be limited to, accreditation review results of evaluation of compliance with individual accreditation standards, noted deficiencies, corrective action plans, and summaries of unmet accreditation requirements.

**42 CFR 438.358 Activities related to external quality review.**

- (a) General rule. The State, its agent that is not an MCO or PIHP, or an EQRO may perform the mandatory and optional EQR-related activities in this section.
- (b) Mandatory activities. For each MCO, the EQRO must use information from the following activities:
  - (1) Validation of performance improvement projects required by the State to comply with requirement set forth in 438.240 (b)(1) and that were underway during the preceding 12 months.
  - (2) Validation of MCO performance measure reported (as required by the State) or MCO performance measure calculated by the State during the preceding 12 months to comply with requirements set forth in 438.240(b)(2).
  - (3) A review, conducted within the previous 3-year period, to determine the MCO's compliance with standards (except with respect to standards under 438.24(b)(1) and (2), for the conduct of performance improvement projects and calculation

of performance measures respectively) established by the State to comply with the requirements of 438.204(g).

**42 CFR 438.204(g) Elements of State quality strategies.**

(g) Standards, at least as stringent as those in the following sections of this subpart, for access to care, structure and operations, and quality measurement and improvement.

**42 CFR 422.158 Procedures for approval of accreditation as a basis for deeming compliance.**

Required information and materials. A private, national accreditation organization applying for approval must furnish to CMS all of the following information and materials. (When applying for approval, the organization need furnish only particular information and materials requested by CMS.

- (1) The types of MA plans that it would review as part of its accreditation process.
- (2) A detailed comparison of the organization's accreditation requirements and standards with the Medicare requirements (for example, a crosswalk).
- (3) Detailed information about the organization's survey process, including—
  - (i) Frequency of surveys and whether surveys are announced or unannounced.
  - (ii) Copies of survey forms, and guidelines and instructions to surveyors.
  - (iii) Descriptions of—
    - (A) The survey review process and the accreditation status decision making process;
    - (B) The procedures used to notify accredited MA organizations of deficiencies and to monitor the correction of those deficiencies; and
    - (C) The procedures used to enforce compliance with accreditation requirements.
- (4) Detailed information about the individuals who perform surveys for the accreditation organization, including—
  - (i) The size and composition of accreditation survey teams for each type of plan reviewed as part of the accreditation process;
  - (ii) The education and experience requirements surveyors must meet;
  - (iii) The content and frequency of the in-service training provided to survey personnel;
  - (iv) The evaluation systems used to monitor the performance of individual surveyors and survey teams; and
  - (v) The organization's policies and practice with respect to the participation, in surveys or in the accreditation decision process by an individual who is professionally or financially affiliated with the entity being surveyed.
- (5) A description of the organization's data management and analysis system with respect to its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.
- (6) A description of the organization's procedures for responding to and investigating complaints against accredited organizations, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and ombudsmen programs.
- (7) A description of the organization's policies and procedures with respect to the withholding or removal of accreditation for failure to meet the accreditation organization's standards or requirements, and other actions the organization takes in response to noncompliance with its standards and requirements.

- (8) A description of all types (for example, full, partial) and categories (for example, provisional, conditional, temporary) of accreditation offered by the organization, the duration of each type and category of accreditation and a statement identifying the types and categories that would serve as a basis for accreditation if CMS approves the accreditation organization.
- (9) A list of all currently accredited MA organizations and the type, category, and expiration date of the accreditation held by each of them.
- (10) A list of all full and partial accreditation surveys scheduled to be performed by the accreditation organization as requested by CMS.
- (11) The name and address of each person with an ownership or control interest in the accreditation organization.
- (b) Required supporting documentation. A private, national accreditation organization applying or reapplying for approval must also submit the following supporting documentation:
  - (1) A written presentation that demonstrates its ability to furnish CMS with electronic data in CMS compatible format.
  - (2) A resource analysis that demonstrates that its staffing, funding, and other resources are adequate to perform the required surveys and related activities.
  - (3) A statement acknowledging that, as a condition for approval, it agrees to comply with the ongoing responsibility requirements of § 422.157(c).
- (c) Additional information. If CMS determines that it needs additional information for a determination to grant or deny the accreditation organization's request for approval, it notifies the organization and allows time for the organization to provide the additional information.
- (d) Onsite visit. CMS may visit the accreditation organization's offices to verify representations made by the organization in its application, including, but not limited to, review of documents, and interviews with the organization's staff.
- (e) Notice of determination. CMS gives the accreditation organization, within 210 days of receipt of its completed application, a formal notice that—
  - (1) States whether the request for approval has been granted or denied;
  - (2) Gives the rationale for any denial; and
  - (3) Describes the reconsideration and reapplication procedures.
- (f) Withdrawal. An accreditation organization may withdraw its application for approval at any time before it receives the formal notice specified in paragraph (e) of this section.
- (g) Reconsideration of adverse determination. An accreditation organization that has received notice of denial of its request for approval may request reconsideration in accordance with subpart D of part 488 of this chapter.
- (h) Request for approval following denial. (1) Except as provided in paragraph (h)(2) of this section, an accreditation organization that has received notice of denial of its request for approval may submit a new request if it—
  - (i) Has revised its accreditation program to correct the deficiencies on which the denial was based;
  - (ii) Can demonstrate that the MA organizations that it has accredited meet or exceed applicable Medicare requirements; and
  - (iii) Resubmits the application in its entirety.
- (2) An accreditation organization that has requested reconsideration of CMS's denial of

its request for approval may not submit a new request until the reconsideration is administratively final.

## **B. LEVEL OF CONTRACT COMPLIANCE – METHODS OF REMEDIATION**

Per Goals 1, 2 and 3, DMAHS utilizes various strategies to assess the level of compliance and to drive improvements in ensuring access and quality of services. The review methods are geared toward using findings from data analysis, monitoring results and feedback from beneficiaries and providers to form strategy development and the policymaking process. Adherence to contract requirements is closely monitored and gaps in compliance are addressed promptly. When a deficiency in contract compliance is noted, a Notice of Deficiency (NOD) and Request for Corrective Action Plan (CAP) will be issued with a 30 day timeframe for response required from the MCO. In some cases, the exigencies of the matter may require the response timeframe to be less than 30 days. If the CAP proves ineffective, a Notice of Intent to Sanction (NOIS) will be issued; and if necessary, a Notice of Sanction (NOS) will follow. The timeframes of response for NOIS and NOS are at the discretion of the State. Contract Articles 7.15 and 7.16 below describe the Sanction process.

### **7.15 SANCTIONS**

In the event DMAHS finds the contractor to be out-of-compliance with program standards, performance standards or the terms or conditions of this contract, the Department shall issue a written notice of deficiency, request a corrective action plan and/or specify the manner and timeframe in which the deficiency is to be cured. If the contractor fails to cure the deficiency as ordered, the Department shall have the right to exercise any of the administrative sanction options described below, in addition to any other rights and remedies that may be available to the Department. The type of action taken shall be in relation to the nature and severity of the deficiency:

- A. Suspend enrollment of beneficiaries in contractor's plan.
- B. Notify enrollees of contractor non-performance and permit enrollees to transfer to another MCO without cause.
- C. Reduce or eliminate marketing and/or community event participation.
- D. Terminate the contract, under the provisions of the preceding Article.
- E. Cease auto-assignment of new enrollees.
- F. Refuse to renew the contract.
- G. Impose and maintain temporary management in accordance with §1932(e)(2) of the Social Security Act during the period in which improvements are made to correct violations.
- H. In the case of inappropriate marketing activities, referral may also be made to the Department of Banking and Insurance for review and appropriate enforcement action.
- I. Require special training or retraining of marketing representatives including, but not limited to, business ethics, marketing policies, effective sales practices, and State marketing policies and regulations, at the contractor's expense.
- J. In the event the contractor becomes financially impaired to the point of threatening the ability of the State to obtain the services provided for under the contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or

suffers or permits the appointment of a receiver for its business or its assets, the State may, at its option, immediately terminate this contract effective the close of business on the date specified.

K. Refuse to consider for future contracting a contractor that fails to submit encounter data on a timely and accurate basis.

L. Refer the matter to the US Department of Justice, the US Attorney's Office, the New Jersey Division of Criminal Justice, and/or the New Jersey Division of Law as warranted.

M. Refer the matter to the applicable federal agencies for civil money penalties.

N. Refer the matter to the New Jersey Division of Civil Rights where applicable.

O. Exclude the contractor from participation in the Medicaid program.

P. Refer the matter to the New Jersey Division of Consumer Affairs.

The contractor may appeal the imposition of sanctions or damages in accordance with Article 7.18.

## **7.16 LIQUIDATED DAMAGES PROVISIONS**

### **7.16.1 GENERAL PROVISIONS**

It is agreed by the contractor that:

A. If contractor does not provide or perform the requirements referred to or listed in this provision; damage to the State may result.

B. Proving such damages shall be costly, difficult, and time-consuming.

C. Should the State choose to impose liquidated damages, the contractor shall pay the State those damages for not providing or performing the specified requirements; if damages are imposed, collection shall be from the date the State placed the contractor on notice or as may be specified in the written notice.

D. Additional damages may occur in specified areas by prolonged periods in which contractor does not provide or perform requirements.

E. The damage figures listed below represent a good faith effort to quantify the range of harm that could reasonably be anticipated at the time of the making of the contract.

F. The Department may, at its discretion, withhold capitation payments in whole or in part, or offset with advanced notice liquidated damages from capitation payments owed to the contractor.

G. The DHS shall have the right to deny payment or recover reimbursement for those services or deliverables which have not been performed and which due to circumstances caused by the contractor cannot be performed or if performed would be of no value to the State. Denial of the amount of payment shall be reasonably related to the amount of work or deliverable lost to the State.

H. The DHS shall have the right to recover incorrect payments to the contractor due to omission, error, fraud, waste, or abuse, or defalcation by the contractor. Recovery to be made by deduction from subsequent payments under this contract or other contracts between the State and the contractor, or by the State as a debt due to the State or otherwise as provided by law.

I. Whenever the State determines that the contractor failed to provide one (1) or more of the medically necessary covered contract services, the State shall have the right to withhold a portion of the contractor's capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the State shall pay to provide such services along with administrative costs of making such payment. Any other harm to the State or the beneficiary/enrollee shall be calculated and applied as damage. The

contractor shall be given written notice prior to the withholding of any capitation payment.

**J. Corrective Action and Liquidated Damages.**

The contractor shall correct or submit a written corrective action plan for any deficiency identified by the Department in writing within ten (10) business days from the date of receipt of the Department's notification or within a time determined by the Department depending on the nature of the issue. For each day beyond that time that the Department has not received an acceptable corrective action plan, monetary damages in the amount of one hundred dollars (\$100) per day for ten (10) days and two hundred fifty (\$250) per day thereafter will be deducted from the capitation payment to the contractor. The contractor shall implement the corrective action plan immediately from the time of Department notification of the original problem pending approval of the final corrective action plan. The liquidated damages shall be applied for failure to implement the corrective action plan from the date of original State notification of the problem. Corrective action plans apply to each of the areas in this Article for potential liquidated damages. Corrective action must be completed within the time period determined and approved by DMAHS in its sole discretion after the date of the final approval of the corrective action plan or monetary damages of \$250 per day will be deducted from the capitation payment.

**K. Self-Reporting of Failures and Noncompliance.** Any monetary damages that otherwise would be assessed pursuant to this Article of this contract, may be reduced, at the State's option, if the contractor reports the failure or noncompliance in written detail to DMAHS prior to notice of the noncompliance from the Department. The amount of the reduction shall be no more than ninety (90) percent of the total value of the monetary damages.

**L.** Nothing in this provision shall be construed as relieving the contractor from performing any other contract duty not listed herein, nor is the State's right to enforce or to seek other remedies for failure to perform any other contract duty hereby diminished.

## **C. LEVEL OF IMPACT FROM USE OF AVAILABLE OR EVOLVING HEALTH INFORMATION TECHNOLOGY**

Health information exchange has been ongoing between DMAHS and NJ DOH for blood lead screening information since 2004 through bi-annual data matching. Through this process, DMAHS has been able to identify children who are lead-burdened or have not received a blood lead screening and share this information with contracted MCOs so that necessary follow-up is initiated. Efforts are underway to make the data exchange more automated, accurate and closer to real-time. The MCI project is key to this HIE initiative and will facilitate other efforts related to the HITECH Act, the Affordable Care Act, the new Medicaid Consolidated Eligibility and Enrollment system under development and the collection of quality measures required by CHIPRA legislation. It is anticipated that as the information infrastructure matures, the ability to provide real time patient information at the point of care to improve quality and safety will also be vastly improved. The eventual measurement and standardization of quality indicators will also help in assessing program performance, increase transparency, provide valuable information to providers on their performance on key areas and encourage adherence to evidence-based guidelines.

## MITA AND THE REPLACEMENT MMIS ON QUALITY

The NJ MMIS is a key facet in the operation of DMAHS programs to deliver high quality, coordinated, person-centered, and cost-effective services. DMAHS completed the Medicaid Information Technology Architecture (MITA) State Self-Assessment in 2010 and is currently in the process of preparing for the re-procurement of the NJ MMIS in SFY 2013.

