NEW JERSEY HEALTH CARE QUALITY INSTITUTE

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To: New Jersey Division of Medical Assistance and Health Services (DMAHS-GeneralComments-MQS@dhs.nj.gov
From: New Jersey Health Care Quality Institute
Date: May 25th, 2022
Re: NJ FamilyCare New Jersey Quality Strategy - Public Comment

We appreciate the opportunity to comment on the NJ FamilyCare Quality Strategy. We commend the Division on its efforts and commitment to achieving high quality, safe, accessible, and equitable care for those enrolled in New Jersey's Medicaid program.

The New Jersey Health Care Quality Institute's Medicaid Policy Center is dedicated to supporting and advancing quality improvement throughout the NJ FamilyCare program. We look forward to working with the Division to advance its Quality Strategy and were pleased to see that the strategy includes direct connection to performance under the Managed Care Organization ("MCO") contract payments and enforcement. Our comments below are focus on:

1. Advancing health equity through data collection and use on race, ethnicity, languages, and disabilities.
2. Improving access to care through enforced network adequacy verification and enforcement.
3. Elevating the quality of care by setting and achieving higher benchmarks.
4. Improving areas of need including Maternal Health, Reproductive Health, Oral Health, and Primary Care.

Advancing Health Equity in the NJ FamilyCare

We appreciate the Division's commitment to take the first step to address health inequities by collecting data. We encourage the Division to be more specific about how the data will collected, verified, and incorporated into ongoing work. As the largest health care payer in the state, it is critical that the Division and its contracted MCOs accurately collect race, ethnicity, and language ("REaL") and disability data and use the REaL data to stratify reporting on all or as many as possible of the quality measures. We support the Division's call to add data cells to the MCO information and use it for this REaL reporting, but more detail should be included in the plan to discuss how the data will be reported and verified and how the data will be used for reporting. In addition, we encourage the Division to include within its plan a strategy to work with the Department of Health and other agencies to incorporate other sources of patient-reported REaL data to further its efforts.

Improving Access to Care

We appreciate the Division's recent strategy to use paid and filed claims from the prior year to verify whether network adequacy requirements are being met. Network adequacy directly effects the timeliness of care and health outcomes. The Quality Strategy could be improved by including more specific enforcement steps, details regarding the basis and factors that will trigger specific corrective actions, and more details regarding the same for penalties for not meeting network adequacy requirements as set forth in the MCO contract. In addition, we would like to see a detailed plan and timeline for improving the network directories and credentialing process to ensure that the public information is accurate including information about whether providers are accepting new patients, the specific locations that a provider sees patients, and other critical consumer information that improves access to timely care and enables the Division to enforce its network adequacy requirements.

The current method of MCO enrollment allows beneficiaries to self-select and enroll in an MCO or if one is not chosen, they will be auto enrolled. We strongly support changes to the MCO auto-assignment algorithm that would direct enrollees that have not selected a plan to a higher performing MCO, including preferential assignment based on quality and network adequacy in their geographic area. We would encourage consideration for including the Quality Strategy and plan for auto-assignment to the MCO that has the highest quality ratings that are specific to the type of care the beneficiary may be utilizing - for example, pediatric preventative care measures or maternity outcomes.

Elevating the Quality of Care

The Division is responsible for paying for the care of over 2 million people in the Garden State — including over 30 percent of the births, over 33 percent of our children, about 56 percent of people living in nursing homes, and individuals with disabilities. Medicaid expenditures were about 25 percent of the state's annual budget with the state share totaling over $16 billion in FY2022. While the state contracts for the management of most of these services, it must demand high quality care and improved access on behalf of the beneficiaries it serves and on behalf of the taxpayers who are supporting the program.

We encourage the Division to raise the expected benchmark for many of the reported CMS Adult and Child Core Measure Set measures and the HEDIS measures including but not limited to: adult and pediatric primary and preventive care, perinatal care, reproductive care, oral health care, and access to follow-up care after hospitalization or mental health issue.

While many MCOs are currently "meeting" the benchmark set by the state, in many cases, that benchmark is a comparison of their performance to a national average set at the midpoint (50%). Given New Jersey's commitment to its residents' health and its investment in NJ FamilyCare, we should be asking for more than achieving a national average especially when some states commitment much less to their Medicaid programs. We recommend that in its Quality Strategy the Division raise the benchmark to the top quartile on all these measures to emphasize the importance of access to these essential health care services.

