

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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State Demonstrations Group

Meghan Davey
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Department of Human Services
Division of Medical Assistance and Health Services
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FEB 14 2019

Dear Ms. Davey:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved the Delivery System Reform Incentive Payment (DSRIP) Program Funding and Mechanics Protocol. This protocol will be incorporated as Attachment H of the Special Terms and Conditions (STCs) for the New Jersey 1115 demonstration project entitled "New Jersey FamilyCare Comprehensive Demonstration" (11-W-00279/2) under authority of section 1115(a) of the Social Security Act. This version supersedes any previous versions. These technical corrections include the finalizing measure specifications, baseline performance thresholds, and improvement target goals for demonstration years 7 and 8.

Your CMS project officer, Ms. Sandra Phelps, is available to address any questions you may have related to this correspondence. Ms. Phelps may be reached by phone at (410) 786-1968 or by email at Sandra.Phelps@cms.hhs.gov.

Official communication regarding official matters should be sent simultaneously to Ms. Phelps and Mr. Ricardo Holligan, Acting Associate Regional Administrator for the Division of Medical and Children's Health in our New York Regional Office. Mr. Holligan can be reached by phone at (212) 616-2424 or by email at Ricardo.Holligan@cms.hhs.gov.

We appreciated your cooperation throughout the review process.

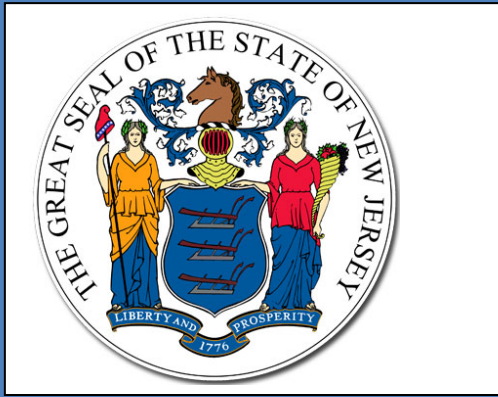
Sincerely,

A handwritten signature in blue ink, appearing to read "Angela D. Garner", with a horizontal line extending to the right.

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: Ricardo Holligan, Acting ARA Region II



STATE OF NEW JERSEY DEPARTMENT OF HEALTH

Section IX of the Special Terms and Conditions (STCs) for the “New Jersey FamilyCare Comprehensive Demonstration” section 1115(a) Medicaid demonstration operated by the New Jersey Department of Human Services, Division of Medical Assistance and Health Services requires the development of “a DSRIP Planning Protocol” to be submitted to CMS for approval. The Department of Health designed and must administer the DSRIP program. This document represents the Department’s final draft to the Centers for Medicaid & Medicaid Services (CMS).

*Delivery System
Reform Incentive
Payment (DSRIP)
Program Planning
Protocol STCs
Section IX:
Attachment H*

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I. Preface

A. Delivery System Reform Incentive Payment Program

The Delivery System Reform Incentive Payment (DSRIP) Program is one component of New Jersey's FamilyCare Comprehensive Demonstration as approved for extension by the Centers for Medicare & Medicaid Services (CMS) in July 2017. DSRIP seeks to result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement.

The project activities funded by the DSRIP Program will be those activities that are directly responsive to the needs and characteristics of the populations and communities served by each hospital. Each participating hospital will develop a Hospital DSRIP Plan, consistent with this DSRIP Planning Protocol, that is rooted in the intensive learning and sharing that will accelerate meaningful improvement. The individual Hospital DSRIP Plan will be consistent with the hospital's mission and quality goals, as well as CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement (without any harm whatsoever to individuals, families or communities). In its Hospital DSRIP Plan, each hospital will describe how it will carry out a project that is designed to improve the quality of care provided, the efficiency with which care is provided, and the overall population health.

Hospitals may qualify to receive incentive payments (DSRIP payments) for fully meeting performance and outcome metrics (as specified in this Planning Protocol, as well as the Funding and Mechanics Protocol), which represent measurable, incremental steps toward the completion of project activities, or demonstration of their impact on health system performance or quality of care.

B. DSRIP Planning Protocol and Program Funding and Mechanics Protocol

This document is the DSRIP Planning Protocol submitted for approval by the New Jersey (NJ) Department of Health to the CMS. This document is Version 2.0, dated May 31, 2018. With this version, the DSRIP Planning Protocol has been updated to reflect the extension period granted to NJ by CMS for the DSRIP program. The extension period dates are as follows:

Demonstration Year	Begin	End
DY6	April 1, 2017	March 31, 2018
DY7	April 1, 2018	March 31, 2019
DY8	April 1, 2019	March 31, 2020

Please also refer to the accompanying *Attachment 1: DSRIP Toolkit* containing the framework for each project, the clinical and quality protocols developed for this initiative, as well as the reporting requirements for the DSRIP Program.

C. High Level Organization of the Planning Protocol

The Planning Protocol has been organized into the following sections.

- I. Preface
- II. DSRIP Eligibility Criteria
- III. Global Context, Goals, and Outcomes
- IV. Project Stages
- V. DSRIP Project Array
- VI. Requirements of the Hospital DSRIP Plans
- VII. Quality & Measures Committee
- VIII. DSRIP Program Performance Management

II. DSRIP Eligibility Criteria

The hospitals eligible to receive funding under the DSRIP program are general acute care hospitals and are listed and shown in the table below. See the Funding and Mechanics Protocol Section for a list of hospital funding targets.

Table 1. DY6-8 participating hospitals, focus area, and approved DSRIP project is as follows:

Participating DSRIP Hospitals	Focus Area	Project Name
Anthony M. Yelesics JFK Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
AtlantiCare Regional Medical Center	DIABETES	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension
Bergen Regional Medical Center	BEHAVIORAL HEALTH	Electronic Self-Assessment Decision Support Tool
Capital Health Medical Center - Hopewell	OBESITY	After School Obesity Program
Capital Health Regional Medical Center	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
CarePoint Health - Bayonne MedicalCenter	CARDIAC CARE	Extensive Patient CHF-Focused Multi-Therapeutic Model
CarePoint Health - Hoboken University Medical Center	CARDIAC CARE	Extensive Patient CHF-Focused Multi-Therapeutic Model

Participating DSRIP Hospitals	Focus Area	Project Name
CarePoint Health - Christ Hospital	CARDIAC CARE	Extensive Patient CHF-Focused Multi-Therapeutic Model
CentraState Medical Center	DIABETES	Diabetes Group Visits for Patients and Community Education
Chilton Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Clara Maass Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Community Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Cooper University Health Care	DIABETES	Diabetes Group Visits for Patients and Community Education
East Orange General Hospital	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Englewood Hospital and Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Hackensack University Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
HMH Palisades Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Inspira Medical Center Elmer	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
Inspira Medical Center Vineland	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
Inspira Medical Center Woodbury	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
Jefferson Health New Jersey	DIABETES	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension
Jersey City Medical Center	ASTHMA	Pediatric Asthma Case Management and Home Evaluations
Jersey Shore University Medical Center	ASTHMA	Pediatric Asthma Case Management and Home Evaluations
Lourdes Medical Center of Burlington County	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Monmouth Medical Center	BEHAVIORAL HEALTH	Integrated Health Home for the Seriously Mentally Ill (SMI)
Monmouth Medical Center Southern Campus	BEHAVIORAL HEALTH	Integrated Health Home for the Seriously Mentally Ill (SMI)
Morristown Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Newark Beth Israel Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Newton Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Our Lady of Lourdes Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Overlook Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Penn Medicine Princeton Medical Center	DIABETES	Diabetes Group Visits for Patients and Community Education
Raritan Bay Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Robert Wood Johnson University Hospital	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
RWJ University Hospital Hamilton	PNEUMONIA	Patients Receive Recommended Care for Community-Acquired Pneumonia
St. Barnabas Medical Center	ASTHMA	Hospital-Based Educators Teach Optimal Asthma Care

Participating DSRIP Hospitals	Focus Area	Project Name
St. Clare's Health System	BEHAVIORAL HEALTH	Electronic Self-Assessment Decision Support Tool
St. Francis Medical Center	DIABETES	Diabetes Group Visits for Patients and Community Education
St. Joseph's Hospital and Medical Center	ASTHMA	Hospital-Based Educators Teach Optimal Asthma Care
St. Mary's General Hospital	CARDIAC CARE	Extensive Patient CHF-Focused Multi-Therapeutic Model
St. Michael's Medical Center	DIABETES	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension
St. Peter's University Hospital	DIABETES	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension
Trinitas Regional Medical Center	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
University Hospital	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Virtua West Jersey Health System	DIABETES	Diabetes Group Visits for Patients and Community Education
Virtua Memorial Hospital of Burlington County	DIABETES	Diabetes Group Visits for Patients and Community Education

III. Global Context, Goals, and Outcomes

The current landscape of NJ health starts with the state's vision for all New Jerseyans. As specified in the Healthy New Jersey 2020 (HNJ2020) plan, that vision is for NJ to be a state in which all people live long, healthy lives. This vision applies to 8.8 million¹ residents of the state.

Healthy New Jersey is the state's health improvement plan and sets the agenda for comprehensive disease prevention and health promotion for NJ for the next decade. It is modeled after the federal Healthy People 2020 initiative and is the result of a multiyear process that reflects the input from a diverse group of individuals and organizations.

The HNJ2020 objectives communicate high-priority health issues. A principal goal stated in the HNJ2020 is to "*Attain high-quality, longer lives free of preventable disease, disability, injury, and premature deaths.*"

Specifically, New Jersey's Leading Health Indicators reflect the state's major public health concerns. New Jersey's Leading Health Indicators are the product of an extensive external and internal feedback process. Over 200 partners participated in a poll and a refined list was vetted and presented to the Department of Health's HNJ2020 Advisory Committee. The five Leading Health Indicators include: 1) access to primary care, 2) birth outcomes, 3) childhood immunizations, 4) heart disease and 5) obesity.

The Department believes that the goals for three of the five leading health indicators will be influenced by the DSRIP program through implementing

¹ The Kaiser Family Foundation, "State Health Facts, Demographics and the Economy" kff.org/statedata/, accessed March 12, 2018

interventions that impact chronic care within NJ. As specified in the HNJ2020, the table below represents baseline and target rates for access to primary care, heart disease and obesity.

Table II. HNJ2020 Baseline and Target Rates for Access to Primary Care, Heart Disease and Obesity

Leading Health Indicator	Measurement	Baseline	Target
Access to Primary Care	Increase the proportion of adults with a personal doctor or health care provider	(2011) 83.0%	(2020) 90.0%
Heart Disease	Reduce the death rate due to coronary heart disease	(2007) 140.1 per 100,000 population (age-adjusted)	(2020) 112.1 per 100,000 population (age-adjusted)
Obesity	Prevent an increase in the proportion of the population that is obese	Adults (20+; 2011) 23.8%	Adults (2020) 23.8%

Although the HNJ2020 is set to improve the lives of all residents, attention must be spent on the most vulnerable population groups to ensure that quality care is received by everyone in the most cost-effective manner. Approximately 10 percent² of the population lives below the poverty line (below 100% of FPL). The number of residents that remain uninsured in the state is above 696,000 and nearly 1.5 million people are covered by Medicaid.³ All residents, but particularly these vulnerable populations, rely on the NJ hospitals to provide quality health services. The state recognizes the integral role and efforts of the state’s hospital systems with attainment of these goals.

As the burden of care for all residents continues to rise, new methods to achieve excellence in health care is an important factor in obtaining value for the health care dollar. Currently, 38 cents of every NJ dollar are being spent in the Medicaid program on emergency department, inpatient and outpatient services.⁴ Charity Care patients alone consume more than \$1.35 billion in hospital care services annually in NJ.⁵

The DSRIP program provides an opportunity to improve patient care for NJ’s low-income population by incentivizing delivery system reforms that improve access, enhance quality of care, and promote the health of patients and the families they serve. These investments contribute directly to CMS’s over-arching “Triple Aim” and position providers for the emerging healthcare market where data, quality,

² The Kaiser Family Foundation, “State Health Facts: Health Coverage,” kff.org/statedata/, accessed March 12, 2018

³ Ibid.

⁴ Data based on SFY 2011 CRCS NJ Medicaid Managed Care Capitation Rates

⁵ New Jersey Hospital Association (2010). “Charity Care Patient Profile: A Deeper Exploration”

and pay for performance initiatives foster competition among facilities and bend the health care cost curve.

In addition to the HN2020 data, the Department has observed that cardiac care, pneumonia, mood disorders, diabetes and asthma all routinely rank in the top 20 for total number of inpatient discharges by principal diagnosis as shown on Table III.

Table III. State Statistics - 2011 New Jersey - Principal Diagnosis Only

Rank order of Clinical Classifications Software (CCS) principal diagnosis category by number of discharges			
Rank	CCS Principal Diagnosis	CCS Category Name	Total Number of Discharges
1	218	Liveborn	101,469
2	108	Congestive heart failure, non-hypertensive	29,519
3	2	Septicemia (except in labor)	28,166
4	122	Pneumonia (except that caused by tuberculosis and sexually transmitted diseases)	27,861
5	657	Mood disorders	25,414
6	106	Cardiac dysrhythmias	24,784
7	197	Skin and subcutaneous tissue infections	21,495
8	101	Coronary atherosclerosis	19,457
9	127	Chronic obstructive pulmonary disease and bronchiectasis	19,030
10	203	Osteoarthritis	18,626
11	102	Nonspecific chest pain	18,317
12	100	Acute myocardial infarction	18,224
13	159	Urinary tract infections	18,028
14	195	Other complications of birth, puerperium affecting management of the mother	17,258
15	109	Acute cerebrovascular disease	16,217
16	50	Diabetes mellitus with complications	16,156
17	237	Complication of device, implant or graft	15,877
18	189	Previous C-section	15,226
19	128	Asthma	15,106
20	149	Biliary tract disease	14,031

State statistics from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases 2011, Agency for Healthcare Research and Quality (AHRQ), Based on data collected by the New Jersey Department of Health and Senior Services and provided to AHRQ. These data reflect 2010 hospital characteristics.

Therefore, in order to focus the DSRIP incentive budget and resources to meet the state's vision, NJ is seeking to move the cost and quality curve for eight prevalent or chronic conditions. These focus areas are as follows:

- 1) Asthma
- 2) Behavioral Health
- 3) Cardiac Care
- 4) Chemical Addiction/Substance Abuse

- 5) Diabetes
- 6) HIV/AIDS
- 7) Obesity
- 8) Pneumonia

Chronic diseases are responsible for about 70% of all deaths nationally even while patients with chronic disease consume 83% of all health care spending in the United States.⁶ This experience is observed in NJ where seven of the ten leading causes of death are due to chronic diseases as shown in Figure I below.

Figure I. Leading Causes of Death, Age-Adjusted Rates New Jersey and the U.S., 2015⁷

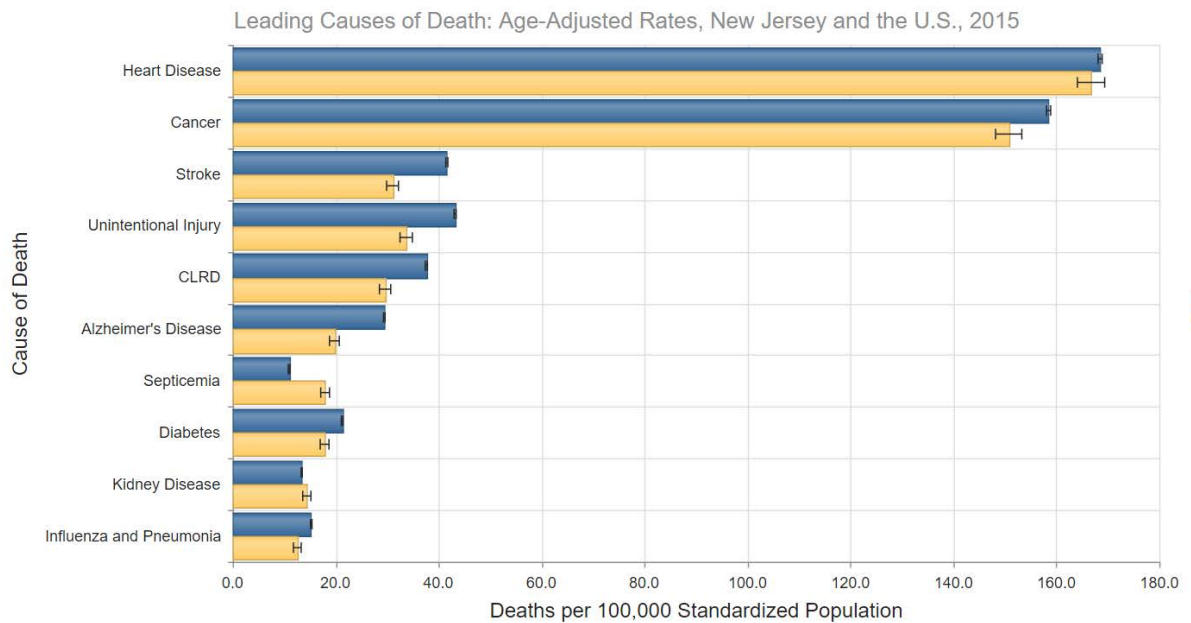


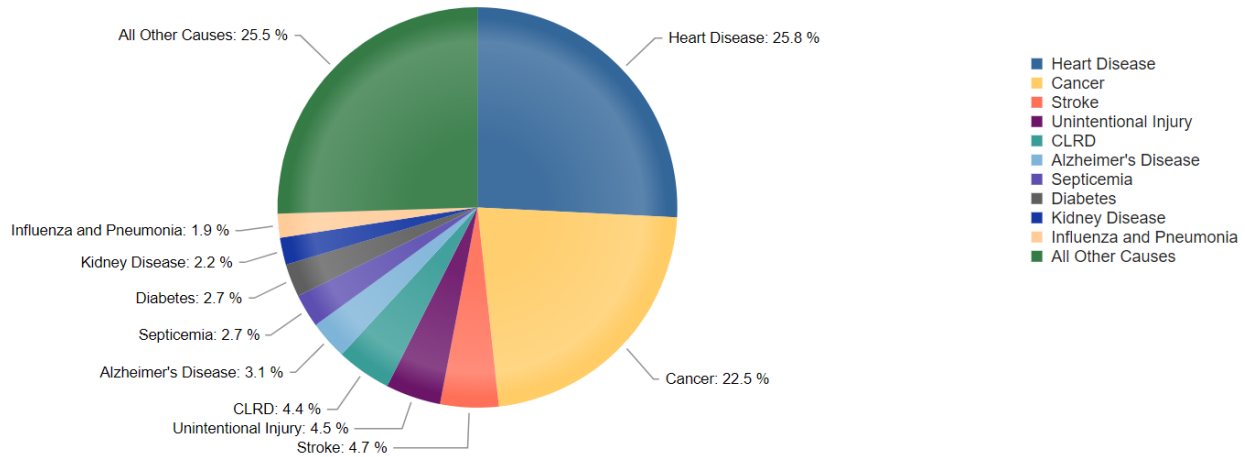
Figure II, below, demonstrates that heart disease, cancer, stroke, and diabetes caused 55.7% of NJ deaths in 2015.

⁶ New Jersey Department of Health, "Introduction to CD Burden"

⁷ NJDOH, New Jersey State Health Assessment Data, Available at: <https://www26.state.nj.us/doh-shad/indicator/view/LCODall.Count10.html>

Figure II. Leading Causes of Death: Counts and Percentages, New Jersey, 2015⁸

Leading Causes of Death: Counts and Percentages, New Jersey, 2015



Fiscally, the impact is sizeable. NJ spent \$23,659 per disabled enrollee in FY2014. Compared to the national average of \$16,859,⁹ this annual per enrollee cost is unsustainable. In order to bring this average down, particular attention must be spent on the at-risk disabled population that may rely on government-funded medical assistance over the course of their lifetime.

Better health management, particularly in members that have multiple chronic conditions, results in improved health outcomes, reduced cost and improved patient satisfaction in treatment. There is a great deal of emerging data to support that these chronic conditions, when effectively managed, could produce cost savings by up to five percent.¹⁰ This is accomplished by improving population health through ensuring that the continuum of patient care is holistic in nature, improving transitions between settings of care and providing optimum care in acute circumstances which are all major features of DSRIP.

Clinical protocols or projects that will be completed by participating hospitals have been designed to achieve one or more core achievement themes, which are specific aims of the NJ Department of Health. These core achievement themes guided the selection of the projects within each focus area. These include:

- Improved Care/Case Management
- Improved Discharge Planning

⁸ Ibid.

⁹ The Kaiser Family Foundation, kff.org "Medicaid Spending per Enrollee (Full or Partial Benefit)" accessed March 9, 2018

¹⁰ Urban Institute, www.urban.org, "The Potential Savings from Enhanced Chronic Care Management Policies," John Holahan, Cathy Schoen, and Stacey McMorro, November 2011.

- Expansion of Primary Care
- Improved Quality of Care
- Improved Access to Care
- Improved Patient Education
- Improved Delivery of Care
- Improved Training and Efficiency
- Any Combination of the Above

This Planning Protocol includes a menu of 17 pre-defined projects with activities that will create financial incentives for New Jersey hospitals to implement programs and interventions to improve care for residents within the eight focus areas. These projects were identified and developed by the Department and the hospital industry because they represent realistic and achievable improvement opportunities for NJ.

IV. Project Stages

This section describes the project stages per subparagraph (c) of the Special Terms and Conditions (STCs), as well as the menu of activities, along with their associated population-focused objectives and evaluation metrics, from which each eligible hospital will select to create its own projects.

During the extension period, there will be changes to the requirements for project stages. The DSRIP Planning Protocol and the Funding and Mechanics Protocol are revised in accordance with the changes as required in STC Section 53. Hospitals must submit DSRIP Renewal Applications that comport with changes to the DSRIP Planning Protocol and Funding and Mechanics Protocol and must update their DSRIP hospital plans, to the extent necessary, based on their approved applications. Therefore, the stages approved during the prior DSRIP period will be effective for Demonstration Year (DY) 6 and the applicable experience period, as described below. This will enable the hospitals to make necessary changes required for the implementation of any changes for DYs 7 and 8, and applicable experience periods.