The goal of the procurement is to provide DMAHS with the system infrastructure, technical capabilities and management tools to effectively manage the State Medicaid programs in an era of dynamic health system transformation. The new system, henceforth referred to as the Replacement MMIS, will help ensure that members receive quality, coordinated and person-centered health services, that programs are effectively administered with the help of decision support tools, that fraud, waste and abuse are prevented, detected and addressed, and that the system is able to adapt and respond timely to regulatory and policy changes. The Replacement MMIS will enable New Jersey to achieve program goals that are critically intertwined with health information technology and electronic exchange of health information to improve health outcomes and control program cost.

As envisioned, the Replacement MMIS will provide a system infrastructure that takes into account the challenges of health care reform, the newest benefits in health information technology (HIT), and the system and policy changes that will enable the State to implement strategies to improve health care outcomes, realize program efficiencies, and achieve cost savings. Based on the vision articulated by the DMAHS leadership and the input provided by over 200 stakeholders during the requirements analysis phase for the new system, the Replacement MMIS will be able to take full advantage of new technologies to enable the following:

- Support of dynamic business processes, allowing for the necessary expansion of all system-maintained data elements and fields to accommodate expanding scope, new services, changing requirements, and legislative mandates;
- Significant reduction of paper-based processing thus reducing paper waste and also provide economical data archiving by using an Electronic Document Management System (EDMS);
- Better, faster, and easier-to-use technology with less operating and maintenance costs, better financial modeling, budgeting tools, and expenditure control practices;
- Better communication and data sharing bridges among internal and external users to improve care and member management; and
- Improved customer service and decision-making tools, enhanced reporting, and better use of staff.

### Anticipated Benefits

- The Replacement MMIS will provide the capabilities that will enable the realization of New Jersey's vision, align with the Medicaid Information Technology (MITA) framework and

comply with the CMS Seven Conditions and Standards. With these capabilities in place the NJ Medicaid Enterprise will be able to:

- Ensure provision of coordinated, accountable and patient-focused care;
- Facilitate data access and health information exchange in real time while ensuring privacy and security;
- Coordinate with other public health agencies to improve surveillance and population health;
- Determine availability of services to improve access to care;
- Promote informed and timely decision-making, both at the policy administration level and at the point of care;
- Provide data that is timely, accurate, usable, accessible;
- Improve healthcare outcomes by providing the right information at the right time to support clinical decisions;
- Promote member engagement in their health care;
- Take advantage of automation and paperless transactions;
- Accommodate current and future business methods;
- Monitor and improve programs and determine cost effectiveness;
- Monitor costs and predict future financial needs;
- Enhance prevention, detection and loss recovery related to fraud waste and abuse;
- Compare service utilization or provider or beneficiary enrollment across state or other geographic boundaries;
- Participate in health information exchange and the Health Insurance Exchange;
- Leverage resources by maximizing the use of shared services;
- Support of dynamic business processes, allowing for modifications to accommodate expanding scope, new services, changing requirements, and legislative mandates; and
- Keep pace with technological innovations that will reduce operating and maintenance costs while enabling better program administration and expenditure control practices.

In summary, the Replacement MMIS provides possibilities for business improvement and the flexibility to accommodate evolving business needs and methods. A more adaptable design will

better position New Jersey's Medicaid Enterprise for the future and provide the ability to more quickly address Medicaid program needs.

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#### **IMPROVEMENT**

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Findings from assessment activities are used to determine compliance, gauge progress and identify opportunities for improvement as well as needed changes in the monitoring strategies. These activities also provide valuable information on promising initiatives that can be replicated on a wider scale.

Displayed in Table 1 are performance data on priority areas for measurement for Year 2012 and corresponding targets objectives for the next five years. The various improvement strategies are anticipated to sustain progress towards the achievement of these target goals.

**TABLE 1 – DASHBOARD QUALITY STRATEGY OBJECTIVES**

Quality Strategy Objective	2012 (Measurement Year 2011)	2013 (Measurement Year 2012)	2014 (Measurement Year 2013)	2015 (Measurement Year 2014)	2016 (Measurement Year 2015)	2017 (Measurement Year 2016)	Trend from 2012-2017 ↑↓
Children and Adolescent's Access to Primary Care – Total	NR						
12 – 24 months	-	97.42					
25 months – 6 years	-	91.20					
7 – 11 years	-	93.24					
12 – 19 years	-	91.55					
Adults' Access to Preventive Care	NR						
Timeliness of Prenatal Care	83.44	83.95					
Postpartum Care	58.16	61.16					
Childhood Immunizations Combination 3	65.74	64.97					
BMI Assessment for Children and Adolescents-Total	51.87	50.40					
Adult BMI Assessment	NR	65.41					
HbA1c Testing	79.38	78.12					
HbA1c control (<8.0%)	46.36	45.41					
Controlling High Blood Pressure	NR	51.70					
Annual Preventive Dental Visits –Categories	NR						
	2011 CAHPS	2012 CAHPS					
Percentage of respondents who responded "None" to question UT1. "In the last 6 months, how many times did you go to an emergency room to get health care for yourself?"	73	72					
Percentage of respondents who responded "Always" to composite questions Adult Q 4 & 6 that asked how often you got health care when needed care right away/an appointment with a doctor/clinic as soon as you thought you needed it.	52	53					
Percentage of respondents who responded "Always" to composite Child questions Q 4 & 6 that asked how often you got health care for your child when it was needed right away/an appointment with a doctor/clinic as soon as you thought your child needed it.	64	61					
Care Management	2011 Measurement	2012 Measurement Year					

	Year						
Audit Score	66-100	55-100					
MLTSS	N/A	N/A					
Hospital admissions of members using HCBS	-	-					
ER utilization of members using HCBS	-	-					
Short stay NF admissions of members using HCBS	-	-					

The EQRO is a valuable partner in advancing the quality program. DMAHS has worked closely with the EQRO to fine-tune the various assessment tools and processes used for evaluations. For example, modifications in the Annual Assessment of MCO Operations included the revision of the document submission tool and report outline to consolidate common themes and improve MCO document submissions for the desk reviews. Additionally, efforts to enhance the EQRO’s evaluation of the QIPs were implemented recently. The new process, which provides more opportunity for feedback and builds MCO capabilities in QIP design, is expected to improve the effectiveness of the initiatives while concurrently streamlining the evaluation process. This process was implemented in 2010.

Key to tracking progress is the availability and reliability of data. The creation of the Encounter Data Monitoring Unit (EDMU), which evaluates encounter data, has helped to ensure that metrics based on encounter data are truly reflective of performance and that data submitted by MCOs are complete.

With the various efforts to promote health information exchange, DMAHS is taking steps to overcome barriers that impede the flow of data to inform care delivery. The MITA assessment along with the MCI project will allow DMAHS to operate beyond just meeting requirements and optimize processes to achieve goals related to improved health outcomes and program cost-effectiveness.

Reports such as the Quality Technical Report, NJ HMO Performance Report and the CAHPS provide valuable and concise insight on overall and comparative performance. DMAHS is working towards increasing the availability of performance indicators in print and other electronic media such as the internet. This will promote accountability, transparency and inform stakeholders of progress in key areas.

Collaboration with varied stakeholders is crucial to DMAHS quality improvement efforts. The New Jersey Department of Health has been a critical partner in many initiatives that include data sharing for blood lead screening, newborn hearing, immunizations and strengthening linkages to improve health service delivery especially for at risk populations. DMAHS has also collaborated with the American Academy of Pediatrics (AAP), American Academy of Pediatric Dentists and the Early Head Start (EHS)/Head Start (HS) programs to promote the establishment of dental homes.

EPSDT standards in the managed care contract require the achievement of the 80% rate for well-visits, dental, immunization and blood lead screenings. Failure to meet the standard may result in corrective action plans (CAPs) or a notice of sanction. Over the years, steady increases in EPSDT rates have been achieved. It is anticipated that improvement will be sustained by holding MCOs to the standard and through the various quality improvement initiatives.

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## **PROCESS FOR QUALITY STRATEGY DEVELOPMENT, REVIEW AND REVISION**

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The Office of Quality Assurance (OQA) within DMAHS develops a quality strategy that is aligned with the vision of the right care, for every person, every time, in the appropriate setting and ensures that members have access to quality, equitable, patient-centered, culturally-competent and cost-effective care that results in optimal outcomes.

On an annual basis, the State reviews findings from monitoring activities to discern trends, identify emerging issues and assess the effectiveness of the monitoring process and quality improvement activities. Feedback, suggestions and recommendations obtained from staff, MCOs, EQRO and other stakeholders are considered to improve strategies. As appropriate, recommendations for managed care contract amendments are made and work plans or scope of work for the EQRO are updated to make the quality strategies more effective.

Enactment or changes in federal or State regulations such as the Deficit Reduction Act of 2005 (DRA), Affordable Care Act (ACA) and the Children's Health Insurance Reauthorization Act (CHIPRA) and updates in CMS guidelines influence quality strategy development. Upon receipt of appropriate guidance, the State determines the necessary adjustments in the quality strategy to comply with the regulatory requirements.

The quality strategy is examined at least annually and updated as needed based on findings and trends identified through the State's monitoring activities. Because the quality strategy and the managed care contract are closely related, changes in either one may result in a corresponding change in the other to ensure alignment. A significant change is one that modifies the quality strategy based on findings identified during monitoring activities that necessitate a contract amendment or require a particular focus or emphasis on an aspect of care.

The State tracks and trends relevant data to ensure that quality assurance activities are data driven and promote quality improvement.

The State also works closely with organizations with technical expertise and resources. These organizations include, but are not limited to, the state contracted External Quality Review Organization (EQRO), Mercer Government Human Services Consulting (Mercer), and the Center for Health Care Strategies (CHCS).

On a quarterly basis, DMAHS convenes the Medical Assistance Advisory Committee (MAAC), which is comprised of beneficiaries, consumer advocates and providers and is open to the public at large. The MAAC meetings provide a forum for all interested parties, including individuals who are eligible for both Medicare and Medicaid, to receive updates on DMAHS programs and initiatives and voice concerns, views and recommendations regarding the Medicaid programs.

The Medical and Dental Advisory Committee is comprised of medical and dental directors and quality staff of participating NJ Medicaid MCOs who meet regularly to discuss policy and operational issues that affect access and quality of health care services. Ensuring that individuals who are eligible for both Medicare and Medicaid receive medical and dental benefits is a standing agenda

item with this work group. These meetings provide opportunities to obtain input and support for quality initiatives and also promote the sharing of effective and promising practices.

DMAHS also collaborates closely with other State agencies such as the Division of Aging Services (DoAS), Department of Children and Families (DCF) and Department of Banking and Insurance (DOBI). This coordination helps ensure that policies and programs that affect health service delivery are communicated across agencies, reduce duplication of activities and promote cooperation and transfer of information to facilitate the achievement of common goals. DMAHS continually seeks to expand its collaborative efforts to include other agencies that may enhance its capacity to ensure access to quality health care.

CMS will be informed of any significant changes in the quality strategy as they occur, including changes made as a result of the Comprehensive Waiver and D-SNPs. The quality strategy, which addresses the comprehensive waiver, must be submitted to CMS for final approval within 90 days before the approval date of the Comprehensive Waiver. The State will provide CMS with quarterly and annual reports on the implementation and effectiveness of the updated quality strategy as it impacts the Comprehensive Waiver.

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## ACHIEVEMENTS AND OPPORTUNITIES

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### NJ DOH CHILDHOOD LEAD POISONING SURVEILLANCE SYSTEM

Efforts to promote data exchange and information flow have improved the delivery of health services. Through a matching of Medicaid information with the NJ DOH Childhood Lead Poisoning Surveillance System, DMAHS has been able to share information with MCOs and providers on which children are lead-burdened or in need of screening so that necessary outreach or follow-up care can be initiated. This has resulted in improved blood lead screening rates and timely case management of lead burdened children. The NJ Medicaid average for the 2012 HEDIS Lead Screening in Children measure was 79.74% and exceeded the national Medicaid average by over eight percentage points. Similar initiatives that facilitate provider access to immunization and newborn hearing screening information available in DOH information systems are also in progress to help inform providers of any needed immunizations or follow-up of children with hearing problems. While progress in these areas is a notable achievement in advancing delivery of EPSDT services, it also presents an opportunity for improving health information exchange to make it more accurate, closer to real-time and delivered through a web interface that is secure and overcomes information silos. Benefits from the MCI, which is an integral component in the Electronic Medical Information for Children (eMedIC) Medicaid transformation grant project, will help improve quality of care and support the broader aims of the ARRA and HITECH Acts.

### DENTAL DIRECTORY

In 2007, NJFC/M worked together with CHCS and the contracted MCOs in a quality improvement project to improve the oral health services for children 0 to 5 years of age enrolled in Medicaid and the State Children's Health Insurance Program. This 18 month collaborative began in fall of 2007 and resulted in a Dental Directory of general and pediatric dental providers for children 5 years old and under. The directory lists dentists by county, by city, and lists handicap accessibility, the insurance plans accepted, whether the dentist is a special needs provider and the ages treated. The NJ Smiles Dental Directory is updated annually.

### CARE MANAGEMENT TOOL

With the assistance from CHCS, the State has developed a care management tool that allows for early identification of members in need of care management services. All new members (except DYSF, DDD and MLTSS eligible members) will be screened using an approved Initial Health Screening tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs as well as the need for more extensive screening. Any member identified by a health care professional as having potential care management needs, all DDD, Division of Child and Protection and Permanency (DCP&P), formerly known as Division of Youth and Family Services and MLTSS-eligible members will receive a more detailed comprehensive needs assessment (CNA) and an ongoing care coordination and management as appropriate. The IHS tool was submitted to and approved by CMS and is currently in its beta test period that commenced on January 2012. Information from the beta test has been received from the MCOs by the OQA and is being trended.

