STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES

Section 93(f) of the Special Terms and Conditions (STCs) for New Jersey's "Comprehensive Waiver" section 1115(a) Medicaid and Children's Health Insurance Plan (CHIP) demonstration operated by the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (the "Department") requires the development of "a DSRIP Program Funding and Mechanics Protocol to be submitted to CMS for approval…

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Version 1.3 – March 27, 2014

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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. This document is Version1.3, dated March 27, 2014.

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

B. High Level Organization of "Attachment I: Program Funding and Mechanics Protocol"

Attachment I has been organized into the following sections.

I. Preface
II. Hospital DSRIP Plan Guidelines and Approval Process
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. Plan Modifications

C. DSRIP Eligibility Criteria

As of September 20, 2013,the hospitals eligible to receive funding under the DSRIP program during Demonstration Year (DY) 2 through DY5 are general acute care hospitals shown in the table below. Hospitals in the table below electing not to participate in the DSRIP program (either by notifying the Department of non-participation or by electing not to submit a DSRIP application on or before September 20, 2013) are eligible to receive transition payments through December 31, 2013, but will not be eligible for any DSRIP payments granted by CMS after December 31, 2013.

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Table I. HOSPITALS ELIGIBLE FOR TRANSITION AND DSRIP PAYMENTS

Medicaid No.	Medicare No.	Hospital Name	County
4139402	310064	ATLANTICARE REG'L MEDICAL CENTER	ATLANTIC
4136705/0167011	310025	BAYONNE HOSPITAL	HUDSON
4141105	310112	BAYSHORE COMMUNITY HOSPITAL	MONMOUTH
4139003	310058	BERGEN REG'L MEDICAL CENTER	BERGEN
4135709	310011	CAPE REGIONAL MEDICAL CENTER	CAPE MAY
3676609	310092	CAPITAL HEALTH SYSTEM - FULD CAMPUS	MERCER
4138201	310044	CAPITAL HEALTH SYSTEM - HOPEWELL	MERCER
4141008	310111	CENTRASTATE MEDICAL CENTER	MONMOUTH
4136209	310017	CHILTON MEMORIAL HOSPITAL	MORRIS
3674207	310016	CHRIST HOSPITAL	HUDSON
4135504	310009	CLARA MAASS MEDICAL CENTER	ESSEX
3674606	310041	COMMUNITY MEDICAL CENTER	OCEAN
4136004	310014	COOPER UNIVERSITY MEDICAL CTR	CAMDEN
4137205	310031	DEBORAH HEART & LUNG CENTER[1]	BURLINGTON
4140001	310083	EAST ORANGE GENERAL HOSPITAL	ESSEX
4138309	310045	ENGLEWOOD HOSPITAL ASSOCIATION	BERGEN
3674100	310001	HACKENSACK UNIVERSITY MEDICAL CENTER	BERGEN
4141300	310115	HACKETTSTOWN COMMUNITY HOSPITAL[1]	WARREN
4137906/0249297	310040	HOBOKEN HOSPITAL CENTER	HUDSON
4135407	310008	HOLY NAME HOSPITAL[1]	BERGEN
4135202	310005	HUNTERDON MEDICAL CENTER[1]	HUNTERDON
4139801	310074	JERSEY CITY MEDICAL CENTER	HUDSON
3675700	310073	JERSEY SHORE MEDICAL CENTER	MONMOUTH
3676803	310108	JFK MEDICAL CENTER {EDISON} / Anthony M. Yelencsics	MIDDLESEX
4140206	310086	KENNEDY MEMORIAL HOSPITALS AT STRATFORD	CAMDEN
3676200	310084	KIMBALL MEDICAL CENTER	OCEAN
3675203	310061	LOURDES MED CTR OF BURLINGTON CNTY	BURLINGTON
4141504/0249297	310118	MEADOWLANDS HOSPITAL MEDICAL CENTER	HUDSON
3674908	310052	MEDICAL CENTER OF OCEAN COUNTY	OCEAN
4138902	310057	MEMORIAL HOSP OF BURLINGTON CTY (Virtua)	BURLINGTON
9031308	310091	MEMORIAL HOSPITAL OF SALEM COUNTY[1]	SALEM
3675807	310075	MONMOUTH MEDICAL CENTER	MONMOUTH
4136101	310015	MORRISTOWN MEMORIAL HOSPITAL	MORRIS
4138708/0139564	310054	MOUNTAINSIDE HOSPITAL	ESSEX
4135008	310002	NEWARK BETH ISRAEL MEDICAL CENTER	ESSEX
4137001	310028	NEWTON MEMORIAL HOSPITAL	SUSSEX

[1] Hospital has elected not to participate in DSRIP.

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Medicaid No.	Medicare No.	Hospital Name	County
4137108	310029	OUR LADY OF LOURDES MEDICAL CENTER	CAMDEN
3674801	310051	OVERLOOK HOSPITAL	UNION
4135105	310003	PALISADES GENERAL HOSPITAL	HUDSON
4137701	310038	R. W. JOHNSON UNIVERSITY HOSPITAL	MIDDLESEX
4137809	310039	RARITAN BAY MEDICAL CENTER	MIDDLESEX
4137400	310034	RIVERVIEW MEDICAL CENTER	MONMOUTH
3674401	310024	ROBERT WOOD JOHNSON AT RAHWAY HOSPITAL[2]	UNION
3676901	310110	RWJ UNIVERSITY MEDICAL CTR AT HAMILTON	MERCER
3674703	310047	SHORE MEMORIAL HOSPITAL[2]	ATLANTIC
4138406	310048	SOMERSET MEDICAL CENTER	SOMERSET
3674509	310032	SOUTH JERSEY HEALTH SYSTEM[3]	CUMBERLAND
3675602	310069	SOUTH JERSEY HEALTH SYSTEM - ELMER[4]	SALEM
4141202	310113	SOUTHERN OCEAN COUNTY HOSPITAL	OCEAN
3675904	310076	ST. BARNABAS MEDICAL CENTER	ESSEX
4138601	310050	ST. CLARE'S-RIVERSIDE MED CTR DENVILLE	MORRIS
4136608	310021	ST. FRANCIS MEDICAL CENTER (TRENTON)	MERCER
4136403	310019	ST. JOSEPH'S HOSPITAL MEDICAL CENTER	PASSAIC
4135300	310006	ST. MARY'S HOSPITAL (PASSAIC)	PASSAIC
4140508	310096	ST. MICHAEL'S MEDICAL CENTER	ESSEX
4139500	310070	ST. PETER'S MEDICAL CENTER	MIDDLESEX
4136900	310027	TRINITAS - ELIZABETH GENERAL	UNION
3676102	310081	UNDERWOOD MEMORIAL HOSPITAL[5]	GLOUCESTER
3677001	310119	UNIVERSITY HOSPITAL	ESSEX
4135601	310010	UNIVERSITY MED CTR PRINCETON @ PLAINSBORO	MIDDLESEX
4135806	310012	VALLEY HOSPITAL[2]	BERGEN
4139208	310060	ST. LUKE'S HOSPITAL (formerly Warren Hospital)	WARREN
3674304	310022	VIRTUA - WEST JERSEY HEALTH SYSTEM	CAMDEN
Hospital Count	**63**		

Note: St. Clare's Sussex #310120 closed Inpatient operations in Oct 2012.

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[2] Hospital has elected to not participate in DSRIP.

[3] Hospital is now Inspira-Vineland

[4] Hospital is now Inspira-Elmer

[5] Hospital is now Inspira-Woodbury

II. Hospital DSRIP Plan Guidelines and Approval Process

A. Hospital DSRIP Plans

Each hospital that elects to participate in the DSRIP program must submit a Hospital DSRIP Plan in accordance with the Hospital DSRIP Plan guidelines outlined in Attachment H: DSRIP Planning Protocol and the accompanying Attachment 1: DSRIP Toolkit. In summary, hospitals will be required to submit a Hospital DSRIP Plan using a Department approved application that identifies the project, objectives, and specific milestones/metrics that meets all requirements pursuant to the Special Terms and Conditions (STCs) and Attachment H: DSRIP Planning Protocol.