As specified by the STCs, and as further developed in the DSRIP protocols, the project stages are as follows:

Demonstration Year 6

- a. DY6 Stage 1: Infrastructure Development – Activities in this stage develop the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.

- b. DY6 Stage 2: Chronic Medical Condition Redesign and Management – Activities in this stage include the piloting, testing, and replicating of chronic patient care models.
- c. DY6 Stage 3: Quality Improvements – This stage involves the measurement of care processes and outcomes that reflect the impact of Stage 1 and Stage 2 activities, in which major improvements in care can be achieved from January 1, 2014 through DY6. Stage 3 measures the clinical performance of the hospital's DSRIP project.
- d. DY6 Stage 4: Population Focused Improvements – Activities in this stage include reporting measures across several domains selected by the Department, in consultation with the NJ hospital industry and CMS.

Demonstration Years 7 & 8

- e. DY7-DY8 Stage 1: System Transformation Measures – This stage includes universal measures of improved access to care, integrated care across health care providers, and improved health care outcomes. System transformation measures will consist of 10 measures selected by NJ and approved by CMS, to be reported annually. This Stage is all pay for reporting.
- f. DY7-DY8 Stage 2: Quality Improvements – This stage involves the monitoring of project-specific clinical measures that are associated with the achievement of milestones. All participating hospitals must report these project-specific outcomes in each demonstration year at a frequency indicated in the STCs and Funding and Mechanics Protocol. This stage is pay for performance.
- g. DY7-DY8 Stage 3: Population Focused Improvements – This stage includes universal metrics reported across several domains selected by the state. These performance indicators are connected to the achievement of providing better care, better access to care, and enhanced prevention of chronic medical conditions and population improvement. Stage 3 measures will consist of a combination of pay-for-reporting and pay-for-performance measures. At least 50% of funding allocated to Stage 3 must be attributed to pay for performance.
- h. Universal Performance Pool – The UPP is a payment type assigned to a subset of twelve Population Focused Improvement measures. All UPP funding is pay for performance.

The menu of activities for each stage, including the application stage, is included in the Hospital DSRIP Plan Template, along with the associated metric(s) and minimum documentation requirements for each activity/metric. For each stage, the Hospital DSRIP Plan Template lists the required and/or elective activities, the associated actions/milestones for each activity, as well as the guideline for

completion by month and year. While the targeted completion by month/year has been determined by the participating hospital for most action/milestones in the DSRIP Plan, the noted completion date by month/year in the Hospital DSRIP Plan Template will serve as a guide for the Department's expected completion date for each stage's activities.

For additional information regarding the project stages, menu of activities, projects, associated population-focused objectives and evaluation metrics, please refer to Attachment 1: DSRIP Toolkit.

V. DSRIP Project Array

As mentioned, a project array of condition-specific projects has been chosen and developed based on the eight conditions listed in the STCs. These conditions represent prevalent, high cost, and/or preventable conditions that impact the underserved populations and NJ's systems of healthcare.

By implementing the core achievement themes for the selected focus areas, DSRIP will provide an unprecedented opportunity to improve patient care for low-income populations in NJ. The NJ health care system will move from serving these patients separately at different sites of care, to one that effectively and seamlessly manages transitions of care as they occur. DSRIP projects engage inpatient and outpatient providers to share accountability in improving the overall patient health of the low-income population. Improving the care for this specific population will positively advance the overall health of the state in order to achieve the HN2020 goals.

Project detail for each pre-defined condition-specific project is included in Attachment 1: DSRIP Toolkit, Section III.

A. Asthma

In NJ, over 600,000 adults and over 167,000 children are estimated to currently have asthma.¹¹ Asthma is a chronic respiratory disease that is characterized by inflammation and episodic narrowing of the airways that carry oxygen in and out of the lungs. Asthma is a chronic disease that cannot be cured, but it can be controlled with an effective medical management plan, treatment of coexisting medical conditions and avoidance of environmental or occupational triggers.

As shown in the following graphs, hospitalization due to asthma was at a rate of 8.59 per 10,000 residents in 2016, though hospitalization rates for asthma do not represent the total burden of the illness. The total number of asthma emergency

¹¹ NJDOH, New Jersey State Health Assessment Data, Available at: <https://www26.state.nj.us/doh-shad/topic/Asthma.html>

department (ED) visits per year ranged from 53,553 to 50,027 during 2014-2016¹².

Figure III. Asthma Hospitalizations, Age-Adjusted Rate by Year, New Jersey, 2000-2016¹³

Asthma Hospitalizations, Age-Adjusted Rate by Year, New Jersey, 2000-2016

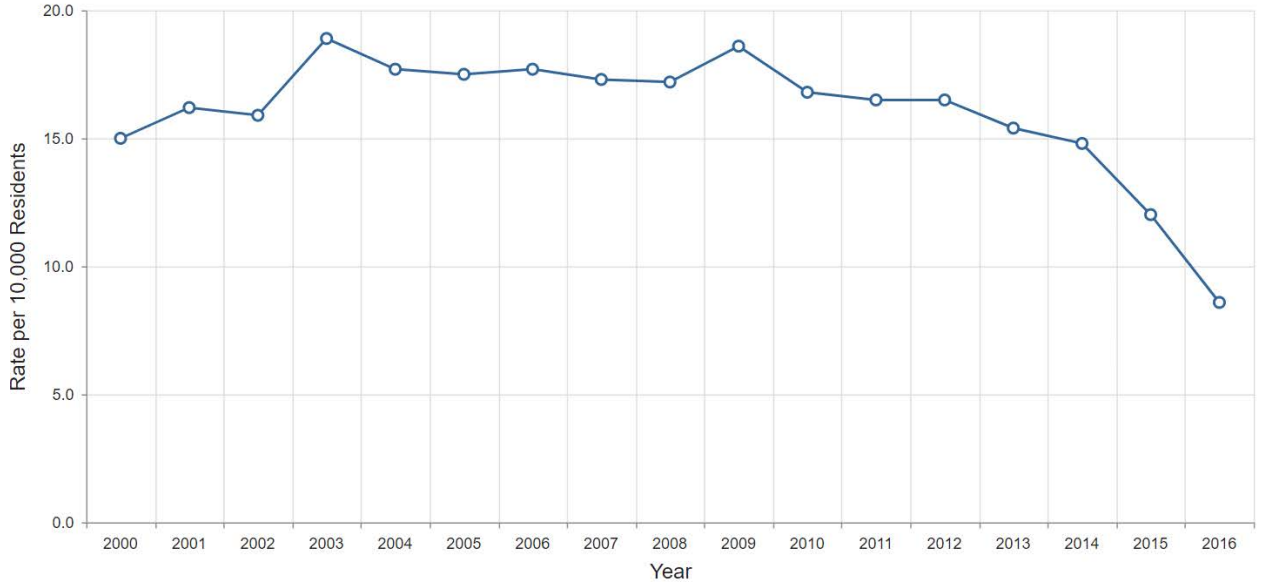
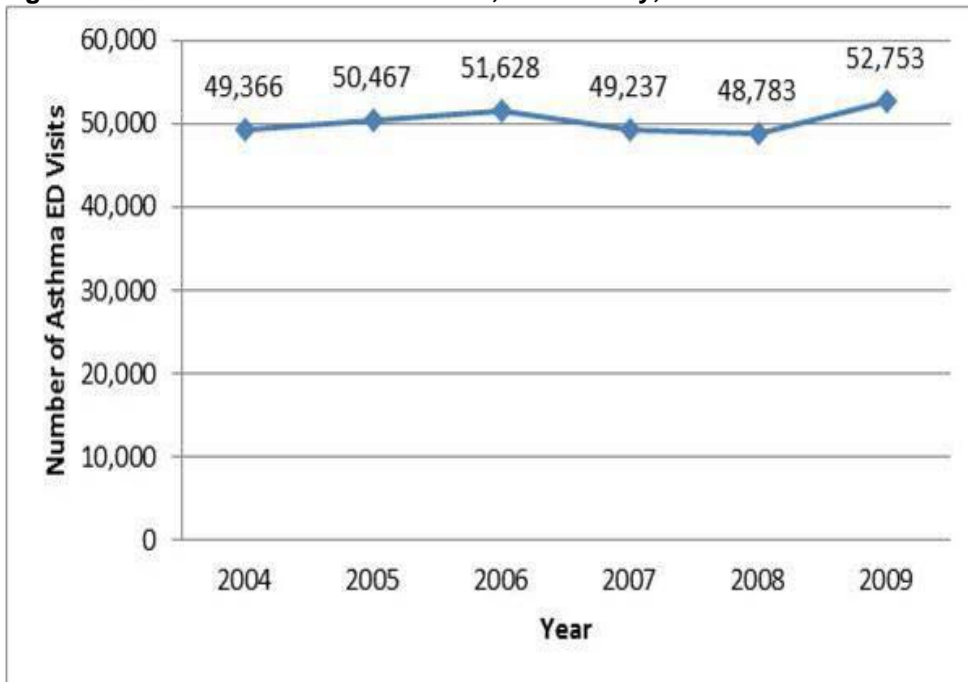


Figure IV. Number of Asthma ED Visits, New Jersey, 2004-2009



¹² NJDOH, New Jersey State Health Assessment Data, Available at: <https://www26.state.nj.us/doh-shad/indicator/view/NJASTHMAHOSP.stateAAR.html>

¹³ Ibid.

Of concern, children ages 0-4 have the highest asthma hospitalization and ED visit rates compared to all age groups; however, about 62% of all asthma ED visits and about 74% of all asthma hospitalizations are for adults¹⁴. Additionally,

- About 8.7% of NJ children 0-17 years have asthma.¹⁵
- Approximately 9% of adults in NJ have asthma.¹⁶
- Annual asthma hospitalization and ED visit rates vary widely by county in NJ. Age-adjusted asthma ED visit rates range from 19.6 per 10,000 (Hunterdon) to 114.96 per 10,000 (Essex).¹⁷
- 52.5% of children with asthma who attend school or child care miss at least one day per year for their asthma.¹⁸
- Among children with asthma:¹⁹
 - 56.5% have received an asthma action plan from a health professional.
 - 43.9% were advised by a health professional to make environmental changes.
 - 40% of those who use long-term control medication report proper use.
 - 59% of those who use quick relief medication report proper use.
- Among adults with asthma:²⁰
 - 34.5% have received an asthma action plan from a health professional.
 - 45.2% were advised by a health professional to make environmental changes.
 - 52% of those who use long-term control medication report proper use.
 - 61% of those who use quick relief medication report proper use.

Strong evidence indicates that more can be done to help those with asthma control their symptoms. The goals for the HN2020 pertaining to asthma include reducing the death rate due to asthma, reducing hospitalizations, reducing ED visits and reducing the proportion of persons with asthma who miss school or work days, and to increase education by health professionals regarding positive changes a patient with asthma can make in the home, school, or work settings.

In order to improve these rates and meet the HN2020 goals, supporting individual patients and performing home evaluations can improve their targeted treatment regimen. Additionally, ensuring that designated treatment educators are made available to patients, the community and providers at large will allow

¹⁴ NJDOH, Asthma Awareness and Education Program (Analysis of 2011 Hospital and ED Files)

¹⁵ NJDOH, New Jersey State Health Assessment Data, Available at: <https://www26.state.nj.us/doh-shad/topic/Asthma.html>

¹⁶ Ibid.

¹⁷ NJDOH, New Jersey State Health Assessment Data, Available at: <https://www26.state.nj.us/doh-shad/indicator/view/AsthmaEDVisRate.html>

¹⁸ NJDOH, New Jersey State Health Assessment Data, Available at: https://www26.state.nj.us/doh-shad/indicator/complete_profile/ACBS.html

¹⁹ Ibid.

²⁰ Ibid.

for sufficient support to a greater range of patients geographically. The following two projects serve to address these issues.

Hospital-Based Educators Teach Optimal Asthma Care

The purpose of this project is to implement a hospital-based asthma educator program in order to provide education to patients, providers and community members on optimum asthma care. In this program, improving training and education is not limited to patient self-care. This project is geared to ensure evidence-based training to inpatient providers, as well as education to targeted staff that routinely interact with asthma patients such as childcare centers and schools. This ensures that the community recognizes asthma triggers and supports asthma action plans to effectively respond with medication treatment protocols in lieu of exacerbating manageable symptoms.

The goals of this project are to 1) reduce admissions, 2) reduce ED visits, 3) improve medication management, and 4) increase patient satisfaction.

Pediatric Asthma Case Management and Home Evaluations

The purpose of this project is to provide case management and home evaluations to reduce admissions, ED visits and missed school days related to asthma.

The primary component of this project is to support the patient by completing a standardized needs assessment along with a home evaluation where a case manager completes an asthma action plan with the goal to remediate exacerbating environmental triggers. This case management allows for targeted support and linkages of care between primary and specialty care services.

The objectives of this project are to 1) reduce admissions, 2) reduce ED visits, 3) improve medication management, 4) reduce missed school days, and 5) improve care processes.

B. Behavioral Health

Of NJ's residents, nearly 259,000 adults live with serious mental illness.²¹

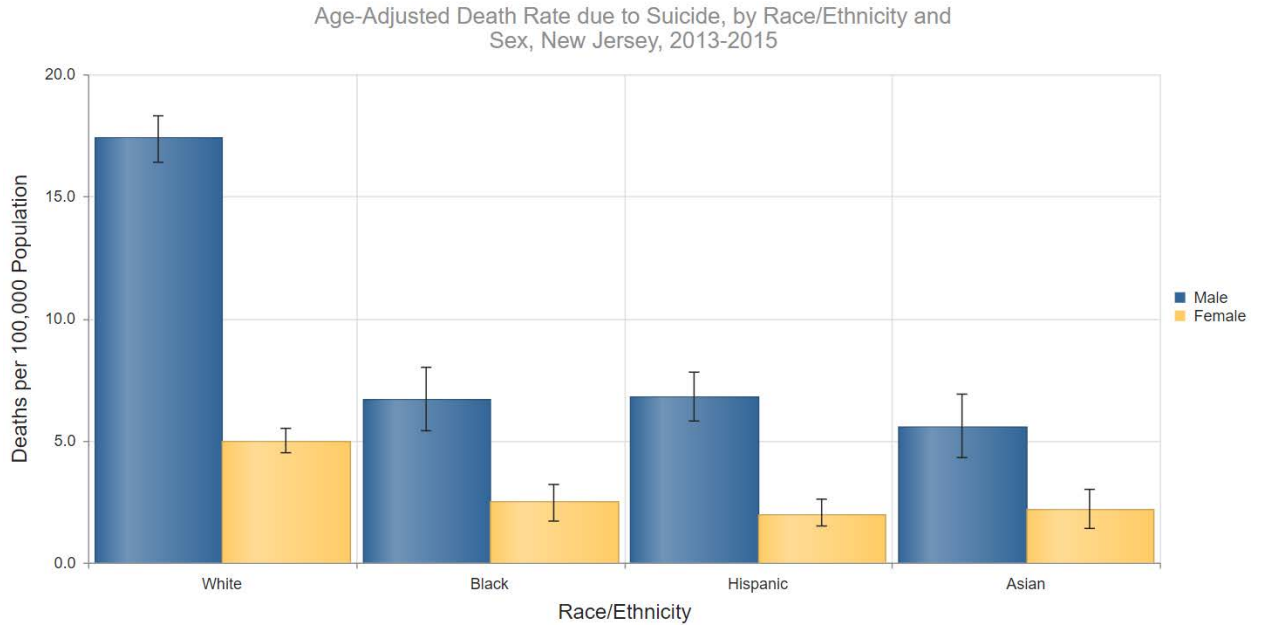
National studies estimate that during a one-year period up to 30 percent of the US adult population meets criteria for one or more behavioral health diagnoses, particularly mood (19%), anxiety (11%) and substance abuse (25%).²²

²¹ National Association of Mental Illness (NAMI) : "NAMI State Advocacy 2010: State Statistics: New Jersey" www.nami.org/ accessed January 31, 2013

²² NJDMHS, "The Comprehensive Waiver Application Overview & Health Care Reform": <http://www.state.nj.us/humanservices/dmhs/news/publications/MBHO%20ASO.ppt>

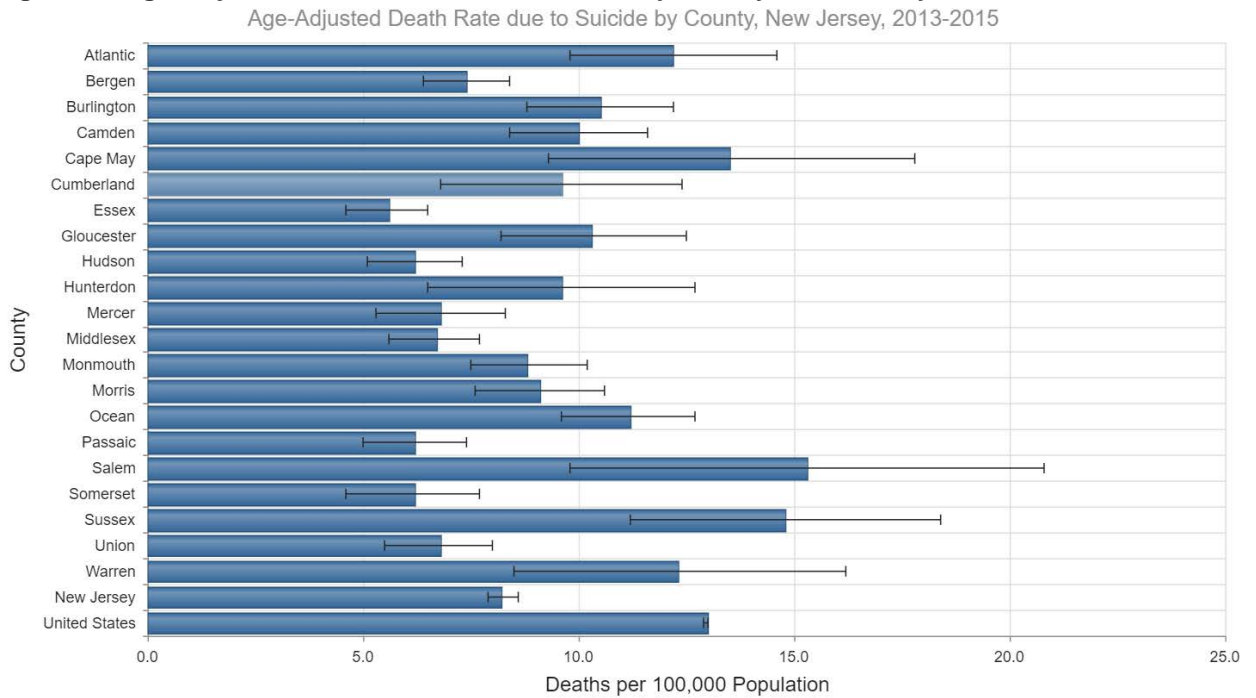
Consumers living with serious mental illnesses are dying years earlier than the general population, often with unmanaged physical health conditions. The incidence of suicide points to untreated or under-treated mental illness.

Figure V. Age-Adjusted Death Rate due to Suicide, by Race/Ethnicity and Sex, New Jersey, 2013-2015²³



²³ NJDOH, New Jersey State Health Assessment Data, Available at: <https://www26.state.nj.us/doh-shad/indicator/view/Suicide.RaceSex.html>

Figure VI. Age-Adjusted Death Rate due to Suicide by County, New Jersey, 2013-2015²⁴



Left untreated, behavioral health problems are associated with considerable functional impairment, poor adherence to treatment, adverse health behaviors that complicate physical health problems and increase healthcare costs. Generally, these individuals use about eight times more healthcare services than the average population. For Medicaid specifically, approximately two-thirds of Medicaid’s highest cost adult beneficiaries have a behavioral health diagnosis.²⁵

Behavioral health conditions are implicated in all major chronic diseases. Mental health problems are two to three times more common for people with chronic medical illnesses such as diabetes, arthritis, chronic pain, and heart disease. As a result, holistic, condition management is a key feature in the following behavioral health projects.

Integrated Health Home for the Seriously Mentally Ill (SMI)

The objective of this project is to fully integrate behavioral health and physical health services for those with a serious mental illness (SMI) diagnosis in order to provide evidence-based whole-person care.

²⁴ NJDOH, New Jersey State Health Assessment Data, Available at: <http://www4.state.nj.us/dhss-shad/indicator/view/Suicide.HighRisk.html>

²⁵ NJDMHS, “The Comprehensive Waiver Application Overview & Health Care Reform”: <http://www.state.nj.us/humanservices/dmhs/news/publications/MBHO%20ASO.ppt>

Integration will be provided in a client-centered model creating one place to access all services and ensuring patients have ongoing relationships with a medical and psychiatric practitioner. Allowing for all services to be co-located increases the attendance and coordination of needed services. A single treatment plan will be developed with goal setting that includes traditional medication interventions, such as gym memberships, nutrition monitoring and healthy lifestyle coaching to improve overall health.

As a result, the objectives of the project are to 1) reduce readmissions, 2) reduce ED visits, 3) improve patient adherence to their treatment regimen, and 4) improve care processes.

Day Program and School Support Expansion

School aged children and adolescents suspended from classrooms due to severe behavioral health issues may be left unsupervised pending approval to return to school. Failure to properly manage the suspension of these students impedes treatment and can delay their return to the school setting. This pilot program provides space, therapy and instruction at the hospital's ambulatory behavioral health center until the students are able to return to full-day attendance within the school setting. Treatment is provided by certified therapists and psychiatrists using evidence-based protocols for pediatric and adolescent care. Relationships and linkages between the behavioral health provider and the school district are expanded to ensure that the schools are supported in their efforts to assist students with behavioral health diagnoses. It is expected that with improved support for both the individual and the school, the following objectives will be realized.

These objectives of the project are to 1) reduce readmissions, 2) improve patient adherence to their treatment regimen, 3) improve care processes, 4) improve school education regarding behavioral health programming and referral processes, and 4) lengthen the uninterrupted student tenure within the school setting.

Electronic Self-Assessment Decision Support Tool

The objective of this project is for the hospital to work with outpatient facilities to implement an electronic self-assessment decision support tool to improve the continuum of care treatment provided to mental health patients by improving the efficiency and effectiveness of treatment planning, adherence and communication between the patient and the mental health provider.

