Welcome to the New Jersey DSRIP Learning Collaborative

September 15, 2016
2:00 PM – 4:00 PM

New Jersey Department of Health (NJDOH)

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Agenda

- **Review DY5 Status and DY4 Performance Achievement**
  - Review DSRIP Program Updates
  - Review DY4 Performance Achievement and Payment Summary Report
  - Review Performance and Payment Achievement Results
    - Statewide
    - Per Learning Collaborative
  - Review Measurement Collection, Calculation and Reporting
- Break
- **Discuss Optional Next Steps**

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DY5 Program Updates

DY5 Q1 Progress Reports

- All 49 progress reports were submitted timely to CMS and are under their review.

DY5 Renewal Applications

- All 49 renewal requests have been approved and letters sent to hospital leadership for signature.

DY5 Activity Adjustments

- Semi-Annual Performance Measurement due October 31, 2016 is being adjusted to be reported by **January 31, 2017**.
- Semi-Annual Attribution expected in August 2016 will be sent to hospitals in **October 2016**.

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DY5 Program Updates

DY5 Funding Allocation adjustments

DSRIP STAGE FUNDING DISTRIBUTION

Stages	DY2	DY3	DY4	DY5
UPP Carve Out	0%	10%	15%	25%
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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DY5 Program Reminder

- Myers and Stauffer Secure File Transfer Protocol (FTP) site
  - Terms of Use (TOU) agreements are required to access the secure FTP site. Ensure that reporting partner contacts have completed all steps to access the FTP to obtain patient rosters.
  - Ensure that changes to primary and secondary contacts are updated so that hospital contacts are current and have access to the FTP and webportal.
  - Users are **not** permitted to share their FTP site username and password with anyone.

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Performance Achievement and Payment Summary Report Review

Performance Achievement and Payment Summary Report Review

DY4 Performance Measure and Payment Achievement Summaries

The tables below provide views for the amount earned for each Stage and the UPP, information on the amount earned in comparison to the appropriate target and the total payments to date. Please note that Stage 1 and 2 payments are included for reference purposes only as they have previously been closed-out with payments allocated.

Please refer to Addendum 1: Stage 3 Measures Catalogue, Addendum 2: Stage 4 Measures Catalogue and the Funding and Mechanics Protocol documents located on the New Jersey DSRIP website (https://dsrip.nj.gov/Home/Resources) for program information.

The table below shows the Total Met/Not Met counts for DY4.

TABLE 1. DY4 Performance Measure Achievement Summary

	Total	Met	Not Met
Stage 3			
Stage 4			
UPP			

Count of measures by achievement

Table columns include:

- Stage 1 and 2 – For display only and are not considered in this notice
- Earned – Total achieved payment earned for each identified Stage
- Forfeited to UPP – Amount transferred to the UPP for measures or activities not met in Stages 1 through 4
- Target & UPP Carve-out – Amounts available to be earned in each stage or the carve-out from the DY target allocated to the UPP
- Analysis (Earned minus Target) - The difference in the Target amount and the amount Earned

TABLE 1.1. DY4 Payment Achievement Summary

	Earned	Forfeited to UPP	Target Amount & UPP Carve-out	Analysus (Earned - Target)
Stages 1 and 2	$	$	$	
Stage 3	$	$	$	
Stage 4	$	$	$	
Stages 1 - 4 SubTotal	$	$	$	$
DY3 Adjustments	$		$	$
UPP	$		$	$
Total	$		$	$

Year-end summary of amount earned and forfeited to UPP by Stage.

Note: Values displayed to nearest dollar but not rounded

Performance Achievement and Payment Summary Report Review

Summary of payments made to hospital and the reason for any adjustments

The table below shows the monthly payment advances as well as any payment adjustments for DY4.

TABLE 1.2. Payment Advance Summary

Payment Period	Payment
July 2015 Payment	$
August 2015 Payment	$
September 2015 Payment	$
Q1 Adjustment	$
Q1 Adjustment Month	$
Q1 Adjustment Reason	$
October 2015 Payment	$
November 2015 Payment	$
December 2015 Payment	$
Q2 Adjustment	$
Q2 Adjustment Month	$
Q2 Adjustment Reason	$
January 2016 Payment	$
February 2016 Payment	$
March 2016 Payment	$
Q3 Adjustment	$
Q3 Adjustment Month	$
Q3 Adjustment Reason	$
April 2016 Payment	$
May 2016 Payment	$
June 2016 Payment	$
Q4 Adjustment	$
Q4 Adjustment Month	$
Q4 Adjustment Reason	$
Total DY4 Payments to Date	$
Total DY4 Earned (From Table 1.1)	$
Final DY4 Payment (Earned minus Payments to date)	$

