

New Jersey Delivery System Reform Incentive Payment (DSRIP) Program Frequently Asked Questions (FAQs)

Document Purpose: This FAQ document is prepared in support of Delivery System Reform Incentive Payment (DSRIP) Program as described in the New Jersey Comprehensive Demonstration Waiver. This document is a living document and is subject to change as additional questions are added. If you have a question that is not addressed within this document, please send your question to: NJDSRIP@mslc.com.

Category	Question	Response
Administration	How will we know when documents are updated?	Please routinely visit the website. If a document is updated, this will be indicated with the new date. It is expected that this will occur once more after CMS has authorized final approval. This change will be clearly indicated.
Attribution	What is an attribution model?	An attribution model is a formula to determine how a population is attributed, or aligned, to an affiliated group of providers responsible for the care of the population. This is common to the Accountable Care Organization (ACO) model in order to monitor quality and financial incentives. This model will require CMS approval.
Funding	What Stage 1 and 2 activities must be completed in DYs 4 and 5 in order to receive those monies allocated to those Stages?	The majority of Stage 1 activities must be completed by September 30, 2014, however, activities 13, 14, and 15 are quarterly activities that will continue throughout the demonstration. Stage 1 activity #15 will not begin until the quarter ending September 2014. Stage 2 activities #1, 2, and 3 must be completed by March 31, 2015. Stage 2 activities 4, 5, and 6 must be completed quarterly throughout the demonstration, beginning with the quarter ending September 30, 2014. Quarterly activities were established so that funding could be received for Stage 1 and 2 during the later years of the demonstration, thus maintaining infrastructure needed throughout the demonstration.
Metrics	What is the DSRIP measurement population?	DSRIP <u>measurements</u> will only use New Jersey Low Income population, which includes Medicaid, CHIP (Children's Health Insurance Program), and Charity Care. Self-pay patients are not included.
	Are DSRIP projects limited to the New Jersey Low Income population?	DSRIP projects are not limited to New Jersey Low Income population. Although a project can be expanded to include other populations such as Medicare, measurements will be based on low income population noted above.
Metrics	Is there a document that clearly defines the definitions for each the Stage 3 & 4 metrics?	Please refer to the technical specifications maintained by the Measure Steward. The Measure Steward is listed in the Addendum 1 and 2 Measures Catalogues.
		If the NFQ number is listed on the Measures Catalogue, providers can also refer to the National Quality Forum website [http://www.qualityforum.org/Measures_Reports_Tools.aspx]. Providers can review the numerator definitions, with (inclusions & exclusions) details related to the measure. Any deviation from the Measure Steward's technical specifications will be described in a Databook that will be provided to the industry by November 15, 2013. Deviation may occur in order to incorporate the New Jersey Low Income attribution model.
Metrics	When will baseline data be available?	Baseline data for claims-based measures are expected to be initially calculated by December 13, 2013. Data will be provided to hospitals for examination. The Improvement Target Goals and Baseline Performance Thresholds are expected to be established by January 31, 2014.

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Metrics	For metrics that require a Chart Audit, can hospitals do a sample or is it a 100% audit?	The sample size must follow the technical specifications of the measurement, therefore there may be instances where 100% of the sample is not a requirement based on the technical specifications. A more detailed review of each measure that requires a chart review will occur and be fully described in the Databook.
Metrics	Where can I find information on the Care Transitions Measure (CTM) - 3?	The http://www.caretransitions.org website lists the specifications on the how CTM-3 measure must be collected. It is recommended that the project participants review and become very familiar with the measure specifications captured by the Measure Steward in order to understand what the numerator criteria (inclusions and exclusions) are for the measures for both claim-based and non claim-based measures.
Metrics	What clinical data is required when my hospital submits its application?	Hospitals must provide data to support that there is a substantial opportunity for improvement in the selected Focus Area. If the hospital is collecting and reporting any of the project measures at the time of application submission, this data should be provided as evidence that the project selected will reduce the gap between current and expected clinical performance. If clinical data is unavailable, a plan to develop and report must be submitted no later than October 31, 2014, unless otherwise stated in the databook.
Metrics	Where can I find the list of substitution measures?	<p>There are two different occasions where a hospital may need to substitute a measure.</p> <p>The first is for Stage 3 measures. If a hospital is above the Baseline Performance Threshold for a Stage 3 P4P measure, the hospital must substitute the measure(s) as described in the Planning Protocol Section VIII. Subsection A.iii. High Performing Hospitals - Baseline Performance Threshold, pages 39 - 41. The substitution measures for the cardiac projects have already been established as the Million Hearts measures. These are indicated by the first asterisk on the Stage 4 Measures Catalogue. The remaining substitution measures have not been identified at this time. The recommendation of these substitution measures for non-cardiac projects will be one of the responsibilities for the Quality & Measures Committee.</p> <p>The second occasion a hospital may substitute a measure(s) is when a hospital does not provide an obstetrical or pediatric service. In order to have all hospitals maintain or improve 12 measures to qualify for UPP payments, a hospital may need to substitute a measure. The measures that qualify to replace OB and pediatric UPP measures are listed in the last column of Addendum 2. These refer to the readmission measures.</p>
Projects	Does my hospital have to receive certification as a patient-centered medical home in order to fulfill the project requirement?	A certification is not required, however the requirements described by national accreditation bodies clearly represent the medical home model and at a minimum should be used as a resource in order to fulfill the project goals.
Reporting	How often does the hospital submit reports to the Department?	Reporting periods are specified in the Toolkit. It is expected that hospitals will submit reports four times per demonstration year, except for DY2, which will only occur once.