This tool should be utilized by patients in the practitioner's office immediately prior to their outpatient mental health visit. The assessment must allow the patient to report on key symptoms and functioning, along with medication

compliance. The tool must immediately generate a consultation report that both the clinician and the client may refer to during the visit that graphs and trends the key indicators allowing the clinician to quickly identify areas of mental and physical health concern that should be addressed.

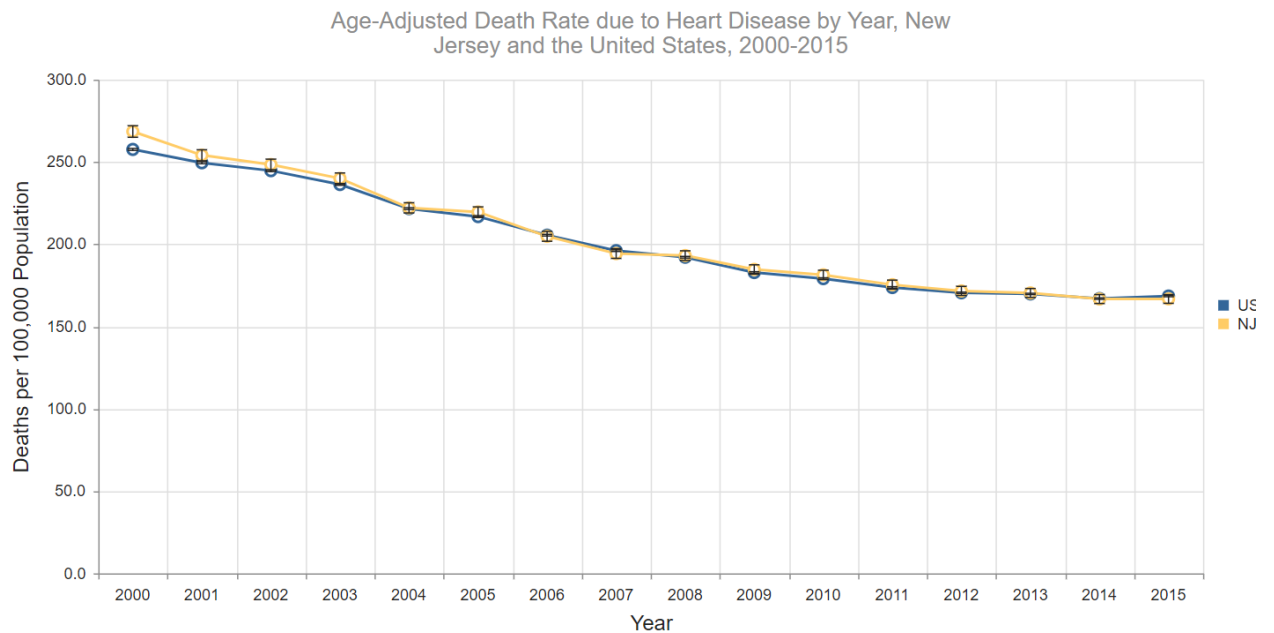
The goals of the assessment report are to 1) reduce readmissions, 2) improve patient-provider communication, 3) increase shared decision-making, 4) improve patient adherence to their treatment regimen, and 4) improve care processes.

C. Cardiac Care

In NJ, although age-adjusted mortality rates for heart disease decreased nearly 38% from the year 2000 to the year 2015, heart disease, remained the leading cause of death in 2015²⁶ among all Americans, and all New Jerseyans, men and women. It is the leading cause of death among Whites and Blacks and the second leading cause of death among Hispanics and Asians.

Figure VII below shows the age-adjusted death rate due to heart disease for both the US and NJ between 2000 and 2015. Although there has been a decline over the years, the rate still remains at near 170 deaths per 100,000 population.

Figure VII. Age-Adjusted Death Rate due to Heart Disease by Year, New Jersey and the United States, 2000-2015²⁷



²⁶ NJDOH, New Jersey State Health Assessment Data; Available at: <http://www4.state.nj.us/dhss-shad/indicator/view/HeartDisDeath.Trend.html>

²⁷ Ibid.

Age-adjusted mortality rates for heart disease are:

- Higher for males (242 per 100,000) as compared to females (15)²⁸ and
- Highest for Blacks (191.9) followed by Whites (175.5), Hispanics (102.5) and Asians (64.4).²⁹

Other cardiac related statistics considered included:

- 85% of heart disease and stroke deaths were for residents aged 65 years and older. Estimated lifetime history of cardiovascular disease among adults is³⁰:
 - 3.9% for coronary heart disease or angina
 - 3.8% for heart attack
 - 2.4% for stroke
- Estimated prevalence of cardiovascular disease risk factors among adults is³¹:
 - 48.9% for participating in 150+ minutes of aerobic physical activity per week
 - 3.7% for being told they have had a heart attack
 - 2.2% for being told they have had a stroke
 - 3.7% for being told they have angina or coronary heart disease
 - 63.4% for being overweight or obese
 - 13.5% for current smoking

There is a great deal of evidence that indicates that co-morbid and the aging “baby-boomer” populations will continue to drive medical costs in the area of cardiac care. NJ has set goals to improve heart health over the course of the next decade. These include moving mortality rates as well as cholesterol checks. The two goals listed in the following table relate to the DSRIP cardiac care projects.

Table IV. HN2020 Goals for Cardiac Care Improvement

Goals for Cardiac Care Condition Improvement	
HDS-1: Reduce the death rate due to coronary heart disease	
Target:	112.1 per 100,000 standard population (age-adjusted)
Baseline (Year):	140.1 per 100,000 standard population (age-adjusted) (2007)
Data source:	Death Certificate Database, Center for Health Statistics, New Jersey Department of Health

²⁸ NJDOH, “Heart Disease and Stroke in New Jersey”

²⁹ NJDOH, New Jersey State Health Assessment Data; Available at: <http://www4.state.nj.us/dhss-shad/indicator/view/HeartDisDeath.Trend.html>

³⁰ NJDOH, “Heart Disease and Stroke in New Jersey”

³¹ Ibid.

HDS-3: Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years	
Target:	86.7 percent (age-adjusted)
Baseline:	78.8 percent (age-adjusted) (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health

The cardiac care projects below seek to improve care coordination, increase consistent evidence-based treatment and improve continuum of care through more supportive patient centered practices in order to improve overall care and treatment in the most appropriate treatment setting.

Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions

The purpose of this project is to create an evidence-based Care Transitions Intervention model for cardiac care. This model will focus on the use of hospital Patient Navigators to assist in supporting the patient education process before and after they leave the hospital to ensure the patient and caregivers are knowledgeable about medications, red-flag indications and how to respond to identified concerns.

The objectives for this project are to 1) reduce readmissions, 2) reduce admissions, 3) increase patient satisfaction, 4) improve medication management, and 5) improve care processes.

Extensive Patient Congestive Heart Failure (CHF) - focused Multi-Therapeutic Model

The purpose of this project is to decrease the number of readmissions by developing a multi-therapeutic medical home. Nurse practitioners with CHF experience will lead patient education and coordinate home visits to ensure care management.

The goals for this program include: 1) reduce readmissions, 2) reduce admissions, 3) increase patient satisfaction, 4) improve medication management, and 5) improve care processes.

The Congestive Heart Failure Transition Program (CHF-TP)

The purpose of this project is to develop an intensive outpatient Congestive Heart Failure Transition Program (CHF-TP) through an enhanced admission assessment and guidance at discharge.

Through this project, the hospital will incorporate a number of components to ensure a safe patient transition to home or other appropriate health care setting. Key elements include enhanced admission and discharge processes, improved communication and education related to self-care, and the development of a patient centered multi-disciplinary team which effectively completes ongoing medical assessments.

The objectives for this project are to 1) reduce readmissions, 2) reduce admissions, 3) increase patient satisfaction, 4) improve medication management, and 5) improve care processes.

D. Chemical Addiction/Substance Abuse

Individuals with untreated substance abuse disorders have higher medical costs than those without such disorders, especially for emergency department visits and hospitalizations. Similarly, families of untreated individuals with substance use disorders also have significantly higher medical costs than other families. These family members use up to five times more health care services driven by hospitalizations, pharmacy costs and primary care visits.³² Reducing the substance use and dependence rate in every county therefore has significant potential to drive health care costs down while improving the long-term health outlook for NJ families.

³² NJDMHS, "The Comprehensive Waiver Application Overview & Health Care Reform": <http://www.state.nj.us/humanservices/dmhs/news/publications/MBHO%20ASO.ppt>

Table V. Substance Abuse Treatment Demand Estimate New Jersey, 2016³³

County	2016 Adult Population [1]	2016 Met Demand [2]	Unmet Demand [3]	Total Demand [2 + 3]	Unmet Demand As Percent of Total Demand
Atlantic	210,289	3,042	1,142	4,184	27.3
Bergen	733,477	2,838	3,983	6,821	58.4
Burlington	350,442	2,151	1,903	4,054	46.9
Camden	390,265	4,564	2,119	6,683	31.7
Cape May	77,433	1,358	420	1,778	23.6
Cumberland	117,347	1,319	637	1,956	32.6
Essex	603,264	4,963	3,276	8,239	39.8
Gloucester	224,509	1,970	1,219	3,189	38.2
Hudson	539,674	3,157	2,930	6,087	48.1
Hunterdon	97,746	710	531	1,241	42.8
Mercer	289,398	2,312	1,571	3,883	40.5
Middlesex	650,406	4,145	3,532	7,677	46.0
Monmouth	484,405	4,394	2,630	7,024	37.4
Morris	385,779	2,059	2,095	4,154	50.4
Ocean	453,260	5,004	2,461	7,465	33.0
Passaic	383,498	3,029	2,082	5,111	40.7
Salem	49,163	408	267	675	39.6
Somerset	254,986	1,564	1,385	2,949	47.0
Sussex	111,025	913	603	1,516	39.8
Union	422,279	2,581	2,293	4,874	47.0
Warren	83,481	728	453	1,181	38.4
New Jersey	6,912,125	53,209	37,533	90,742	41.4

The complications related to addiction and abuse for self-management cause an important need for overall health management support. Ensuring medical management screenings and treatment for addiction allows improved whole person care. The following projects strive to ensure more immediate symptomatic treatment for withdrawal and a pathway to long term treatment and recovery.

³³ Department of Human Services Division of Mental Health and Addiction Services Office of Planning, Research, Evaluation and Prevention, "Substance Abuse Overview 2016 Statewide", June 2017. Available at: <http://nj.gov/health/integratedhealth/publications-reports/statistical/Substance%20Abuse%20Overview/2016/statewide.pdf>

Hospital-Wide Screening for Substance Use Disorder

The objective of this project is to ensure the utilization of hospital-wide screening tools to detect alcohol or substance withdrawal for all patients admitted to the hospital regardless of the admitting diagnosis or event in order to effectively manage these symptoms. Upon screening, precautionary or treatment algorithms will be initiated as needed. Proper identification of withdrawal symptoms allows management of the symptoms prior to more serious complications.

The objectives of this project are to 1) decrease length of stay, 2) decrease use of restraints, 3) decrease in transfer of patients with delirium tremens or other complications to the intensive care unit (ICU), 4) increased referral/admissions to substance abuse treatment programs/facilities, and 5) improve care processes.

Hospital Partners with Residential Treatment Facility to Offer Alternative Setting to Intoxicated Patients

The purpose of this project is to offer an alternative treatment setting for acute alcohol intoxicated patients to lower the emergency department length of stay and offer immediate access to treatment.

This project requires a partnership between EDs and addiction service providers in order to allow stabilized patients suffering from acute intoxication to be transferred to a treatment setting.

The objectives for this project include 1) lower ED length of stays for intoxicated patients, 2) increase referral/admissions to substance abuse treatment programs/facilities, and 3) improve care processes.

E. Diabetes

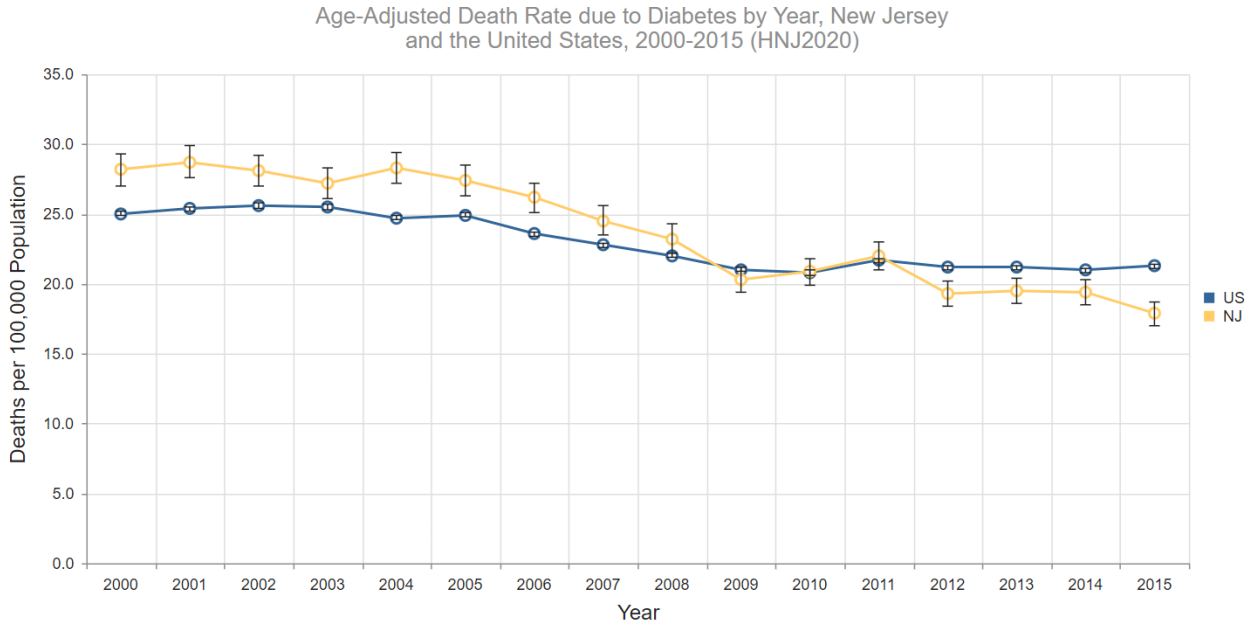
In NJ, diabetes is not only common, it is also costly and significant in its impact on health. Diabetes was the eighth leading cause of death in 2015³⁴ and about 77% of diabetes-related deaths were for residents aged 65 years and older.³⁵

Figure VIII below shows the age-adjusted death rate due to diabetes for both the US and NJ between 2000 and 2015. Over the years, the rate has declined for both NJ and the US; however, the NJ rate continues to be more than 17 deaths per 100,000 population for this manageable condition.

³⁴ NJDOH, New Jersey State Health Assessment Data; Available at: <https://www26.state.nj.us/doh-shad/indicator/view/DiabetesDeath.Trend.html>

³⁵ New Jersey Death Certificate Database, NJDOH, Center for Health Statistics, New Jersey State Health Assessment Data: <http://nj.gov/health/shad>

Figure VIII. Age-Adjusted Death Rate due to Diabetes by Year, New Jersey and the United States, 2000-2015 (HNJ2020)³⁶



Other diabetes related statistics considered included:

- Age-adjusted prevalence estimate for adults increased from 4.3% in 1993 to 8.2% in 2016.³⁷
- About 8.2% of adults have diabetes. Diabetes prevalence estimates for adults are³⁸:
 - Highest for 65-74 years (23.3%) and lowest for 18-24 years (1%)
 - Highest for Black (15.5%) followed by Hispanic (10%), and then White (6%)
 - Highest for those unable to work (21.3%). Those who are Out of work (14.5%) and Students (13.6%) are also at a higher risk
 - Highest for those who did not graduate high school (13.4%)
- Among adults with diabetes³⁹ approximately:
 - 53.9% were aware they had hypertension
 - 62.4% were aware they had high cholesterol
 - 48.5% are obese
 - 18.7% are current smokers
 - 65.8% had two or more A1c tests in the prior year

³⁶ NJDOH, New Jersey State Health Assessment Data; Available at: <https://www26.state.nj.us/doh-shad/indicator/view/DiabetesDeath.Trend.html>

³⁷ Ibid.

³⁸ Ibid.

³⁹

Centers for Disease Control and Prevention: National Diabetes Surveillance System. Available online at: <http://www.cdc.gov/diabetes/statistics>. Retrieved [03/12/2018]

- 58% had a dilated eye exam in the last year
- 61.1% had a foot exam in the prior year
- 60% perform daily self-monitoring of blood glucose
- 42.4% received an influenza immunization in the prior year
- 50.8% ever received a pneumococcal immunization
- 42.7% ever attended a diabetes self-management class
- In 2014, a rate of 189.1 per 100,000 adults began treatment for diabetes-related end-stage renal disease.⁴⁰

As described in the HNJ2020, the goals set for diabetes improvement include:

Table VI. HNJ2020 Goals for Diabetes Improvement

Goals for Diabetes Improvement	
DM-1: Reduce the death rate due to diabetes	
Target:	15.8 per 100,000 standard population (age-adjusted)
Baseline (Year):	24.4 per 100,000 standard population (age-adjusted) (2007)
Data source:	Death Certificate Database, Center for Health Statistics, New Jersey Department of Health
DM-2: Reduce the rate of lower extremity amputations in persons with diagnosed diabetes	
Target:	28.6 per 1,000 persons diagnosed with diabetes
Baseline (Year):	31.8 per 1,000 persons diagnosed with diabetes (2009)
Data source:	Uniform Billing Patient Summary Data, Office of Health Care Quality Assessment, New Jersey Department of Health
DM-3: Increase the proportion of adults with diabetes who have an annual dilated eye examination	
Target:	72.2 percent (age-adjusted)
Baseline (Year):	65.6 percent (age-adjusted) (2009-2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
DM-4: Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement (AC1) at least twice a year	
Target:	59.4 percent (age-adjusted)
Baseline (Year):	54.0 percent (age-adjusted) (2009-2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health

Finding better and consistent methods to increase patient self-care and training is critical to managing this chronic condition.

⁴⁰ Ibid.

Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension

The purpose of this project is to develop and implement a patient centered medical home for patients with diabetes mellitus and hypertension resulting in improved overall quality of care.

The goals are to 1) reduce admissions, 2) reduce ED visits, 3) improve care processes, and 4) increase patient satisfaction.

Diabetes Group Visits for Patients and Community Education

The purpose of this project is first to ensure that all newly diagnosed diabetic patients have a clear understanding of their plan of care. Second, that patients are knowledgeable regarding expected outcomes and disease management and third, to improve the opportunity for medical staff to gain continued and ongoing education from endocrinology areas.

The goals of this project are to 1) reduce admissions, 2) reduce ED visits, 3) improve care processes, and 4) increase patient satisfaction.

Develop Intensive Case Management for Medically Complex High Cost Patients

The purpose of this project is to reduce inpatient admissions and ED visits for the most costly, medically complex patients with a primary diagnosis of diabetes through an intensive case management and care coordination program. This program assigns each enrolled patient to a physician-led team of multi-therapeutic providers. This team is available to help the individual navigate the health care system, access available financial assistance and utilize appropriate community resources.

The goals are to 1) reduce admissions, 2) reduce ED visits, 3) improve care processes, and 4) increase patient satisfaction.

F. HIV/AIDS

As of December 2016, 37,170 people were reported living with HIV or AIDS in NJ.⁴¹ The data indicates that:

- Minorities account for 78% of adult/ adolescent cumulative (reported to the state) HIV/AIDS cases and 77% of all persons living with HIV/AIDS.⁴²

⁴¹ NJDOH, "HIV, STD, and TB Services", Accessed March 12, 2018: <http://www.nj.gov/health/hivstdtb/hiv-aids/statmap.shtml>

⁴² Ibid.

- Seventy-one percent (71%) of those persons living with HIV/AIDS are 45 years of age or older.⁴³
- Injection drug use (18%) and sexual contact (67%) remain the major modes of exposure to HIV infection. The proportion of reported cases with HIV/AIDS who were exposed through injection drug use (IDU) is lower than in the past, while the proportion of cases that were exposed through sexual contact is increasing.⁴⁴

**Table VII. State of New Jersey: Persons Living with HIV/AIDS as of 12/30/2016
Number of Living Cases by Racial/Ethnic Group and Sex⁴⁵**

State of New Jersey Residents: Persons Living with HIV/AIDS as of 12/31/2016						
Table 3. Number of living cases by race/ethnicity and sex						
Race/ethnicity	Males		Females		Total	
	Cases	%	Cases	%	Cases	%
Hispanic, All races	7260	29	2921	24	10181	27
Not Hispanic, Black or African American	11326	45	7373	61	18699	50
Not Hispanic, White	6017	24	1692	14	7709	21
Other/Unknown	427	#	154	#	581	#
Total	25030	100	12140	100	37170	100

Note: Percentages may not add to 100 due to rounding.

As described in the HNJ2020, some of the goals set for HIV/AIDS improvement include:

Table VIII. HNJ2020 Goals for HIV/AIDS

Goals for HIV/AIDS Improvement	
<u>HIV-1</u> : Reduce the rate of HIV transmission among adolescents and adults	
Target:	12.5 per 100,000 population
Baseline (Year):	15.6 per 100,000 population (2008)
Data source:	Enhanced HIV/AIDS Reporting System, Division of HIV/AIDS, STD, and TB Services, New Jersey Department of Health
<u>HIV-2</u> : Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards	
Target:	65 percent
Baseline (Year):	54 percent (2008)
Data source:	Enhanced HIV/AIDS Reporting System, Division of HIV/AIDS, STD, and TB Services, New Jersey Department of Health
<u>HIV-3</u> : Reduce the death rate due to HIV infection	

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Ibid.

Target:	4.2 per 100,000 standard population (age-adjusted)
Baseline (Year):	5.3 per 100,000 standard population (age-adjusted) (2007)
Data source:	Death Certificate Database, Center for Health Statistics, New Jersey Department of Health

As new therapies become available, a larger percentage of patients will remain HIV positive for longer periods of time before developing AIDS. Ensuring that these patients are managed effectively is important to reduce incidence and prevalence of exposure. This population is dealing with complex social issues and medication regimens due to their illness, however with effective support, the condition can be managed by improving the overall quality of life for people living with HIV/AIDS. This project is geared to assisting the individual patient and the community at-large.