Hospitals who do not submit a Hospital DSRIP Plan to the Department by September 20, 2013, with exception of hospitals meeting the criteria in subsection E below, will be precluded from participating in New Jersey DSRIP in subsequent demonstration years 2 through 5.

B. State of New Jersey Department of Health (Department) Review and Approval Process

On or before September 20, 2013, each eligible hospital, identified above in the list in subsection I.C, "DSRIP Eligibility Criteria," who decides to participate in DSRIP will submit a 3 1/2-year Hospital DSRIP Plan to the Department for review. The Department will review all Hospital DSRIP Plan applications prior to submission to CMS for final approval according to the schedule below.

On or before November 15, 2013, the Department will submit the Department's approach and review criteria for reviewing Hospital DSRIP Plan applications, as well as a draft DSRIP Plan Initial Review Checklist outlining the state's initial review of the DSRIP Plans to CMS. CMS will provide comments within one week of the Department's submission. CMS and the Department will work collaboratively to refine the criteria, approach, and DSRIP Plan Checklist to support a robust review process and compelling justification for approval of each project. In order to ensure the hospitals submit plans in accordance with the review criteria established, the Department will conduct conference calls and face-to-face meetings with the hospitals to provide training on the development and completion of the Hospital DSRIP Plan and applications, as well as to answer hospital questions on the review process. The Department will apply this review process to ensure that Hospital DSRIP Plans are thoroughly and consistently reviewed.

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At a minimum, the Department shall review and assess each plan according to the following criteria using the DSRIP Plan Checklist:

- The plan is in the prescribed format and contains all required elements described herein and is consistent with special terms and conditions including STCs 93(g).
- The plan conforms to the requirements for Stages 1, 2, 3, and 4, as described herein, as well as in Attachment H: DSRIP Planning Protocol, and Attachment 1: DSRIP Toolkit, Section VI (Hospital DSRIP Plan Submission Requirements), Subsection A, "DSRIP Checklist."
- Stages 1 and 2 clearly identify goals, milestones, metrics, and expected results. Stage 3 clearly identifies the project-specific metrics to be reported. Stage 4 clearly identifies the population-focused health improvement measures (i.e. universal metrics) to be reported.
- The description of the project is coherent and comprehensive and includes a logic map clearly representing the relationship between the goals, the interventions and the measures of progress and outcome.
- The project selection is grounded in a demonstrated need for improvement at the time that the project is submitted and is sufficiently comprehensive to meaningfully contribute to the CMS three part aim for better care for individuals, better health for the population, lower costs through improvement (i.e. Triple Aim).
- The goals are mapped to a robust and appropriate set of research hypotheses to support the evaluation.
- There is a coherent discussion of the hospital's participation in a learning collaborative that is strongly associated with the project and demonstrates a commitment to collaborative learning that is designed to accelerate progress and mid-course correction to achieve the goals of the project and to make significant improvement in the stage 3 and 4 outcome measures.
- The amount and distribution of funding is in accordance with Section VI: "DSRIP Payment Based on Achievement of Milestones and Metrics," included in this protocol.
- The plan, project, milestones, and metrics are consistent with the overall goals of the DSRIP program.

By November 21, 2013, the Department will submit two or three Hospital DSRIP Plans that the Department has initially reviewed, based on the agreed approach, review criteria, and DSRIP Plan Checklist. CMS will review the approved Plans, and submit to the Department any comments or requests for modifications to the approach, review criteria, or checklist. The Department and CMS will agree to any modifications to the approach, review criteria, and checklist by November 30, 2013.

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During the time the Department is reviewing Hospital DSRIP Plans, the Department and CMS will hold bi-weekly half-hour conference calls to share progress updates and discuss challenges and concerns.

The Department will complete its initial review of each timely submitted Hospital DSRIP Plan application using the DSRIP Plan Checklist, the Funding and Mechanics Protocol, the DSRIP Planning Protocol, and the STCs by January 31, 2014. The Department will notify the hospital in writing of any questions or concerns identified with the hospital's submitted DSRIP Plan.

The requesting hospital shall respond in writing to any notifications of questions or concerns by the Department. The hospital's responses must be received by the dates specified in the aforementioned notification. The requesting hospital's initial response may consist of a request for additional time to address the Department's comments provided that the hospital's revised (i.e., final) DSRIP plan addresses the Department's comments and is submitted to the Department within 15 days of the notification.

No later than March 7, 2014, the Department will take action on each timely submitted Hospital DSRIP Plan; will approve each plan that it deems has met the criteria outlined in Attachment H: DSRIP Planning Protocol, Attachment I: DSRIP Program Funding and Mechanics Protocol, and "DSRIP Plan Checklist"; and submit approved plans (along with their completed DSRIP Plan Checklists and supporting documentation) to CMS for review and approval. The Department will notify the hospital in writing that the plan has been approved and submitted to CMS for consideration. CMS will subsequently notify the Department by March 21, 2014, of any additional questions or concerns CMS has on the state approved plan.

It is the Department's intent to submit plans continuously in batches to CMS upon the Department's approval of the Hospital's DSRIP Plan in order to incorporate meaningful feedback from CMS into the Department's DSRIP Plan review process.

C. CMS Review and Approval Process

CMS will review the hospitals' 3 1/2-year Hospital DSRIP Plan upon receipt from the Department. CMS will return any Hospital DSRIP Plan to the Department without review if it is received by CMS after March 15, 2014. Hospitals whose plans are returned by CMS for this reason are excluded from DSRIP, unless the hospital qualifies to submit a plan under subsection E, "Consideration of a Hospital's DSRIP Plan Due to Exceptional Circumstance."

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CMS will conduct an initial review of the submitted Hospital DSRIP Plans, in order to validate the Department's assessment based on the results from the Department's DSRIP Plan review process and DSRIP Plan Checklist. CMS will notify the Department within 15 days of receipt, if based on its initial review it concludes that there were systemic gaps or weaknesses in the Department's review of the Hospital DSRIP Plans. CMS and the Department will work together to develop guidance to the hospitals to revise and resubmit their plans, if necessary. At a minimum, CMS will not approve a plan if the plan has not answered the following questions:

- Is the project new or significantly enhanced for the hospital?
- Does the hospital describe any funding currently received from the U.S. Department of Health and Human Services or other Federal sources?
    - If yes, does the hospital indicate that the DSRIP program does not duplicate activity already funded by HHS or other federal government funded initiative?

CMS will complete its review of Department-approved Hospital DSRIP Plans, and will either:

- Approve the Hospital DSRIP Plan for both DY2 and DY3; or
- Notify the Department of any questions, concerns, or issues identified in the application that without resolution within 30 days of notification would result in a denial of the Hospital DSRIP Plan.

The Department will send written notification to the hospital within five business days following notice from CMS related to Hospital DSRIP Plan decisions.

In the event that CMS determines that a Hospital DSRIP Plan, or component thereof, requires revision, the hospital may revise and resubmit its plan to the Department to remedy the deficiencies. The revised plan must be received by the Department no later than 15 days following the notification date, provided the requirements for revision are understood by the State and the hospital . During the resubmission period, the hospital will not receive FFP portions of the DSRIP payments until formal approval is rendered by CMS.

Within 30 days of CMS notification, the Department shall submit the revised Hospital DSRIP Plans to CMS and CMS shall approve or deny the plans in writing within 30 days of receiving the revised Hospital DSRIP Plans from the Department. The Department will not draw any federal financial participation for DSRIP payments to a hospital prior to the date that CMS has approved the hospital's DSRIP Plan.

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D. Review Process for Hospital-Specific Focus Area or Off-Menu Project

A pre-defined list of projects have 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. 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

If a hospital chooses to develop a project that is not from the pre-defined list in Attachment H: DSRIP Planning Protocol, the hospital shall submit a 3 1/2-year Hospital DSRIP Plan to the Department for review on or before September 9, 2013.