## MEDICAL HOME

Effective, July 2011, the NJ State Medicaid Contract, Section 4.2.10, requires that the contracted MCOs must participate in the Medicaid Medical Home demonstration. Primary care providers must be identified for participation in the demonstration project that provides care to enrollees with a chronic health condition and/or behavioral health condition using a medical home model. Focus is encouraged to the development of Medical Homes for the developmentally disabled and frail elderly. The MCOs will ensure that selected medical homes attain the following accreditation:

- NCQA Level I by end of year 1 of the pilot
- NCQA Level II by end of year 2 of the pilot
- NCQA Level III is optional

The services offered to enrollees participating in the Medical Home demonstration project include:

- Patient care coordination through multi-disciplinary teams;
- Individualized customized care plans that promote self-management;
- Patient/family education for enrollees with chronic diseases;
- Home-based services;
- Telephonic communications;
- Group care;
- Oral health examinations; and
- Culturally and linguistically appropriate care.

The MCOs are required to submit for DMAHS review their proposed payment methodologies that support care coordination and reward quality and improved patient outcomes. Additionally, on an annual basis, the MCO will evaluate their medical home programs and report to the State their findings regarding:

- Cost savings and supporting documentation;
- Types and rate of health screening;
- Health outcome measures, including:
  - emergency room visit rates;
  - hospitalization rates;
  - avoidable hospital readmission rates;
  - comparing medical home cohorts;
- At a minimum, two clinical measures; and
- Satisfaction measures, e.g. CAHPS measures.

The Medical Home will be guided by the Joint Principles of the Patient Centered Medical Home (PCMH):

- Personal physician: each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care;
- Physician directed medical practice: the physician leads a team of health care members at the practice level who collectively take responsibility for the ongoing care of patients;
- Whole person orientation: the personal physician is responsible for providing all of the patient's healthcare need or taking responsibility for appropriately arranging care with other qualified professionals;
- Care is coordinated and/or integrated across settings;
- Quality and safety are assured by planning process, evidence-based medicine, clinical decision-support tools, performance measurement, active participation of patients in decision making, information technology, a voluntary recognition process, quality improvement activities;
- Enhanced access to care is available (expanded hours, enhanced communication options);
- Payment must appropriately recognize the added value provided to patients who have a patient-centered medical home.

## NJ ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT

On August 19, 2011, the New Jersey Governor signed into law the Medicaid Accountable Care Organization Demonstration Project. As noted in the law, the goals are to:

- (1) Increase access to primary care, behavioral health care, pharmaceuticals, and dental care by Medicaid recipients residing in defined regions;
- (2) Improve health outcomes and quality as measured by objective metrics and patient experience of care; and
- (3) Reduce unnecessary and inefficient care without interfering with patients' access to their health care providers or the providers' access to existing Medicaid reimbursement systems.

The ACO demonstration will achieve these goals through two overarching strategies articulated in the legislation:

- Community-based innovation: New Jersey's ACOs will be driven by identified local health care needs, resources, and solutions. Each ACO will consist of a collaboration of practices, hospitals, and community organizations serving all eligible Medicaid beneficiaries in a designated area.
- Shared savings: ACO will benefit from a value-based purchasing strategy that supports more integrated and coordinated systems of care.

The legislation stipulates that qualified ACOs must seek and be certified by the New Jersey Department of Human Services. Under the law, New Jersey nonprofit corporations that wish to form a community-based ACO must demonstrate the support of all general hospitals, no fewer than 75% of qualified primary care providers, and at least four qualified behavioral health care providers located in the designated area served by the ACO.

The ACO will be required to provide a comprehensive plan and processes for accomplishing the Medicaid ACO Demonstration project objectives. As part of certification, the ACO must describe its plan for improving health outcomes and the quality of care by increasing access to primary and behavioral health care services and utilization of preventive care and reducing use of emergency rooms and in-patient care settings for routine care. The ACO's performance will be measured by objective quality benchmarks (Appendix C), as well as patient, and if available caregiver, experience of care. ACOs will be expected to undertake necessary activities to accomplish these goals, such as: care coordination through multi-disciplinary teams; expansion of the medical home and chronic care models; increased patient medication adherence and use of medication therapy management services; use of health information technology and sharing of health information; use of open access scheduling in clinical and behavioral health care settings; and services such as patient or family health education and health promotion, home-based services, group care and culturally and linguistically appropriate care.

## VALUE-BASED PURCHASING

Beginning on July 1, 2013, New Jersey DMAHS will initiate a performance-based contracting (PBC) incentive program. This program is designed to motivate the MCOs' innovation to improve and sustain improvement in clinical areas that are a priority to NJ DMAHS and DOH's Healthy New Jersey 2020 program and their clients. The clinical priority areas include: birth outcomes, diabetes and obesity. Additionally, part of the incentive will encourage the MCOs to achieve NCQA accreditation.

Funding will be provided by setting aside a portion of the capitation rate and a revision of the associated efficiency expectations in SFY 2015. MCOs will have the opportunity to earn PBC amounts based on improved performance measure results from baseline (CY 2013) to measurement year 1 (CY 2014). In addition to the potential to earn PBC payment based on performance in the clinical priority areas, NJ may establish other means to effect performance improvement (E.g., public dissemination of results, adjustment to enrollment algorithms, etc.).

## DELIVERY SYSTEM INCENTIVE PAYMENT PROGRAM

The Delivery System Reform Incentive Payment (DSRIP) Program is one component of the New Jersey's Comprehensive Medicaid Waiver as approved by the Centers for Medicare & Medicaid Services (CMS). DSRIP is a demonstration program designed to result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower costs by transitioning hospital funding to a model where payment is contingent on achieving health improvement goals.

This innovative program provides incentives to hospitals to improve the quality of care they offer to patients within their community by achieving measureable, incremental clinical outcome results demonstrating the initiatives' impact on improving the New Jersey health care system. The former Hospital Relief Subsidy Fund (HRSF) is being transitioned to a performance-based, competitive DSRIP program. Under the new program, all acute care hospitals will be eligible to receive funding.

Hospitals will begin submitting DSRIP applications in September 2013. The state and CMS will review the applications and determine initial funding opportunities. Through this funding, hospitals have an opportunity to develop projects that advance the health of their communities. As part of DSRIP, hospitals may choose one of eight chronic diseases or medical conditions on which to focus improvements. Hospitals will choose among the following diseases and conditions: HIV/AIDS, Cardiac Care, Asthma, Diabetes, Obesity, Pneumonia, Behavioral Health and Substance Abuse.

The DSRIP program supports the Healthy New Jersey 2020 vision: “For New Jersey to be a state in which all people live long, healthy lives”.

## DISPARITIES

The DMAHS has included language in the July 2014 NJFC/M Managed Care Contract that will require the MCOs to develop a program to identify, prevent and reduce health care disparities. This program shall include, but is not limited to the following:

1. Evidence of a process to identify and evaluate healthcare disparities within the MCO, by subgroups including: gender, race, ethnicity, primary language and disability status;
2. Barrier analysis and a written action plan to address the disparities identified;
3. Implementation of an action plan with continuous monitoring of outcomes; and
4. Ongoing evaluation of the effectiveness of the action plan

The program will be evaluated annually during the Annual Assessment of MCO Operations. Failure to submit an effective work plan may result in a Notice of Deficiency (NOD) and Request for Corrective Action Plan (CAP). Continued deficiency will result in a Notice of Intent to Sanction (NOIS) followed by a Notice of Sanction (NOS) if the MCO fails to appropriately remedy the issue. For more information regarding see the section of this document Level of Contract Compliance – Methods of Remediation that describes the process for issuing Sanctions.

## LOOKING TOWARD THE FUTURE

The DMAHS will continue to collaborate with Division of Developmental Disabilities, Division of Mental Health and Addiction Services, Division of Aging Services and Division of Disability Services, as well as stakeholders to identify areas needing improvement and to develop methods to effect change. The State will continue to take steps to ensure that the NJFC/M, including the MLTSS population and D-SNP programs will offer the right care and supports, for every person, every time, in the appropriate setting that ensures members have access to quality, equitable, person-centered, culturally-competent and cost-effective care that results in optimal outcomes, including maximum independence and quality of life.



## APPENDIX A

### NJFC/M MANAGED CARE CONTRACT ARTICLE 1

**Medically Necessary Services**--services or supplies necessary to prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition, or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the type of provider and setting, must be reflective of the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective. Course of treatment may include mere observation or, where appropriate, no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are not medically necessary for purposes of this contract.

Medically necessary services provided must be based on peer-reviewed publications, expert pediatric, psychiatric, and medical opinion, and medical/pediatric community acceptance.

In the case of pediatric enrollees, this definition shall apply with the additional criteria that the services, including those found to be needed by a child as a result of a comprehensive screening visit or an interperiodic encounter whether or not they are ordinarily covered services for all other Medicaid enrollees, are appropriate for the age and health status of the individual and that the service will aid the overall physical and mental growth and development of the individual and the service will assist in achieving or maintaining functional capacity.

**42 CFR 438.204 (b)(1) Elements of State quality strategies.**

At a minimum, the State must include the following...

(b) Procedures that --

(1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs.

Pursuant to 42 CFR 438.204(b)(1) the State includes the definition of special needs in the Managed Care Contract as follows: **Enrollee with Special Needs**--for adults, special needs includes complex/chronic medical conditions requiring specialized health care services, including persons with physical, mental/substance abuse, and/or developmental disabilities, including such persons who are homeless. Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Pursuant to 42 CFR 438.208(c)(1), the State uses program status codes and capitation codes to identify enrollees with special health care needs, such as Aged Blind and Disabled, DCP&P, DDD and MLTSS. Additionally, the State provides risk scores of all members to the assigned MCOs.

**42 CFR 438.208 Coordination and continuity of care.**

(c) Additional services for enrollees with special health care needs.

(1) Identification. The State must implement mechanisms to identify persons with special health care needs to MCOs, PIHPs and PAHPs, as those persons are defined by the State. These identification mechanisms –

(i) Must be specified in the State's quality improvement strategy in 438.202; and

(ii) May use State staff, the State's enrollment broker, or the State's MCOs, PIHPs and PAHPs.

## APPENDIX B

### PROTOCOL FOR REPORTING “UNABLE TO CONTACT” UNDER MLTSS

All instances of “unable to contact” an MLTSS member must be reported through the Critical Incident Reporting system (CIRS) designated by the State. (CIRs TBD)

“Unable to contact” shall mean that an MLTSS member is absent without notification from any program or service offered under MLTSS and the provider is unable to identify the location of the member using contact information in the client file.

#### Actions:

##### Provider

- When notified that an MLTSS member is absent without notification, the provider shall immediately outreach to the client using contact information on file.
- If no response, contact emergency contacts for that client.
- If the client is under the Office of Public Guardian (OPG), notify OPG; when under the Bureau of Guardianship (BGS), notify BGS.
- If unsuccessful to all of the above, notify the member’s Managed Care Organization (MCO) care manager/community based Care Manager.
- File a Critical Incident Report as required through the designated state system to the MCO.

##### MCO

- If the provider is unsuccessful with outreach attempts, the member’s MCO care manager/community based Care Manager shall attempt contact; if contact is not successful, the MCO care manager shall arrange/conduct a home visit to ascertain the safety of the member.
- If the client is under the Office of Public Guardian (OPG), the MCO care manager shall notify OPG; if the client is under the DDD Bureau of Guardianship, notify BGS.
- File a Critical Incident Report as required through the designated state system.
- If, after 24 hours, the individual cannot be contacted or his/her location determined using all of the above, local law enforcement may be notified and their assistance requested.

##### State

- If the whereabouts or status of the member cannot be determined using all of the above, a “Notice of Intent to Terminate” from MLTSS letter shall be issued to the member and/or his/her authorized representative by the designated State authority and the State shall dis-enroll the individual from MLTSS.
- If there is no response from the member or the member’s authorized representative within (10) business days, the member shall be terminated from MLTSS and the termination will be effective 30 days of the date of the Notice of Intent to Terminate. The Notice shall also inform members of appeal or Fair Hearing process.
- All MLTSS capitation for that member shall be discontinued.
- The member shall not be dis-enrolled from Medicaid or the MCO unless determined financially ineligible for Medicaid.