Improving Areas of Need

Maternal Health:

- We agree with the Division that timely prenatal and postpartum visits are good measures to include in the Quality Strategy. We suggest that the measures be stratified based on REaL data to show existing health inequities and to support focused quality improvement efforts. For example, California includes this in its quality strategy and proposed to decrease the disparities by 50% by 2025.
- In addition, we suggest that Maternal Depression Screening and care referrals be measured and focused on as mental health is a leading contributor to perinatal morbidity and mortality. California has a measure to improve its outcomes on this by 2025.
- The Perinatal Risk Assessment (PRA) tool, which is discussed in the Quality Strategy, should be measured for completion at two points during the perinatal period, but more importantly, should be tracked and reported for use to connect patients to services. This could be done as an electronic measure that is developed, tested, and then used during the 3-year period of the Quality Strategy. The PRA should be integrated into providers' electronic health records and used for referrals in real time. Otherwise, it is not meaningful and is an administrative burden to providers.

Reproductive Health:

- We support the continued use of the National Quality Forum (NQF) endorsed measures related to contraceptive care to ensure individuals have access to the full spectrum of contraceptive care. However, we want to caution the Division on how these measures should be used. The Division should use the measures for reviewing accessibility, but not to encourage or pay for increases in utilization rates. Using these measures to drive higher utilization of certain contraceptive care can create built in incentives for health care providers to steer patients to contraceptive choices, which must be avoided. Rather, high quality reproductive health includes patient-centered contraceptive counseling which provides the patient with all the information they need in a manner and at a time and place that empowers them to make the best decision for themselves based on their goals.
- As noted in the Quality Strategy, a significantly low number of postpartum women receive any form of contraceptive immediately within three days of delivery. We encourage the state to pursue payment and policy interventions to address this issue. We have researched the current barriers and are willing to support the Division in this work. One suggestion for the Quality Strategy is to include a focus on ensuring that healthcare providers are discussing postpartum contraception with patients during their third trimester prenatal visits and providing contraception immediately postpartum, when clinically appropriate and as requested by the patient. This change would help support safe spacing of pregnancies and ensure individuals who do not attend postpartum visits still have access to the contraception of their choice. These changes align with the Division's October 2018 provider newsletter which announced some policy changes to support payment for these services.

Oral Health Measures:

- New Jersey's long-standing commitment to a dental benefit for both children and adults is admirable but must be delivered upon. The data surrounding the dental benefit shows that we have significant work to improve access to care and to connect more people to dental services. Despite our history of providing this benefit, the state is just above the national median on the percentage of Medicaid beneficiaries from age one to 20 who receive one preventive dental visit annually. While the national median is 49.1 percent, New Jersey was ranked 11th and achieved 52.8 percent. This statistic reveals that about 47 percent of our Medicaid beneficiaries ages 1 to 20 years old are not receiving basic preventive oral health care each year. We need to ensure that the

dental networks have adequate availability for pediatric members and must set the benchmark for dental care higher and place added attention on oral health access and education, especially during the perinatal period where oral health directly relates to birth outcomes.

Primary Care Measures:

- We appreciate the reference in the Appendix to the Quality Strategy of the future development of a Comprehensive Primary Care model. We understand that the work has yet to be done and offer our support and ideas. This is an issue that the Quality Institute and many others have been working on for years. We encourage the Division to consider the resources that already exist, the delivery and payment models that have been tested in New Jersey and nationally since 2010, and to implement a meaningful, uniform system that provides data and incentives to health care providers and leads to a better quality of life and care for patients of all ages.
- The National Academies of Sciences Engineering Medicine (National Academies) released, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*, a comprehensive report that outlines primary care's positive effects on society. The report sets forth a five-part implementation plan that includes a mechanism for every person in the nation to choose or be assigned a primary care practice that offers on-going primary and preventive care. The report defines primary care as "[t]he provision of whole-person, integrated, accessible, and equitable health care by inter-professional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities." We urge the Division to align with this holistic approach and focus on an integrated model of primary care that includes mental health providers, dentists, social workers, community health workers, pharmacists, and others.
- Some of the items that relate to primary care are important to track and report as part of a strategic quality improvement plan are: percentage of total spending going to primary care; percentage of primary care patient care revenue paid through capitation (as opposed to fee-for-service); percentage of adults and of children without a primary care clinician; primary care physicians per 100,000 people in both medically underserved and not underserved areas; percentage of physicians, nurses, and physician assistants working in primary care; percentage of physicians, nurses, and physician assistants entering primary care each year.

We appreciate your consideration of our comments. Thank you for your shared commitment to advancing the health care equity, quality, and access for New Jersey residents receiving NJ FamilyCare.