In addition to the Hospital DSRIP Plan guidelines and the review and approval processes identified in subparagraphs B and C of this section, the hospital shall conduct an analysis and submit with the Hospital DSRIP Plan application a strong and compelling justification for the project selection by:

i. Reviewing the menu of projects included in the DSRIP Planning Protocol, Attachment 1: DSRIP Toolkit (toolkit), and showing that the proposed project could not be accommodated within any of the model projects of the toolkit.
ii. Providing internal and external data to demonstrate that the new hospital project is beyond those listed in the toolkit, has an outpatient focus, and that it would achieve the Triple Aim.
iii. Providing data demonstrating that the hospital-specific focus area or project is responsive to local data and community needs, and provides a greater opportunity to improve patient care for New Jersey's low income population by addressing an area of poor performance and/or health care disparity that is important to the Medicaid, CHIP and/or uninsured population.
iv. Explaining why this "off-menu" project is particularly innovative or promising, and that it employs an evidence-based approach (with literature clearly cited).
v. Identifying at least four Stage 3 project-specific metrics based on nationally recognized metrics (such as NQF-endorsed or NCQA-endorsed metrics) that will be used to monitor the clinical processes and outcomes

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of the project. The hospital should select from the Stage 3 catalogue of approved metrics, as applicable. The hospital must propose which outcome metrics should be tied to pay for performance (e.g. pay for improvement). There must be, at a minimum, two clinical measures that are outcomes-based measurements. Outcome measures monitor patient health and should be tied to pay for performance. Process measures, which measure the quality of health care provided to patients, may be chosen but will be tied to pay for reporting only.[6] The hospital will need to describe the sources of the data that will be used in the measurement of Stage 3 project-specific metrics.

vi. Showing (using the proposed project-specific metrics) that there is demonstrable need for improvement, and having clearly identified improvement objectives that can be measured with the proposed metrics.

vii. Identify and provide justification for how the hospital-specific focus area of the hospital project is intended to achieve one or more of the Core Achievement Themes listed in Attachment H: DSRIP Planning Protocol.

E. Consideration of a Hospital's DSRIP Plan Due to Exceptional Circumstance

In the event that a hospital provides documentation that they meet one of the following criteria, the Department will review a Hospital DSRIP Plan outside the schedule described above:

i. If a hospital failed to submit a Hospital DSRIP Plan by September 20, 2013 because of a significant adverse unforeseen circumstance (e.g. hurricane, emergency event) and the hospital's prior year HRSF payment was not less than 0.5% of the hospital's annual Net Patient Service Revenues as shown on the most recent year audited Financial Statements. A significant adverse unforeseen circumstance is one not commonly experienced by hospitals.

ii. If a hospital did not receive approval of its Hospital DSRIP Plan or failed to submit a plan and the hospital received certificate of need approval of a merger, acquisition, or other business combination of a hospital within the State of New Jersey, provided the successor hospital is a participating provider contracted with any Medicaid Managed Care Insurers licensed and operating in their service area.

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[6] Mant, Jonathon. "Process versus outcome indictors in the assessment of quality of health care." International Journal for Quality in Health Care (2001) 13(6): 475-480 doi:10.1093/intqhc/13.6.475

To qualify under (ii) above, the application for certificate of need must have been received by the Department on or after the approval of these protocols and before September 20, 2013.

Documentation would include audited financial statements that identify net patient service revenues, copy of the hospital's certificate of need approval of a merger, acquisition or other business combination, and description of perceived unforeseen circumstance with justification. The Department will not consider the Hospital DSRIP Plan for approval if it is determined that the hospital does not meet one of the above criteria.

The Hospital DSRIP Plan shall demonstrate that participation in the DSRIP Program shall begin no later than July 1, 2014, which would allow the hospital to qualify for DSRIP payments in DY3 through DY5, if approved by the Department and CMS.

The Department and CMS approvals will follow the processes described above in subparagraphs B and C of this section except for the following changes.

- The Hospital DSRIP Plan must be submitted to the Department no later than May 15, 2014.
- The Department will take action on each timely submitted reconsiderations no later than June 13, 2014; will approve each plan that it deems meets the criteria outlined in Attachment H: DSRIP Planning Protocol, Attachment I: DSRIP Program Funding and Mechanics Protocol, and "DSRIP Plan Checklist"; and will submit approved plans (along with their completed DSRIP Plan Checklists and supporting documentation) to CMS for final review and approval.
- In the event CMS requests additional information, the Department shall submit revised Hospital DSRIP Plans to CMS within 30 days of request from CMS and CMS shall approve or deny the plans in writing to the Department by August 29, 2014.
- Hospitals submitting a plan under this section would be eligible to begin receiving DSRIP payments in DY3.

F. Revisions to the DSRIP Planning Protocol

If the CMS review process of Hospital DSRIP Plans results in the modification of any component of a hospital's DSRIP Plan, including but not limited to projects, milestones, metrics, or data sources, that was not originally included in the DSRIP Planning Protocol, New Jersey may revise the DSRIP Planning Protocol accordingly. CMS will review these proposed revisions within 30 days of submission by the Department and approve those it finds to be in

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accordance with the final approved Hospital DSRIP Plan(s) prompting the revision(s) and all applicable STC requirements.

G. DSRIP Review Process Flow

The diagram on the following page summarizes the above process.

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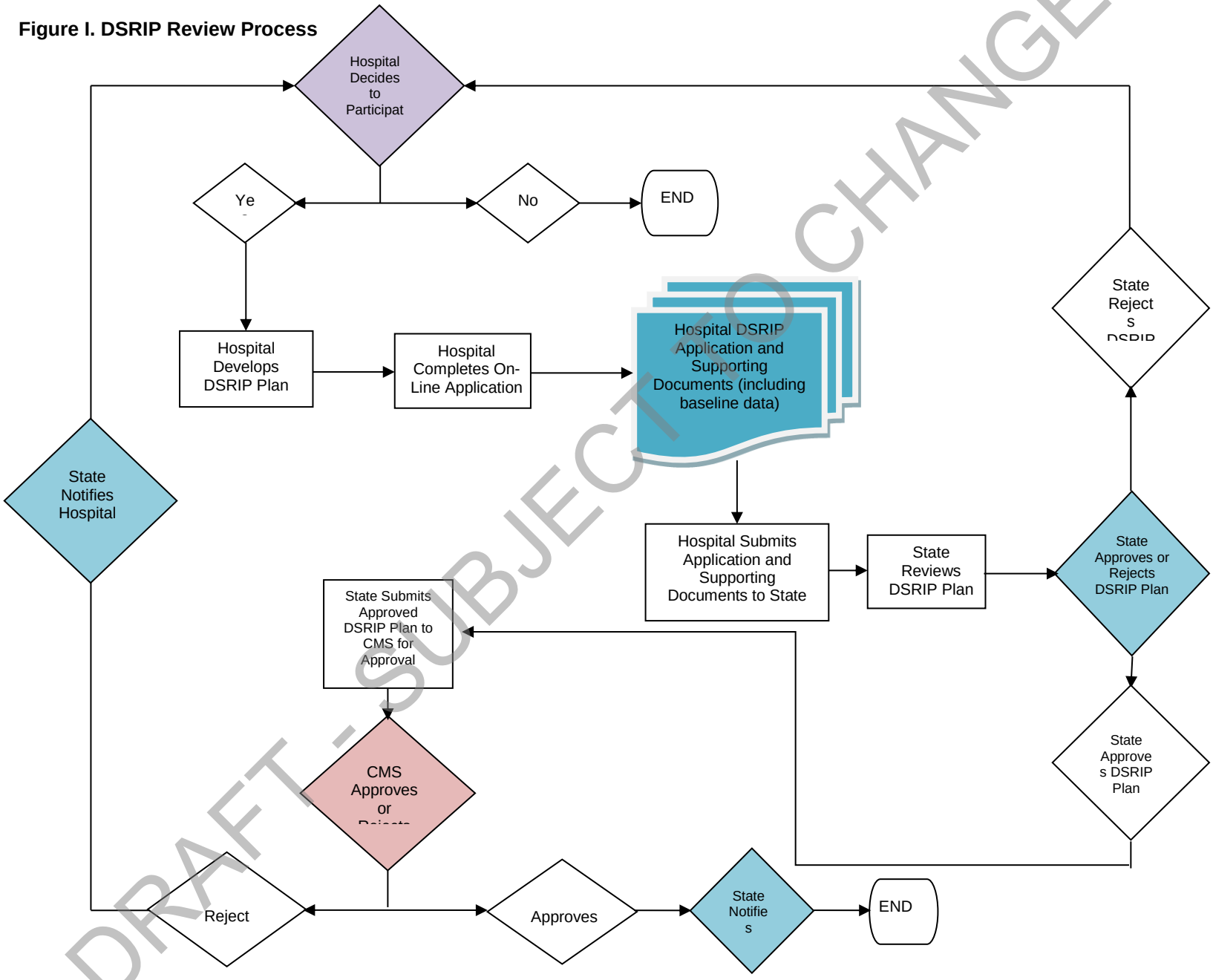
Figure I. DSRIP Review Process



