DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

State Demonstrations Group

Jennifer Langer Jacobs
Director, Department of Human Services
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

Dear Ms. Jacobs:

This letter is to inform you that the Centers for Medicare and Medicaid Services (CMS) has approved your request to modify the Delivery System Reform Incentive Payment (DSRIP) Funding and Mechanics Protocol (FMP) for the last year of DSRIP Program to reduce the administrative burden to providers during the COVID-19 public health emergency and focus provider efforts on critical patient care needs. The amended 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 previously approved versions.

The amended FMP provides a 60-day extension for data collection and submission of the Standard Reporting Workbooks and Measure Validation Templates for non-claims-based measures for Demonstration Year (DY) 8 Progress Report 2. In addition, CMS approves the state's request to distribute the DY8 interim payments to hospitals based only on DY8 claims-based (Medicaid management information system) measure performance, while the remaining DY8 final payment would be based on non-claims-based (chart) measure performance calculations, post-appeal adjustments, and the universal performance pool remainder.

We look forward to our continued work with you and your staff. If you have questions or concerns, please contact your CMS project officer, Mr. Jack Nocito at (410) 786-0199 or at Jack.Nocito@cms.hhs.gov.

Sincerely,

Angela D. Garner -S

Digitally signed by Angela D. Garner -S
Date: 2020.04.09 10:24:09 -04'00'

Angela D. Garner
Director
Division of System Reform Demonstrations

cc: Michael Cutler, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

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

Special Terms and Conditions
Section IX

Version 1.1
January 31, 2019

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. Yelecsics 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 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
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 **June 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. Yelecsics 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

In Thousands	**DY6**
DSRIP Target Funding	$166,600
Total Demonstration Year Funding	**$166,600**
Less: Not Participating Hospitals	**$ 4,893**
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**

In Thousands	**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**
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

		6		7		8	
Period	Significance	Begin	End	Begin	End	Begin	End
Demonstration Year	Contractual year: Governs NJ-CMS obligations	7/1/17	6/30/18	7/1/18	6/30/19	7/1/19	6/30/20
Experience Period	Operational year: 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	Measurement year: 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*.5 *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 of10. 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.

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.

$$\frac{\text{DY6 Stage 3 or DY7-DY8 Stage 2 Allocation}}{\text{Total P4P measures}}$$

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-1st Reporting Period due October 31st	5	$75,000	$375,000
Semi-Annual Metrics- 2nd Reporting Period due April 30th	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 ssis 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 target 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 90th percentile NJ measure values	=2
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:

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Carve-out Payments have been made:	***Interim Earned***	***Final Earned***
Universal Performance Pool	***DY Amount***	***DY Amount***
Funding from Non- Participating Hospitals	$4,060,000	$4,060,000
Payment Forfeitures [stages 1-4, plus UPP]	$18,000,000	$12,000,000
UPP Balance after carve-out payments	$22,060,000	$16,060,000
Earned Payments	$144,540,000	$150,540,000
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, once the scoring and evaluation of claims-based (MMIS) metrics has been completed by the Department and CMS, each hospital will be notified of the amount of interim DSRIP Payments earned. Upon approval from CMS, the Department may claim FFP for and distribute to hospitals interim DSRIP payments earned based on MMIS measure performance.. DY8 final payments will be made once all DY8 appeals have been adjudicated. Upon approval from CMS, the Department may claim FFP for and distribute the remaining hospital earned DY8 funds, inclusive of non-claims-based performance results, plus or minus any adjustments made as a result of the approved DY7 and DY8 appeals and the UPP remainder.

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.

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 DS RIP 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.