Note: Values displayed to nearest dollar but not rounded

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TABLE 2. DY4 Stage 3 Payment Summary

Achieved	
Max Possible	
Percent Achieved	
Stage 3 Target	$
Stage 3 Earned	$
Stage 3 Forfeited to UPP	$

Note: Values displayed to nearest dollar but not rounded

Stage 3 Achievement
EITG Met = 1 point
EITG Not Met = 0 points

Stage 4 Achievement
Reported = 1 point
Not Reported = 0 points

TABLE 3. DY4 Stage 4 Payment Summary

Achieved	
Max Possible	
Percent Achieved	
Stage 4 Target	$
Stage 4 Earned	$
Stage 4 Forfeited to UPP	$

Note: Values displayed to nearest dollar but not rounded

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Performance Achievement and Payment Summary Report Review

TABLE 4. DY4 NJDSRIP Program UPP Summary

UPP Carve-out	
Non-Participating Forfeit to UPP	
DY3 Q4 Appeal Adjustment	
Stage 1 and 2 Forfeiture	$
Stage 3 Forfeiture	$
Stage 4 Forfeiture	$
Total	**$**

Note: Values displayed to nearest dollar but not rounded

UPP contains payments from:
UPP Carve-out
Non-Participating hospitals
Prior Year Appeal Adjustment (decrease)
Forfeitures from each stage

UPP Payment Calculation
See example on next slide

TABLE 4.1. DY4 UPP Payment Summary

Achieved	
Percent Achieved	
Admission Percent	
Adjusted Percent Achieved	
Total Adjusted Percent Achieved	
Final Percent Achieved	
UPP Total	$
UPP Payment	**$**

Note: Values displayed to nearest dollar but not rounded, percentages displayed to the hundredths place

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Performance Achievement and Payment Summary Report Review

✓ UPP Achievement = PAV*(Hospital's Low Income Discharge Percentage to all Statewide Low Income Discharges) *UPP funds available

Example: $5M available for distribution	A	B = A/12	C	D = B * C	E = D/.61	F = E * 5M
	Total Achievement Value Score	**Percentage Achievement Value**	**Low Income Discharge % ****	**Adjusted Total Score Adjusted by Low Income Discharge %**	**Percent to Total**	**UPP Payment**
Hospital A	**10.5**	**87.50%**	**9%**	**0.08**	**0.13**	**$649,485**
Hospital B	7.5	62.50%	26%	0.16	0.27	$1,340,206
Hospital C	3	25.00%	22%	0.06	0.09	$453,608
Hospital D	10.5	87.50%	8%	0.07	0.12	$577,320
Hospital E	3	25.00%	9%	0.02	0.04	$185,567
Hospital F	10.5	87.50%	18%	0.16	0.26	$1,298,969
Hospital G	9	75.00%	8%	0.06	0.10	$494,845
Total			100%	0.61	1	$5,000,000

****Percentage of hospital's Low Income (Medicaid/CHIP/Charity Care) admissions to all statewide Low Income admissions.**

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Performance Achievement and Payment Summary Report Review

For Example: Of the 12 UPP measures a hospital achieved and met the performance requirement for 8 measures and regressed in performance for 4 measures. Note check the *DY4 Performance Measures Results* worksheet sent to each hospital on or around September 1, 2016 for hospital specific results. For example purposes assume the hospital specific low income population percentage is 2.75%

- The percent achieved is calculated as follows:

Number of measures where achievement is met	**8**
Number of measures where achievement is not met	4
Total Number of Measures	12
Net Achieved [8*1 =8, 4 *-.5 =-2. 8-2 =6]	6
Percent Achieved [6/12]	50%

- Adjusted Percent Achieved = Percent achieved, 50% multiplied by Admissions percent, 2.75%, or 1.375%.
- Total Adjusted Percent Achieved = 30.70% [Note: this is a statewide value and the same used in the UPP calculation for every hospital].
- Final Percent Achieved = Adjusted Percent Achieved divided by the Total Adjusted Percent Achieved. Based on the above 1.375% divided by 30.70% or 4.4788%.
- UPP Payment = Total Amount Available for distribution $50,232,021 multiplied by the Final Percent Achieved 4.4788% or $2,249,805.