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III. Reporting Requirements

A. Participating Hospital Reporting for Payment in DY2

i. Hospital DSRIP Plan Submission

Submission of a Department-approved Hospital DSRIP Plan to CMS shall serve as the basis for payment of 50 percent of the DY2 Target Funding Amount. The state will not claim FFP for any monthly DSRIP payments made to a hospital until CMS has approved a Hospital DSRIP Plan for that hospital. Upon approval of a facility's Hospital DSRIP Plan by CMS, the state can claim FFP for all DSRIP Payments in accordance with paragraph 92 of the STCs.

ii. Hospital DSRIP Plans Not Approved by CMS

All hospitals whose Hospital DSRIP Plan is not approved in full by CMS shall be at risk for recoupment of their entire DY2 DSRIP monthly payments paid out in DY2. (Transition Payments are not subject to recoupment.) Within 60 business days of CMS written denial of a Hospital DSRIP Plan, the Department shall recoup the DY2 DSRIP monthly payments previously paid to the hospital. Hospital DSRIP payments recouped shall be added to the Universal Performance Pool and will be disbursed to qualifying facilities.

iii. DY2 Baseline

Participating hospitals will be provided with the numerator, denominator and rate for each state-calculated Stage 3 and Stage 4 measures based on the hospital's selected project. Hospitals will be asked to confirm receipt within 15 days of notification. After 15 days from notification the Department will finalize the baseline measurements and compute the improvement target goals and baseline performance thresholds.

iv. DSRIP Progress Report Submission for DY2

Participating hospitals seeking payment under the DSRIP program in DY2 for the remaining 50 percent of the DY2 Target Funding Amount shall submit a progress report describing the extent of their progress on their project to the Department within 30 days after Department notification of plan approval by CMS, but no later than June 1, 2014. Successful submission of this report shall qualify a participating hospital for its remaining DY 2 DSRIP payment. Should a participating hospital fail to submit its report by the indicated due date, all DY 2 funding for progress report submission will be deemed unmet, and incentive payments associated with this progress report will be forfeited to the Universal

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Performance Pool to be redistributed. See section VI, subsection F, "DSRIP Universal Performance Pool" for more information.

The progress report shall be submitted using the standardized reporting form approved by the Department and CMS. Based on this report, participating hospitals shall earn DSRIP payments, calculated by the Department, based on successful submission of the DY2 progress report. The submitted progress report shall include:

- The progress of each process metric from the date of application through March 31, 2014
- The progress of all current and planned activities from the date of application through March 31, 2014, including whether the stage activity has been completed, is in progress, or has not been started
- The infrastructure developments made and outcomes of those developments
- The project developments and outcomes as they relate to the pilot populations
- Summary of the hospital's stakeholder engagement and activities
- Work accomplished with external partners

A timeline of future activities

Once the Department accepts the report, the Department shall have up to 30 days to review and approve, with approval no later than June 15, 2014. Initial approval will be completed by the Department and submitted to CMS by June 30, 2014.

Providers will not receive any DSRIP funding for any actions/milestones initially targeted for completion in DY2 experience period. DY3 funding will be based on those actions/milestones initially targeted for DY3 and as calculated in section VI "DSRIP Payment Based on Achievement of Milestones and Metrics" However, in the first DY3 quarterly report, providers will be required to provide additional documentation about the completion of DY2 milestones as appropriate.

B. Participating Hospital Reporting for Payment in DY3-DY5

i. Annual DSRIP Application Renewal

- For participation in DSRIP in DY3-DY5, the hospital will be required to submit an annual DSRIP Application Renewal as noted below.
  - DY3: Annual DSRIP Application Renewal due within 5 days after notification of approval of DY2 application

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        - For DY 3, the hospital will provide the Department the Hospital's notification of intent to continue in the DSRIP Program in DY3.
    - DY4: Annual DSRIP Application Renewal due April 30, 2015
    - DY5: Annual DSRIP Application Renewal due April 30, 2016
- Each Annual DSRIP Application Renewal for DY4 and DY5 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

ii. *Approval of DSRIP Application by the Department/CMS*

If a hospital's DSRIP Plan was approved for DY2/DY3, DSRIP Hospital Plans submitted with the annual DSRIP Application in DY4 andDY5 will not require re-approval by the Department/CMS, unless the hospital's recommended changes or modifications from the approved DY2/DY3 Hospital DSRIP Plan would alter the DSRIP project goals or departures from the approved DY2/DY3 Plan would affect payment and/or change the valuation of any measure. If such modifications to, or departures from, the original DY2/DY3 DSRIP Hospital Plan are noted, the Department/CMS approvals will follow the processes described above Section II, subsections B and C except for the following changes.

- The Department will take action on each timely submitted modified DSRIP Plan no later than 45 days after date of submission (June 15); will approve each plan that it deems meets the criteria outlined in Attachment H: "DSRIP Planning Protocol," Attachment I: "DSRIP Program Funding and Mechanics Protocol," and "DSRIP Plan Checklist"; and will submit approved plans (along with their completed DSRIP Plan Checklists) to CMS for final review and approval.
- In the event CMS requests additional information, the Department shall submit revised Hospital DSRIP Plans to CMS within 30 days of request from CMS and CMS shall approve or deny the plans in writing to the Department with 15 days.

iii. *Modified Hospital DSRIP Plans Not Approved by CMS*

All hospitals submitting a modified Hospital DSRIP Plan for DY4, or DY5 which is not approved in full by the Department or CMS shall be at risk for recoupment of their entire demonstration year incentive payment paid out

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in the demonstration year for which the plan was modified. Within 60 business days of CMS written denial of a modified Hospital DSRIP Plan, the Department shall recoup the demonstration year payments previously paid to the hospital. Hospital DSRIP payments recouped shall be added to the Universal Performance Pool and will be disbursed to qualifying facilities.

iv. DSRIP Progress Report Submission for DY4 and DY5

Four times per year in DY4 and DY5, participating hospitals seeking payment under the DSRIP program shall 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 shall be submitted using the standardized reporting form approved by the Department and CMS which shall include a databook for metric reporting. The reports shall also include all supporting data and back-up documentation. Based on these reports, participating hospitals shall 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 shall include:

- The progress of each process metric
- Verification of State calculated claims-based Stage 3 and Stage 4 metrics, including a description of how the hospital verified the reported metrics and an attestation of the verification (October and April progress reports)
- 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 infrastructure developments made and outcomes of those developments
- The project developments and outcomes as they relate to the pilot 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

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- A timeline of future activities
- Budget and return on investment analysis

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

- **DY3-DY5 Progress Report 1:** This report is due no later than **July 31 of the current DY** and shall include the following,
  - List of Stage 1 and 2 activities completed during the experience period **April 1 of prior DY through June 30 of the prior DY**
  - Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed on the current DY Progress Report 1

- **DY3-DY5 Progress Report 2:** This report is due no later than **October 31 of the current DY** and shall include the following,
  - List of Stage 1 and 2 activities completed during the experience period **July 1 through September 30 of the current DY**
  - List of Stage 1 and 2 activities completed during the experience period **April 1 of prior DY through June 30 of prior DY**, but not otherwise claimed as completed in current DY Progress Report 1
  - Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed on the current DY Progress Report 2
  - Stage 3 and Stage 4 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 verified by the hospital
    - For DY3, unless otherwise stated in the databook, all measures must be reported by October 31, 2014. If a measure is required to be reported October 31, 2014 and is not included in DY3 Progress Report 2, funding shall be considered not earned and forfeited. If the databook indicates otherwise for a given metric, the

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progress report should include rationale for omission of the metric and a plan for obtaining the metric by April 30, 2015, otherwise funding for the metric will be forfeited.