APPENDIX C

NJ ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT MEASURES

**NJ Accountable Care Organization Demonstration Project Demonstration Measures**

	MEASURE SOURCE					
	MCO Contract	HEDIS	Meaningful Use	Dartmouth	NCQA – ACO Certification	2701
<b>MANDATORY MEASURES</b>						
<b>Prevention/Effectiveness of Care</b>						
Screening for Clinical Depression and Follow Up Plan						X
Annual Dental Visit		X				
<b>Acute Care</b>						
RSV in Neonates <35 weeks						
<b>Behavioral Health</b>						
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		X	X			X
Anti-depressant Medication Management		X	X		X	X
<b>Chronic Conditions</b>						
Annual Monitoring for Patients on Persistent Medications (year 2)		X		X	X	X
Annual HIV/AIDS Medical Visit		X	X		X	X
<b>Resource/Utilization</b>						
Emergency Department Visits		X		X		
Inpatient Readmission within 30 days		X		X		
Preventable Hospitalizations				X		
Provider visit within 7 days of Hospital Discharge				X		
Return to ED within 7 days of Hospital Discharge						
All Hospitalizations						
Percent of PCPs for Successfully Qualify for EHR Incentive Payment			X			
<b>CAHPS/Satisfaction</b>						
Getting Timely Care, Appointments and Information	X	X		X	X	X
How Well Your Doctor Communicates	X	X		X	X	X
Patients Rating of Doctor	X	X		X	X	X
Access to Specialists	X	X		X	X	X
Health Promotion and Education	X	X		X	X	X
Shared Decision Making	X	X		X	X	X
Health Status/Functional Status	X	X		X	X	X
<b>VOLUNTARY MEASURES (Must Select 1 Prevention and 5 Chronic Condition Measures)</b>						
<b>PREVENTION</b>						
Childhood Immunization Status	X	X	X	X		
Adolescent Immunization	X	X				
Well Child Visits first 15 months	X	X				
Well Child Visits 3, 4, 5, & 6	X	X				
Adolescent Well Care	X	X				
Weight Assessment and Counseling for Children and Adolescents	X	X	X	X		
Frequency of Ongoing Prenatal Care	X	X				
Medical Assistance with Smoking and Tobacco Use Cessation		X	X		X	X
Cervical Cancer Screening	X	X	X	X		X
Colorectal Cancer Screening		X	X	X		

Tobacco Screening and Cessation		X		X		
Breast Cancer Screening	X	X	X	X	X	X
Chlamydia Screening in Women 21-24	X	X	X	X	X	X
Prenatal and Postpartum Care	X	X				X
<b>CHRONIC CONDITIONS</b>						
Cardiovascular Disease						
Cholesterol Management for Patients with Cardiovascular Conditions		X	X	X		
Controlling High Blood Pressure		X	X	X	X	X
Complete Lipid Panel and LDL Control						
Use of Aspirin or Another Antithrombic						
Beta Blocker Therapy for Left Ventricular Systolic Dysfunction						
Drug Therapy for Lowering LDL Cholesterol						
ACE or ARB Therapy for Patients with CAD or LVSD						
Diabetes						
HbA1c Testing*	X	X	X	X	X	X
HbA1c Poor Control >9*	X	X	X	X		
Control <8*	X	X	X	X		
LDL Screening	X	X	X	X	X	X
LDL Control <100*	X	X	X	X		
Neuropathy Monitoring*	X	X	X	X		
BP Control <140/80*	X	X	X	X		
Eye Exam*	X	X	X	X		
Respiratory						
Use of Appropriate Medications for People with Asthma*	X	X	X	X		
Medication Management for People with Asthma						
Use of Spirometry Testing in Assessment & Diagnosis of COPD						
Pharmacotherapy of COPD exacerbation						
<b>Resource/Utilization</b>						
30 day Readmission Rate following AMI				X		
30 day Readmission Rate following HF				X		
30 day Readmission Rate following PNE				X		
COPD Admission Rate						X
CHF Admission Rate						X
Adult Asthma Admission Rate						X
<b>DEMONSTRATION MEASURES (not included in Savings Model)</b>						
Follow up After Hospitalization for Mental Illness	X (DDD)	X			X	X
Medication Reconciliation (year 2)		X		X		
Mental Health Utilization		X				
Transportation						
Referrals/Connections to Social Supports (housing, food)						
Identification of Alcohol & Other Drug Services		X				

## **9.10 CRITICAL INCIDENT REPORTING**

### **9.10.1 GENERAL MLTSS REQUIREMENTS**

- A. The Contractor shall develop policies and implement procedures for critical incident (CI) reporting and management for incidents that occur in a NF/SCNF, inpatient Behavioral Health, or home and community-based long-term care service delivery setting, including: community alternative residential settings, adult day care centers, other HCBS provider sites, and a Member's home. The Contractor's policy and procedures shall address the process to report potential violations of criminal law to local law enforcement authorities.
- B. The Contractor shall develop its CI system in accordance with the direction provided by DMAHS and other State entities responsible for the oversight and investigation of CIs including use of all forms, tools and report formats required by the State.
- C. The Contractor shall be familiar with State statute and regulations regarding critical incident reporting, including N.J.A.C. 10:42, also known as Danielle's Law that requires a Member of the staff at a facility for persons with developmental disabilities or a facility for persons with traumatic brain injury or a Member of the staff at a public or private agency, who in either case works directly with persons with developmental disabilities or traumatic brain injury, shall be required to call the 911 emergency telephone services for assistance in the event of a life-threatening emergency at the facility or the public or private agency and to report that call to the State.

In all MLTSS provider contracts, the Contractor shall require full adherence to the mandatory training and reporting requirements set forth in Section 9.11 and those applicable to Adult Protective Services, Office of Institutionalized Elderly, Department of Health, the Department of Children and Families and the Division of Disability Services including, but not limited to:

1. N.J.A.C. 8:39- 9.4
2. N.J.A.C. 8:36-5.10(a)
3. N.J.A.C. 8:43F-3.3
4. N.J.A.C. 8:43J-3.4

5. N.J.S.A. 52:27D-409

6. N.J.A.C. 8:57

D. Critical incidents shall include but not be limited to the following incidents when they occur in settings as defined in section -9.10.1A:

1. Unexpected death of a member;
2. Missing person or Unable to Contact;
3. Theft with law enforcement involvement;
4. Severe injury or fall resulting in the need for medical treatment;
5. Medical or psychiatric emergency, including suicide attempt;
6. Medication error resulting in serious consequences;
7. Inappropriate or unprofessional conduct by a provider/agency involving the member;
8. Suspected or evidenced physical or mental Abuse, (including seclusion and restraints, both physical and chemical);
9. Sexual abuse and/or suspected sexual abuse;
10. Neglect/Mistreatment, including self-neglect, caregiver overwhelmed, environmental;
11. Exploitation, including financial, theft, destruction of property;
12. Failure of a member's back-up plan;
13. Elopement/wandering from home or facility;
14. Eviction/loss of home;
15. Facility closure, with direct impact to member's health and welfare;
16. The potential for media involvement;
17. Cancellation of utilities;
18. Natural disaster, with direct impact to member's health and welfare;
19. Other, Explain:

#### **9.10.2 REPORTING AND MONITORING REQUIREMENTS**

A. The Contractor shall identify, track, review and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues. The Contractor shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations; identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of MLTSS delivery.

- B. The Contractor shall require its staff Members and contracted MLTSS providers to report, respond to, and document critical incidents as specified by the Contractor. This shall include, but not be limited to the following:
1. Requiring that the Contractor's staff and contracted MLTSS providers report critical incidents to the Contractor in accordance with applicable requirements. The Contractor shall develop and implement a critical incident reporting process, including the form provided by the State, to be used to report critical incidents and reporting timeframes. The maximum timeframe for reporting an incident to the Contractor shall be one business day. The initial report of an incident within one business day may be submitted verbally, in which case the person/agency/entity making the initial report shall submit a follow-up written report within two business days.
  2. Requiring that suspected abuse, neglect, and exploitation of Members is immediately reported in accordance with the State rules noted in section 9.10.1.C.
  3. Requiring that its staff Members and contracted MLTSS providers immediately (which shall not exceed one business day) take steps to prevent further harm to any and all Members and respond to any emergency needs of Members.
  4. Requiring that contracted MLTSS providers with a critical incident conduct an internal critical incident investigation and submit a report on the investigation within the timeframe specified by the Contractor. The timeframe for submitting the report shall be as soon as possible, may be based on the severity of the incident, and, except under extenuating circumstances, shall be no more than thirty (30) calendar days after the date of the incident. The Contractor shall review the provider's report and follow-up with the provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.
  5. Requiring that its staff Members and contracted MLTSS providers cooperate with any investigation conducted by the Contractor, its designee or outside agencies, including law enforcement.
  6. Defining the role and responsibilities of the fiscal intermediary in reporting, responding to, documenting, and investigating any critical incidents, which shall include reporting and investigating critical incidents and submitting a report on investigations to the Contractor and reporting to the Contractor within one business day in accordance with the abuse and neglect plan protocols anytime there is a suspicion of abuse or neglect; training employees, Contractors of the fiscal intermediary, and self-directed workers regarding reporting, responding to, documenting, and cooperating with the investigation of any critical incidents; and training consumers and caregivers regarding critical incident reporting and management. Such role and responsibilities

shall be defined in a manner that is consistent with requirements in this section 9.10 as well as the State's contract with the fiscal intermediary and the model contract between the Contractor and the fiscal intermediary.

7. Reviewing the fiscal intermediary's reports and investigations regarding critical incidents and follow-up with the State and/or fiscal intermediary as necessary regarding corrective actions determined by the Member and/or authorized representative to help ensure the Member's health and safety.
  8. Providing appropriate training and taking corrective action as needed to ensure its staff Members, contracted MLTSS providers, the fiscal intermediary, and workers comply with critical incident requirements.
  9. The Contractor shall report to DMAHS any death and any incident that could significantly impact the health or safety of a Member (e.g., physical or sexual abuse) within one business day of detection or notification.
- C. The maximum timeframe for reporting an incident to the Contractor from the time the MLTSS provider or the Contractor's staff Member discovers or is informed of the incident shall be one business day.
1. The initial report of an incident may be submitted verbally, in which case the person/agency/entity making the initial report shall submit a follow-up written report within two business days from the time the MLTSS provider or Contractor staff Member discovers or is informed of the incident.
  2. Requiring that Contractor staff Members and contract MLTSS providers immediately (which shall not exceed one business day) take steps to prevent further harm to any and all Members from the time the MLTSS provider or the Contractor's staff Member discovers or is informed of the incident, and respond to any emergency needs of Members.
  3. Requiring that contracted MLTSS providers with a critical incident conduct an internal critical incident investigation and submit a report on the investigation to Contractor within the timeframe specified by the Contractor. The timeframe for submitting the report shall be as soon as possible, may be based on the severity of the incident, and, except under extenuating circumstances, shall be no more than thirty (30) calendar days after the date of the incident. The Contractor shall review the provider's report and follow-up with the provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.

### 9.10.3 REPORTING SYSTEM

- A. The Contractor shall use the State established reporting system for all Critical Incident reporting. The information to be entered into the system will include;
1. Member Information
    - a. Member name, street address, city, zip code, Medicaid Number and date of birth
  2. Contractor Information
    - a. Name of MCO
    - b. Name of the MCO Supervisor/QA Coordinator completing this report
  3. Incident Type and date
    - a. All Critical Incidents as noted in 9.10.1 D
  4. Primary Medical Complexity
    - a. Heart/Circulation (i.e. CVA, Hypertension, CHF)
    - b. Muscular/Skeletal (i.e. Arthritis, Fracture)
    - c. Neurological (i.e. Alzheimer's, MS, Head Trauma, Quadriplegia, Seizure disorder)
    - d. Psychiatric/Mood (i.e. Anxiety, Depression, Behavior, Mental illness, Psychiatric diagnosis)
    - e. Pulmonary (i.e. Emphysema, Asthma, COPD)
    - f. Sensory (i.e. Vision, Hearing Impairments)
    - g. Other Diseases (i.e. Renal Failure, Cancer)
    - h. Infections (i.e. Pneumonia, TB, UTI)
  5. Critical Incident Narrative
    - a. Explain the relationship of the Critical Incident to the member's present Health Status,
      - i. Is there a Risk Assessment Agreement?
      - ii. Was the backup plan on members Plan of Care?
      - iii. Does the backup plan need to change?
  6. Incident Information in Narrative

- a. If incident was inflicted by another individual, identify the alleged offender by name, if possible
- b. Document if there is a relationship between alleged offender and client
- c. Document and identify if the alleged offender was one of the following:
  - i. Power of Attorney
  - ii. Authorized Representative
  - iii. Guardian
  - iv. Self-direction provider
- d. Location of Incident:
  - i. Private Home
  - ii. Facility-based setting

If facility-based, indicate the setting type:

- a) Assisted Living Residence
- b) Comprehensive Personal Care Home
- c) Nursing Facility
- d) Adult Day Health Service/Medical Day Center
- e) Social Day Center
- f) Community Residential Service home
- g) Group Home/Boarding Home
- h) Other

Name of facility: \_\_\_\_\_

- iii. Community/General Public area

- 7. Document if a referral was made to an administrative agency, licensing agency or law enforcement agency.
- 8. Document if the Critical Incident was resolved or unresolved at time of the report.

## APPENDIX E

The following Performance Standards apply to New Jersey FamilyCare/Medicaid populations:

### Access Performance Standards

#### Delivery Network

##### **Contracted network of appropriate Providers (42 CFR 438.206(b)(1))**

Each HMO must meet the following requirements.

Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each HMO must consider the anticipated Medicaid enrollment, the expected utilization of services, and take into consideration the characteristics and health care needs of specific Medicaid populations enrolled with the Contractor. The HMO must also consider the numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services, the numbers of network providers who are not accepting new Medicaid patients, and the geographic location of providers and Medicaid members. Distance, travel time, the means of transportation ordinarily used by Medicaid members, will be considered, and whether the location provides physical access for Medicaid members with disabilities.

The networks must be comprised of hospitals, physicians, behavioral health providers, long term care providers (institutional and HCBS), and other specialists in sufficient numbers to make available all covered services in a timely manner.