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Statewide Payment and Performance Achievement Results

Statewide Payment Summary

Target Funding Summary			
	Target Funding	**Total Earned + Forfeited**	**Difference**
Stage 1 and 2	$ 69,079,886.49	$ 69,079,886.49	$ (0.00)
Stage 3	$ 48,355,920.54	$ 48,355,920.54	$ -
Stage 4	$ 20,723,965.95	$ 20,723,965.95	$ -

DY4 Amount Earned Summary		
	Total Earned	**Forfeit to UPP**
Non-Participating Hospitals	$ -	$ 4,059,090.62
UPP Carve-Out	$ -	$ 24,381,136.41
DY3 Adjustments	$ 40,857.33	$ -
Stage 1 and 2	$ 69,067,919.13	$ 11,967.35
Stage 3	$ 26,542,379.50	$ 21,813,541.04
Stage 4	$ 20,716,822.63	$ 7,143.31
UPP Total (Forfeiture - DY3 Adjust)		$ 50,232,021.40
UPP Earned	$ 50,232,021.40	
DY4 Total	$ 166,600,000.00	

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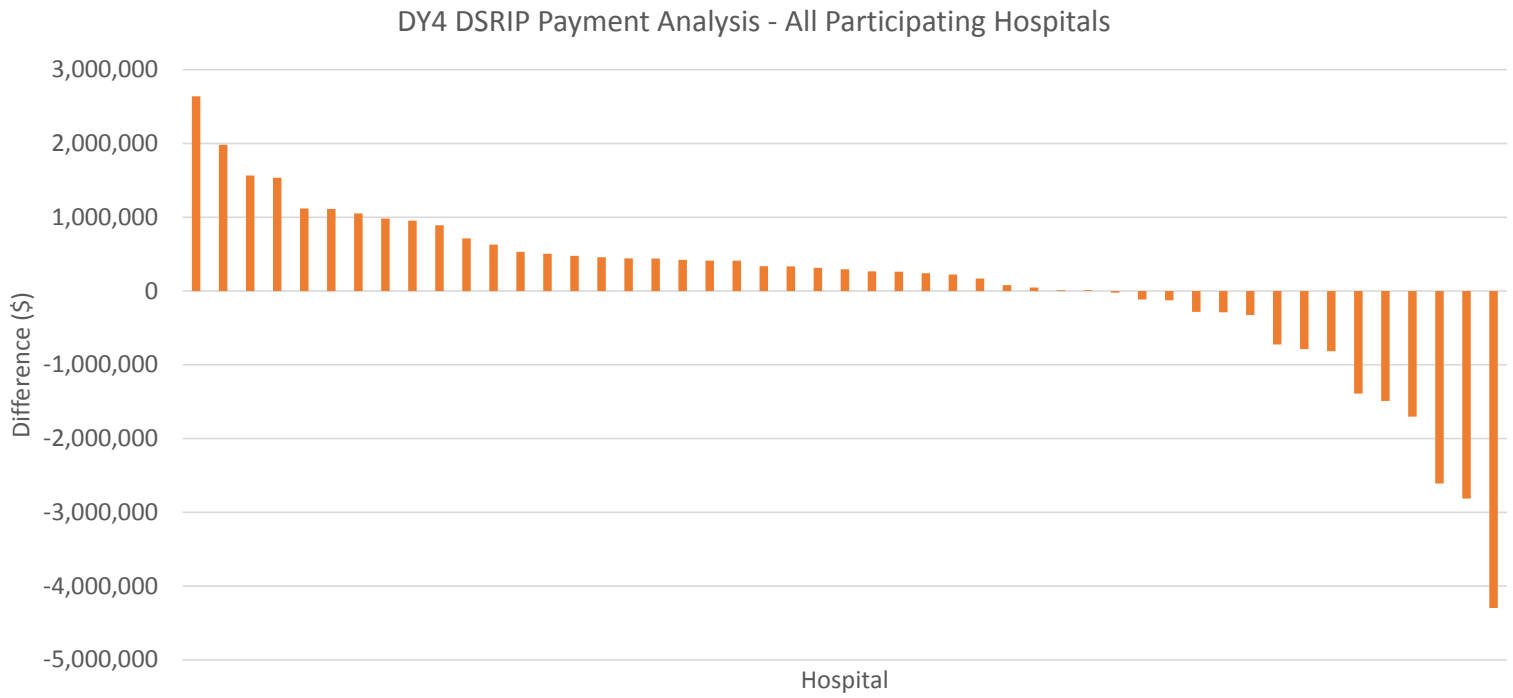
Statewide Payment Summary