Patient Centered Medical Home for Patients with HIV/AIDS

The objective of this project is to develop and implement a patient centered medical home for patients with HIV ensuring interdisciplinary outpatient management, intensive hospital discharge planning, and dedicated patient navigation services to ensure the receipt of optimal social services.

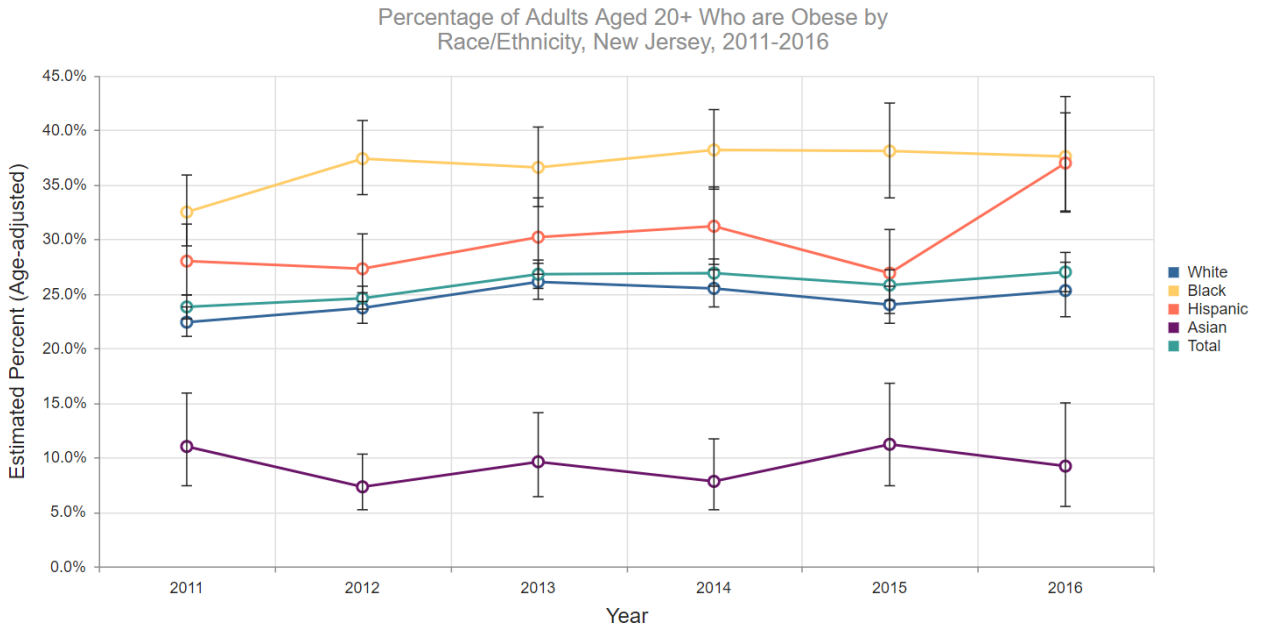
With increased support, it is expected that these objectives will be met: 1) reduce readmissions; 2) improve patient adherence to their treatment regimen; 3) improve care processes; and 4) increase patient satisfaction.

G. Obesity

More than one out of four (27%) NJ adults are obese.⁴⁶ Figure IX shows the percent of adults who are obese in NJ by race/ethnicity.

⁴⁶ NJDOH, New Jersey State Health Assessment Data; Available at: <https://www26.state.nj.us/doh-shad/indicator/view/DiabetesDeath.Trend.html>

Figure IX. Percent of Adults Aged 20+ Who are Obese by Race/Ethnicity, New Jersey, 2011-2016⁴⁷



Particularly NJ counties, Cumberland (36.6%), Salem (35.1%), and Camden (32.3%), have the highest rates of adult obesity in NJ while Hunterdon (18.3%), Morris (19.8%), and Somerset (21.7%) counties have the lowest rates⁴⁸.

If obesity rates continue to increase at their current pace, nearly half (48.6%) of NJ adults will be obese in 2030. Unfortunately, NJ has one of the three highest obesity rates in the nation among low-income children, ages 2-5 (15.3%).⁴⁹

Ten percent (10%) of children, ages 10-17 are obese in NJ. Nine percent (9%) of NJ high school students are obese and fourteen (14%) are overweight⁵⁰. Today's childhood obesity rates are putting NJ children on course to be the first generation in this country to live shorter and less healthy lives than their parents.

In 2008, NJ spent \$2.2 billion on obesity-related health care. If obesity rates continue to increase, NJ's obesity-related healthcare spending will quadruple to \$9.3 billion by 2018.⁵¹

⁴⁷ Ibid.

⁴⁸ Ibid.

⁴⁹ NJDOH, "Physical Activity, Nutrition and Obesity New Jersey Fact Sheet," December 2016.

⁵⁰ Ibid.

⁵¹ Ibid.

As indicated in the HNJ2020, some of the NJ goals in this topic area, shown in Table IX below, include ensuring that these target rates move or continue to match the benchmark.

Table IX. HNJ2020 Goals for Obesity

Goals for Obesity Condition Improvement	
NF-1: Prevent an increase in the proportion of the population that is obese	
NF-1a: adults aged 18 years and older	
Target:	23.8 percent
Baseline (Year):	23.8 percent (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
NF-1b: high school students (grades 9-12)	
Target:	10.3 percent
Baseline (Year):	10.3 percent (2009)
Data source:	New Jersey Student Health Survey of High School Students, New Jersey Department of Education
NF-2: Increase the proportion of the population consuming five or more servings of fruits and vegetables per day	
NF-2a: adults aged 18 years and older	
Target:	28.7 percent
Baseline (Year):	26.1 percent (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
NF-2b: high school students (grades 9-12)	
Target:	22.1 percent
Baseline (Year):	20.1 percent (2009)
Data source:	New Jersey Student Health Survey of High School Students, New Jersey Department of Education
NF-3: Increase aerobic physical activity	
NF-3a: Proportion of adults who meet current Federal physical activity guidelines for moderate or vigorous physical activity	
Target:	58.5 percent (age-adjusted)
Baseline (Year):	53.2 percent (age-adjusted) (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
NF-3b: Proportion of high school students that meet current physical activity guidelines for moderate or vigorous physical activity	
Target:	23.4 percent
Baseline (Year):	21.3 percent (2009)
Data source:	New Jersey Student Health Survey of High School Students, New Jersey Department of Education

The following DSRIP projects are primarily geared to children and developing healthy habits for those less than 18 years of age in NJ.

After School Obesity Program

The purpose of this project is to develop community partnerships to create school-based wellness programs for overweight children. The program is to provide education, exercise, and medical services, such as targeted screenings (e.g. cholesterol and lipid screening, hypertension screening) by licensed practitioners.

The goals for this project are to 1) reduce patient body mass index (BMI), 2) improve patient adherence to their treatment regimen, and 3) improve care processes.

Wellness Program for Parents and Preschoolers

The purpose of this project is to develop a wellness program to help obese preschoolers and overweight parents improve eating habits and reduce BMI. The program consists of alternating group-based sessions and in-home, one-on-one consultations.

The goals are to 1) reduce patient BMI, 2) improve patient adherence to their treatment regimen, and 3) improve care processes.

H. Pneumonia

Influenza and pneumonia combined are the tenth leading cause of death among NJ residents. Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Vaccination against pneumococcal disease has been effective in reducing infections among seniors and persons with medical conditions. Table X provides an overview of how NJ performed from years 2006-2010 for several quality measures for pneumonia care.

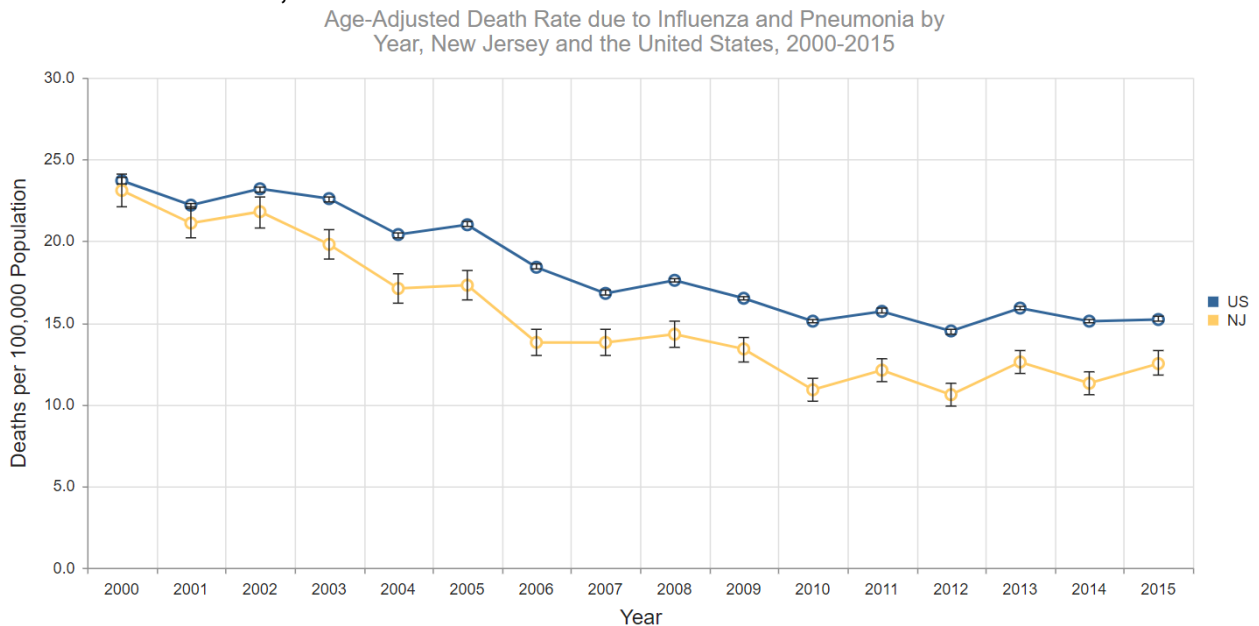
Table X. New Jersey Hospital Quality Scores

QUALITY MEASURE	2006	2007	2008	2009	2010
PNEUMOCOCCAL VACCINATION	87	91	93	95	96
ANTIBIOTIC SELECTION	89	92	92	94	95
ANTIBIOTIC TIMING			95	96	97
BLOOD CULTURES	94	94	95	97	97

SMOKING CESSATION ADVICE	94	96	97	99	100
INFLUENZA VACCINATION		87	90	93	95

The age-adjusted death rate due to influenza and pneumonia for both the US and NJ between 2000 and 2015, shown in Figure X below, has declined over the years, but NJ continues to look for ways to decrease this rate. Current measurement results indicate that the NJ influenza and pneumonia death rate of 12.5 was below the US average of 15.2 per 100,000. However, this rate reflects 1,402 deaths which suggests that more can be done.⁵²

Figure X. Age-Adjusted Death Rate due to Influenza and Pneumonia by Year, New Jersey and the United States, 2000-2015⁵³



The following project will work towards improving recommended pneumonia care.

Patients Receive Recommended Care for Community-Acquired Pneumonia

The purpose of this project is to ensure that patients with community-acquired pneumonia (CAP) receive recommended care as measured by the Joint Commission/CMS Pneumonia Core Measure Set. A multi-therapeutic workgroup will ensure the implementation of standardized order sets for both the emergency department and the inpatient setting to ensure a consistent, evidence-based care approach.

⁵² NJDOH, New Jersey Health Assessment Data; Available at: <http://www4.state.nj.us/dhss-shad/indicator/view/PneuFluDeath.Trend.html>

⁵³ Ibid.

The objectives are expected to 1) reduce readmissions, 2) decrease length of stay for CAP, and 3) improve care processes.

VI. Attribution

For both Quality Improvement and Population Focused Improvement metrics, DOH measures improvement for specified population groups, including the Charity Care, Medicaid and CHIP populations, collectively referred to as the Low Income population.

An attribution model to link the Low Income (Charity Care, Medicaid and CHIP) population with DSRIP project partners for Quality Improvement and Population Focused Improvement performance measurement has been developed by the Department with input by and support of the hospital industry. The attribution model is described in the *DSRIP Performance Measurement Databook*.

VII. Requirements of the Hospital DSRIP Plans

This section details the requirements of the Hospital DSRIP Plans, consistent with subparagraph (g) of the STCs.

A. General Requirements

Each hospital that elects to participate in the DSRIP program must have an approved Hospital-specific DSRIP Plan using a Department approved application that identifies the project, objectives, specific milestones, and metrics and meets all requirements pursuant to the STCs.

Hospitals have selected projects in one of the eight focus areas:

- Asthma
- Behavioral Health
- Cardiac Care
- Chemical Addiction/Substance Abuse
- Diabetes
- HIV/AIDS
- Obesity
- Pneumonia

Hospitals participating in the NJ DSRIP program during DY6 through DY8 are required to continue with the DSRIP project and project plan approved by NJ and CMS for DSRIP demonstration years 2 through 5. Project plans may be amended as part of the annual application renewal; however, hospitals are not permitted to change projects during DY6 through DY8.

i. Milestones and Metrics Table

The approved DSRIP Plan indicates by demonstration year when project activities and milestones will be achieved and indicate the data source that will be used to document and verify achievement.

- In DY6, Hospitals will complete all of the defined activities in Chronic Medical Condition Redesign and Management (DY6 Stage 2).
- For DY7-DY8, Stage 1 activities and metrics consist of System Transformation measures as pay-for-reporting. Further detail on how DY7-DY8 Stage 1 is funded is included in the Funding and Mechanics Protocol.
- Quality Improvement (DY6 Stage 3, DY7-DY8 Stage 2) and Population Focused Improvement (DY6 Stage 4, DY7-DY8 Stage 3) activities consist of reporting the project-specific metrics and the universal metrics, respectively. Hospitals are required to report these metrics throughout the demonstration period. Funding for this activity is based on reporting and/or meeting improvement targets. Further detail on how this reporting activity ties to funding is included in the FMP.

B. Project Activities, Milestones, and Metrics

Demonstration Year 6

The DSRIP Plans include sections for each of the stages specified above in Section IV. Project Stages. The following are the requirements for the DSRIP application and each of the four stages.

i. DY6 Stage 1 Requirements: Infrastructure Development

DY6 Stage 1 involves procuring the necessary resources identified in the application and the infrastructure needed to conduct the project.

ii. DY6 Stage 2 Requirements: Chronic Medical Condition Redesign and Management

DY6 Stage 2 involves activities related to piloting the project to the hospital selected pilot population, as well as re-designing the project based on the results of the pilot. All DY6 Stage 2 activities, identified in the Hospital DSRIP Plan Template (Attachment 1: DSRIP Toolkit), are required.

iii. DY6 Stage 3 Requirements: Outcome Reporting and Quality Improvements

DY6 Stage 3 involves the monitoring of project-specific clinical measures that are associated with the achievement of implementing DY6 Stage 1 and 2 project activities and meeting milestones. All participating hospitals must report these project-specific outcomes in each demonstration year at

a frequency indicated in Attachment 1: DSRIP Toolkit, Section II. Calendar - Timelines.

Improvement target goals for selected measures will be established based on the methodology described in the FMP. The metrics must assess the results of care experienced by patients, including patient's clinical events, patient's recovery and health status, patient's experiences in the health system, and efficiency/cost.

iv. DY6 Stage 4 Requirements: DSRIP Performance Indicators (i.e. Universal Metrics)

Pursuant to the STCs, hospitals will be required to report DSRIP performance indicators as a DY6 Stage 4 activity. These universal metrics will be reported across several domains selected by the Department based on community readmission rates and hospital acquired infections. DSRIP performance indicators will be connected to the achievement of providing better care, better access to care, and enhanced prevention of chronic medical conditions and population improvement. In accordance with this requirement, hospitals must include reporting of all defined DSRIP universal metrics.

In addition to reporting and payment of DY6 Stage 4 measures, hospitals will be eligible to receive payments for a core set of DY6 Stage 4 measures through a financial performance pool. The Universal Performance Pool (UPP) rewards hospitals that maintain or improve hospital performance across a broad spectrum of critical domains of inpatient care.

Demonstration Years 7 & 8

i. DY7-DY8 Stage 1 Requirements: System Transformation

Starting in DY7, Stage 1 System Transformation measures will develop the foundation for future delivery systems aimed at improving access to care, integrated care across health care providers, and improved health care outcomes. System Transformation measures will consist of 10 measures selected by NJ and approved by CMS reported annually. This Stage is all pay for reporting. The measures eligible for this pool are denoted in the Addendum 1: Stage 1 System Transformation Measure Catalogue.

ii. DY7-DY8 Stage 2 Requirements: Quality Improvement

- 1) DY7-DY8 Stage 2 involves the monitoring of project-specific clinical measures. All participating hospitals must report these project-specific outcomes in each demonstration year at a frequency indicated in Attachment 1: DSRIP Toolkit, Section II. Calendar - Timelines.

- 2) Improvement target goals for selected measures will be established based on the methodology described in the FMP. The metrics must assess the results of care experienced by patients, including patient's clinical events, patient's recovery and health status, patient's experiences in the health system, and efficiency/cost. The measures eligible for this pool are denoted in the measure addenda.

iii. DY7-DY8 Stage 3 Requirements: Population Focused Improvement (i.e. Universal Metrics)

- 3) Pursuant to the STCs, hospitals will be required to report Population Focused Improvement measures as a DY7-DY8 Stage 3 activity. These universal metrics will be reported across several domains selected by the Department based on community readmission rates and hospital acquired infections. Population Focused Improvement measures will be connected to the achievement of providing better care, better access to care, and enhanced prevention of chronic medical conditions and population improvement. DY7-DY8 Stage 3 will consist of not less than 50% pay-for-performance measures and not more than 50% pay-for-reporting measures selected and approved by NJ and CMS.

iv. DY7-DY8 Universal Performance Pool (UPP)

In addition to reporting and payment of DY7-DY8 Stage 3 measures, hospitals will be eligible to receive payments for a core set of DY7-DY8 UPP measures through a universal performance pool. The UPP rewards hospitals that maintain or improve hospital performance across a broad spectrum of critical domains of inpatient care. The measures eligible for this pool are denoted in the Addendum 4: UPP Measure Catalogue.

C. High Performance on Quality Improvement (DY6 Stage 3, DY7-DY8 Stage 2)

It has been the expectation of the Department and CMS that hospital projects will result in substantial improvement in the selected focus areas. Therefore, for each Quality Improvement pay for performance metric, an Improvement Target Goal (ITG) is set which serves as the standard level of performance that NJ hospitals will strive to obtain.

i. Improvement Target Goal (ITG)

The ITG has been determined using national benchmark data or statewide benchmark data whichever results in a higher ITG for the performance metrics.

The following process was followed to set a measure's high-performance level (ITG):

Step 1: Select the most challenging of the following sources:

- a) 95th percentile of National benchmark if available
- b) 95th percentile of NJ statewide benchmark if available
- c) 90th percentile of DSRIP-participating hospitals (MMIS or Chart/EHR based)
- d) Current ITG in use for DY6-DY8

Step 2: If the above options are not available, choose from the following:

- a) 90% compliance for process measures
- b) 95th percentile of custom ITG based on measure specification and available information for outcome measures.

In a change from the DSRIP Program's original demonstration period, the rules for substitution in DY6 Stage 3 and DY7-DY8 Stage 2 no longer apply. Starting in DY6, if a hospital achieves a result on a Quality Improvement measure that is equal to or better than the ITG on that measure, then that hospital must meet or exceed the ITG in future years to earn payment, subject to the regression provision described in the following section.

ii. Regression Provision

The exception introduced in DY6-DY8 is the regression provision. Once a hospital that has exceeded the ITG for a measure, the hospital must at least maintain performance results in each following year to meet achievement eligible for payment. The regression provision applies to the following 6 measures in DY6 DSRIP #15, DSRIP #31, DSRIP #33, DSRIP #45, DSRIP #73 and DSRIP #80. In DY7 &DY8, the regression provision applies to all Stage 2 measures.

For reference to the ITG calculation, please review the Funding and Mechanics Protocol Section VII.B.

D. High Performance on Population Focused Improvements (DY7-DY8 Stage 3)

For the DY7-DY8 Stage 3 pay-for-performance Population Focused Improvement measures, hospitals that have met or exceeded the high-performance threshold (below) will be considered a high performer. In DY7, to determine whether a hospital is a high performer on a specific Stage 3 P4P measure, the Department

will look at each hospital's measure result from DY6. If the measure result is above the high-performance threshold, the hospital will be considered a high performer for that measure. This process will be repeated for DY8 using hospitals' DY7 measure results. Any hospital designated as a high performer on a Stage 3 P4P measure during DY7-DY8 will receive full AV for that measure in the subsequent performance year when the hospital demonstrates a relative improvement of 2 percent.

- DSRIP 3: The high-performance threshold for 30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization is 0 percent.
- DSRIP 8: The high-performance threshold for Ambulatory Care – Emergency Department Visits is 33.66 visits per 1,000.
- DSRIP 31: The high-performance threshold for Controlling High Blood Pressure (CBP) is 96 percent.
- DSRIP 36: The high-performance threshold for Diabetes Short-Term Complications Admission Rate is .233 per 1,000.
- DSRIP 38: The high-performance threshold for Engagement of alcohol and other drug treatment is 22 percent.
- DSRIP 41: The high-performance threshold for Follow-up After Hospitalization for Mental Illness 7 days post discharge is 77 percent.
- DSRIP 88: The high-performance threshold for Well-Child Visits in First 15 Months of Life is 96.42 percent.

VIII. Quality & Measures Committee (Committee)

The Department will develop and put into action a committee of stakeholders who will be responsible for supporting the clinical performance improvement cycle of DSRIP activities. The Committee will serve as an advisory group offering expertise in health care quality measures, clinical measurement and clinical data used in performance improvement initiatives.

Final decision-making authority will be retained by the Department and CMS, although all recommendations of the committee will be considered by the Department and CMS.