Contractors must ensure that their networks include providers who specialize in the care of HIV/AIDS members, including HIV/AIDS specialty centers (Center of Excellence), and shall establish linkages with AIDS clinical educational programs to keep current on up-to-date treatment guidelines and standards.

Contractor's shall ensure that all laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number, and comply with the NJ DHSS disease reporting requirements.

Each HMO primary care network must have at least 1 full time equivalent (FTE) PCP for every 2,000 members, with 1 FTE per 3,000 members cumulatively across all contractors. Additionally, each HMO primary care network must have 1 FTE PCP for every 1,000 DD members and 1 FTE per 1,500 DD members cumulatively across all contractors. The State must approve all capacity changes that exceed 2,000 members.

##### **Geographic Access.**

The contractor shall maintain networks that comply with the geographic access standards in accordance with N.J.A.C. 11:24-6 et seq. and with the State Managed Care contract for PCPs, primary care dentists and hospitals. The following lists guidelines for urban geographic access for the DMAHS population.

1. Beneficiary children who reside within 6 miles of 2 PCPs whose specialty is Family Practice, General Practice or Pediatrics or 2 CNPs/CNSs; within 2 miles of 1 PCP whose specialty is Family Practice, General Practice or Pediatrics or 1 CNP or 1 CNS
2. Beneficiary adults who reside within 6 miles of 2 PCPs whose specialty is Family Practice, General Practice or Internal Medicine or 2 CNPs or 2 CNSs; within 2 miles of 1 PCP whose specialty is Family Practice, General Practice or Internal Medicine or 1 CNP or 1 CNS
3. Beneficiaries who reside within 6 miles of 2 providers of general dentistry services;

- within 2 miles of 1 provider of general dentistry services
4. Beneficiaries who reside within 15 miles of acute care hospital.
  5. Beneficiaries with desired access and average distance to 1, 2 or more providers
  6. Beneficiaries without desired access and average distance to 1, 2 or more providers

#### **Access Standards**

1. 90% of the members must be within 6 miles of 2 PCPs and 2 PCDs in an urban setting
2. 85% of the members must be within 15 miles of 2 PCPs and 2 PCDs in a non-urban setting
3. Covering physicians must be within 15 miles in urban areas and 25 miles in non-urban areas.

#### **Travel Time Standards**

The contractor shall adhere to the 30 minute standard, i.e., members will not live more than 30 minutes away from their PCPs, PCDs or CNPs/CNSs. The following guidelines shall be used in determining travel time.

1. Normal conditions/primary roads - 20 miles
2. Rural or mountainous areas/secondary routes - 20 miles
3. Flat areas or areas connected by interstate highways - 25 miles
4. Metropolitan areas such as Newark, Camden, Trenton, Paterson, Jersey City - 30 minutes travel time by public transportation or no more than 6 miles from PCP
5. Other medical service providers must also be geographically accessible to the members.
6. Exception: SSI or New Jersey Care-ABD members and clients of DDD may choose to see network providers outside of their county of residence.

#### **Conditions for Granting Exceptions to the 1:2000 Ratio Limit for Primary Care Physicians**

1. A physician must demonstrate increased office hours and must maintain (and be present for) a minimum of 20 hours per week in each county.
2. In private practice settings where a physician employs or directly works with nurse practitioners who can provide patient care within the scope of their practices, the capacity may be increased to 1 PCP FTE to 3500 members. The PCP must be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances will a PCP relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCP.
3. In private practice settings where a primary care physician employs or is assisted by other licensed, but non-participating physicians, the capacity may be increased to 1 PCP FTE to 3500 members.
4. In clinic practice settings where a PCP provides direct personal supervision of medical residents with a New Jersey license to practice medicine in good standing with State Board of Medical Examiners, the capacity may be increased with the following ratios: 1 PCP to 2000 members; 1 licensed medical resident per 1100 members. The PCP must be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances will a PCP relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCP.
5. Each provider (physician or nurse practitioner) must provide a minimum of 15 minutes of patient care per patient encounter and be able to provide four visits per year per member.
6. The contractor shall submit for prior approval by DMAHS a detailed description of the PCP's delivery system to accommodate an increased patient load, work flow, professional relationships, work schedules, coverage arrangements, 24 hour access system.
7. The contractor shall provide information on total patient load across all plans, private patients, Medicaid fee-for-service patients, other.
8. The contractor shall adhere to the access standards required in the contractor's contract with the Department.
9. There will be no substantiated complaints or demonstrated evidence of access barriers

due to an increased patient load.

10. The Department will make the final decision on the appropriateness of increasing the ratio limits and what the limit will be.

**Conditions for Granting Exceptions to the 1:2000 Ratio Limit for Primary Care Dentists.**

1. A PCD must provide a minimum of 20 hours per week per county.

2. In clinic practice settings where a PCD provides direct personal supervision of dental residents who have a temporary permit from the State Board of Dentistry in good standing and also dental students, the capacity may be increased with the following ratios: 1 PCD to 2000 members per contractor; 1 dental resident per 1000 members per contractor; 1 FTE dental student per 300 members per contractor. The PCD shall be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances shall a PCD relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCD.

3. In private practice settings where a PCD employs or is assisted by other licensed, but non-participating dentists, the capacity may be increased to 1 PCD FTE to 3500 members.

4. In private practice settings where a PCD employs dental hygienists or is assisted by dental assistants, the capacity may be increased to 1 PCD to 3500 members. The PCD shall be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances shall a PCD relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCD.

5. Each PCD shall provide a minimum of 15 minutes of patient care per patient encounter.

6. The contractor shall submit for prior approval by the DMAHS a detailed description of the PCD's delivery system to accommodate an increased patient load, work flow, professional relationships, work schedules, coverage arrangements, 24 hour access system.

7. The contractor shall provide information on total patient load across all plans, private patients, Medicaid fee-for-service patients, other.

8. The contractor shall adhere to the access/appointment availability standards required in the contractor's contract with the Department.

9. There must be no substantiated complaints or demonstrated evidence of access barriers due to an increased patient load.

10. The contractor shall monitor the providers and practices granted an exception every other month to assure the continued employment of an adequate number and type of auxiliary personnel described in 4.8.8.L.4, to warrant continuation of the exception.

11. The contractor shall submit reports to the DMAHS, bi-monthly, of the additions, deletions or any other change of auxiliary personnel; and include the names, license numbers, functions and work schedules of each currently employed auxiliary staff.

12. The Department will make the final decision on the appropriateness of increasing the ratio limits and what the limit will be.

## **Access Performance Standards**

### **Direct Access to Women's Health Specialist (42 CFR 438.206(b)(2))**

- Provides female members with direct access to a women's health specialist within the framework for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.
- Contractors must ensure that the network procedures for accessing family planning services are convenient and easily comprehensible to members.
- Obstetrical services shall be provided in the same amount, duration, and scope as the Medicaid program and consistent with accepted medical community standards for care.
- The contractor shall not limit benefits for postpartum hospital stays to less than forty-eight (48) hours following a normal vaginal delivery or less than ninety-six (96) hours following a cesarean section, unless the attending provider, in consultation with the mother, makes the decision to discharge the mother or the newborn before that time and the provisions of N.J.S.A. 26:2J-4.9 are met.

### **Adequate and Timely Second Opinion (42 CFR 438.206(b)(3))**

- Provides for a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member.

### **Adequate and Timely Out-of-Network Providers (42 CFR 438.206(b)(4) & (b)(5))**

- If the network is unable to provide necessary services, covered under the contract, the HMO must adequately and timely cover these services out of network for the member, for as long as the HMO is unable to provide them.
- Requires out-of-network providers to coordinate with the HMO with respect to payment and ensures that cost to the member is no greater than it would be if the services were furnished within the network.
- The HMO is responsible for making timely payment to out-of-network providers for medically necessary, covered services, up to their fee maximum for contracting providers.
- All HMOs must reimburse out-of-network providers for family planning services rendered to members.

### **Provider Credentialing as required in regulation (42 CFR 438.206(b)(6))**

Demonstrates that its providers are credentialed and compliant with 438.214.

### **Timely Access (42 CFR 438.206(c)(1)(i-vi))**

Each HMO must meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for service. Refer to [Appointment Availability Study](#) found on page 16 of the Quality Strategy.

Ensure that the 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, if the provider serves only Medicaid members.

Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.

Establish mechanisms to ensure compliance by providers, monitor providers regularly to determine compliance, and take corrective action if there is a failure to comply.

The HMO must agree to make available to every member a choice of 2 or more PCPs whose office is located within the county of the member's place of residence.

## Access Performance Standards

### Cultural Considerations (42 CFR 438.206(c)(2))

- Each HMO will participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds by: ensuring that the HMO staff have training and experience needed to provide effective services to members with communication –affecting conditions and include staff who speak English, Spanish and any other language which is spoken as a primary language by the population that exceeds five (5) percent of the contractor's NJ FamilyCare members or two hundred (200) members in the contractor's plan, whichever is greater. Contractor's shall participate in the DHS Cultural and Linguistic Competency Task Force, and provide culturally competent services that address the relationship between culture, language and health care outcomes.
  - The HMO is required to have available 24-hour interpreter services for all members speaking non-English languages.
  - The HMO is required to have 24 –hour access to interpreter services for all members needing TDD/TT services.
  - The HMO will encourage and foster cultural competency in its employees.

### Assurances of Adequate Capacity 42 CFR 438.207

#### Documentation and Assurances of Adequate Capacity and Services (42 CFR 438.207 (b), (c))

- Each HMO must give assurances to the State and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care.
- Nature of supporting documentation. Each HMO must submit documentation to the State, in a format specified by the State to demonstrate that it complies with the requirements below.
  - Offers an appropriate range of preventive, primary care, and specialty services that are adequate for the anticipated number of members for the service area.
  - Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.
- Timing of documentation. Each HMO must submit the required documentation, no less frequently than:
  - at the time it enters into a contract with the State or at any time there has been a significant change (as defined by the State) in the HMOs operations that would affect adequate capacity and services, including changes in Contractor services, benefits, geographic service area, payments or enrollment of a new population with the HMO.

## Access Performance Standards

### Coordination and Continuity of Care 42 CFR 438.208

Primary Care and Coordination of Health Care Services for all MCOs. (42 CFR 438.208 (a)(b)(1)-(b)(4))

The MCO will comply with all State standards identified in the QMS.

Each MCO must implement procedures to deliver primary care to and coordinate health care service for all MCO members ensuring that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member.

MCO must implement procedures for transition of new members; transition of members receiving long term care services at the time of MLTSS implementation; transition of care; MCO case management; care coordination of MLTSS members; consumer direction of HCBS; coordination and collaboration for member with behavioral health needs; coordination and collaboration of behavioral health providers

The MCO must have written policies and procedures for assigning each of its members to a primary care provider.

The contractor shall place a high priority on enrolling members with their existing PCP. If an member does not select a PCP, the member shall be assigned to his/her PCP of record (based upon prior history information) if that PCP is still a participating provider with the contractor, as well as taking into consideration such things as residence and language.

The primary care provider serves as the member's initial and most important contact and maintains the continuity of a member's health care.

Coordinate the services the MCO furnishes to the member with the services the member receives from any other MCO or behavioral health provider.

Share with other MCOs serving the member with special health care needs the results of its identification and assessment of that member's needs to prevent duplication of those activities.

Ensure that in the process of coordinating care, each member's privacy is protected in accordance with privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

The MCO must have written policies and procedures for maintaining the confidentiality of data, including medical records/member information and adolescent/STD appointment records.

The MCO must maintain a case management program. The MCO will assure case managers initiate and maintain a member care/treatment plan that includes:

- a thorough initial assessment including all domains of care with periodic updates, including member strengths and barriers to care
- short and long term goals that are developed in collaboration with the member
- periodic assessment of goal achievement and development of new goals
- identification and documentation of coordination of care opportunities with all providers involved in the members care.

#### **Additional Services for Members with Special Health Care Needs**

The HMO must demonstrate that they have in place all of the following to meet the needs of Children with Special Health Care Needs:

- Satisfactory methods for ensuring their providers are in compliance with Title II and III of the Americans with Disabilities Act.
- Members with disabling conditions or chronic illnesses may request that their primary care physicians be specialists.

- Satisfactory care coordination and case management systems for coordinating service delivery with out-of-network providers, including behavioral health providers and ongoing service providers.
- Policies and procedures to allow for the continuation of existing relationships with out-of-network providers, when considered to be in the best interest of the member.
- Demonstrate satisfactory methods for care coordination with the Department of Education, school districts, the Division of Family Services, early intervention programs and other agencies for the purpose of coordinating and assuring appropriate service delivery.
- The contractor shall contract with the Children’s Hospital of New Jersey at Newark Beth Israel Medical Center for the provision of primary health care services, including but not limited to, EPSDT services, and dental care services, to be provided at designated schools in the city of Newark. Providers at the school-based clinics shall meet the contractor’s credentialing and program requirements of this contract.
- Contract with Centers of Excellence for children with special needs as well as other specialty providers/centers by direct contracting, as a consultant or on a referral basis.
- To the extent possible, and as permitted by NJ statutes and regulations, the HMOs and their network providers shall participate in the statewide immunization registry database. Contractors must assure all childhood immunizations are obtained and should report immunization levels as required under the DMAHS data and reporting requirements.
- Include an adequate network of pediatric providers and sub-specialists, and contractual relationships with tertiary institutions, to meet members’ medical needs.
- Satisfactory methods for assuring that children with serious, chronic, and rare disorders receive appropriate diagnostic workups on a timely basis
- A satisfactory approach for assuring access to allied health professionals (Physical Therapists, Occupational Therapists, Speech Therapists) experienced in dealing with children and their families.