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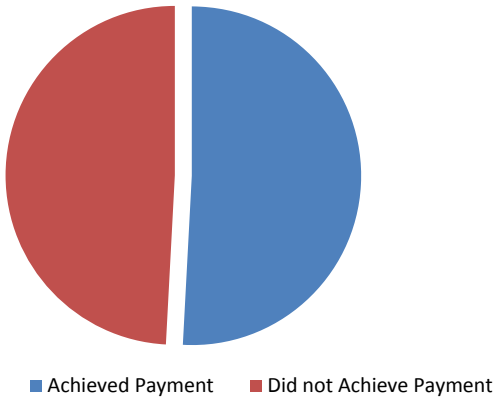
Statewide Performance Achievement Summary - Stage 3



Hospital and Measure Summary	Count	Percent
Achieved Payment	90	51.14%
Did not Achieve Payment	86	48.86%
Total	176	100.00%

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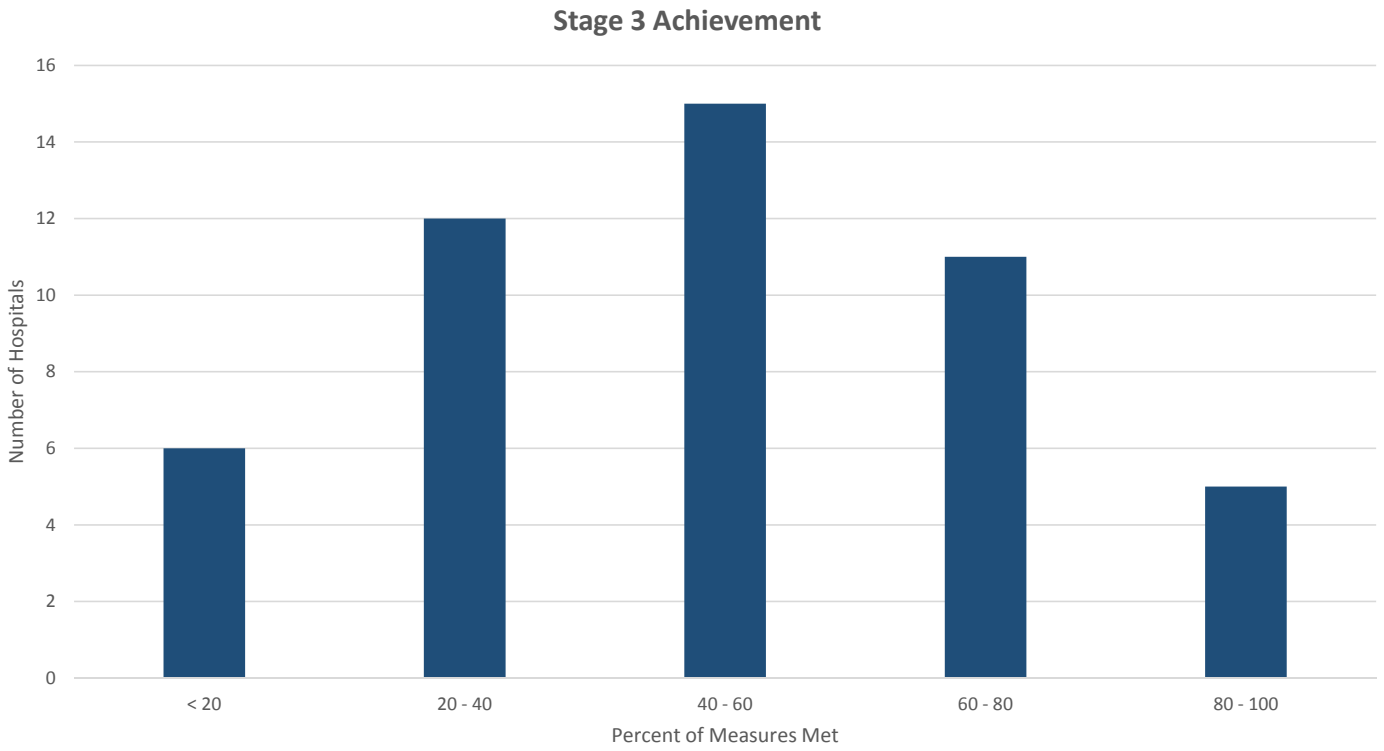
Statewide Performance Achievement - Stage 3