Specifically, the Quality & Measures Committee will provide feedback to the Department regarding:

- Development of the Low Income attribution model
- Selection of additional metrics for hospitals who have reached the Metric Baseline Performance Threshold
- Selection of the ITG for Quality Improvement (DY6 Stage 3, DY7-DY8 Stage 2) performance metrics tied to incentive payments

A. Composition of the Committee

The membership of the committee must consist of between seven and nine members with no more than three members employed by NJ hospitals. All members will be appointed by the Commissioner of Health based on the following composition criteria:

- Representation from community health centers serving the low-income population.
- Several members must be clinical experts in one of the following specialty care areas: Behavioral Health, Cardiology, HIV/AIDS, Pulmonology, and Primary Care. Clinical experts are physicians, physician assistants, nurse practitioners, and registered nurses.
- At least two members must have significant expertise in clinical quality measurement of hospitals. Significant expertise is defined as not less than five years of recent full-time employment in quality measurement in government service or from companies providing quality measurement services to hospitals.
- A member from the New Jersey Hospital Association, the largest trade association in NJ, with current expertise and engagement in quality management services provided to NJ hospitals.
- A member as a consumer.

IX. DSRIP Program Performance Management

Performance management and assessment of the DSRIP program will occur throughout the duration of the demonstration and will take on several forms. Each area of assessment is interrelated to ensure a continuous cycle of quality improvement and shared learning.

- 1) A formative evaluation of DSRIP will occur on a regular basis which seeks to provide timely and actionable feedback on the initiative's progress, in terms of both implementation activities and outcomes. The formative evaluation, or performance management, will track and report regularly on actions, progress towards achieving a health care system based on the Triple Aim, and progress toward achieving the primary goals of DSRIP.
- 2) Learning collaboratives will be implemented to seek peer-to-peer (hospital-to-hospital) input on project level development of action plans, implementation approaches and project assessment. The Department will be responsible for leading the collaborative approach to ensure effective sharing of information (e.g. best practices, case studies, challenges, results).
- 3) A final summative assessment of DSRIP will be completed by the independent DSRIP evaluator describing changes in quality and access outcomes resulting from DSRIP, as well as other outcomes of interest and identifying the changes in outcomes resulting from transformation activities.

A. New Jersey DSRIP Performance Management

The Department, or its designee, will conduct robust monitoring and assessment of all submitted reports, hospital progress, challenges and completion no less frequently than semi-annually, and as appropriate in order to monitor DSRIP implementation and activities.

Upon this review, an analysis will be made regarding:

- the extent of progress each hospital is making towards meeting each milestone;
- the specific activities that appear to be driving measurable change;
- the key implementation challenges associated with specific activities designed to drive improvement; and
- the identification of adjustments to the DSRIP program, and/or projects as observed through the analysis of submitted hospital-level data and/or onsite findings as they occur.

Comparative analysis and findings will be performed and summarized into actionable reports that provide the right level of information to various program stakeholders to help facilitate learning at the hospital level, as well as the DSRIP program level. The reports will be used to drive peer-to-peer hospital discussion regarding opportunities for improvement and methods for course correction through the use of the Learning Collaborative. The results of these assessments will be disseminated to the independent DSRIP evaluation contractor and CMS. This information is expected to inform the DSRIP evaluation during both the mid-point and summative evaluations to understand key factors related to the performance and progression of the DSRIP program to date.

The Department, or its designee, will take effective action, as needed, to remedy a finding to promote fulfillment of the DSRIP goals. This may include providing feedback to the hospital industry at-large, or individual project participants if significant issues are observed.

B. Learning Collaborative

One facet of the DSRIP program is the development of the Learning Collaborative. The purpose of the Learning Collaborative is to promote and support a continuous environment of learning and sharing within the NJ healthcare industry in an effort to bring meaningful improvement to the landscape of healthcare in NJ.

The Learning Collaborative has been and will continue to be managed by the Department and through in-person collaboration and other delivery venues that both builds relationships as well as facilitates program analysis and

measurement. The Learning Collaborative will be designed to promote and/or perform the following:

- Sharing of DSRIP project development including data, challenges, and proposed solutions based on the hospitals' quarterly progress reports
- Collaborating based on shared ability and experience
- Identifying key project personnel
- Identification of best practices
- Provide updates on DSRIP program and outcomes
- Track and produce a "Frequently Asked Questions" document
- Encourage the principles of continuous quality improvement cycles

There will be multiple collaboratives developed based on the number and type of projects chosen by hospitals. For each collaborative, the Department will designate personnel to be responsible for guiding and facilitating the Learning Collaborative.

An online, web-based tool has been and will continue to be utilized to effectively manage the collection and the dissemination of information related to the DSRIP program and projects. A key component of the online tool is a reporting feature that allows tiered-level reporting that conveys key information to the various levels of stakeholder groups interested in learning and tracking performance of the DSRIP program. This tool acts as a repository with reporting capability for various audiences including that of the general public, the Department, CMS, and the healthcare industry.

The tool will deliver data in ways that can be 1) easily interpreted by various stakeholders, 2) promote self-evaluation, and 3) promote the diffusion of effective intervention models.

i. Operational Report

An operational report at the project level will be the primary report to manage and report DSRIP performance. The operational report will have the functionality to report on project-level data related to hospitals performing the same project. This may include such data elements as:

- Identification of participating hospitals
- Completion factor of hospitals, by Stage by hospital
- Dashboard of project-specific Quality Improvement (DY6 Stage 3, DY7-DY8 Stage 2) measure results
- Summary of applied interventions
- Summary of pilot models
- Summary of reported challenges
- Summary of reported successes
- Noted best practices

This report will be used to inform and direct the Learning Collaboratives. It will be used to ensure consistent analysis on key implementation activities across hospitals and act as a platform for discussion during monthly conference calls and quarterly in-person collaboration meetings. This report may be utilized by the hospital project personnel as a primary tool to aid routine collaboration among hospitals implementing the same project. This level of reporting may also show progress of the learning process itself by tracking the frequency of meetings by activity and participation in order to confirm that the learning collaborative activity is being fulfilled by the hospital.

It will be the responsibility of each project participant to ensure effective diffusion of learning amongst hospitals who have selected the same project focus area. This includes discussing the types of innovations, strategies and Plan-Do-Study-Act (PDSA) cycles that have been implemented throughout the demonstration.

ii. Executive Level Report

An executive level report will have the functionality to report on high-level summary statistics related to the most recent quarter's DSRIP reports. This may include such data components as:

- Number of participating hospitals
- Number of approved/ rejected plans
- Count of plans by focus area and by project
- Completion factor of plans by Stage
- Dashboard of universal Population Focused Improvement (DY6 Stage 4, DY7-DY8 Stage 3) measure results

This report may be utilized by the public, CMS and the Department to track the overall progress of the DSRIP program.

iii. Consumer Level Report

A consumer level report will have the functionality to report on high-level geographic and project-specific data elements in order to understand which hospitals in their area are driving to improve quality and the area of focus for that hospital. The report may include:

- County-level map that indicates all NJ hospitals
- County-level map that indicates all participating hospitals and participating outpatient providers

This report may also have drill-down functionality to learn summary detail about the objective, methodology and expected results of each hospital.

C. DSRIP Program Evaluation

i. Evaluation Objectives and Research Questions

The Center for State Health Policy (CSHP) at Rutgers University will provide a final, summative evaluation of the DSRIP program, answering research questions detailed in the STCs issued by CMS upon approval of the NJ FamilyCare Comprehensive Demonstration.

This evaluation will utilize a mix of quantitative and qualitative methods.

The summative evaluation is designed to provide an independent analysis of key metrics to address how well the DSRIP Program achieves better care and better health for populations in the hospital catchment areas, as well as lower costs through improvement. Qualitative analysis, including key informant interviews and document review, will be conducted throughout planning and implementation of the DSRIP Program, to provide stakeholder perceptions of improvements in care and strengths and weaknesses of the program. The final, summative evaluation will be completed by the end of June 2021.

The evaluation will use quantitative and qualitative research methodologies to test NJ's global hypothesis about the effectiveness of the DSRIP program.

“The DSRIP Program will result in better care for individuals (including access to care, quality of care, health outcomes), better health for populations and lower cost through improvement.”

The following overall research questions (detailed in the STCs) guide the scope for the evaluation:

- 1) To what extent does the program achieve better care?
- 2) To what extent does the program achieve better health?
- 3) To what extent does the program lower costs?
- 4) To what extent did the program affect hospital finances?
- 5) To what extent did stakeholders report improvement in consumer care and population health?
- 6) How do key stakeholders perceive the strengths and weaknesses of the program?

Quantitative process and outcome measures along with inputs from qualitative analyses will be utilized to independently analyze data evaluating items 1-4. A qualitative approach will answer questions 5 and 6 based on

stakeholder interviews, observations of program meetings, and review of relevant documents.

The mid-point and summative evaluation will meet all standards of leading academic institutions and academic peer review, as appropriate for both aspects of the DSRIP program evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings.

Evaluation Hypotheses and Metrics

Hypotheses and sub-hypotheses will be tested relating to specific program interventions and population-focused health improvement initiatives.

Hypothesis 1: The adoption of projects in a specific focus area (e.g., cardiac care, asthma) will result in greater improvements in those outcomes for patients in hospitals adopting these interventions compared to hospitals which do not adopt these interventions.

After hospital projects are approved and finalized, this general hypothesis can be broken down into sub-hypotheses, tailored to specific projects:

Hypothesis 1a: Rates of 30-day hospital readmissions arising from heart failure, and associated costs will decrease in hospitals adopting cardiac care interventions during the DSRIP program.

Hypothesis 1b: Rates of asthma admissions and ED visits will decrease for patients in hospitals adopting asthma management programs.

Hypothesis 2: During implementation of the DSRIP, population-based rates of potentially avoidable inpatient hospitalizations and treat-and-release emergency department visits (that reflect inadequate care) and associated costs will decrease among hospitals participating in the DSRIP.

Hypothesis 3: Hospitals which participate in the DSRIP program will improve racial/ethnic and gender disparities in avoidable hospital admissions, treat and release ED visits, and hospital readmissions.

Hypothesis 4: Hospitals which achieve their performance objectives and receive incentive payments under the DSRIP will experience no adverse impact on their finances.

Hypothesis 5: Stakeholders will report improvements in consumer care.

Hypothesis 6: Stakeholders will report improvements in population health.

Hypothesis 1 will examine the effectiveness of the individual projects by assessing hospital performance on the basis of selected metrics (See Table XI) which will be calculated for all hospitals. Calculation of project-specific metrics for all hospitals irrespective of the program chosen by them will facilitate evaluation of these programs by ensuring comparison groups. Table XII lists additional measures (relating to hypothesis 2) that reflect quality of care within the overall delivery system, such as rates of ambulatory care sensitive hospitalizations, and treatment costs at the hospital inpatient and ED care settings. These measures can be independently calculated from hospital discharge and/or claims based data for comparison with hospital-reported data. In addition, these measures will be reported for all demonstration populations, facilitating comparisons as appropriate.

Measures have been selected which can be independently calculated by the evaluator from hospital discharge and/or claims-based data and are thus available for all hospitals to facilitate comparison with hospital-reported data. Metrics that require medical charts and cannot be calculated from administrative data e.g., those related to screening for depression, are not included, since they cannot be independently calculated.

Measures are intended to reflect the effect of the intervention on the overall delivery system, e.g., readmissions or ambulatory care sensitive admissions. The measures were chosen to assess inpatient as well as ambulatory care received by patients, in contrast to much narrower inpatient process measures which are further removed from patient outcomes.

The list of metrics includes those chosen to reflect the current policy changes related to hospital financing, such as rates of all-cause readmissions from initial hospitalizations of heart failure, AMI and pneumonia. The measures of potentially avoidable inpatient hospitalizations and primary care preventable/avoidable treat-and-release ED visits will be used across all populations covered by the NJ FamilyCare Comprehensive Demonstration.

In addition, the evaluators will examine changes over the DSRIP years in up to ten (10) measures reported by hospitals or the state. For each metric, we will require the magnitude (N) of the population denominators used by each hospital as the basis for each measure in order to generate standard errors and compute statistically significant differences. The (N) refers to the actual number of the population denominator used for each measure that is required to calculate the standard errors for statistical comparisons. The ten measures chosen for evaluation reporting should not require adjustment for patient characteristics. A list of candidate measures might include:

- COPD Admission Rate
- CHF Admission Rate
- Controlling High Blood Pressure

- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women Age 21-24
- Diabetes Screening for people with schizophrenia or bipolar disorder who are prescribed with antipsychotic medications
- Measures relating to childhood immunization status; well-child visits; and access to primary care.

The final list may differ.

Table XI: Project-Specific Metrics

Stage III-Project	Metric	Data source
Asthma	Percent of patients who have had a visit to an Emergency Department (ED) for asthma in the past six months*. <i>Adult Asthma Admission Rate</i>	UB; MC UB; MC
Behavioral Health	Follow-up After Hospitalization for Mental Illness (30 days post discharge) <i>Follow-up After Hospitalization for Mental Illness (7 days post discharge)</i>	MC MC
<u>Cardiac Care</u>	30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization** <i>30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization**</i>	UB; MC UB; MC
<u>Chemical Addiction/ Substance Abuse</u>	Engagement of alcohol and other drug treatment <i>Initiation of alcohol and other drug treatment</i>	MC MC
<u>Diabetes</u>	Diabetes Short-Term Complications Admission Rate	UB; MC
HIV/AIDS	Percentage of HIV patients who had 2 or more CD4 T-cell counts performed during the measurement year	MC
<u>Pneumonia</u>	30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization	UB; MC

Notes:

Metrics adapted from the 'Catalogue of Project Specific Metrics' accompanying the DSRIP planning protocol

UB-All-payer uniform billing discharge data for inpatient stays and/or emergency department visits

MC- Medicaid Claims & Encounter Data

Some metrics reflecting outpatient services can only be calculated with Medicaid claims data

*original metric included visits to urgent care office; which cannot be identified all-payer discharge data or Medicaid claims/encounter data

Table XII: Metrics for Overall Evaluation of the DSRIP Program

Stage IV Metrics	Description	Data Source
Mental Health Utilization	The number and percentage of patients receiving inpatient mental health services during the measurement year.	UB; MC
30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization	The measure estimates a hospital-level, risk-standardized, all-cause 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Heart Failure (HF).	UB; MC
30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization	The percent of 30 day all-cause readmission rate for patients with AMI.	UB; MC
30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization	The percent of 30 day all-cause readmission rate for patients with pneumonia.	UB; MC
30-Day All-Cause Readmission Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	The percent of 30 day all-cause readmission rate for patients with COPD.	UB; MC
Hospital Acquired Potentially-Preventable Venous Thromboembolism	The number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.	MC
Rate of potentially avoidable inpatient hospitalizations reflecting inadequate level of ambulatory care. Based on AHRQ methodology for calculating Prevention Quality Indicators. ⁵⁴		UB
Rate of Primary Care Preventable/Avoidable Treat and Release ED visits. Based on methodology by John Billings, New York University. ⁵⁵		UB
Total hospital inpatient , and treat-and-release Emergency Department costs stratified by patient age and race/ethnicity		UB
Hospital Total and Operating Margin		Hospital Financial Statements

Notes:

Metrics adapted from the Catalogue of Universal Metrics accompanying the DSRIP planning protocol
 UB-All-payer uniform billing discharge data for inpatient stays and/or emergency department visits
 MC- Medicaid Claims & Encounter Data
 Some metrics reflecting outpatient services can only be calculated with Medicaid claims data

⁵⁴ Bindman AB, K Grumbach, D Osmond, M Komaromy, K Vranizan, N Lurie, J Billings, and A Stewart. "Preventable Hospitalizations and Access to Health Care." *Journal of the American Medical Association* 274, no. 4 (1995): 305–11.

⁵⁵ Billings J, N Parikh, and T Mijanovich. [Emergency Department Use: The New York Story](#). New York: Commonwealth Fund, 2000.

The qualitative methods used to gather and analyze data to address Hypotheses 5 and 6 are detailed in the section below.

ii. Data Sources and Collection

The evaluation metrics (with the exception of hospital total and operating margin) can be consistently calculated across hospitals and for the state as a whole using all-payer, uniform billing (UB) NJ hospital discharge data, or NJ Medicaid paid claims and managed care encounter data. Those measures utilizing UB data can be calculated for all payers, while those using Medicaid paid claims/encounters can be calculated for Medicaid only. UB data will be used to identify trends in hospital utilization that may differ across payers.

UB data can be obtained approximately nine months after the end of each calendar year, although the data years can be aggregated to calculate measures using time periods which span successive years, e.g. federal fiscal years or other definitions used in endorsed specifications. CSHP has had an existing arrangement with the New Jersey Department of Health, Center for Health Statistics to merge multiple years of UB data to identify patient level utilization/ readmissions over time and provide the data without personal identifiers. This will provide the ability to track patients and utilization over time. We will work with the Department of Health to obtain approval to extend this arrangement for the DSRIP evaluation. CSHP is executing a Data Use Agreement with Medicaid which will provide paid claims and encounter data every six months during the period of the evaluation. Medicaid has advised us that all claims are subject to retroactive adjustment and have suggested that CSHP apply a lag period of nine months to allow for updates to the data for the most accurate measurement of utilization, costs and payments. Use of this approach would provide consistency and comparability with other parts of the evaluation.

The baseline period for the evaluation will be calendar years 2010-2012, and UB and Medicaid data for this period is expected to be available in late 2013. UB data can be updated annually, and the latest year for which annual hospital all-payer data will be available for the evaluation is 2020. Both the standard UB and the merged readmissions data which include calendar year 2020 should be available in the third quarter of 2021. Medicaid data will be available on a six-month basis throughout the evaluation through March 2020, although the final six months of data received in the first quarter of 2021 will not be updated with retroactive adjustments.

For the summative evaluation, 2020 data is expected in the third calendar quarter of 2021. Contingent upon timely receipt of Medicaid claims data from DHS and hospital discharge data from DOH, all analyses can be completed

and a final summative report for the DSRIP can be delivered by December 31, 2021.

Rates and population denominators for the ten hospital or state reported measures selected for the evaluation should be provided to the evaluators at the time state reports are due.

Acute Care Hospital Financial Reports will be used to assess financial performance. All acute care hospitals submit these annually to the Department of Health by June 30 for the previous year. The reports are available after processing and auditing, approximately three months later.

iii. Evaluation Method and Design

The evaluation will identify the effects of the DSRIP program by measuring changes in the levels and trends of health care-related outcomes, and indicators of hospital financial performance (detailed in Tables XI and XII above) over time using comparison groups, wherever available. For this analysis, the various outcomes of interest will be analyzed at the hospital as well as patient level. The evaluation team will independently calculate all these evaluation-related measures for all hospitals using New Jersey all-payer discharge data or NJ Medicaid claims. The methods chosen will support measurement of the impact of the demonstration's interventions on the demonstration goals and sub-hypotheses, explain causal relationships, and explore the effect of other interventions in the state that may have interacted with this demonstration, such as the implementation of the Accountable Care Organizations and the effect of potential 2014 Medicaid expansion.

a. Quantitative

The evaluation will utilize a *difference-in-differences* estimation technique that examines specific performance measures in time periods *before* and *after* the implementation of the program/policy comparing DSRIP hospitals in specific programs and comparison hospitals not engaged in those interventions.

Such estimation strategy adjusts for temporal variations in outcomes, thereby distinguishing program impacts from secular trends. In order to generate comparison hospitals that are necessary to implement this approach, a selected number of project-specific metrics (see table XII) will be calculated for all hospitals using the NJ uniform billing data, or Medicaid claims, as described above. For example, trends in adult asthma admission rates will be calculated for all hospitals, comparing hospitals that selected asthma as one of the focus areas to those which did not. For both sets of hospitals, those with interventions for management of asthma

and the comparison groups, we will use a baseline/pre-intervention period of 3 years over 2016-2018.

For the measures used to evaluate all DSRIP hospitals, NJ-based comparison hospitals will be unavailable (unless some hospitals decline to participate in DSRIP). For those measures, segmented regression analysis/interrupted time series modeling will be used to allow inferences about DSRIP impact. Interrupted time series modeling will also be used to identify the effect of DSRIP on financial performance of hospitals. We will use operating margin, total margin and other indicators of financial performance that will be available to assess hospital finances. Our estimation procedures will be conducted using standard inferential statistical techniques employing STATA 12.1 or SAS 9.2 software.

The evaluation questions will involve calculation and examination of performance metrics for individual hospitals – comprising intervention and comparison groups. All these rates will be stratified by race/ethnicity and age. Because of the diversity of the NJ population, we expect to find differences in the effect of the DSRIP program among demographic groups and we will document these differences.

We also will replicate the statistical analysis for these subpopulations of hospital patients to further identify the effects of the intervention within patient groups classified by these demographic characteristics to the extent that sample sizes permit. Finally, we will examine the metrics for all payers combined and also, where supported by the data, separately for Medicaid patients. Hospital-level trends will also be compared to benchmark statewide trends. For population-based measures (e.g., adult asthma discharge rate), we will define market catchment areas for each hospital defined as the smallest number of zip codes accounting for 80% of the respective hospital's total inpatient admissions. Age-sex adjustment, whenever appropriate, will be applied in calculating these measures. We will also review hospital-reported data relating to our selected evaluation metrics for accuracy and consistency in measurement across hospitals.

b. Qualitative

To address research questions 5 and 6, assessing stakeholder perceptions, the evaluation team will develop interview protocols and web surveys to gather views of stakeholder perceptions about DSRIP program effectiveness in improving access, quality of care, and population health outcomes.

Qualitative data will be collected in two phases. Information from phase 1 will be utilized to enhance and expand quantitative findings for the mid-

point assessment, and information from phase 2 will be added to phase 1 for the summative evaluation:

Phase 1) Stakeholder feedback about the successes and challenges of the DSRIP program, to be collected January 2020 to April 2020.

The summative evaluation will utilize key informant interviews and a web survey, as well as the analysis of information from hospital projects, such as program materials, community outreach materials, and presentations. The evaluation team will also review planning and implementation documents and reports from participating hospitals to provide background for the stakeholder feedback. Our reports will draw on the monitoring and award information as we fully describe DSRIP activities and outcomes. Interview and survey protocols will be approved by the Rutgers University Institutional Review Board, and interviewers will be trained to ensure privacy and confidentiality.

Key informant interviews will be conducted with officials from the Department of Health and the Department of Human Services, as well as executives who served on the DSRIP steering committee from the New Jersey Hospital Association, and the Hospital Alliance of New Jersey. If any acute-care hospitals do not participate in the DSRIP Program, we will seek key informant interviews with representatives of those hospitals. Interviews will also be conducted with representatives from hospitals' community partners to obtain viewpoints about expected benefits and unanticipated consequences for patients and families.