- For DY4 and DY5, if the hospital fails to submit the metrics by the deadline, the funding shall be considered not earned and forfeited.

- **DY3-DY5 Progress Report 3:** This report is due no later than **January 31 of the current DY** and shall include the following,
  - List of Stage 1 and 2 activities completed during the experience period **October 1 through December 31 of the current DY**
  - List of Stage 1 and 2 activities completed during the experience period **April 1 of prior DY through September 30 of current DY**, but not otherwise claimed as completed in current DY Progress Reports 1 and 2
  - Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed in the current DY Progress Report 3

- **DY3-DY5 Progress Report 4:** This report is due no later than **April 30 of the current DY** and shall include the following,
  - List of Stage 1 and 2 activities completed during the experience period **January 1 through March 31 of the current DY**
  - List of Stage 1 and 2 activities completed during the experience period **April 1 of prior DY through December 31 of current DY**, but not otherwise claimed as completed in current DY Progress Reports 1, 2, and 3.
  - Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed in the current DY Progress Report 4
  - Stage 3 and Stage 4 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 verified by the hospital
    - If the hospital fails to submit the metrics by the

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deadline, the funding shall be considered not earned and forfeited

- In DY5, the Progress Report 4 reporting submission deadline and review period will be adjusted to ensure that all DSRIP monies, including the UPP payment will be paid no later than the end of the final demonstration year, June 30th, 2017. Therefore, the hospital must submit their final DY5 report one week prior to normal submission deadline, April 21, 2017.

Any Stage 1 or 2 actions/milestones that were initially targeted to be completed between the period September 20, 2013 through March 31, 2014, but were otherwise completed after March 31, 2014, will not be tied to any DSRIP funding. DY3 funding will be based on those actions/milestones initially targeted for DY3 and as calculated in section VI "DSRIP Payment Based on Achievement of Milestones and Metrics".

For DY3-DY5, 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 time period in Progress Report 4, will be forfeited and moved to the Universal Performance Pool to be redistributed. Quarterly activities must be completed in the designated quarter or funding tied to such activities will be forfeited and moved to the Universal Performance Pool to be redistributed. See section VI, subsection F, "DSRIP Universal Performance Pool" for more information.

For DY3, unless otherwise indicated in the databook, any DSRIP funds tied to Stage 3 and 4 metrics which were required to be reported but were not reported in DY3 Progress Report 2 will be forfeited and moved to the Universal Performance Pool to be redistributed. Any DY3 DSRIP funds tied to Stage 3 and 4 metrics which were required to be reported but were not reported in DY3 Progress Report 4 will be forfeited and moved to the Universal Performance Pool to be redistributed. See section VI, subsection F, "DSRIP Universal Performance Pool" for more information.

For DY4 and DY5, all Stage 3 metrics, 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

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the DY will be forfeited and moved to the Universal Performance Pool. 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 Universal Performance Pool to be redistributed.

Once the report is accepted by the Department, the Department and CMS shall have a total of 45 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 21 days following the Department's acceptance of the report. If additional information is requested, the participating hospital shall respond within 15 days and both the Department and CMS shall have an additional 15 days to concurrently review, approve, or deny the request for payment, based on the data provided.

C. State Reporting and Communications with CMS

The Department and CMS will use a portion of the Monthly Monitoring Calls (see paragraph 101 of the STCs) for March, June, September, and December of each year for an update and discussion of progress in meeting DSRIP goals, performance, challenges, mid-course corrections, successes, and evaluation.

IV. Hospital's DSRIP Target Funding Amount

A. Demonstration Year (DY) 2

In DY2, DSRIP funding amounts identified in paragraphs 95 and 96 of the Special Terms and Conditions (STCs) will be allocated to eligible hospitals per the list in subsection I.C., "DSRIP Eligibility Criteria," according to the following formula:

Step 1 – The initial DSRIP target funding amount for each hospital shall be one half of their SFY 2013 Hospital Relief Subsidy Fund (HRSF) amount (DY1 Transition Payments plus UPL payments made under the Medicaid state plan in SFY 2013) and subjected to the adjustments noted in Steps 2 and 3 below.

Although all DSRIP payments are at risk to the participating hospital (i.e., payments are reward-based for documented achievement on project milestones and metrics), providing a target funding amount provides a degree of predictability to hospitals and ensures that hospitals are able to manage

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their finances with reasonable stability while incentivizing and rewarding investment in quality improvement.

Step 2 – For those hospitals whose State Fiscal Year (SFY) 2013 Hospital Subsidy Relief Fund amount is less than a floor amount of $125,000, the DSRIP target funding amount will be adjusted to the floor amount. For these hospitals, this shall be their Adjusted DSRIP Target Funding Amount for DY2. Providing for a floor amount appropriately incentivizes every hospital to participate and invest in quality improvement.

Step 3 – For those hospitals whose SFY 2013 HRSF amount is greater than or equal to the floor, the hospitals shall have their initial DSRIP target funding amount decreased proportionately in order to maintain total statewide DSRIP funding amount per the STCs (i.e., $83,300,000). The result of this reduction yields their Adjusted DSRIP Target Funding Amount for DY2.

Step 4 – The Adjusted DSRIP Target Funding Amount for DY2 is forfeited and added to the UPP for the following hospitals:

- Those hospitals who elect not to participate in DSRIP, by either notifying the Department of non-participation or by not submitting a DSRIP application by September 20, 2013
- Those hospitals whose submitted DY2 DSRIP Plan\Application was denied by CMS.

B. Demonstration Years 3-5

For Demonstration Years 3-5, DSRIP funding amounts identified in paragraphs 95 and 96 of the STCs shall be allocated to eligible hospitals per the list in subsection I.C, "DSRIP Eligibility Criteria," according to the following formula:

Step 1 – The Initial DSRIP Target Funding Amount for each hospital shall be the hospital's final DSRIP Target Funding Amount for DY2 times 2 and will then be subjected to the adjustment in Step 2.

- If a hospital did not participate in DY2 due to circumstances described in Section II, subsection E above, and the hospital's plan was approved to participate in DY3, the hospital's Initial DSRIP Target Funding Amount will be the forfeited DY2 final DSRIP Target Funding Amount times 2 and will then be subjected to the adjustment in Step 2.
- If a hospital did not participate in DY2 due to either circumstance in Step 4 in subsection A. above, the hospital's final DSRIP Target Funding Amount for DY2 times 2 will be forfeited and added to the UPP.

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Step 2 – A proportionate share of the target funding amounts (Step 1) shall be directed to a Universal Performance Pool (UPP), which shall be available to hospitals that successfully maintain or improve on a subset of Stage 4 DSRIP Performance Indicators. The initial DSRIP Target Funding Amount after the reduction for the UPP shall be the hospital's Adjusted DSRIP Target Funding Amount for DY3-DY5. The UPP allows for greater rewards to hospitals that meet or improve their universal performance metrics. The carved out amount for the UPP is as follows for each demonstration year:

DY3	DY4	DY5
10%	15%	25%

Funds in the UPP shall be distributed to qualifying hospitals using the formula described in Section VII, subsection E, "DSRIP Universal Performance Pool" below.

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

For DY2, transition payments will continue for six months from July 1, 2013 through December 31, 2013. The DSRIP Target Funding Amounts for DY2, representing potential DSRIP payments for January 2014 through June 2014, is the amount that will be distributable for the approved DY2 DSRIP Hospital Plan/Application and the submission of an approved DY2 progress report. The DY2 DSRIP Target Funding amount will be equally allocated (50/50) to the approved Hospital DSRIP Plan/Application and the submission of an approved DY2 progress report.

For DY3-DY5, the DSRIP Target Funding Amount less the UPP carve out will be distributable to Stages 1-4 only.

Table II below illustrates, by demonstration year, the overall amounts allocated to Stages 1-4, considering transition payments (DY2), carve out for UPP (DY3-5), and funding tied to the approval of the Hospital DSRIP Plan Application (DY2) and DY2 progress report.