**Identification and Assessment (42 CFR 438.208(c)(1)(2))**

- Each HMO must implement mechanisms to assess each Medicaid member identified by the State, or its Health Benefits Manager, and identified to the HMO and by the State as having special health care needs. This is done to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

## **Access Performance Standards**

### **Mechanisms for Members with Special Health Care Needs: Development of Treatment Plans (42 CFR 438.208(c)(3))**

- HMOs will produce a treatment plan for members with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring. The treatment plan must be:
  - Developed by the member's primary care provider with member participation and in consultation with any specialists caring for the member in a timely manner.
  - In accordance with any applicable State quality assurance and utilization review standards.

### **Mechanisms for Members with Special Health Care Needs: Direct Access to Specialists (42 CFR 438.208(c)(4))**

- For members with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, each HMO must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for members condition and identified needs.
- The HMOs will have documented policies and procedures for members with special health care needs to achieve direct access to Specialist services as appropriate for member's condition and identified needs.

## **Coverage and Authorization of Services 42 CFR 438.210**

### **Amount, Scope and Duration of Service Coverage (42 CFR 438.210(a)(1-4))**

- HMOs are required to provide for all medically necessary and appropriate Medicaid covered services, consistent with FFS Medicaid, in sufficient amount, scope, and duration to achieve the purpose of the service(s) and, may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.
- The HMO may place appropriate limits on a service based criteria applied under the State plan, such as medical necessity or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose and specify what constitutes "medically necessary services" in a manner that:
  - is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and
  - addresses the extent to which the HMO is responsible for covering services related to the following:
    - prevention, diagnosis, and treatment of health impairments,
    - ability to achieve age-appropriate growth and development, and
    - ability to attain, maintain, or regain functional capacity.
- The HMO UR/UM staff must be fully aware of the Medicaid medical necessity definition and covered benefits, including authorization of long term care services, and transition of members receiving long term care services.

## Access Performance Standards

### **Policies and Procedures for Authorization of Services (42 CFR 438.210(b)(1), (2), and (3))**

- For processing of initial and continuing authorization of services, the HMO and its subcontractors must have in place, and follow, written policies and procedures addressing denial of services, prior approval, and hospital discharge planning.
- The HMO must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and procedures to consult with the requesting provider when appropriate.
- That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

### **Notice of Adverse Action (42 CFR 438.210(c))**

The HMO must have and follow policies and procedures defining requirements for notifying the requesting provider, and providing the member written notice of any decision by the HMO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested, except the HMO's notice must meet the requirements of 438.404 except the notice to the provider need not be in writing.

### **Timeframe for decisions (42 CFR 438.210(d))(1), (2)&(e)**

The HMO must provide the following decisions and notices meeting the following requirements:

- *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the member's health condition requires and within State-established timeframes of 10 business days following receipt of the request for service, with a possible extension of up to 10 additional calendar days, if—
  - The member, or the provider, requests extension; or
  - The HMO justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest.
- *Expedited authorization decisions.* For cases in which a provider indicates, or the HMO, determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the HMO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires within 24 hours and no later than 3 working days after the receipt of the request for service.
- The HMO may extend the 3 working days time period by up to 14 calendar days if the member requests an extension, or if the HMO or justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest.
- Compensation for utilization management activities: Compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

## Access Performance Standards

### Compensation for UM activities (42 CFR 438.210(e))

The HMOs compensation structure shall not have incentives based on approvals, limitations, or denials of medically necessary services for members.

### Emergency and Post–Stabilization Care Service (42 CFR 438.114)

The HMO will comply with the following definitions:

- Emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
  - 1) Placing the health of the individual or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
  - 2) Serious impairment to bodily functions; or
  - 3) Serious dysfunction of any bodily organ or part.
- Emergency service means covered inpatient or outpatient services that are:
  - 1) Furnished by a provider who is qualified to furnish these services under this title; or
  - 2) Needed to evaluate or stabilize an emergency medical condition.
- Post-stabilization care services are defined as covered services, related to an emergency medical condition that are provided after an member is stabilized in order to maintain the stabilized condition or to improve or resolve the members condition.
- The HMO must cover Post Stabilization services without requiring authorization, and regardless of whether the member obtains the services within or outside the Contractor's provider network if any of the following circumstances exist:
  1. The Post stabilization Services were pre-approved by the Contractor;
  2. The Post Stabilization Services were not pre-approved by the Contractor because the Contractor did not respond to the Provider's request for these Post stabilization services within one (1) hour of the request;
  3. The Post stabilization services were not pre-approved by the Contractor because the Contractor could not be reached by the provider to request pre-approval for these post stabilization services; or
  4. The Contractors representative and the treating physician cannot reach an agreement concerning the member's care and a Contracting physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician and treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR 422.113 (C) (3) is met.

The HMOs may not deny payment for treatment if member had an emergency medical condition, or if representative of the HMO instructs the member to seek emergency services.

The HMOs may not limit what constitutes an emergency medical condition on the basis of lists of diagnosis or symptoms.

The HMO may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider's HMO

## Access Performance Standards

or applicable State entity of the member's screening and treatment within 10 calendar days of presentation for emergency services.

The HMO must assure that a member who has an emergency not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

The HMO must assure that the attending emergency physician or the treating provider is responsible for binding determination of member stabilization for transfer or discharge based upon the general rule for coverage and payment.

## Structure and Operations Performance Standards

### Provider Selection

#### Selection and Retention (42 CFR 438.214 (a), (b)(2))

- The HMO must have written credentialing and re-credentialing policies and procedures for determining and assuring that all providers under contract to the plan are licensed by the State and qualified to perform their services according to DMAHS Quality Management.
- A documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements with the HMO and how the HMO will follow those processes.
- Verification of provider qualifications will include but is not limited to:
  - Current valid license to practice
  - Clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility
  - Valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate
  - Education and training including evidence of graduation from the appropriate professional school and completion of a residency or specialty training
  - Board certification of the practitioner states s/he is board certified on the application
  - Current, adequate malpractice insurance meeting the HMOs requirements
  - History of professional liability claims that resulted in settlements or judgments by or on behalf of the practitioner (May be obtained by the National Practitioner Data Bank)
  - Information about sanctions or limitations on licensure from the applicable state licensing agency or board
  - Information about sanctions or limitations by Medicare or Medicaid
  - Consultation with State staff

#### Nondiscrimination (42 CFR 438.214(c)) (42 CFR 438.12(a))

- Policies and procedures and documented practice within the HMO must be free of any indication of discrimination related to the population served or the cost of covered treatment. If the HMO declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.
- Contractors must also have a written appeals process providers will use to challenge any denial of credentialing resulting from this process.

#### (42 CFR 438.12 (b)(1))

- The HMOs will not be required to contract with providers beyond the number necessary to meet the needs of the members.

## Structure and Operations Performance Standards

### (42 CFR 438.12(b)(2))

- The HMOs may use different reimbursement amounts for different specialties or for different practitioners in the same specialty.

### (42 CFR 438.12(b)(3))

- The HMO is not precluded from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

### Excluded Providers (42 CFR 438.214(d))

- The HMO must be consistent with policy, procedure, and regulatory requirements and may not employ or contract with providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Act.

### State Requirements (42 CFR 438.214(e))

- The HMO will have written policies and procedures for monitoring its providers and for disciplining providers who are found to be out-of-compliance with the Contractors medical management standards.
- The contractors shall log, track and respond to provider complaints and grievances/appeals. On a quarterly basis, the contractors shall submit a report of all provider grievance/appeal requests and dispositions to DMAHS for review. Additionally, provider grievance/appeals logs are subject to on-site review by DMAHS staff.

## Structure and Operations Performance Standards

### Confidentiality 42. CFR 438.224

#### Confidentiality requirements consistent with (42 CFR 438.224), (45 CFR parts 160 and 164)

- The HMO, including all providers, physicians' practitioners, suppliers, etc., shall have in place policies and procedures to maintain the confidentiality of all-medical records and assure that all records and their use meet all HIPPA requirements.
- The State is not required to obtain written approval from a member before requesting the member's record from the primary care provider or any other provider and shall be afforded access within thirty 30 calendar days to all members' medical records whether electronic or paper. If there is an urgent need, the Department shall have the right to demand the record in less than 30 days, but no less than 24 hours.
- The Contractor shall upon the written request of the member, guardian or legally authorized representative of a member, furnish a copy of the medical records of the member's health history and treatment rendered. Such record shall be furnished within a reasonable time of the receipt of the written request.
- When a member chooses a new primary care provider within network, the member's medical records or copies of medical records must be forwarded to the new primary care provider in a timely manner that ensures continuity of care.
- The HMO must have written policies and procedures for maintaining the confidentiality of data, including medical records/member information. For members who are eligible through the Division of Youth and Family Services, records shall be kept in accordance with State law.
- Access to all individually identifiable information relating to Medicaid members that is obtained by the HMO shall be limited by the HMO to persons or agencies that require the information in order to perform their duties in accordance with this contract, and to such others as may be authorized by the State in accordance with applicable law.
- The HMO must provide safeguards that restrict the use or disclosure of information concerning members to purposes directly connected with the administration of the contract.

### Enrollment and Disenrollment 42 CFR 438.226

#### Enrollment and Disenrollment (42 CFR 438.226)

- The HMOs must ensure compliance with the enrollment and disenrollment requirements and limitations set forth in 438.56.

## Structure and Operations Performance Standards

### **Transfer: Requirements and Limitations (42 CFR 438.56)**

- The HMOs must have written policies that specify the reasons for which the HMO may request disenrollment of a member and reasons a disenrollment may not be requested. The HMO may not initiate disenrollments due to health status, need for health services or a change in health status. In no way can this provision be applied to individuals on the basis of their physical condition, utilization of services, age, socio-economic status, mental disability or uncooperative or disruptive behavior resulting from the member's special needs.
- The HMO will identify methods to assure the State that it does not request disenrollment for reasons not covered by contract.

### **Disenrollment requested by the member**

- The HMO must provide that a recipient may request disenrollment for cause at any time and without cause, at the following times:
  - During the 90 days following member's initial enrollment date or State notice of enrollment date, whichever is later
  - At least once every 12 months thereafter
  - Upon automatic reenrollment per 42 CFR 438.56(g).
  - Upon State imposed sanctions per 42 CFR 438.702(a) (3)

### **Procedures for Disenrollment**

- The HMO may initiate Disenrollment for valid reasons including:
  - Member becomes ineligible, has moved to a residence outside of the enrollment area for more than 30 days; upon death or incarceration.
- The HMO must have attempted through education and case management to resolve any difficulty leading to a request for disenrollment at least three (3) times before requesting transfers, unless the member has demonstrated abusive or threatening behavior.

Contractor shall submit quarterly reports that include written documentation to DMAHS of the members' action that are inconsistent with membership in the contractor's plan.

All notifications regarding requests for disenrollment must inform the member of appeal rights and be documented.

## Structure and Operations Performance Standards

### Grievance Systems 42 CFR 438.228

#### Grievance Systems (42 CFR 438.228(a))

- The HMOs must have a grievance system in place that meets the requirements of subpart F of 42 CFR 438.

#### Statutory Basis and Definitions 42 CFR 438.400

- The HMO is required to establish and maintain internal grievance system procedures under which Medicaid members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.
- An “action” shall be defined as:
  - Denial or limited authorization of a requested service, including the type or level of service;
  - Reduction, suspension, or termination of a previously authorized service;
  - Denial, in whole or in part, of payment for a service;
  - Failure to provide services in a timely manner, as defined by the State or act within the timeframes of 42 CFR 438.208;
- *Appeal* means a request for review of an action as defined in 42 CFR 438.400.
- *Grievance* means an expression of dissatisfaction about any matter other than an action, as “action” is defined in the section. The term is also used to refer to the overall system that includes grievances and appeals handled at the HMO level and access to the State fairhearing process.

### General Requirements 42 CFR 438.402

#### The Grievance System (42 CFR 438.402 (a))

- Each HMO must have a system in place for members that include a grievance process, an appeal process, and access to the State’s fair hearing system.

#### Authority to File (42 CFR 438.402(b))

- A member may file a grievance or a HMO level appeal and may request a State Fair Hearing. A provider or the member's legal representative acting on behalf of the member and with the member’s written consent, may file an appeal. A provider may file a grievance or request a State fair hearing on behalf of a member.

## Structure and Operations Performance Standards

### Timing (42 CFR 438.402(b)(2))

- A member may file a grievance either orally or in writing. A provider may file a grievance as the State permits the provider to act as the member's authorized representative.
- A member or the provider may file an appeal in a timeframe not less than 60 days and not more than 90 days (90 days per State Contract) from the date of the contractor's notice of action. In the case of a Medicaid Fair Hearing, the member must file a request within 20 days of the date of the adverse action.

### Procedure (42 CFR 438.402(b)(3))

- A member may file a grievance orally or in writing with the HMO (Per State Contract, members may file an oral appeal and it does not need to be followed up with a written request).

## Notice Of Action 42 CFR 438.404, 438.200, 438.228, 438.206

### 42 CFR 438.228, 431.206(b) and 431.210:

New Jersey must ensure, through its managed care contracts, that each HMO has in effect a grievance system that meets the requirements of 42 CFR 438 subpart F.