Interviewers will use a semi-structured guide containing key questions to ensure data collection consistency while allowing for follow-up questions and probes to elicit more in-depth responses to the primary questions. Data from key informant interviews will be transcribed and de-identified, then independently coded by two researchers to identify themes and patterns in the data. Ongoing analysis of completed interviews will inform subsequent interviews.

A web survey will be developed, informed by a review of the approved DSRIP project plans and information from the key informant interviews. The survey will be administered to a purposive sample of clinical, administrative, and financial leadership from all participating hospitals. Hospitals will provide valid contact information. In addition to the topics noted, questions may include asking about previous activities relating to the hospital's focus area, approaches to enrolling patients, responses from different groups within the community, unexpected successes, and recommendations for other hospitals. Advance communication about the survey will be sent in collaboration with the Department of Health and the

hospital associations. Two follow-ups will be sent in addition to the original distribution of the surveys.

Data from the web survey will be analyzed using statistical software for closed-ended questions and items which can be coded into simple categories. If open-ended questions requiring complex responses are used, these responses will be analyzed along with the key informant data.

For the summative evaluation, the primary objectives will be to gather information regarding the following questions, along with others which will emerge during the implementation of the DSRIP:

- What improvements in health care were made as a result of the DSRIP projects?
- Which community/patient groups benefitted most?
- What new clinical partnerships were developed?
- What new community partnerships were developed?
- What difficulties were encountered during the DSRIP implementation?
- How were difficulties addressed? Which strategies were most successful?
- How did community members react to the DSRIP project? Were there different reactions from different parts of the community?
- What problems or improvements in consumer care have been noted in your community?
- What problems or improvements in the health of specific population groups have been noted in your community?
- What help was provided by the Learning Collaborative? What could have made the Learning Collaborative more successful?
- Were there unanticipated consequences in hospital operations, other programs, or financial status?

Key informant interviews will be conducted with community advocates, officials from the Department of Health and the Department of Human Services, staff of the Learning Collaborative, and members of the DSRIP steering committee. The information from these interviews will inform the development of the web survey.

A web survey will be developed to gather information about implementation of DSRIP over time, experiences with the Learning Collaborative, successes achieved by DSRIP projects, and suggestions for improvement. As in phase 1, the survey will be administered to a purposive sample of clinical, administrative, and financial leadership from all participating hospitals.

Data from key information interviews and web surveys will be analyzed in

accordance with the methods shown above, and the summative review will be completed by August 31, 2021.

iv. Evaluation Reports and CMS Opportunity to Comment

For the summative evaluations, CMS will have 60 days to review and comment before they are made final. The evaluation contractor shall not be required to accept comments by the Department or CMS challenging the underlying methods or results, to the extent that the contractor finds such comments inconsistent with applicable academic standards for such analyses, interpretation and reporting. Final reports will be submitted to CMS within 60 days after CMS has submitted its comments to the Department. Draft versions of reports related to the midpoint and summative evaluations will not be routinely released, except as required by state and federal law.

Data and findings resulting from all stages of the evaluation will be publicly shared as part of the Department's commitment to feedback and continuous improvement. Key pathways for dissemination and use of the evaluation findings beyond the required reporting to CMS include:

- Posting to publicly available websites
- Making copies of the mid-point and summative evaluations available to the Quality & Measures Committee

Prior to July 1, 2022 (two years after the end of the demonstration), or 12 months from the date that the final reports for these evaluations are provided to CMS (if later), CMS will be notified prior to the release or presentation of these reports, and related journal articles, by the evaluator or any other third party. For this same period of time, and prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. For this same period, CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline to review, some or all, of these notifications and reports.

NJ agrees that, when draft and final summative evaluation reports are due, CMS may issue deferrals in the amount of \$5,000,000 (federal share) for any such reports that are not provided timely to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS. *CMS will rescind the deferral of payment when New Jersey has accepted the summative report and New Jersey may then claim Federal Financial Payments [FFP].*

State of New Jersey

Departments of Health and
Human Services

NJ FamilyCare Comprehensive
Demonstration

Delivery System Reform
Incentive Payment [DSRIP]

Funding and Mechanics Protocol
State Fiscal Years 2018-2020
Demonstration Years 6-8

Version 1.1
January 31, 2019

Special Terms and
Conditions
Section IX

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I. Preface

A. DSRIP Planning Protocol and Program Funding and Mechanics Protocol

This document is the DSRIP Funding and Mechanics Protocol submitted for approval by the New Jersey Department of Human Services (Department) to the Centers for Medicare & Medicaid Services (CMS). This document is Version 1.1, dated January 31, 2019.

Unless otherwise specified, denoted dates refer to calendar days, and any specified date that falls on a weekend or federal holiday is due the subsequent business day.

B. High Level Organization of “H. Program Funding and Mechanics Protocol”

Program Funding and Mechanics Protocol Attachment H has been organized into the following sections.

- I. Preface
- II. Hospital DSRIP Plans
- III. Reporting Requirements
- IV. Hospital’s DSRIP Target Funding Amount
- V. Allocation of Hospital’s Adjusted DSRIP Target Funding Amount to DSRIP Stages
- VI. DSRIP Payment Based on Achievement of Milestones and Metrics
- VII. DSRIP Payment Calculations
- VIII. Mergers, Acquisitions, and Business Combinations
- IX. Program Management and Modification

C. DSRIP Eligibility Criteria

Hospitals eligible to receive funding under the DSRIP program during Demonstration Year (DY) 6 through DY8 are general acute care hospitals shown in the table below. Hospitals electing to discontinue participation in any demonstration years are subject to payment recoupment back to the start of the demonstration year and including any appeal adjustments from prior years the hospital elected to discontinue participation. Hospitals electing to not participate or discontinue participation are not eligible for further participation in the DSRIP program.

Table I. PARTICIPATING HOSPITALS ELIGIBLE FOR DSRIP PAYMENTS

Medicaid No.	Medicare No.	Hospital Name	County
3676803	310108	Anthony M Yelencsics JFK Medical Center	Middlesex
4139402	310064	AtlantiCare Regional Medical Center	Atlantic
4139003	310058	Bergen Regional Medical Center	Bergen
0167011	310025	CarePoint Health - Bayonne Medical Center	Hudson
0295655	310016	CarePoint Health - Christ Hospital	Hudson
0267431	310040	CarePoint Health - Hoboken University Medical Center	Hudson
3676609	310092	Capital Health Regional Medical Center	Mercer
4138201	310044	Capital Health Medical Center - Hopewell	Mercer
4141008	310111	CentraState Medical Center	Monmouth
0390330	310017	Chilton Medical Center	Morris
4135504	310009	Clara Maass Medical Center	Essex
3674606	310041	Community Medical Center	Ocean
4136004	310014	Cooper University Health Care	Camden
0502588	310083	East Orange General Hospital	Essex
4138309	310045	Englewood Hospital and Medical Center	Bergen
3674100	310001	Hackensack University Medical Center	Bergen
4135105	310003	HMH Palisades Medical Center	Hudson
3675602	310069	Inspira Medical Center Elmer	Salem
3674509	310032	Inspira Medical Center Vineland	Cumberland
3676102	310081	Inspira Medical Center Woodbury	Gloucester
4140206	310086	Jefferson Health New Jersey	Camden
4139801	310074	Jersey City Medical Center	Hudson
3675700	310073	Jersey Shore University Medical Center	Monmouth
3675203	310061	Lourdes Medical Center of Burlington Cty.	Burlington
3675807	310075	Monmouth Medical Center	Monmouth
0469351	310084	Monmouth Medical Center - Southern	Ocean
4136101	310015	Morristown Medical Center	Morris
4135008	310002	Newark Beth Israel Medical Center	Essex
0257109	310028	Newton Medical Center	Sussex
4137108	310029	Our Lady of Lourdes Medical Center	Camden
3674801	310051	Overlook Medical Center	Union
4135601	310010	Penn Medicine Princeton Medical Center	Middlesex
4137809	310039	Raritan Bay Medical Center	Middlesex
4137701	310038	Robert Wood Johnson University Hospital	Middlesex
3676901	310110	RWJ University Hospital Hamilton	Mercer
3675904	310076	St. Barnabas Medical Center	Essex

0482897	310050	St. Clare's Health System	Morris
4136608	310021	St. Francis Medical Center	Mercer
4136403	310019	St. Joseph's Hospital and Medical Center	Passaic
0432491	310006	St. Mary's General Hospital	Passaic
0508110	310096	St. Michael's Medical Center	Essex
4139500	310070	St. Peter's University Hospital	Middlesex
4136900	310027	Trinitas Regional Medical Center	Union
0358240	310119	University Hospital	Essex
4138902	310057	Virtua Memorial Hospital of Burlington County	Burlington
3674304	310022	Virtua West Jersey Health System	Camden
Hospital Count	46	Participating Hospitals	

II. Hospital DSRIP Plans

A. Hospital DSRIP Plans

Hospitals participating in the NJ DSRIP program during DY6 through DY8 are required to continue with the DSRIP project and project plan approved by NJ and CMS for DSRIP DYs 2 through 5. Project plans may be amended as part of the annual application renewal, however hospitals are not permitted to change projects during DY6 through DY8.

B. NJ Pre-defined menu of Focus Areas

A pre-defined list of projects has been developed to move the cost and quality curve for eight prevalent or chronic conditions, or Focus Areas, listed in the Special Terms and Conditions [STCs]. These Focus Areas are as follows:

- 1) Asthma
- 2) Behavioral Health
- 3) Cardiac Care
- 4) Chemical Addiction/Substance Abuse
- 5) Diabetes
- 6) HIV/AIDS
- 7) Obesity
- 8) Pneumonia

As part of the renewal applications in DY7 and DY8 hospital renewal plans will need to comply with NJ FamilyCare Comprehensive Demonstration STCs, the NJ DSRIP Planning Protocol and the NJ DSRIP Funding and Mechanics Protocol.

Table II. Participating DSRIP Hospitals, Focus Area, and Projects

Participating DSRIP Hospitals	Focus Area	Project Name
Anthony M. Yelesics JFK Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
AtlantiCare Regional Medical Center	DIABETES	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension
Capital Health Medical Center - Hopewell	OBESITY	After School Obesity Program
Capital Health Regional Medical Center	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
CarePoint Health - Bayonne Medical Center	CARDIAC CARE	Extensive Patient CHF-Focused Multi-Therapeutic Model
CarePoint Health - Hoboken University Medical Center	CARDIAC CARE	Extensive Patient CHF-Focused Multi-Therapeutic Model
CarePoint Health - Christ Hospital	CARDIAC CARE	Extensive Patient CHF-Focused Multi-Therapeutic Model
CentraState Medical Center	DIABETES	Diabetes Group Visits for Patients and Community Education
Chilton Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Clara Maass Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Community Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Cooper University Health Care	DIABETES	Diabetes Group Visits for Patients and Community Education
East Orange General Hospital	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Englewood Hospital and Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Hackensack University Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
HMH Palisades Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Inspira Medical Center Elmer	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
Inspira Medical Center Vineland	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
Inspira Medical Center Woodbury	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
Jefferson Health New Jersey	DIABETES	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension
Jersey City Medical Center	ASTHMA	Pediatric Asthma Case Management and Home Evaluations
Jersey Shore University Medical Center	ASTHMA	Pediatric Asthma Case Management and Home Evaluations
Lourdes Medical Center of Burlington County	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Monmouth Medical Center	BEHAVIORAL	Integrated Health Home for the Seriously Mentally Ill (SMI)

Participating DSRIP Hospitals	Focus Area	Project Name
	HEALTH	
Monmouth Medical Center Southern Campus	BEHAVIORAL HEALTH	Integrated Health Home for the Seriously Mentally Ill (SMI)
Morristown Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Newark Beth Israel Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Bergen Regional Medical Center	BEHAVIORAL HEALTH	Electronic Self-Assessment Decision Support Tool
Newton Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Our Lady of Lourdes Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Overlook Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Penn Medicine Princeton Medical Center	DIABETES	Diabetes Group Visits for Patients and Community Education
Raritan Bay Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Robert Wood Johnson University Hospital	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
RWJ University Hospital Hamilton	PNEUMONIA	Patients Receive Recommended Care for Community-Acquired Pneumonia
St. Barnabas Medical Center	ASTHMA	Hospital-Based Educators Teach Optimal Asthma Care
St. Clare's Health System	BEHAVIORAL HEALTH	Electronic Self-Assessment Decision Support Tool
St. Francis Medical Center	DIABETES	Diabetes Group Visits for Patients and Community Education
St. Joseph's Hospital and Medical Center	ASTHMA	Hospital-Based Educators Teach Optimal Asthma Care
St. Mary's General Hospital	CARDIAC CARE	Extensive Patient CHF-Focused Multi-Therapeutic Model
St. Michael's Medical Center	DIABETES	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension
St. Peter's University Hospital	DIABETES	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension
Trinitas Regional Medical Center	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
University Hospital	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Virtua Memorial Hospital of Burlington County	DIABETES	Diabetes Group Visits for Patients and Community Education
Virtua West Jersey Health System	DIABETES	Diabetes Group Visits for Patients and Community Education

Hospitals participating in the NJ DSRIP program during DY6 through DY8 are required to continue with the DSRIP project and project plan approved by NJ and CMS for DSRIP DYs 2 through 5. While the project plan may be amended as part of the annual application renewal, hospitals are not permitted to change projects during DY6 through DY8.

III. Reporting Requirements

A. Participating Hospital Reporting for Payment in DY6-DY8

i. *Annual DY6-DY8 DSRIP Application Renewal*

- For participation in DSRIP in DY6-DY8, the hospital will be required to submit an annual DSRIP Application Renewal that must be approved by NJ and CMS as noted below.

- DY6: Annual DSRIP Application Renewal due 60 calendar days from the Issuance of the DY6-DY8 Funding and Mechanics Protocol.
 - DY7: Annual DSRIP Application Renewal due April 30, 2018
 - DY8: Annual DSRIP Application Renewal due April 30, 2019
- Each Annual DSRIP Application Renewal for DY6-DY8 will include the following:
- Hospital's notification of intent to continue in the DSRIP Program.
 - Indication of any changes or modifications that are required to be made to the DSRIP Plan in order to continue participation
 - Annual Status Report outlining the hospital's progress in the current demonstration year.
 - Updated annual project budget analysis demonstrating the hospital budget is equal to or greater than 80% of the applicable demonstration year initial funding target.

ii DSRIP Progress Report Submission for DY6

Two times per year in DY6, participating hospitals seeking payment under the DSRIP program must submit progress reports to the Department demonstrating progress on their project as measured by stage-specific activities/milestones and metrics achieved during the reporting period. The reports must include all supporting data and back-up documentation.

Two times per year in DY6, reports must be submitted using the standardized reporting form approved by the Department and CMS to collect performance measure reporting.

Based on these reports, participating hospitals must earn DSRIP payments, calculated by the Department, based on meeting performance metrics as prescribed in Section VI: "DSRIP Payment Based on Achievement of Milestones and Metrics." Submitted progress reports must include:

- The progress of each process metric
- The progress of all current and planned activities, including whether the stage activity has been completed, is in progress, or has not been started
- Documentation supporting the completion of milestones during the report period
- The project developments and outcomes as they relate to the project populations
- How rapid-cycle evaluation was used for improvement
- Summary of the hospital's stakeholder engagement and activities

- Work accomplished with external partners
- How the project tools and processes were modified based on the pilot testing results
- A timeline of future activities
- Budget and return on investment analysis in the format prescribed by the NJ Department of Health

These reports will be due as indicated below at the end of each reporting period. These reports must include Stage 3 and 4 non-claims based performance metrics data, as well as acknowledgement of the Department provided claims-based performance metrics data:

- **DY6 Progress Report 1:** This report is due no later than **January 31, 2018** and must include the following,
 - List of Stage 1 and 2, if applicable, activities completed during the experience period **April 1, 2017 through September 30, 2017.**
 - Documentation to support the completion of Stage 1 and/or Stage 2, if applicable, milestones/metrics reported as completed on the DY6 Progress Report 1.
- **DY6 Progress Report 2:** This report is due no later than **April 30, 2018** and must include the following,
 - List of Stage 1 and 2 activities, if applicable, completed during the experience period **October 1, 2017 through March 31, 2018.**
 - List of Stage 1 and 2 activities, if applicable, completed during the experience period **October 1, 2017 through March 31, 2018**, but not otherwise claimed as completed in current DY Progress Report 1
 - Documentation to support the completion of Stage 1 and/or Stage 2, if applicable, milestones/metrics reported as completed on the current DY Progress Report 2 Stage 3 Quality Improvement and Stage 4 Population Focused Improvement metrics for the experience period listed for each metric in the DSRIP Planning Protocol Addendums 1 and 2.
 - To include both non-claims based metrics and claims based metrics provided by the Department and acknowledged by the hospital
 - For DY6 if the hospital fails to submit the metrics by the deadline, the funding must be considered not earned and forfeited.

iii DSRIP Progress Report Submission for DY7-DY8

Two times per year in DY7 and DY8, participating hospitals seeking payment under the DSRIP program must submit progress reports to the Department demonstrating progress on their project as measured by stage-specific activities/milestones and metrics achieved during the

reporting period. The reports must include all supporting data and back-up documentation. Reports must be submitted using the standardized reporting form approved by the Department and CMS to collect performance measure reporting.

Based on these reports, participating hospitals must earn DSRIP payments, calculated by the Department, based on meeting performance metrics as prescribed in Section VI: “DSRIP Payment Based on Achievement of Milestones and Metrics.” Submitted progress reports must include:

- Documentation supporting the completion of milestones during the report period
- The project developments and outcomes as they relate to the project populations
- How rapid-cycle evaluation was used for improvement
- Summary of the hospital’s stakeholder engagement and activities
- Work accomplished with external partners
- How the project tools and processes were modified based on the pilot testing results
- A timeline of future activities
- Budget and return on investment analysis in the format prescribed by the NJ Department of Health

These reports will be due as indicated below at the end of each reporting period. These reports must include non-claims based performance metrics data for all applicable stages, as well as acknowledgement of the Department provided claims-based performance metrics data:

- **DY7 Progress Report 1:** This report is due no later than **October 31, 2018.**
- **DY7 Progress Report 2:** This report is due no later than **April 30, 2019** and must include the following,
 - List of Stage 1, 2, and 3 measures, if applicable, completed during the measurement period **January 1, 2018 through December 31, 2018.**
- **DY8 Progress Report 1:** This report is due no later than **October 31, 2019.**
- **DY8 Progress Report 2:** This report is due no later than **April 30, 2020** and must include the following,
 - List of Stage 1, 2, and 3 measures, if applicable, completed during the measurement period **January 1, 2019 through December 31, 2019.**

For DY6, any DSRIP funds tied to Stage 1 or 2 activities that were targeted to be completed between the period April 1 of the prior DY

through March 31 of the current DY, but were not otherwise reported as having been completed during that period in Progress Report 2, will be forfeited and moved to the UPP to be redistributed. Semi-annual activities must be completed in the designated reporting period or funding tied to such activities will be forfeited and moved to the UPP to be redistributed. See section VII, subsection C, “DSRIP Universal Performance Pool” for more information.

For DY6, all Stage 3 measures, whether a pay for performance metric or not, are required to be reported for release of any Stage 3 pay for performance funding. If any Stage 3 metric, including Stage 3 replacement metrics, is not reported when required, all Stage 3 funding for the DY will be forfeited and moved to the UPP. If pay for performance is not met on a Stage 3 pay for performance metric, funding for the metric will be forfeited and moved to the UPP to be redistributed.

In DY7-DY8, hospital organizations are eligible to earn funding on the Stage 1 measures that they report as completed in a measurement period. For measures not reported as having been completed during a measurement period in Progress Report 2, associated measure-specific funding will be forfeited and moved to the UPP to be redistributed.

In DY7-DY8, all Stage 2 and 3 measures, whether pay for performance or pay for reporting, are required to be reported for release of funding allocated to each stage. If any Stage 2 or 3 measures are not reported when required, funding allocated to that stage for the DY will be forfeited and moved to the UPP. If pay for performance is not met on any Stage 2 or 3 pay for performance metric, funding for the measure will be forfeited and moved to the UPP to be redistributed.

Once the report is accepted by the Department, the Department and CMS will have a total of 60 business days to review and approve or request additional information regarding the data reported for each milestone/metric and measure. Initial approval will be completed by the Department before submission to CMS, which will occur no later than 30 calendar days following the Department’s acceptance of the report. If additional information is requested, the participating hospital must respond within 15 calendar days and both the Department and CMS will have an additional 15 business days to concurrently review, approve, or deny the request for payment, based on the data provided.

- In DY8, the final Progress Report reporting submission deadline and review period may be accelerated to ensure that all DSRIP monies,

including the UPP payment, will be paid as soon as possible after the end of the final demonstration year after all demonstration year appeals have been adjudicated by NJ and CMS.

B. State Reporting and Communications with CMS

The state will have a process in place to ensure there is no duplication of federal funding for any aspect of the demonstration.

IV. Hospital’s DSRIP Target Funding Amount

A. DY6-DY8

If a hospital elects to discontinue participation in DY6-DY8, such hospitals are subject to payment recoupment back to the start of the demonstration year the hospital elected to discontinue participation and may include payment adjustments related to adjudicated appeals.