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Table II. TOTAL DSRIP FUNDING DISTRIBUTABLE TO STAGES 1-4

In Thousands	DY2	DY3	DY4	DY5
Transition Payments (6 months)	$83,300	$0	$0	$0
DSRIP Target Funding	$83,300	$166,600	$166,600	$166,600
Total Demonstration Year Funding	**$166,600**	**$166,600**	**$166,600**	**$166,600**
DSRIP Target Funding	$83,300	$166,600	$166,600	$166,600
	0%	10%	15%	25%
Less UPP "Carve Out"	$0	$16,660	$24,990	$41,650
Adjusted DSRIP Target Funding Amount	**$83,300**	**$149,940**	**$141,610**	**$124,950**
	50%	0%	0%	0%
Less Funding for DSRIP Application	$41,650	$0	$0	$0
Less Funding for Approved DY2 DSRIP	50%	0%	0%	0%
Progress Report	$41,650	$0	$0	$0
Total Distributable Amount for Stages 1-4	**$0**	**$149,940**	**$141,610**	**$124,950**

Based on the above table, the Total Distributable Amount for Stages 1-4 are then further allocated to each stage as follows:

Table III. DSRIP STAGE FUNDING DISTRIBUTION

Stages	DY2	DY3	DY4	DY5
1 & 2	0%	75%	50%	25%
3	0%	15%	35%	50%
4	0%	10%	15%	25%
Total	**0%**	**100%**	**100%**	**100%**

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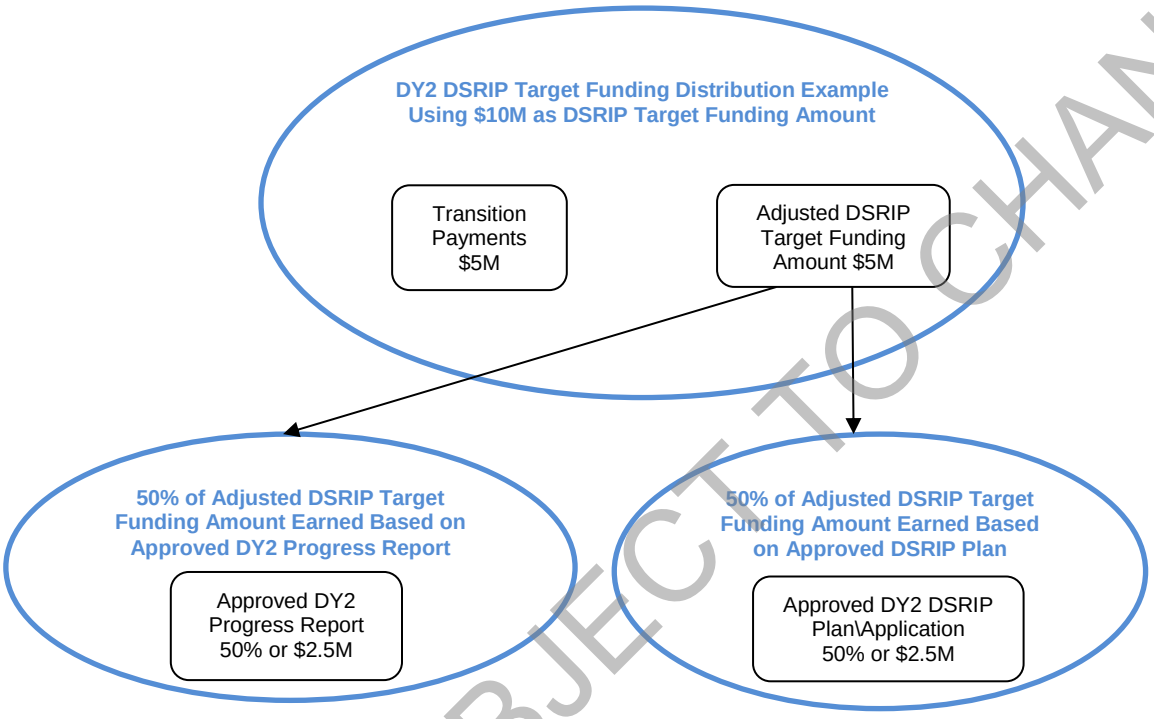
The following provides an illustration of how a hospital's DSRIP Target Funding Amount, calculated in accordance with Section IV: "Hospital's DSRIP Target Funding Amount," is both distributed and earned in DY2. A hospital DSRIP Target Funding Amount of $10 million is used in the illustration.

Figure II. DY2 DSRIP Target Funding Distribution Example[7]



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[7] Example assumes no adjustment for floor ($125,000) was required. Adjusted DSRIP Target Funding amount of $5,000,000 would most likely be adjusted down to account for participating hospitals whose Initial DSRIP Target Funding amounts were below $125,000 floor.

VI. DSRIP Payment Based on Achievement of Milestones and Metrics

Hospital DSRIP Plans shall include a narrative that describes the stages and activities selected by hospitals for their project. Each activity will have at least one milestone/metric that will be used to determine payment.

A. General Requirements

As described in the New Jersey DSRIP Planning Protocol, a DSRIP participating hospital will select one project, from a menu of projects based on eight focus areas or will propose a unique focus area or an off-menu project. The hospital will then select activities from a pre-determined menu of activities. Hospitals are encouraged to use innovative and value-driven approaches in accomplishing the project activities. As discussed in the DSRIP Planning Protocol, Section V: "DSRIP Project Array," Department and CMS approval will be required for all hospital unique focus areas and off-menu projects.

B. Milestone and Measure Valuation

The Hospital DSRIP Plan will include sections on each of the 4 stages and the activities included in each stage as specified in the DSRIP Planning Protocol. 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. With exception of DY2, a participating hospital must fully achieve a metric in order to receive payment (i.e., no payment for partial completion). These metrics will be valued as follows:

i. 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. With exception of those milestone/metrics targeted for completion in DY2, each milestone/metric targeted for completion in the demonstration year's Stage 1 experience period will be valued equally. No funding will be tied to milestone/metrics targeted for completion in DY2. For Stage 1 experience periods, see section C. Experience Period below.

- With exception of quarterly activities, all 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 quarterly activities must be completed by the targeted completion date for each quarter. A hospital completing a Stage 1 activity which was targeted for the current demonstration year's experience period but

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was completed in a subsequent demonstration year's experience period, will not achieve payment for this activity.

ii. Stage 2: Chronic Medical Condition Redesign and Management

Activities in this stage include the piloting, testing, and replicating of chronic patient care models. With exception of those milestone/metrics targeted for completion in DY2, each milestone/metric targeted for completion in the demonstration year's Stage 2 experience period will be valued equally. No funding will be tied to milestone/metrics targeted for completion in DY2. For Stage 2 experience periods, see section C. Experience Period below.

- With exception of quarterly activities, 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 quarterly activities must be completed by the targeted completion date for each quarter. A hospital completing a Stage 2 activity which was targeted for the current demonstration year's experience period but was completed in a subsequent demonstration year's experience period, will not achieve payment for this activity.

iii. Stage 3: Quality Improvement

This stage involves the broad dissemination of Stage 1 and Stage 2 activities. Stage 3 measures the clinical performance of the hospital's DSRIP project and thus, valuation of this stage will be equally based on the reporting of clinical (Stage 3) measures in DY3 for the project. Reporting of Stage 3 measures in DY2 will not be tied to funding. For DY4 and DY5, 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. 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, with exception of DY2, all hospitals are expected to report Stage 4 DSRIP Performance Indicators selected by the Department and CMS. Beginning with the first Progress Report for DY3, baseline Stage 4 DSRIP

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Performance Indicators data will be due with the submission of the progress report. If the measure cannot be provided, the hospital must submit a plan to provide the measure by October 31, 2014 (DY3), unless otherwise stated in the databook. No later than the end of DY3, hospitals shall establish a baseline for all Stage 4 DSRIP Performance Indicators, including those attributed to the UPP.

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 Universal Performance Pool to be redistributed.

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 claim lag. For certain Stage 1 and 2 activities and milestones, hospitals will be required in their Hospital DSRIP Plan to identify the targeted date of completion. This targeted date will be required to be completed within a specified experience period. The activity can be completed within a given demonstration year, but in order for payment to occur before the demonstration year ends, reporting and review time must be factored in for the hospital, the Department, and CMS. Additionally, due to claims lag, the experience period for Stages 3 and 4 activities will also differ from the demonstration period. For these reasons, the experience period may not necessarily coincide with the demonstration year.