### HMO Notification of State Procedures (42 CFR 438.200(b))

- The HMO is required to provide information on State Fair Hearing procedures including, but not limited to the member's right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing. Additionally, the State fair hearing description must be included in member and provider information.
- The HMO must give the member written notice of any action to include but not limited to, service authorizations, within the timeframes for each type of action.
- HMOs are responsible to ensure timely notification of members of his/her right to use the State administrative grievance process.

### Language and Format (42 CFR 438.404(a), 42 CFR 438.10(c) and (d)) Language:

- The HMO is required to make written information available in prevalent non-English languages in its particular service areas. E.g. Spanish, other bilingual translations and in a format accessible to the visually impaired, such as Braille or audio tape.
- Inform the member about rights as a member of HMO services; this will include informing the member both orally and in a clearly written format in the member's own language about both the HMO and State grievance and appeal procedures; if the member has an auditory and/or visual impairment, reasonable accommodations must be made to assure that the member is informed and understands his/her rights

### Format:

- The HMO must produce written materials including notice of actions and must meet the language and format requirements to ensure ease of understanding. Information must be available in alternative formats and in an appropriate manner.
- The HMO is required to notify all members and potential members that information is available in alternative formats and how to access those formats.

## Structure and Operations Performance Standards

### Notice of Adverse Action Content (42 CFR 438.404(b)) (42 CFR 431.206(b) and 431.210)

The notice must explain the action the HMO or its sub-contractor has taken or intends to take; the reason for the action and the member's or provider's right to file an appeal with the HMO or to request a state fair hearing; procedures for exercising the member's right to appeal or grieve. Circumstances under which an expedited resolution is available and how to request it, and the member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services. The HMO will also inform members that:

- 1) the member may represent himself or use legal counsel, a relative, a friend, or other spokesman
- 2) the specific regulations that support, or the change in Federal or State law that requires, the action
- 3) an explanation of the member's right to request an evidentiary hearing if one is available or a state agency hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted.

### Timeframes for Notice of Action: (42 CFR 438.404(c)(1))

#### Termination, Suspension, or Reduction of Services

Notice of Action. Notice of Action shall be in writing and shall meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding. In the case of expedited appeal process, the contractor shall also provide oral notice. Written notification shall be given on a standardized form approved by the Department and shall inform the provider, member or authorized person of the following:

- a. Results of the resolution process and the effective date of the denial, reduction, suspension or termination of service, or other medical coverage determination;
- b. The member's rights to, and method for obtaining, a State hearing (Fair Hearing and/or IURO) to contest the denial, deferral or modification action;
- c. The member's right to represent himself/herself at the State hearing or to be represented by legal counsel, friend or other spokesperson;
- d. The action taken or intended to be taken by the contractor on the request for prior authorization and the reason for such action including clinical rationale and the underlying contractual basis or Medicaid authority;
- e. The name and address of the contractor;
- f. Notice of internal (contractor) appeal rights and instructions on how to initiate such appeal;
- g. Notice of the availability of the clinical review criteria relied upon to make the determination;
- h. The notice to the member shall inform the member that he or she may file an appeal concerning the contractor's action using the contractor's appeal procedure prior to or concurrent with the initiation of the State hearing process;
- i. The contractor shall notify members, and/or authorized persons within the time frames set forth in this contract, P.L. 2005, c.352 and in 42 CFR 438.404(c);
- j. The member's right to have benefits continue (see Article 4.6.4C) pending resolution of the appeal that requires that the contractor shall continue the member's benefits while an appeal is pending. Members requesting continuation of benefits must do so in writing within 10 days of the denial letter or prior to the intended effective date of the MCO proposed action, whichever is later.

In no instance shall the contractor apply prior authorization requirements and utilization controls that effectively withhold or limit medically necessary services, or establish prior authorization requirements and utilization controls that would result in a reduced scope of benefits for any member.

### Timeframes of Notice of Action (42 CFR 438.404(c)(2), (3), (4), (5)&(6)) Untimely Service Authorization Decisions

- The HMO is required to give notice on the date that timeframes expire if service authorization decisions are not reached for either standard or expedited service requests. Untimely service authorizations constitute a denial and are considered adverse actions. For denial of payment, the HMO is required to give notice at the time of any action affecting the claim.
- For standard service authorization decisions, (42 CFR 438.210 (d) (1)), that deny or limit services, notification occurs within the timeframe specified in Coverage and Authorization of Services.
- If the HMO is granted an extension, the member must be given written notice of the extension, and be offered the opportunity to file a grievance if they disagree with the decision. The HMO must carry out the decision as expeditiously as the member's health condition requires and no later than the date the extension expires.
- For service authorization decisions not reached within the timeframes (which constitutes a denial and is thus an adverse action), notification occurs on the date that the timeframes expire.
- For expedited service authorization decisions, notification occurs within the timeframe specified in Coverage and Authorization of Services.

## Handling of Grievances and Appeals 42 CFR 438.406

### General Requirements (42 CFR 438.406(a))

- The HMOs grievance and appeals process must be approved by the State. The appeals process shall consist of an informal internal review by the HMO (Stage 1 appeal); a formal internal review by the HMO (Stage 2 appeal) and a formal external review by an independent utilization review organization under DOBI (Stage 3 appeal) and/or the Medicaid Fair Hearing process in accordance with N.J.A. C. 11: 10:49 et seq. Stage 1 – 3 appeals shall be in accordance with N.J.A.C. 11:24-8 with the exception of the time frames stated in stages 1 and 2 appeals where, the NJFC Contract requires the contractor must allow the member 90 days for filing an appeal and 20 days to request a Fair Hearing.

Plan A and ABP members have the right to a State Medicaid Fair Hearing, whether or not they have filed an appeal with the HMO. Plan B, C and Plan D members do not have the right to a Medicaid Fair Hearing.

- The HMO will provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
- The HMO will acknowledge the receipt of each grievance and appeal within 10 business days of receipt.
- Ensure that individuals who make decisions on Grievances and Appeals are individuals who were not involved in any previous level of review or decision-making and who if deciding an appeal of a denial that is based upon lack of medical necessity or grievance resolution regarding denial of expedited resolution of an appeal or a grievance or appeal that involves clinical issues are health care professionals who have the appropriate clinical expertise as determined by the State, in treating the members condition or disease.

### Special Procedures – The Process for Appeals (42 CFR 438.406(b))

- The member or provider may file an appeal either orally or in writing and must follow the oral filing with a written, signed appeal.

## Structure and Operations Performance Standards

The HMO must:

- Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the member or provider requests expedited resolution;
- Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing and inform the member of the limited time for this in the case of an expedited resolution;
- Allow the member and representative the opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records
- Consider the member representative, or estate representative of a deceased member as parties to the appeal

## Resolution and Notification: Appeals. 42 CFR 438.408

### Resolution and Notification (42 CFR 438.408(a), (b), (c))

- The HMO must resolve each appeal and provide notice as expeditiously as the member's health condition requires but within the State established timeframes not to exceed:
- Stage 1 Appeal: must be concluded as soon as possible, in accordance with the medical exigencies of the case and must not exceed 72 hours for urgent/emergent cases; an admission; availability of care; continued stay, health care services for which the member received emergency services but has not been discharged from a facility and 10 calendar days for all other appeals.
- Stage 2 Appeal: must be concluded as soon as possible, in accordance with the exigencies of the case and must not exceed 72 hours in urgent/emergent cases; admission; availability of care; continued stay and health care services for which the member received emergency services but has not been discharged from a facility and in no event to exceed 20 business days in the case of all other appeals.
- Stage 3 Appeal (IURO) A member/ provider shall have a minimum of a four month period from the receipt of the final internal adverse benefit determination to file a written request for an IURO appeal. The IURO shall complete its review and issue its decision as soon as possible in accordance with the medical exigencies of the case which shall not exceed 45 days for non-emergent cases and 48 hours for urgent/emergent cases.
- For Standard resolution of an appeals and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day the HMO receives the appeal and for expedited resolution of an appeal and notice to affected parties, the timeframe is no longer than 3 working days after the HMO receives the appeal.
- The HMO may extend the timeframes by up to 14 days if the member requests an extension, or the HMO shows there is need for additional information and that the delay is in the member's interest. For an extension not at the member's request, the HMO must give the member written notice of the reason for the delay. If the HMO extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.

### **Format and Content of Resolution Notice (42 CFR 438.408(d)(e))**

- The HMO must follow State defined requirements for notification of a member of the disposition of an appeal.
- The HMO will provide written notice of disposition of grievances and appeals and for expedited resolution; the HMO must also make reasonable efforts to provide oral notice.
- The HMO must provide written notice of disposition, which must include the results date of appeal resolution. And for decisions not wholly in the members favor:
  - The right to request a State fair hearing
  - How to request a State fair hearing
  - The right to continue to receive benefits pending a hearing
  - How to request continuation of benefits

### **Requirements for State Fair Hearings (42 CFR 438.408(f))**

- Ensure that the HMOs appeal system cannot be prerequisite to, nor a replacement for, the member's right to request a fair hearing in accordance with 42 CFR 431, Subpart E.
- The entire Appeal/Fair Hearing process must be accomplished within the specified 90-day period from notice of "action". The parties to the State fair hearing include the HMO as well as the member and his or her representative or a deceased member's estate.
- The parties to the State fair hearing include the HMO as well as the member and his or her representative or the representative of a deceased member's estate
- The contractor's system and procedure shall be available to both Medicaid beneficiaries and NJ FamilyCare beneficiaries. All members have available the complaint and grievance/appeal process under the contractor's plan, the Department of Banking and Insurance and, for Medicaid and certain NJ FamilyCare beneficiaries (i.e., NJ FamilyCare A members and beneficiaries with a PSC of 380 under NJ FamilyCare D), the Medicaid Fair Hearing process. Individuals eligible solely through NJ FamilyCare B, C, and D, (except for D individuals with a program status code of 380), do not have the right to a Medicaid Fair Hearing. •

### **Expedited Appeals Process: 42 CFR 438.410**

#### **General (42 CFR 438.410(a))**

•The HMO must establish and maintain an expedited appeal process. The expedited review process is necessary when the HMO determines, or the provider indicates, that the time required for a standards resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

All three stages of appeals must be concluded as soon as and in accordance with the exigencies of the case and in the case of Stages 1 and 2 shall not exceed 72 hours.

#### **Punitive Action (42 CFR 438.410(b))**

The HMO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a member's appeal.

#### **Action following a denial of a Request for Expedited Resolution (42 CFR 438.410(c))**

If an HMO denies a request for an expedited resolution of an appeal, it must:

- Transfer the appeal to the standard timeframe of no longer than 10 calendar days for a Stage 1 appeal; 20 days for a Stage 2 appeal and 45 days for a Stage 3 appeal from the day the HMO received the appeal.
- Give the member prompt oral notice of the denial then written notice.

## Structure and Operations Performance Standards

### Information about the grievance system to providers and subcontractors. 42 CFR 438.414

#### Information (42 CFR 438.414) (438.10 (g))

- The HMO must provide procedures and timeframes related to grievance, appeal, and fair hearings to all providers and subcontractors at the time they enter into a contract.
- Information must include the right to a State fair hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing.
- The right to file grievances and appeals with requirements and timeframes for filing a grievance or appeal.
- The availability of assistance in the filing process including the toll-free numbers that the member can use to file a grievance or an appeal by phone.
- The fact that, when requested by the member, benefits will continue if the member files an appeal or a request for State fair hearing within the timeframes specified for filing.
- Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.

### Record keeping and Reporting Requirements. 42 CFR 438.416

- The HMO is required to maintain records of grievances and appeals. Those records will include, at a minimum, a log of all grievances/appeals, whether verbal or written. The log should include Member identifying information, a statement of the appeal and resolution, if affected. Log data should be analyzed monthly to identify trends and/or patterns for administrative use and review
- Logs must always be available for State and CMS review.

### Continuation of benefits while the HMO or PIHP appeal and the State fair hearing are pending. 42 CFR 438.420

#### Terminology, Timely Filing and Continuation of Benefits (42 CFR 438.420(a), (b))

- Timely filing means that the appeal is filed on or before the later of the following:
  - Within 10 days of the HMO mailing the notice of action, or
  - The intended effective date of the HMO proposed action;
- The HMO must continue the member's benefits if the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- An authorized provider ordered the services and the authorization period has not expired.
- In New Jersey, DOBI regulation no longer requires that the member request continuation of services

## Structure and Operations Performance Standards

### Duration of Continued or Reinstated Benefits (42 CFR 438.420(c))

- If the HMO continues or reinstates benefits, they will be continued until the member withdraws the appeal or does not request a fair hearing within 10 days from when the HMO mails an adverse HMO decision. Benefits will also continue until a State fair hearing decision adverse to the member is made or the authorization expires or authorization service limits are met.
- Information regarding continuance of benefits must be included in the “Notice of Action” letters to the member or the member’s representative.

### Member Responsibility for Services Furnished (42 CFR 438.420(d))

- The HMO may recover the cost of the continuation of services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements of the contract and in accordance with (431.230 (b)), if the final resolution of the appeal upholds the HMOs action.

### Effectuation of Reversed Appeal Resolutions. 42 CFR 438.424

#### Effectuation when Services were not Furnished (42 CFR 438.424(a))

- The HMO must authorize or provide the disputed services promptly and as expeditiously as the member’s health condition requires if the HMO or State fair hearing officer reverses the decision to deny, limit, or delay services.