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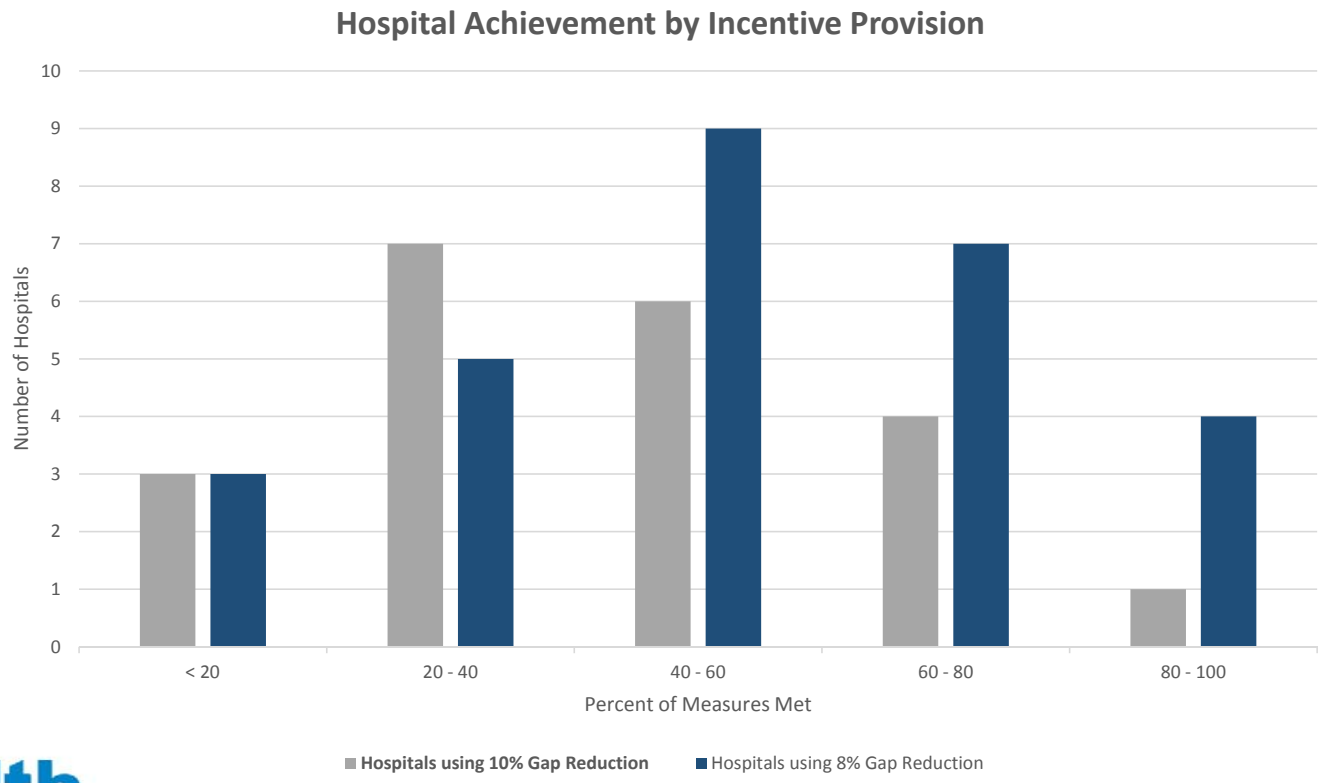
Statewide Performance Achievement – Stage 3 - Incentive Provision



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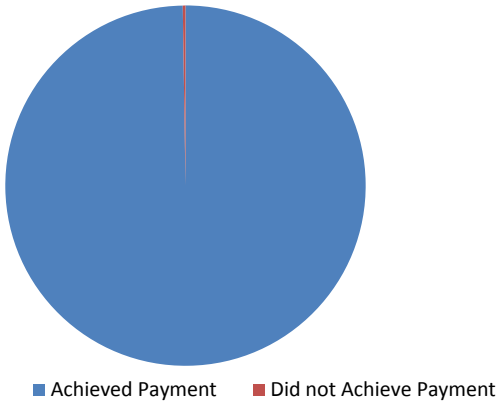
Statewide Performance Achievement Summary – Stage 4



Hospital and Measure Summary	Count	Percent
Achieved Payment	1613	99.75%
Did not Achieve Payment	4	0.25%
Total	1617	100.00%