B. Table III Participating DSRIP Hospitals: Funding Targets

For DY6-DY8 the funding target for each participating hospital is shown in table III:

Table III Participating DSRIP Hospital	Annual DY6-DY8 Funding Target	Annual DY6-DY8 UPP Carve-out (25%)	Annual DY6- DY8 Adjusted Funding Target
Anthony M. Yelesics JFK Medical Center	\$408,104	\$102,026	\$306,078
AtlantiCare Regional Medical Center	\$6,676,138	\$1,669,034	\$5,007,103
Bergen Regional Medical Center	\$14,046,927	\$3,511,732	\$10,535,195
Capital Health Medical Center – Hopewell	\$1,898,860	\$474,715	\$1,424,145
Capital Health Regional Medical Center	\$3,535,341	\$883,835	\$2,651,505
CarePoint Health - Bayonne Medical Center	\$250,000	\$62,500	\$187,500
CarePoint Health - Christ Hospital	\$2,203,816	\$550,954	\$1,652,862
CarePoint Health - Hoboken University Medical Center	\$1,053,708	\$263,427	\$790,281
CentraState Medical Center	\$425,804	\$106,451	\$319,353
Chilton Medical Center	\$250,000	\$62,500	\$187,500
Clara Maass Medical Center	\$2,755,066	\$688,766	\$2,066,299
Community Medical Center	\$452,606	\$113,152	\$339,455
Cooper Hospital University Health Care	\$6,122,062	\$1,530,515	\$4,591,546
East Orange General Hospital	\$2,687,750	\$671,937	\$2,015,812
Englewood Hospital and Medical Center	\$404,564	\$101,141	\$303,423
Hackensack University Medical Center	\$1,479,694	\$369,923	\$1,109,770
HMH Palisades Medical Center	\$897,627	\$224,407	\$673,220
Inspira Medical Center Elmer	\$250,000	\$62,500	\$187,500
Inspira Medical Center Vineland	\$4,350,233	\$1,087,558	\$3,262,675

Inspira Medical Center Woodbury	\$763,136	\$190,784	\$572,352
Jefferson Health New Jersey	\$6,402,389	\$1,600,597	\$4,801,791
Jersey City Medical Center	\$7,596,119	\$1,899,030	\$5,697,089
Jersey Shore University Medical Center	\$3,529,681	\$882,420	\$2,647,260
Lourdes Medical Center Burlington County	\$2,047,576	\$511,894	\$1,535,682
Monmouth Medical Center	\$7,642,526	\$1,910,631	\$5,731,894
Monmouth Medical Center Southern Campus	\$4,969,597	\$1,242,399	\$3,727,198
Morristown Medical Center	\$451,595	\$112,899	\$338,696
Newark Beth Israel Medical Center	\$12,336,508	\$3,084,127	\$9,252,381
Newton Medical Center	\$250,000	\$62,500	\$187,500
Our Lady of Lourdes Medical Center	\$2,428,853	\$607,213	\$1,821,640
Overlook Medical Center	\$264,483	\$66,121	\$198,363
Penn Medicine Princeton Medical Center	\$298,872	\$74,718	\$224,154
Raritan Bay Medical Center	\$2,444,506	\$611,126	\$1,833,379
Robert Wood Johnson University Hospital	\$3,927,127	\$981,782	\$2,945,345
RWJ University Hospital Hamilton	\$250,000	\$62,500	\$187,500
St. Barnabas Medical Center	\$462,214	\$115,554	\$346,661
St. Clare's Health System	\$5,530,996	\$1,382,749	\$4,148,247
St. Francis Medical Center	\$1,250,987	\$312,747	\$938,240
St. Joseph's Hospital and Medical Center	\$10,705,204	\$2,676,301	\$8,028,903
St. Mary's General Hospital	\$2,302,211	\$575,553	\$1,726,659
St. Michael's Medical Center	\$6,635,156	\$1,658,789	\$4,976,367
St. Peter's University Hospital	\$4,532,171	\$1,133,043	\$3,399,128
Trinitas Regional Medical Center	\$9,421,729	\$2,355,432	\$7,066,297
University Hospital	\$13,516,857	\$3,379,214	\$10,137,643
Virtua West Jersey Health System	\$887,512	\$221,878	\$665,634
Virtua Memorial Hospital of Burlington County	\$710,516	\$177,629	\$532,887
Total Statewide	\$161,706,819	\$40,426,704	\$121,280,115

The UPP allows for greater rewards to hospitals that meet or improve their universal performance metrics. The carve-out amount for the UPP will be 25% of the Annual Funding Target as shown above. Funds in the UPP will be distributed to qualifying hospitals using the formula described in Section VII, subsection C. i., “DSRIP Universal Performance Pool” below.

V. Allocation of Hospital’s Adjusted DSRIP Target Funding Amount to DSRIP Stages

For DY6-DY8, the DSRIP Target Funding Amount less the UPP carve out will be distributable only as shown in Table V, below:

Table IV. TOTAL DSRIP FUNDING DISTRIBUTABLE TO DEMONSTRATION YEARS

<i>In Thousands</i>	DY6
DSRIP Target Funding	\$166,600
Total Demonstration Year Funding	\$166,600
Less: Not Participating Hospitals	\$ 4,893
<hr/>	
DSRIP Target Funding	\$161,707
	25%
Less UPP "Carve Out"	\$40,426.8
Adjusted DSRIP Target Funding Amount	\$121,280
Total Distributable Amount for Stages 1-4	\$121,280

<i>In Thousands</i>	DY7	DY8
DSRIP Target Funding	\$166,600	\$166,600
Total Demonstration Year Funding	\$166,600	\$166,600
Less: Not Participating Hospitals	\$ 4,893	\$ 4,893
<hr/>		
DSRIP Target Funding	\$161,707	\$161,707
	25%	25%
Less UPP "Carve Out"	\$40,426.8	\$40,426.8
Adjusted DSRIP Target Funding Amount	\$121,280	\$121,280
Total Distributable Amount for Stages 1-3	\$121,280	\$121,280

Based on the above table, the Total Distributable Amount for all Stages are then further allocated to each stage as follows in table VI:

Table V. DSRIP STAGE FUNDING DISTRIBUTION

DY6

Stage	Payment Allocation %	Payment Allocation
Stage 1 & 2	25%	\$ 30,320,500
Stage 3	50%	\$ 60,640,000
Stage 4	25%	\$ 30,320,500
Total	100%	\$121,280,000

DY6 pay-for performance is 63% of annual funding

DY7-DY8

Stage	Payment Allocation %	Payment Allocation
Stage 1	25%	\$ 30,320,500
Stage 2	50%	\$ 60,640,000
Stage 3	25%	\$ 30,320,500
Total	100%	\$121,510,000

DY7-DY8 pay-for performance is 72% of annual funding.

VI. DSRIP Payment Based on Achievement of Milestones and Metrics

A. General Requirements

As described in the NJ DSRIP Planning Protocol, a DSRIP participating hospital has been approved for one project, from a menu of projects based on eight focus areas. Hospitals are encouraged to use innovative and value-driven approaches in accomplishing the project activities.

B. Milestone and Measure Valuation

For each action/milestone associated with a stage activity, the participating hospital will include in the hospital's progress reports the progress made in completing each metric associated with the milestone. Hospitals must fully achieve a metric in order to receive payment (i.e., no payment for partial completion). These metrics will be valued as follows:

DY6

*i. **DY6 Stage 1: Infrastructure Development***

Activities in this stage will develop the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services. Each milestone/metric targeted for completion in the demonstration year's Stage 1 experience period will be valued equally.

Stage 1 activities targeted for completion within the demonstration year's Stage 1 experience period must be completed within that timeframe for payment. All Stage 1 semi-annual activities must be completed by the targeted completion date for each semi-annual report. A hospital completing a Stage 1 activity which was targeted for the current demonstration years' experience period but was completed in a subsequent demonstration years' experience period, will not achieve payment for this activity. Stage 1 infrastructure development should be complete by DY6 unless proposed by a hospital as part of its renewal application and approved by NJ and CMS.

*ii. **DY6 Stage 2: Chronic Medical Condition Redesign and Management***

Activities in this stage include testing, and replicating of chronic patient care models. Each milestone/metric targeted for completion in the demonstration year's Stage 2 experience period will be valued equally.

All Stage 2 activities targeted for completion within the demonstration year's Stage 2 experience period must be completed within that timeframe for payment. All Stage 2 activities must be completed by the targeted completion date for each semi-annual reporting period. A hospital completing a stage which was targeted for the current demonstration years' experience period but was completed in a subsequent demonstration years' experience period will not achieve payment for this activity.

iii. DY6 Stage 3: Quality Improvement

Stage 3 measures the clinical performance of the hospital's DSRIP project and thus, valuation of this stage will be based on achieving expected performance improvement target goals for clinical (Stage 3) measures. For DY6, Stage 3 valuation will be equally based on performance as described in Section VII, subsection B, "Calculating DSRIP Payments for Stage 3 Project-Specific Metrics" below. If a measure is reported more frequently than annually or pay for performance is determined more frequently than annually by the Department, the measure's valuation will be divisible by the frequency.

iv. DY6 Stage 4: Population Focused Improvements

Activities in this stage include reporting measures across several domains selected by the Department based on community readmission rates and hospital acquired infections, which will allow the impact of activities performed under Stages 1 through 3 to be measured, and may include: patient experience; care outcomes; and population health. Pursuant to the STC, all hospitals are expected to report Stage 4 DSRIP Performance Indicators selected by the Department and CMS Performance Indicators data will be due with the submission of each progress report.

Valuation of metrics included in Stage 4 will be equally funded based on reporting Stage 4 universal measures. If a measure is reported more frequently than annually, the measure's valuation will be divisible by the frequency. If a Stage 4 measure is not reported according to reporting requirements, the valuation of that measure will be considered forfeited and moved to the UPP to be redistributed.

DY7-DY8

v. DY7-DY8 Stage 1: System Transformation Measures

System transformation measures will develop the foundations for future delivery systems aimed at improving access to care, integrated care across health care providers, and improved health care outcomes.

System transformation measures will consist of 10 measures selected by NJ and approved by CMS. These measure results will be reported by hospitals annually.

All Stage 1 measures must be reported by the targeted completion date for each annual report. A hospital completing a Stage 1 activity which was targeted for the current demonstration years' experience period but was completed in a subsequent demonstration years' experience period, will not achieve payment for this activity. This Stage is all pay for reporting.

*vi. **DY7-DY8 Stage 2: Quality Improvement***

Stage 2 measures the clinical performance of the hospital's DSRIP project and thus, valuation of this stage will be equally based on achieving expected improvement target goals for clinical (Stage 2) measures used for DY7-DY8, Stage 2 valuation will be based on performance as described in Section VII, subsection B, "Calculating DSRIP Payments for Stage 2 Project-Specific Metrics" below. Starting in DY7, all hospitals are required to have at least three P4P Quality Improvement (Stage 2) measures.

*vii. **DY7-8 Stage 3: Population Focused Improvements***

Activities in this stage include reporting measures across several domains selected by the Department based on community readmission rates and hospital acquired infections, which will allow the impact of activities performed under Stages 1 and 2 to be measured, and may include: patient experience; care outcomes; and population health. Pursuant to the STCs, Stage 3 measures will consist of a combination of pay-for-reporting and pay-for-performance measures. At least 50% of funding allocated to Stage 3 must be attributed to pay for performance.

Stage 3 population focused improvement measures will consist of at least 50% pay-for-performance measures, where there is significant opportunity for improvement, and at the most, 50% pay-for-reporting measures. All pay-for-reporting and pay-for performance measures will be selected by NJ and approved by CMS.

Pay-for-performance measure selection priority must be measures where there is significant opportunity for improvement, MMIS measures, and measures with statistically reliable data. Measure selection by NJ and approved by CMS is an integral part of the Stage 3 program design and therefore not appealable by hospitals.

Valuation of metrics included in Stage 3 will be equally funded for reporting and performance in Stage 3 universal measures.

C. Experience Period

The experience period for completing a milestone/measure will vary from the demonstration year period due to such factors as reporting, review, and claims lag. The activity must be completed within a given demonstration year, but for payment to occur before the demonstration year ends, reporting and review time must be factored in for the hospital, the Department, and CMS. Although some activities must be completed by a specified date, the following time periods may be used as a guide.

Table VI. DSRIP TIME PERIODS BY DEMONSTRATION YEAR

Period	Significance	6		7		8	
		Begin	End	Begin	End	Begin	End
Demonstration Year	<u>Contractual year:</u> Governs NJ-CMS obligations	7/1/17	6/30/18	7/1/18	6/30/19	7/1/19	6/30/20
Experience Period	<u>Operational year:</u> Used by hospitals for project planning and progress reporting	4/1/17	3/31/18	4/1/18	3/31/19	4/1/19	3/31/20
Measurement Period	<u>Measurement year:</u> Used by hospitals and partners for data collection and measurement	1/1/17	12/31/17	1/1/18	12/31/18	1/1/19	12/31/19

Since Quality Improvement and Population Focused Improvements are based on metric reporting/performance, experience periods will vary from metric to metric, depending on the technical specifications and on whether the metric is reported annually or semi-annually. Specific experience periods for Quality Improvement and Population Focused Improvement metrics will be included in the databook, along with the required reporting period (annual/semi-annual).

D. Reporting Completion of Measures/Milestones

In the hospital's DSRIP Plan, the hospital will be required to indicate the targeted date of completion for certain DY6 activities in Stage 1 and Stage 2. Hospitals will be required to report the progress of completing these activities in periodic progress reports. Minimum submission requirements for each milestone/metric are documented in the Planning Protocol, Attachment A: Toolkit. Payment for completion of a milestone/metric will not be made for incomplete submissions. Completion of DY6 Stage 1 and

Stage 2 milestone/metric must be included in semi-annual progress reports. DY6-DY8 Quality Improvement and Population Focused Improvement measures must be reported in the semi-annual progress reports on either an annual or semi-annual basis, depending on the measure. See III. Reporting Requirements, above, for further reporting requirements.

VII. DSRIP Payment Calculations: DY6-DY8

Hospitals will receive DSRIP payments based on expected completion of activities and measurement performance. The frequency of these payments will be dependent on the stage and reporting. The draw of the FFP match for Quality Improvement and Population Focused Improvement performance measures, or reporting of payments on the CMS-64 form, will not occur until the activity has been verified by both the Department and CMS as complete. The CMS-64 form is used by the state to claim federal matching funds.

For DY6, Stage 3 project related Quality Improvement metrics will be based on pay for performance (P4P), all Quality Improvement metrics are required to meet expected improvement target goals to earn any payment tied to performance. Payment for the P4P metrics will coincide with the metric reporting frequency. Federal match for Quality Improvement P4P metrics will not occur until performance has been met and verified by both the Department and CMS for the P4P metric and all required Quality Improvement metrics have been reported. Therefore, in DY6 any payment for Quality Improvement P4P metrics which were not earned will be recouped from the hospital and transferred to the Universal Performance Pool.

For DY7-DY8, Stage 2 project related Quality Improvement metrics will be based on P4P; all Quality Improvement metrics are required to meet expected improvement target goals to earn any payment tied to performance. Payment for the P4P metrics will coincide with the metric reporting frequency. Federal match for Quality Improvement P4P metrics will not occur until performance has been met and verified by both the Department and CMS for the P4P metric and all required Quality Improvement metrics have been reported. Therefore, in DY7-DY8 any payment for Quality Improvement P4P metrics which were not earned will be recouped from the hospital and transferred to the Universal Performance Pool.

For DY6 Stage 4 Population Focused Improvement metrics will be reported either annually or semi-annually, depending on the metric. Payment for reporting these metrics will coincide with the metric reporting frequency. Federal match for reporting Stage 4 metrics will not occur until the metric has been reported and verified by both the Department and CMS. Therefore, any payment for Population Focused Improvement metrics which

were not reported as outlined in the databook (as updated in the Planning Protocol, Attachment A: Toolkit) will be subject to recoupment from the hospital.

For DY7-DY8 Stage 3 Population Focused Improvement metrics will be reported annually. Payment for reporting these metrics will coincide with the metric reporting frequency. Federal match for reporting Stage 3 metrics will not occur until the metric has been reported and verified by both the Department and CMS. Therefore, any payment for Population Focused Improvement metrics which were not reported as outlined in the databook (as updated in the Planning Protocol, Attachment A: Toolkit) will be subject to recoupment from the hospital.

Stage 3 population focused improvement measures will be comprised of at least 50% pay-for-performance and up to 50% pay-for-reporting measures.

As shown below, based on reporting and verification of completion and performance the Department will calculate the DSRIP payment earned for each stage activity/metric and will reconcile the earned DSRIP payment to the cumulative DSRIP payment made to the hospital. Adjustments to monthly payments to DSRIP participating hospitals will be made as needed.

A. Calculating DSRIP Payments for Stages 1 and 2

i. DY6

The Achievement Value (AV) for each Stage 1 and 2 metric will be calculated as a 0 or 1 value. A Stage 1 or 2 metric considered by the Department and/or CMS to be incomplete will receive an AV of 0. A metric considered by the Department and CMS as complete, will receive an AV of 1. The AV for each metric will be summed to determine the Total Achievement Value (TAV) for the stage. The Percentage Achievement Value (PAV) is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Stage 1 and 2 activities determined by multiplying the total amount of funding allocated to Stage 1 and 2 by the PAV.

Example:

The hospital's Stage 1 and 2 activities in DY6 is valued at \$4 million and has five metrics. Under the payment formula, the five metrics represent a maximum TAV of five. The participating hospital reports the following progress at six months:

Metric	Status	Achievement
Stage 1: Metric 1	Complete	1
Stage 1: Metric 2	Complete	1
Stage 1: Metric 3	Not Complete	0
Stage 2: Metric 1	Not Complete	0
Stage 2: Metric 2	Not Complete	0
TAV		2
PAV (2/5)		40%

At the 6 months reporting period, the hospital has only earned 40% of Stage 1 and 2 funding or \$800,000 [$\$4,000,000 \cdot .5 \cdot 40\%$].

ii. DY7-DY8 System Transformation

Calculating Payments for Stage 1 for DY7-DY8

The AV for each Stage 1 metric will be calculated as a 0 or 1 value. A Stage 1 metric considered by the Department and/or CMS to be incomplete will receive an AV of 0. A metric considered by the Department and CMS as complete, will receive an AV of 1. The AV for each metric will be summed to determine the TAV for the stage. The PAV is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Stage 1 metrics reported determined by multiplying the total amount of funding allocated to Stage 1 the PAV. All Stage 1 metrics for DY7-DY8 are pay-for-reporting metrics reported annually.

Example:

The hospital's Stage 1 metrics in DY7-DY8 are valued at \$1 million and has 10 metrics. Under the payment formula, the 10 metrics represent a maximum TAV of 10. The participating hospital reports the following progress:

Metric	Status	Achievement
Stage 1: Metric #1	Met	1
Stage 1: Metric #2	Met	1
Stage 1: Metric #3	Met	1
Stage 1: Metric #4	Met	1
Stage 1: Metric #5	Met	1
Stage 1: Metric #6	Met	1
Stage 1: Metric #7	Not Met	0
Stage 1: Metric #8	Not Met	0
Stage 1: Metric #9	Not Met	0
Stage 1: Metric 10	Not Met	0

At the end of the reporting period, the hospital has earned 60% of Stage 1 or \$600,000 [(\$1 Million divided by 10 metrics) times 6 met metrics].

B. Calculating DSRIP Payments for DY6-DY8 for Quality Improvement Project-Specific Metrics

As described above in Section VI, subsection B, "Milestone and Measure Valuation," DSRIP payments for DY6-DY8 will be based on performance.

i. DY6 [Stage 3 metrics]-DY7-DY8 [Stage 2 metrics]

To receive an incentive payment during the Quality Outcome Stage of pay for performance the Department will first require the hospital to report all Quality Outcome measures. The DSRIP payment will then be based on the requirement that the hospital will make measurable improvement in a set of the hospital's Quality Outcome performance measures as defined in the Planning Protocol Section VII. Requirements of the Hospital DSRIP Plans, Sub-section C. High Performance in Quality Improvement. A measurable improvement is considered to be either a minimum of a ten percent (10%) reduction in the difference between the hospitals baseline performance and an improvement target goal (ITG) or a minimum of an eight percent (8%) reduction, if the hospital has met the gap reduction incentive criteria.

The gap reduction incentive is met if a provider has either a. or b. shown below:

- a. A single community-based reporting partner or a collection of such partners, with no less than 1,000 unique NJ DSRIP Low Income patients at the time of attribution. A community-based reporting partner is defined as a Medicaid-enrolled clinic, facility, or physician practice group that can and will comply with reporting outpatient data, and has a data use agreement, or other formal data sharing arrangement in place with the hospital by April 1 of the applicable demonstration year.
- b. An enhanced reporting partner. An enhanced reporting partner is defined as a Medicaid-enrolled clinic, facility or physician practice group that will comply with reporting outpatient data that has no existing employment, relationship, or ownership with the hospital and/or hospital system during the DY3 period, and a data use agreement, or other formal data sharing arrangement in place by April 1 of the applicable demonstration year.

All performance metrics will be rounded to the thousandth place according to normal rounding practices to compute results. Four and below will be rounded down; five and above will be rounded up.

Step 1 – For each claims-based measure, the Department will calculate the current NJ Low Income hospital performance for all Quality Outcome P4P measures for every project. The baseline performance will represent the most recent performance available following the measure’s technical specifications and be no older than calendar year 2015 dates of service.

Step 2 – The performance results will be shared with the Quality & Measures Committee. The ITG serves as the standard level of performance that NJ hospitals will strive to obtain.

The ITG will be determined through the use of national benchmark data or statewide benchmark data whichever results in a higher ITG for the performance metrics. For measures that do not have national benchmark data available, NJ state data may be used to determine the ITG. If NJ state data results in a higher expected improvement target goal than national benchmarks, state data should be used. DSRIP data may be used only when there is not an appropriate national or state benchmark data available. The state will provide the source of the national or state benchmark in the reporting process.

The NJ Low Income ITG will remain stable for the life of the demonstration to maintain predictability for the hospitals.

Step 3 – For each suitable measure tied to pay for performance, the Department will incentivize the hospital to reduce the difference between their hospital’s baseline performance and the ITG, otherwise known as the “Gap.” The hospital’s baseline used for pay for performance is the initial starting point from which the hospital’s future performance will be compared. This pay for performance baseline will be from each metric’s most current reporting period reported in DY5.

To compute the Gap, the Department will subtract the hospital’s P4P baseline performance rate from the ITG.

Step 4 - In order to receive an incentive payment, the Department requires the hospital’s gap in performance to be reduced by the applicable ten percent (10%) or eight percent (8%) during the pay for performance demonstration years. Therefore, in DY6-DY8, the hospital must reduce its gap at a minimum by the applicable 10% or 8%. This will result in a minimum overall total reduction for the demonstration period of between twenty-four (24%) and thirty percent (30%) of the Gap.

The Department will multiply the Gap by the required annual reduction (10% or 8%) to determine the improvement required.