Although some Stage 1 and 2 activities must be completed by a specified date, the following experience periods will be used as a guide for most Stage 1 and 2 activities.

Table IV. STAGES 1 AND 2 EXPERIENCE PERIODS, BY DEMONSTRATION YEAR
Demonstration Year

Demonstration Year	Begin	End
DY2	September 20, 2013	March 31, 2014
DY3	April 1, 2014	March 31, 2015
DY4	April 1, 2015	March 31, 2016
DY5	April 1, 2016	March 31, 2017

Since Stages 3 and 4 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 Stage 3 and 4 metrics will be

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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, for certain activities in Stage 1 and Stage 2, the hospital will be required to indicate the targeted date of completion. 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 received for incomplete submissions. Completion of Stage 1 and Stage 2 milestone/metric must be included in quarterly progress reports. Stage 3 and Stage 4 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: DY 3-DY 5

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. Although completion of Stage 1 and 2 activities will be reported quarterly, New Jersey intends to provide payment to the participating hospitals for these stage activities on a monthly basis in order to maintain adequate cash flow to the hospitals during the demonstration. Monthly payments will be adjusted by the Department if review of a quarterly progress report reveals that sufficient activities have not been completed to support amounts paid to date. The draw of the federal financial participation (FFP) match for Stage 1 and 2 activities, 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. Therefore, any DY 3 – DY 5 payment for Stage 1 and 2 activities which were not completed (not earned) by the targeted completion date, will be at risk to the Department and subject to recoupment from the hospital if not completed within the demonstration year's experience period.

Stage 3 metrics will be reported either annually or semi-annually, depending on the metric. In DY3, payment to hospitals for reporting Stage 3 metrics will coincide with the metric reporting frequency. Federal match for payments to hospitals for reporting Stage 3 metrics, or reporting of such payments on the CMS-64, will not occur until the metric has been reported and verified by both the Department and CMS. Therefore, in DY3 any payment for Stage 3 metrics which were not reported as outlined in the databook (as updated in the Planning Protocol, Attachment A: Toolkit), will be at risk to the Department and subject to recoupment from the hospital.

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For DY4 and DY5, although only a subset of Stage 3 metrics will be based on pay for performance (P4P), all Stage 3 metrics are required to be reported to earn any payment tied to performance. Payment for the P4P metrics will coincide with the metric reporting frequency. Federal match for Stage 3 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 Stage 3 metrics have been reported. Therefore, in DY4 and DY5 any payment for Stage 3 P4P metrics which were earned will be at risk to the Department and subject to recoupment from the hospital.

Stage 4 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 Stage 4 metrics which were not reported as outlined in the databook (as updated in the Planning Protocol, Attachment A: Toolkit) will be at risk to the Department and subject to recoupment from the hospital.

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

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 DY3 is valued at $10 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	AV
Stage 1: Metric 1	Complete	1

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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 $4,000,000. Since Stage 1 and 2 is paid monthly, the hospital has already received $5,000,000 ($10 million/12*6 months). The Department will adjust remaining demonstration year monthly payments going forward.

At the end of the DY3, the participating hospital successfully completes the remaining metrics. The hospital has satisfied the requirements to receive the balance of the DSRIP payments related to Stages 1 and 2.

B. Calculating DSRIP Payments for Stage 3 Project-Specific Metrics

Stage 3 Project-Specific Metrics are required to be reported in DY3-DY5, however, specific Stage 3 metrics will be tied to performance in DY4 and DY5. As described above in Section VI, subsection B, "Milestone and Measure Valuation," DSRIP payment in DY3 will be based on the metrics reported, whereas DSRIP payments for DY4 and DY5 primarily will be based on performance.

i. DY3

The DSRIP payment for Stage 3 to a participating hospital will be based on the hospital successfully reporting all Stage 3 metrics when required. Each metric will be valued equally. Since some Stage 3 metrics require a semi-annual reporting frequency, the value of those metrics will then be halved. Therefore, the AV for each Stage 3 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

Any Stage 3 metric not reported on October 31, 2014, unless otherwise stated in the databook, will receive an AV of 0 in DY3.

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 metric determined by multiplying the total amount of funding allocated to Stage 3 by the PAV.

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ii. DY4 and DY5

In order to receive an incentive payment during the Stage 3 pay for performance demonstration years, DY4 and DY5, the Department will first require the hospital to report all Stage 3 measures. The DSRIP payment will then be based on the requirement that the hospital will make measurable improvement in a core set of the hospital's Stage 3 performance measures. A measurable improvement is considered to be a minimum of a ten percent reduction in the difference between the hospitals baseline performance and an improvement target goal. All performance metrics will be rounded to the hundredth place according to normal rounding practices. Four and below will be rounded down; five and above will be rounded up.

The following steps will be performed to determine Stage 3 pay for performance improvement targeting for each suitable measure:

Step 1 – For each claim-based measure, the Department will calculate the current New Jersey Low Income hospital performance for all Stage 3 P4P measures for every project. This performance will be used to determine the Improvement Target Goal described further in Step 2. For non-claim based measures, a hospital cannot receive incentive payments in DY 4 or DY5 for any measure for which the hospital has not reported a baseline value. The baseline performance will represent the most recent performance available following the measure's technical specifications and be no older than calendar year 2010 dates of service.

Step 2 – The performance results will be shared with the Quality & Measures Committee in order to select the New Jersey Low Income Improvement Target Goal for all Stage 3 P4P measures. The Improvement Target Goal serves as the standard level of performance that New Jersey hospitals will strive to obtain as recommended by the Quality & Measures Committee (see Planning Protocol, Section IX) and agreed to by the Department and CMS. The Improvement Target Goal for any given metric will be no less than the 75th percentile and no higher than the 90th percentile.

For measures that have insufficient data to compile a New Jersey Low Income Improvement Target Goal, the Department, or its designee, will determine if there are publicly available benchmarks (e.g. national, Medicare-only, or commercial) that may be substituted for the New Jersey Low Income Improvement Target Goal.

The New Jersey Low Income Improvement Target Goal will remain stable for the life of the demonstration to maintain predictability for the hospitals.

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Step 3 – For each suitable core measure tied to pay for performance, the Department will incentivize the hospital to reduce the difference between their hospital's baseline performance and the Improvement Target Goal, 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 P4P baseline will be from each metric's most current reporting period reported in DY3.

To compute the Gap, the Department will subtract the hospital's P4P baseline performance rate from the Improvement Target Goal.

Step 4 - In order to receive an incentive payment, the Department requires the hospital's gap in performance to be reduced by ten percent (10%) during the pay for performance demonstration years. Therefore, in DY4 and DY5, the hospital must reduce its gap at a minimum by ten percent. This will result in a minimum overall total reduction for the demonstration of twenty percent (20%).

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

If a measure's performance period is less than an annual period (i.e. calendar, state fiscal year, or federal fiscal year), the required reduction percentage will be adjusted accordingly in order to achieve the same annual reduction total (e.g. semi-annual measures require a 5% reduction in the Gap per performance period).

Step 5 – The Department will add this rate of improvement to the hospital's baseline rate of performance in order to establish the "Expected Improvement Rate."

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

The Department will then compare the Actual Performance Result to the Improvement Target Goal. If the Actual Performance Result is at, or above, the Improvement Target Goal, the hospital is eligible to receive an incentive payment for that performance period.

If it is not, the Department will compare the Actual Performance Result to the Expected Improvement Rate. If the Actual Performance Rate is at, or above, the Expected Improvement Rate the hospital is eligible to receive an incentive payment for that performance period.

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The improvement calculation will initially be performed at the end of DY3 for future DY4 performance and then repeated for each subsequent performance period. When the Expected Improvement Target is calculated for subsequent performance periods, the better of the Actual Performance Result or the Expected Improvement Target will be utilized as the baseline performance.

The above calculation is further illustrated in Table V.