#### Effectuation when Services were Furnished (42 CFR 438.424(b))

- The HMO or the State must pay for disputed services in accordance with State policy and regulation if the HMO or State fair hearing officer reverses the decision to deny authorized services and the member received the disputed services while the appeal was pending.

## Structure and Operations Performance Standards

### Sub contractual Relationships and Delegation 42 CFR 438.230

#### **Written Agreement (42 CFR 438.230 (a), (b))**

- The HMO is accountable for any functions and responsibilities that it delegates to any subcontractor as well as any payments to a subcontractor for services related to the contract.
- The HMO shall give the State immediate notice in writing, by certified mail, of any action or suit filed and of any claim made against the HMO or subcontractor(s) that, in the opinion of the HMO, may result in litigation related in any way to the contract with the State.
- HMOs are responsible to maintain a written agreement between the entity and subcontractor that specifies the delegated scope of work, and report responsibilities including revocation of agreement.
- Before any delegation, each Contractor must evaluate the prospective subcontractor's ability to perform the activities to be delegated.

#### **Periodic Performance Review (42 CFR 438.230(b))**

- HMOs are responsible for periodic evaluation of subcontractor performance consistent with established state schedule, industry standards or state HMO laws and regulations.

#### **Corrective Action Plan (42 CFR 438.230(b))**

- HMOs must ensure that identified deficiencies or areas for improvement are subject to corrective action.

## Measurement and Improvement Performance Standards

### Practice Guidelines

#### Dissemination (42 CFR 438.236(c))

- HMOs will disseminate the guidelines and new technologies to all affected providers, and upon request to members, potential members, consumer advocates.

#### Application (42 CFR 438.236(d))

- HMOs will assure that decisions regarding utilization management, member education, coverage of services and other areas to which the guidelines apply are consistent with the guidelines.

### Quality Assessment and Performance Improvement Program

#### Requirements (42 CFR 438.240(b))

- HMOs are required to have an ongoing quality assessment and performance improvement program consistent with contractual obligations, State and Federal requirements and accreditation guidelines and should address physical health, behavioral health, and long term care.
- Contractors must survey their members on at least an annual basis to determine satisfaction with Contractor's services.
- The HMO must also have a quality management plan for the upcoming year that is consistent with the State Quality Plan. This plan must describe the program's scope; objectives and all planned projects, activities, and focused studies for the upcoming year. The plan must also describe monitoring of previously identified issues including tracking of issues over time. A timetable must be included, which clearly identifies target dates for implementation and completion of all phases of activities. This plan must be approved by DMAHS prior to implementation.
- The Program at a minimum must outline the administrative and organizational structures and design of the quality management program.
- Describe methodologies and mechanisms for objective and systematic monitoring of access to care and services provided to members.
- Describe mechanisms to ensure that findings, conclusions, recommendations, actions taken, and results of actions taken are documented and reported to individuals within the organization for use in conjunction with other related activities.
- Describe methodologies and mechanisms for tracking issues over time with an emphasis on improving health outcomes; such mechanisms should be developed in accordance with the guidelines of the *Guide to Clinical Preventive Services (Report of the U.S. Preventive Services Task Force)*, the EPSDT guidelines, or other criteria based on scientifically or clinically validated analysis.

## Measurement and Improvement Performance Standards

### Performance Measures &/or Performance Improvement Projects (42 CFR 438.240) (b))

- The State and CMS may specify performance measures and topics for required HMO performance improvement projects, which must be achieved through ongoing measurements and intervention, and must result in significant improvement, sustained over time, clinically and non clinically, with favorable effect on health outcomes and member satisfaction.

### Under-utilization and Over-utilization (42 CFR 438.240(b)(3))

- HMOs are required to implement mechanisms to detect over- and under-utilization of services.
- The HMO will develop a Utilization Management Plan and annual work plan.
- Describe methodologies and mechanisms for monitoring and auditing provider performance, identifying deficiencies, addressing deficiencies with corrective action, monitoring of corrective actions for intended results, and communication of all findings to providers.

### Quality and Appropriateness of Care (42 CFR 438.240(b)(4))

- HMOs are required to have in place mechanisms to assess the quality and appropriateness of care furnished to all members with particular emphasis on children with special health care needs.

### Performance Measurement Requirements (42 CFR 438.240(b)(2) and 42 CFR 438.240(c))

The HMOs are responsible to provide:

- A full description of how they will address the clinical program initiatives as specified by the State for the Medicaid population.
- Ongoing reports quarterly, semi-annually, and annually as specified in the reporting section. Additional reports as determined necessary by the State for quality assurance and improvement activities.

### Requirements (42 CFR 438.240(b)(1) and 42 CFR 438.240(d)(1))

- The HMOs are responsible to conduct performance improvement projects, approved by the State that will achieve demonstrable and sustained improvement over time incorporating performance improvement standards of measurement, including objective quality indicators, implementation, and evaluation and planning.

### Performance Measurement (42 CFR 438.204(c))

- The HMOs must measure and report to the State its performance using standard measures required by the State including those developed in consultation with States and other relevant stakeholders. (42 CFR 438.204c and 438.240(a)(2)). The HMO must submit data specified by the State to enable the State to measure the HMOs performance.

**Reporting and Outcome (42 CFR 438.240(d)(2))**

- HMOs are required to report the status and results of each project to the State upon request and annually as requested for the EQR process and must produce new information on quality of care every year.

## Measurement and Improvement Performance Standards

### Information Requirements

#### **Member Information as required by 42 CFR 438.10 (42 CFR 438.218) The State assumes the following responsibilities:**

- 438.10(a) The State defines the following terms compliant with the 438.10(a), “member” means a Medicaid recipient who is currently enrolled in an HMO in a given managed care program. A “potential member” means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet a member of a specific HMO.
- 438.10(b)(1)(d)(1)(i) The State, the enrollment broker and the HMOs will provide all enrollment-related notices, informational materials, and instructional materials to members/potential members in a manner and format that may be easily understood.
- The State and/or their enrollment broker have the following mechanisms in place to help the members and potential members understand the State’s managed care program: NJ FamilyCare Hotline, Medicaid Hotline, Office of Customer Service (Central and local offices) and various State websites including the NJ FamilyCare web site. Options Counseling is offered by the State to explain to the MLTSS members their care options regarding Nursing Facility level of care both in a facility and HCBS.
- The 42 CFR 438.10(c)(3)&(4)&(5) The State, the enrollment broker and HMOs make their written information available in the prevalent non-English languages in its particular service area, as specified by the State in the contract. The State assures that the enrollment broker and HMO’s make oral interpretation services available free of charge to each potential member and member. The State, enrollment broker and HMOs must notify the members:
  - that oral interpretation is available for any language
  - that written information is available in prevalent languages
  - how to access the interpretation services and written information
- 42 CFR 438.10(d)(1)(ii)&(d)(2) Information - Alternative formats. The State is responsible to assure written material is available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All members and potential members must be informed that information is available in alternative formats and how to access those formats.
- 42 CFR 438.10 (e)(f) Information - Potential Members and Members non-covered services. The State and the enrollment broker must provide that each managed care member is informed of any services available under the State plan and not covered by the capitated or FFS contractor. The State and the enrollment broker shall make available to potential members and new members, information in a written and prominent manner of any benefits to which the member may be entitled but which are not made available to the member by the entity. Such information shall include information on where and how such member may access benefits not made available to the member through the HMO.

## Measurement and Improvement Performance Standards

- 42 CFR 438.10(e)(1) & (e)(2) 42 CFR 438.102(c) Information - Potential Members. The State and the enrollment broker must provide the information listed in 42 CFR 438.10 and 438.102 to each potential member as follows:
  - At the time the potential member first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program.
  - Within a timeframe that enables the potential member to use the information in choosing among available HMOs.

The information for potential members must include the following:

- General information about:
  - the basic features of managed care
  - which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program
  - HMO responsibilities for coordination of member care.
- Information specific to each HMO program operating in potential member's service area. A summary of the following information is sufficient, but the State must provide more detailed information upon request:
  - benefits covered
  - cost sharing, if any
  - service area
  - names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not accepting new patients. For HMOs this includes at minimum information on primary care physicians, specialists, hospitals, facilities, and HCBS providers.
- The State and the enrollment broker will provide information to members indicating benefits that are available under the State plan but are not covered under the contract, including how and where the member may obtain those benefits, any cost sharing, and how transportation is provided. This includes counseling or referral services that the HMO does not cover because of moral or religious objections.
- 42 CFR 438.10(f)(3) Information - Members. The State, the enrollment broker and/or the HMOs must provide information to each member as follows:
  - Notify all members of their disenrollment rights, at a minimum, annually. For States that choose to restrict disenrollment for periods of 90 days or more, States must send the notice no less than 60 days before the start of the member's 12 month enrollment period.
  - Notify all members, at the time of enrollment, of the member's rights to change providers or disenroll enrollment for cause.

### Information Requirements (42 CFR 438.10 (a), (b))

438.10(a) the HMO will be compliant with how the State defines the following terms compliant with 438.10(a), "member" means a Medicaid recipient who is currently enrolled in a HMO in a given managed care program. A "potential member" means a Medicaid recipient who is

## Measurement and Improvement Performance Standards

### Measurement and Improvement Performance Standards

subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet a member of a specific HMO.

The HMO is required to meet the following State standards regarding information:

(b) The HMO must provide all informational materials, and instructional materials relating to members and potential members in a manner and format that may be easily understood.

(2) The State must have in place a mechanism to help members and potential members understand the State's managed care program.

(3) The HMO will have in place a mechanism to help members and potential members understand the requirements and benefits of the plan.

(c) (1) *Language*. The HMO must comply with the States definition of prevalent non- English languages spoken by members and potential members throughout the State.

(c) (3) The HMO will make available written information in each prevalent non-English language in its service area.

(c), (4) The HMO will make oral interpretation services available and free of charge to each potential member and member in its service area for Spanish at all times and for all languages not just those identified by the State as prevalent upon request.

(c)(5) (i)&(ii) The HMO will notify its members:

- that oral interpretation is available for any language and written information is available in prevalent languages
- how to access those services

(d) Format.

(1) The State expects the HMO will assure that written material uses:

- (i) easily understood language and format
- (ii) written materials are available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

(2) The HMO will inform all members and potential members that information is available in alternative formats and how to access those formats.

(f)(4) The HMO will provide members with written notice of any change (that the State defines as "significant") in the information specified in 42 CFR 438.10 (f) (6) and if applicable, paragraphs (g) and (h), at least 30 days before the intended effective date of the change.

(f)(5) The HMO must make a good faith effort to give written notice of termination of a contracted provider, within 30 days after receipt or issuance of the termination notice, to each member who received his or her primary care from the provider.

## Measurement and Improvement Performance Standards

### Measurement and Improvement Performance

438.10(f)(6)(i) The HMO will provide the following information to members;

- Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the member's service area, include identification of providers that are not accepting new patients. For HMOs, this includes, at minimum, information on primary care physicians, specialists, hospitals.
- 438.10(f)(6)(ii) restrictions on the member's freedom of choice among network providers.
- 438.10(f)(6)(iii) member rights consistent with 42 CFR 438.100.
- 438.10(f)(6)(iv) information on grievance and fair hearing procedures, and for HMO and PIHP members, the information specified in 42 CFR 438.10(g)(1), and for PAHP members, the information specified in 42 CFR 438.10(h)(1).
- 438.10(f)(6)(v) describing the amount, duration, and scope of benefits, and in sufficient detail to assure the member understand entitled benefits.
- 438.10(f)(6)(vi) the procedures for obtaining benefits and authorizations for services.
- 438.10(f)(6)(vii) the extent and how members may obtain benefits, including family planning services from out of network providers, and
- 438.10(f)(6)(viii) the extent of and how after hour emergency services are provided including:
  - 438.10(f)(6)(viii), (A) what constitutes and emergency providing definition consistent with 438.114
  - 438.10 (f)(6)(viii) ( B) a prior authorization is not required for Emergency Services
  - 438.10 (f)(6)(viii)(C) the process and procedures for obtaining emergency, including use if the 911 telephone system
  - 438.10(f)(6)(viii)(D) locations of emergency setting and locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract
  - 438.10(f)(6)(viii)(E) informing members that they have a right to access the nearest emergency facility without regard to contracting status

- 438.10(f)(6)(E)(ix) The HMO will provide information to members congruent with 422.113;
- 438.10 (6)(E)(x) policy on referral for specialty care and other benefits not furnished by the members primary care provider
- 438.10(6)(E)(xi) cost sharing if any.

## Measurement and Improvement Performance Standards

### Measurement and Improvement Performance Standards

#### Information to Members 42 CFR 438.10 (g)

The HMO will provide members with information about State fair hearing, including

- the right to a hearing;
- the method for obtaining a hearing;
- the rules that govern representation at the hearing;
- the right to file grievances and appeals;
- requirements and timeframes for filing a grievance or appeal;
- the availability of assistance in the filing process;
- the toll-free numbers that the member can use to file a grievance or an appeal by phone
- the fact that, when requested by the member, benefits will continue if the member files an appeal or a request for State fair hearing within the timeframes specified for filing; and the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member
- any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service
- advance directives, as set forth in 42 CFR 438.6(i) (2)

Additional information that is available upon request, including the following:

- Information on the structure and operation of the HMO
- Physician incentive plans as set forth in 42 CFR 438.6(h)