Step 5 – The Department will add this rate of improvement to the hospital’s baseline rate of performance in order to establish the “Expected ITG.”

Step 6 – Upon close of an applicable performance period, the Department will re-compute the measure to determine the hospital’s Actual Performance Result (APR).

The Department will then compare the APR to the ITG. If the APR is at, or above, the ITG, the hospital is eligible to receive a payment for that performance period.

If it is not, the Department will compare the APR to the Expected ITG. If the APR is at, or above, the expected ITG the hospital is eligible to receive a payment for that performance period.

The improvement calculation will initially be performed for DY6 performance and then repeated for each subsequent performance period. The APR or the EITG can be utilized as the baseline from which to calculate the EITG for the subsequent performance period. When the expected ITG is calculated for subsequent performance periods, the better of the APR or the Expected ITG will be utilized as the baseline performance. The above calculation is further illustrated in Table VII.

Table VII. DSRIP PAY FOR PERFORMANCE IMPROVEMENT CALCULATION

Line 1	Improvement Target Goal
Line 2	Better of the Hospital Rate in the prior performance period or the Expected Improvement Target (Baseline)
Line 3	Subtract the hospital’s rate (line 2) from the improvement target goal (line 1). This is the gap between the hospital’s prior performance period rate and the improvement target goal. (Gap)
Line 4	Required annual reduction in the gap (10% or 8%)
Line 5	Multiply the gap (line 3) by the 10% or 8% required annual reduction in the gap (line 4). This results in the rate of improvement required.
Line 6	Add the hospital’s baseline rate (line 2) to the rate of improvement (line 5). (Expected Improvement Target Goal)

Line 7	Compare Expected Improvement Target Goal to Actual Performance Result; Is the Actual Performance Result at the Improvement Target Goal? Is the Actual Performance Result at the Expected Improvement Target Goal? If either are Yes – then the Payment Incentive is Awarded.
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For DY6 Stage 3, or DY7-8 Stage 2 measures, ITGs were updated from the DY3-5 period to the DY6-8 period based on the updated hierarchy and are recorded on the ITG Reference document.

For DY6 , some ITGs were approved by CMS with a regression provision applied. The regression provision applies to DSRIP #15, DSRIP #31, DSRIP #33, DSRIP #45, DSRIP #73 and DSRIP #80.

For DY7 & 8, the regression provision applies to all Stage 2 measures.

The regression provision requires that once a hospital has exceeded the ITG for the measure, the hospital must maintain above the ITG or improve performance results in each following year to meet achievement eligible for payment.

To determine the amount of incentive payment that the hospital will receive, an allocation amount is calculated for each measure. Each P4P measure will have equal allocation over the demonstration year.

In each demonstration year for which pay for performance applies, the Department will compute the payment allocation for each P4P measure for each hospital. The Department will divide the hospital's total Quality Outcome allocation amount by the total number of P4P measures tied to the project the hospital has selected.

DY6 Stage 3 or DY7-DY8 Stage 2 Allocation

Total P4P measures

For any measure that has less than an annual performance period and requires reporting and computing of improvement results more than once, that measure's allocation will be divided by the number of times this computation must occur (i.e. the allocation for semi-annual measures will be divided by two to determine how much the hospital can receive for each performance period). The Department may elect to defer payment for semi-annual measures until the end of the demonstration year. Appeals for any semi-annual measures may be adjudicated as part of the year-end appeal process.

For any measure that the Department determines, with CMS concurrence, that the above calculation cannot be computed, the Department will authorize a simple ten percent rate of improvement or an alternative rate of improvement mutually agreed to by NJ and CMS, over the hospital's baseline performance rate per year as the expected ITG for that measure. This may occur if there is insufficient data to develop a

national or NJ statewide benchmark.

C. Calculating DSRIP Payments for Population Focused Improvements DSRIP Performance Indicators (i.e. Universal Metrics) for DY6 Stage 4 and DY7-DY8 Stage 3

DY6 Stage 4

The DSRIP payment for DY6 Stage 4 Population Focused Improvement to a participating hospital will be based on the hospital successfully reporting all Population Focused Improvement metrics. Each metric will be valued equally. Since some Population Focused Improvement metrics require a semi-annual reporting frequency, the value of those metrics will then be halved. Therefore, the AV for each Population Focused Improvement metric will be calculated as:

- 0 if metric is not reported
- 1 if annual metric is reported
- 0.5 if semi-annual metric is reported

If a hospital cannot report an obstetrical or pediatric related measure because the hospital does not have an obstetrical or pediatric department, the hospital will be required to indicate in the progress report why the measure cannot be reported. The AV value for any unable to be reported measures will be reduced to 0 to account for any measure the hospital is unable to report and payment allocated to this stage will be based on the remaining measures.

The AV for each metric will be summed to determine the TAV for the stage. The PAV is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Population Focused Improvement metric determined by multiplying the total amount of funding allocated to Stage 4 by the PAV.

Example:

The hospital's Population Focused Improvement allocation in DY6 is valued at \$4,950,000. A total of 33 metrics are required to be reported. Under the payment formula, the 33 metrics represent a maximum TAV of 33. Therefore, each Population Focused Improvement metric is valued at \$150,000 ($\$4,950,000/33$). Any Population Focused Improvement metric required to be reported on a semi-annual reporting frequency will have a value of \$75,000 ($\$150,000$). The participating hospital reports 28 annual metrics and 5 semi-annual metrics. The hospital has earned \$4,950,000 for Population Focused Improvement as shown below:

	(A) Reported	(B) Value	(A*B) Total Earned
Annual Metrics	28	\$150,000	\$4,200,000
Semi-Annual Metrics-1 st Reporting Period due October 31 st	5	\$75,000	\$375,000
Semi-Annual Metrics- 2 nd Reporting Period due April 30 th	5	\$75,000	\$375,000
Total Population Focused Improvement Earned			\$4,950,000

DY7-DY8 Stage 3 Population Focused Improvement Indicators (i.e. Universal Metrics) DSRIP payments for DY7-DY8 population focused improvement indicators will be based on a hospital successfully reporting on 7 population focused improvement indicators and a hospital achieving expected improvement target goals for 7 population focused improvement indicators.

DY7-DY8 Stage 3 funding will be allocated up to 50% for pay-for-reporting and at least 50% for pay-for-performance.

i. Population Focused Improvement Indicators Pay-For-Reporting

The portion [up to 50%] of the DSRIP payment for DY7-DY8 Stage 3 Population Focused Improvement to a participating hospital will be based on the hospital successfully reporting no more than 50% of Population Focused Improvement metrics. Each metric will be valued equally. Since some Population Focused Improvement metrics require a semi-annual reporting frequency, the value of those metrics will then be halved. Therefore, the AV for each Population Focused Improvement metric will be calculated as:

- 0 if metric is not reported
- 1 if annual metric is reported

If a hospital cannot report an obstetrical or pediatric related measure because the hospital does not have an obstetrical or pediatric department, the hospital will be required to indicate in the progress report why the measure cannot be reported. The AV value for any unable to be reported measures will be reduced to 0 to account for any measure the hospital is unable to report and payment allocated to this

stage will be based on the remaining reportable measures.

The AV for each metric will be summed to determine the TAV for the stage. The PAV is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Stage 3 Population Focused Improvement pay-for-reporting metrics determined by multiplying the total pay-for-reporting amount of funding allocated to DY7-DY8 Stage 3 by the PAV.

ii. Population Focused Performance Indicators Pay-For-Performance

The portion [at least 50%] of the DSRIP payment for DY7-DY8 Stage 3 Population Focused Improvement to a participating hospital will be based on the hospital successfully achieving performance requirements in 50% or more of Population Focused Improvement metrics where there is significant opportunity for improvement as determined by NJ and approved by CMS. For DY7, performance requirements for each pay-for-performance metric requires hospitals to achieve not less than a 5% improvement over self, using the DY6 baseline metric value. For DY8, performance requirements for each pay-for-performance metric requires hospitals to achieve not less than a 5% improvement over self, using the better of the DY6 baseline metric value and DY7 measure results. The AV for each Population Focused Improvement metric will be calculated as:

- 0 if metric is not achieved
- 1 if annual metric is achieved

If a hospital cannot report an obstetrical or pediatric related measure because the hospital does not have an obstetrical or pediatric department, the hospital will be required to indicate in the progress report why the measure cannot be reported. The AV value for any measures will be reduced to 0 to account for any measure the hospital is unable to report and payment allocated to this stage will be based on the remaining reportable measures.

For the DY7-DY8 Stage 3 pay-for-performance Population Focused Improvement measures, hospitals that have met or exceeded the high-performance threshold (below) will be considered a high performer. In DY7, to determine whether a hospital is a high performer on a specific Stage 3 P4P measure, the Department will look at each hospital's measure result from DY6. If the measure result is above the high-performance threshold, the hospital will be considered a high performer for that measure. This process will be repeated for DY8 using hospitals' DY7

measure results. Any hospital designated as a high performer on a Stage 3 P4P measure during DY7-DY8 will receive full AV for that measure in the subsequent performance year when the hospital demonstrates a relative improvement of 2 percent. Note: High performer levels will be evaluated annually. A hospital's DY6 performance value will determine their high performer status for DY7. A Hospital's DY7 performance value will determine their high performer status in DY8.

- DSRIP 3: The high-performance threshold for 30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization is 0 percent.
- DSRIP 8: The high-performance threshold for Ambulatory Care – Emergency Department Visits is 33.66 visits per 1,000.
- DSRIP 31: The high-performance threshold for Controlling High Blood Pressure (CBP) is 96 percent.
- DSRIP 36: The high-performance threshold for Diabetes Short-Term Complications Admission Rate is .233 per 1,000.
- DSRIP 38: The high-performance threshold for Engagement of alcohol and other drug treatment is 22 percent.
- DSRIP 41: The high-performance threshold for Follow-up After Hospitalization for Mental Illness 7 days post discharge is 77 percent.
- DSRIP 88: The high-performance threshold for Well-Child Visits in First 15 Months of Life is 96.42 percent.

The AV for each metric will be summed to determine the TAV for the stage. The PAV is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Stage 3 Population Focused Improvement pay-for-performance metrics determined by multiplying the total pay-for-performance amount of funding allocated to DY7-DY8 Stage 3 by the PAV.

Example of Stage 3 pay-for-performance calculation for 1 measure:

Line	Description	Example Calculation
1	DY6 Measure Value (Baseline)	50.00
2	DY7 Percent Improvement Required	5%
3	DY7 Required Increment of Improvement [Line 1 multiplied by Line 2]	2.50
4	DY7 Goal [Line 1 plus Line 3]	52.50
5	DY8 Percent Improvement Required	5%

6	DY8 Required Increment of Improvement [Line 4 multiplied by Line 5]	2.625
7	DY8 Goal [Line 4 plus Line 6]	55.125

Example of Stage 3 pay-for-performance calculation for 1 measure when a hospital regresses from the baseline:

Line	Description	Example Calculation
1	DY6 Measure Value (Baseline)	50.00
2	DY7 Percent Improvement Required	5%
3	DY7 Required Increment of Improvement [Line 1 multiplied by Line 2]	2.50
4	DY7 Goal [Line 1 plus Line 3]	52.50
5	Hospital's DY7 Measure Result	48.50
6	DY8 Percent Improvement Required	5%
7	DY8 Required Increment of Improvement [Line 1 multiplied by Line 6]	2.50
8	DY8 Goal [Line 4 plus Line 7]	52.50

DSRIP Universal Performance Pool

All participating hospitals will be eligible for the Universal Performance Pool (UPP). The UPP will be made up of the following funds:

- For DY6-DY8:
 - Hospital DSRIP Target Funds from hospitals that elected to not participate.
 - The percentage of the total DSRIP funds set aside for the UPP, known as the Carve Out Allocation amount set at 25% of each hospitals funding target as shown in Table II.
 - Target Funds that are forfeited from hospitals that do not achieve project activities/metrics
 - Forfeited amounts from hospitals electing to discontinue participation in the DSRIP Program.

The total UPP amount determined above will be distributed to hospitals based on maintaining or improving on a specific set of twelve Population Focused Improvement metrics identified as a UPP metric. As some hospitals may not have service areas required to calculate one or more of the twelve UPP metrics, these hospitals must substitute those metrics for one or more of the four replacement UPP metrics, not to exceed twelve total metrics. See DSRIP Planning Protocol, Addendum 2 for a list of the twelve

UPP metrics and the four UPP replacement metrics. The baseline performance periods from which the UPP will be calculated will be included in the Planning Protocol as it is updated with the Databook.

All hospitals must have a total of twelve UPP measures and only those hospitals that lack obstetrical (OB) or pediatric departments must choose substitute measures from the substitution list. These (non-OB/non-pediatric) hospitals will have selected their substitution choice in their submitted Hospital DSRIP Data Reporting Plan. Hospitals that have obstetrical and pediatric departments cannot substitute UPP measures and therefore must use the set of twelve UPP measures.

For DY6-DY8, the carve-out amount from each participating hospital initial funding target will be established as the UPP carve-out funding target. For all met UPP performance measures, defined as not regressed from the baseline value, or for measures where the hospital has achieved the NJ DSRIP 90th percentile for any UPP measure, an AV and a PAV will be calculated.

The UPP carve-out funding target achievement value will be determined based on the sum of achievement values of the twelve metrics. The UPP metric AV will be determined as follows:

- UPP Metric is at or improves from baseline, or is at or greater than the 90th percentile of NJ DSRIP hospitals AV = 1
- UPP Metric has regressed from baseline, AV = 0

For each hospital, a TAV score will be established by summing the AV scores for each metric. The TAV score will be no higher than 12 and no lower than 0. The PAV is then calculated by dividing the TAV by the maximum AV (12) UPP measures.

For each hospital the PAV will be multiplied by the UPP carve-out funding target to determine the UPP carve-out funding payment.

Forfeiture portion of the UPP will consist Initial Funding allocated amounts from Non-Participating hospitals, Stage 1 through 4 (Stage 1-3 in DY7 and DY8) measure forfeitures, and the any UPP carve-out funding measure forfeitures. Payments will then be allocated to each eligible hospital based on the ratio of the hospital specific earned payments to Total Statewide earned payments for the applicable demonstration year across all stages including the UPP target funding. Hospitals eligible to participate in the forfeiture portion of the UPP must achieve a met status of not less than 8 of 12 UPP measures.

Example of UPP Carve-out Funding Target Payment:

A hospital is at the baseline value for 4 measures, has improved from the

baseline for 3 measures, is greater than the 90th percentile of the NJ DSRIP measure value for 2 measures and has regressed from the baseline value for 3 measures. The UPP carve-out payment is calculated as follows:

Measures at the baseline value	=4
Measures improved from the baseline value	=3
Measures greater than the 90 th percentile NJ measure values	<u>=2</u>
Total Achievement Value [TAV]	=9
Percentage Achievement Value [PAV] (9/12 UPP measures)	=75%

Hospital UPP funding target [i.e. hospital carve-out amount]	= \$1,000,000
UPP carve-out funding target payment [75% * \$1,000,000]	= \$ 750,000
UPP payment forfeiture	= \$ 250,000

Example of UPP Payments from Non-Participating hospitals and Measure Forfeitures:

SS

<u>Carve-out Payments have been made:</u>	<i>Interim Earned</i>	<i>Final Earned</i>
<u>Universal Performance Pool</u>	<u>DY Amount</u>	<u>DY Amount</u>
Funding from Non- Participating Hospitals	\$4,060,000	\$4,060,000
Payment Forfeitures [stages 1-4, plus UPP]	<u>\$18,000,000</u>	<u>\$12,000,000</u>
UPP Balance after carve-out payments	\$22,060,000	\$16,060,000
Earned Payments	<u>\$144,540,000</u>	<u>\$150,540,000</u>
Total Payments	\$166,600,000	\$166,600,000

Note: Payment forfeitures for Final Earned DY Amount reflects adjudicated appeals

Demonstration year payments for Hospital A after all appeals have been adjudicated is \$3,750,000. Hospital A would receive an allocation from the balance in the UPP [after the carve-out amount has been allocated to each hospital] as follows:

Hospital A earned payments after all adjudicated appeals	\$3,750,000
Total Earned Payments after adjudicated appeals	\$150,540,000
Ratio of Hospital A to Total Statewide Earned Payments	2.49%
UPP Balance after adjudicated appeals	\$16,060,000
Hospital A allocation of UPP balance [\$16,060,000*2.49%]	\$400,060

D. Forfeiture of DSRIP Payments and Appeals

At the conclusion of the demonstration year, once the scoring and evaluation of metrics has been completed by the Department and CMS, each hospital will be notified of the amount of interim DSRIP UPP Payments earned. Upon approval from CMS, the Department may claim FFP for interim DSRIP payments earned and paid to hospitals. Once all appeals of interim DSRIP

payments have been adjudicated, final demonstration year payment will be calculated. Differences between Interim DSRIP Payments and Final DSRIP Payments will be made as part of payments in the subsequent demonstration year. In DY8, no interim payments will be made. Final payments will be made once all appeals have been adjudicated.

Upon notification by the Department and receipt of supporting documentation, of the interim amount earned for the applicable demonstration year, a hospital will have 30 days to submit a reconsideration request to the Department in accordance with Section VII.D, Forfeiture of DSRIP Payment and Appeals. The reconsideration period is available to address reporting or computational errors. Hospitals are not permitted to resubmit Electronic Health Record (EHR)/Chart measure data after the initial submission on April 30th of each demonstration year.

The Department will make all DSRIP payments for the SFY and DY once all activity milestones and measure metrics have been approved by the Department and CMS and all appeals have been adjudicated. Upon making those final payments, funding attributable to that DSRIP year will be considered closed and final, and no subsequent adjustments will be made.

VIII. Mergers, Acquisitions, and Business Combinations

A number of NJ hospitals have initiated and likely will initiate business mergers and acquisitions or business combinations with other organizations. Sometimes the transaction takes place at the health system parent organization level instead of at the hospital level. For this purpose, the term health system and hospital are used interchangeably. The proposed transactions range from a full acquisition of one hospital by a successor organization where the acquired hospital conducts business under a new parent organization to a sole member substitution where there is a substitution replacing the governing board of the acquired hospital with a newly named governing board of the acquiring organization and both hospitals continue to conduct business under their existing provider numbers. Mergers, Acquisitions, and Business Combinations include sales, leases, sale-leaseback arrangements, joint ventures, asset transfers, stock acquisitions and transfers, exclusive licensing arrangements, and other organization changes that qualify as reportable events to the State of NJ.

i. DSRIP Merger, Acquisition or Business Combination Reporting

Hospitals undergoing a merger, acquisition or business combination must submit the following information:

- A description of the proposed transaction NJ Certificate of Need, Community Hospital Asset Protection Act filings, or documents part of other regulatory filings.

- A description of how services provided to patients are expected to change under the proposed transaction by both parties including the location of patient services and patient populations served.
- An analysis of the expected changes in the low income population served before and after the transaction by both parties.
- A forecast of Medicaid admissions for all hospitals involved in the merger, acquisition, or business combination. The forecast needs to show Medicaid admissions before and after the completed transaction.
- A detailed list of any expected changes to the approved DSRIP project applications for either party.
- A written explanation of how the acquired hospital will continue to conduct business and bill using its current provider numbers and how patient level detail will be transmitted to the MMIS system and Chart/EHR data captured so DSRIP measures can be calculated.
- A list of any changes to the medical staff, project partners, or affiliated providers that would lead to a change in project partners for either party.
- Any changes to the hospital DSRIP management or staff.

ii. Approval Designations

The following approval designations are available to the Department and CMS once the information listed above has been reviewed:

- Approval for the acquired and successor hospitals to continue in the DSRIP Program, as may be applicable, based on approved applications subject to the following conditions:
 - The successor hospital is required to submit an attestation signed by the hospital CEO indicating the commitment to support the Department and CMS approved DSRIP application including any modifications.
 - Approval is subject to: The attestation to include acceptance of the terms and conditions included on the DSRIP application approval letter issued by the State of NJ and CMS, and confirmation of the hospitals' ability to provide MMIS and Chart/EHR data as described above. If the conditions listed above are not met the successor and/or the acquired hospital will forfeit DSRIP funding.
- Require modification to the hospital approved applications that may include additional conditions, and funding modifications as determined by the Department and CMS providing a one year approval with a look back on fulfilling conditions imposed, performance outcomes and other indicators.
- Discontinue the acquired hospitals' participation in the DSRIP program if the successor organization is unwilling to comply with the

terms and conditions in the application approval letter issued by NJ and CMS, and transfer hospital specific funding to the UPP.

- Any amounts forfeited under any approval options listed above will be allocated to the UPP.

iii. Steps and Timeline

Below are the steps and timeline that the NJ DSRIP Program must follow when a NJ DSRIP Hospital is completing a merger, acquisition or business combination:

1. Hospitals are required to notify DSRIP consultants (Public Consulting Group) by email when NJ DSRIP Hospitals are completing a merger, acquisition or business combination. NJ DSRIP Hospitals are also required to submit the necessary documentation described in the DSRIP Merger and Acquisition Guidance Document on the NJ DSRIP Resources website. Hospitals have 60 days to notify and submit documents to the NJ DSRIP consultants.
2. The NJ Department of Health and NJ DSRIP consultants will review merger, acquisition and business combination documents provided by the NJ DSRIP hospital. The Department of Health and NJ DSRIP consultants must agree that the new organization is committed to the low-income population. The Department of Health and NJ DSRIP consultants have 30 days to review these materials and determine the organizational commitment to the low-income population.
3. After the review in step 2 is complete, the NJ DSRIP consultants will send the merger, acquisition or business combination approval letter to the NJ DSRIP hospital. The NJ DSRIP Hospital has 10 days to sign and return the letter to the NJ Department of Health. If the successor organization is unwilling to comply with the terms and conditions in the approval letter, the Department of Health would discontinue the acquired hospitals' participation in the DSRIP program and transfer hospital specific funding to the Universal Performance Pool.

IX. Program Management and Modification

The Department may request approval from CMS to modify the Funding and Mechanics Protocol, operating procedures used by the Department in administering the DSRIP program, measures used in the Quality Outcomes and the Population Focused Improvement Stages or reports required by the STC section IX, or the Planning Protocol. These changes are to be defined as program modifications. The Department will strive to provide CMS with as much advance notice as possible in seeking approval for a program modification.