Table V. 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%)
Line 5	Multiply the gap (line 3) by the 10% 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)***
Line 7	Compare Expected Improvement Target to Actual Performance Result; Is the Actual Performance Result at the Improvement Target Goal? Is the Actual Performance Result at the Expected Improvement Target? If either are Yes – then the Payment Incentive is Awarded.

If a measure's performance period is less than an annual period, the Department may compute a year-to-date performance rate along with the rate for the specified performance period. Upon review of the actual performance data, the Department may determine, with CMS concurrence, that the better of performance between these two rates will be used to compare against the Expected Improvement Rate for determining eligibility for payment. This has the effect of smoothing inconsistent and irregular data patterns that may be seen over a shorter performance period.

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.

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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 Stage 3 allocation amount by the total number of P4P measures tied to the project the hospital has selected.

$$\frac{\text{Stage 3 Allocation}}{\text{Total P4P measures}}$$

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. (e.g. The allocation for semi-annual measures will be divided by two to determine how much the hospital can receive for each performance period.)

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 over the hospital's baseline performance rate per year as the Expected Improvement Target for that measure. This may occur if there is insufficient data to develop a New Jersey Low Income Improvement Target Goal, or if national benchmarking data is unavailable.

C. Calculating DSRIP Payments for Stage 4 DSRIP Performance Indicators (i.e. Universal Metrics)

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

Any Stage 4 metric not reported on October 31, 2014, unless otherwise stated in the databook, will receive an AV of 0 in DY3. 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 these measures will be 1 so long as the hospital has indicated why the measure cannot be reported.

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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 4 metric determined by multiplying the total amount of funding allocated to Stage 4 by the PAV.

Example:
The hospital's Stage 4 in DY3 is valued at $5 million. A total of 45 metrics are required to be reported. Under the payment formula, the 45 metrics represent a maximum TAV of 45. Therefore, each Stage 4 metric is valued at $111,111.11 ($5 million/45). Any Stage 4 metric required to be reported on a semi-annual reporting frequency will have a value of $55,555.56 ($111,111.11*0.5). At six months, the participating hospital reports 20 annual metrics and 10 semi-annual metrics. The hospital has earned $2,777,777.80 for stage 4 as shown below:

	(A) Reported	(B) Value	(A*B) Total Earned
Annual Metrics	20	$111,111.11	$2,222,222.20
Semi-Annual Metrics	10	$55,555.56	$555,555.60
		Total Stage 4 Earned	**$2,777,777.80**

Since Stage 4 is paid semi-annually, the hospital would receive $2,500,000 ($5 million/2) at the 6 month reporting period. The hospital has therefore earned more than the 6 month Stage 4 payment. The Department may therefore determine if an additional payment shall be made at that time or held until the last reporting period.

D. Forfeiture of DSRIP Payments

Scoring and evaluation of metrics will be completed based on the submission and review process describe above in Section III: "Reporting Requirements."

With exception of DY2, participating hospitals must fully achieve all milestones and metrics as described in their Hospital DSRIP Plans within a particular demonstration year's experience period in order to receive a DSRIP payment. No funding will be tied to milestone/metrics targeted for completion in DY2. Failure to achieve a metric within a given demonstration year's experience period will permanently forfeit the otherwise available DSRIP funding. All DSRIP funds that are forfeited by a hospital shall be added to the Universal Performance Pool and distributed according to the methodology described in subsection E, "DSRIP Universal Performance Pool" below.

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Once the scoring and evaluation of metrics has been completed by the Department and CMS, each hospital will be notified of the amount of DSRIP Incentive Payments earned. Upon approval from CMS, the Department may claim FFP for DSRIP payments earned and paid to the hospitals. If at any time the Department determines that a hospital will not achieve all their metrics and receive 100% of their DSRIP Incentive Target amount based on submitted progress reports, the Department will reduce the hospital's monthly DSRIP payment to ensure that the hospital is not overpaid. Any overpayment determined by the Department will be recouped from the hospital.

Upon notification by the Department of the final amount earned for the applicable demonstration year, a hospital shall have 30 days to submit a reconsideration request to the Department. The reconsideration period is available to address reporting or computational errors. Because the outcome of a reconsideration, as determined final by the Department and/or CMS, could impact the amount of funding that is forfeited and available for deposit in the DSRIP Universal Performance Pool (UPP), distribution of the UPP shall not occur until after the 30 day reconsideration period has ended.

With the exception of DY5, the Department will make all final DSRIP payments for the SFY and DY no later than 31 days following the end of the SFY. Upon making those final payments, funding attributable to that DSRIP year will be considered closed and final, and no subsequent adjustments will be made. DSRIP funds are not fungible between SFYs or DYs. For DY5, the Department will make all final DSRIP payments by June 30, 2017.

E. DSRIP Universal Performance Pool

All hospitals with approved Hospital DSRIP Plans will be eligible for the Universal Performance Pool (UPP). The UPP will be made up of the following funds:

- For DY2, hospital DSRIP Target Funds from hospitals that elected to not participate or where CMS did not approve the hospital's submitted plan. There will be no Carve Out Allocation amount for DY2.
- For DY3 – DY5:
  - 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. See Section IV: "Hospital's DSRIP Target Funding Amount," paragraph B, step 2 above, applicable to DYs 3-5.
  - Target Funds that are forfeited from hospitals that do not achieve project milestones/metrics, less any prior year appealed forfeited

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funds where the appeal was settled in the current demonstration year in favor of the hospital.

The total UPP amount determined above shall be distributed to qualifying hospitals based on maintaining or improving on a specific set of twelve Stage 4 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, Attachment 1: DSRIP Toolkit 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 must indicate its substitution choice in its submitted Hospital DSRIP Plan. Hospitals that have obstetrical and pediatric departments cannot substitute UPP measures and therefore must use the set of twelve UPP measures indicated.

The UPP amount will be distributed based on the sum of achievement values of these twelve metrics along with the hospital's state-wide Low Income Discharge percentage. The UPP metric AV will be determined as follows:

- UPP Metric is at or improves from baseline, AV = 1
- UPP Metric has regressed from baseline, AV = -0.5

For DY2, the AV will automatically be calculated as 1 for each UPP metric since the experience period for each UPP metric would be pre-DSRIP implementation.

For DY3-DY5, payment will be earned based on outcome of the 12 Universal Stage 4 metrics designated as UPP metrics (or replacement UPP metric, if applicable). Each of the 12 metrics will be evaluated separately and receive an achievement value (AV) score of either 1 or -0.5.

For each hospital, a total AV (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 Percentage Achievement Value (PAV) is then calculated by dividing the TAV by the maximum AV (12).

The hospital's PAV will then be weighted based the hospital's percent of Low Income discharges, using the percentage rate of the hospital's Low Income

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(Medicaid/CHIP/Charity Care from the MMIS data source) discharges to all statewide Low Income discharges. The result will be reflected as a percentage to total and the UPP will be distributed accordingly

The statewide Low Income discharge totals will be updated regularly, to occur no more frequently than on an annual basis, to reflect current hospital discharge data. Prior to UPP payment distribution, the Department will provide to CMS the calculation of the discharge distribution and the resulting discharge report that will be used.

VIII. Plan Modifications

Consistent with the recognized need to offer participating hospitals with flexibility to modify their plans over time considering evidence and learning from their own experience, as well as unforeseen circumstances or other good cause, a participating hospital may request prospective changes to its Hospital DSRIP Plan through a plan modification process.

Participating hospitals may submit requests to the Department to modify elements of an existing project prospectively, including changes to milestones and metrics with good cause. Modifications require re-approval by the Department/CMS if the hospital's recommended changes or modifications from the approved DY2 Hospital DSRIP Plan would alter the DSRIP project goals or departures from the approved DY2 Plan would affect payment and/or change the valuation of any measure. Such requests must be submitted to the Department with the annual DSRIP Renewal Form for changes to go into effect the following demonstration year. See above Section III Reporting Requirements, subsection B.i. for due date of annual DSRIP Renewal Form.

If such modifications to or departures from the original DY2 DSRIP Hospital Plan are noted, the Department/CMS approvals will follow the processes described above Section II, subsections B and C and Section III, subsection B.i. "Approval of DSRIP Application by the Department/CMS."

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