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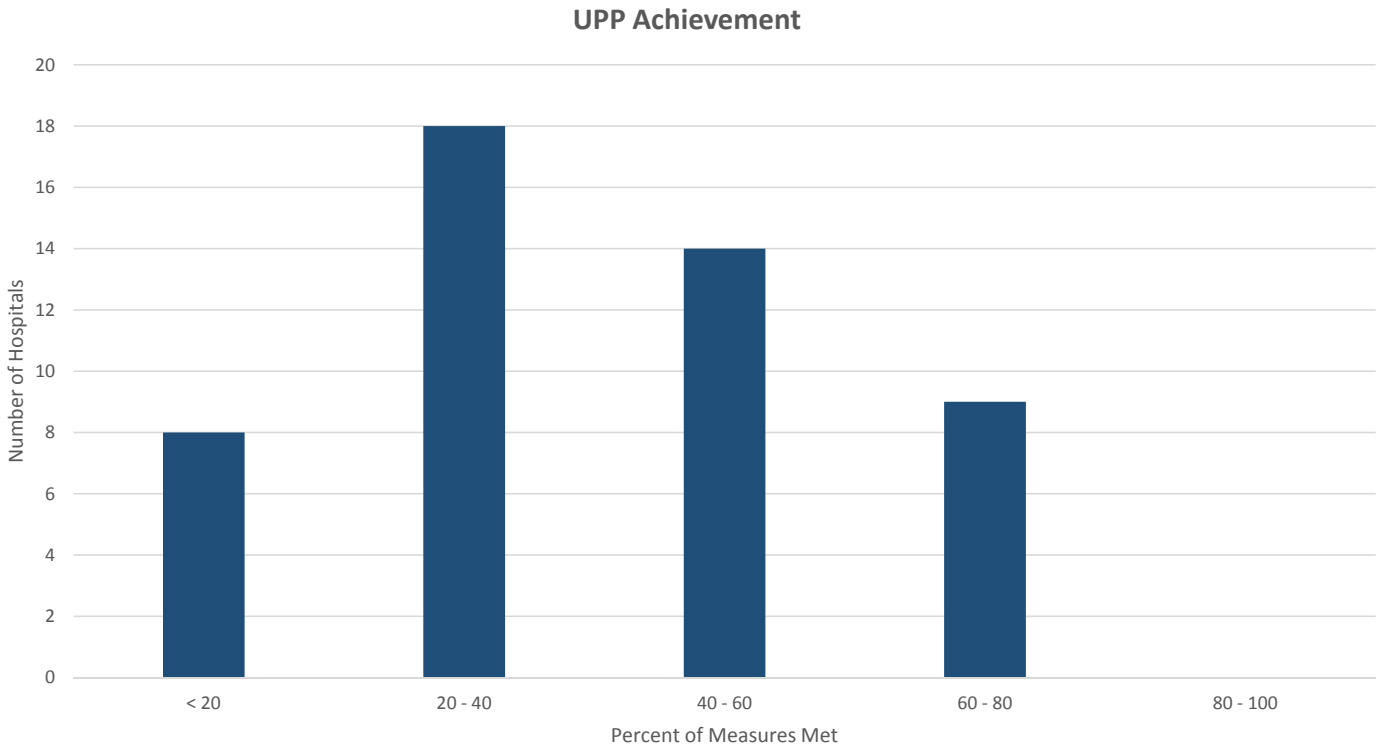
Statewide Performance Achievement – UPP



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Performance Achievement Results for Each Learning Collaborative

Performance Achievement – Learning Collaborative 1

Focus	Project #	Project	Hospital Count
Asthma	Project 1	Hospital-Based Educators Teach Optimal Asthma Care	2
Asthma	Project 2	Pediatric Asthma Case Management and Home Evaluations	2
Pneumonia	Project 17	Patients Receive Recommended Care for Community-Acquired Pneumonia	1

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Performance Achievement – Learning Collaborative 1

- 5 Hospitals in LC

- P4P Measures Utilized in DY4
  - Adult Asthma Admission Rate - DSRIP #6
  - Asthma Admission Rate – DSRIP #13
  - Cervical Cancer Screening – DSRIP #22
  - Chlamydia Screening in Women – DSRIP #28
  - Medical Management for People with Asthma – 75% (under 18, 18-64) – DSRIP #60
  - Percent of Patients Evaluated for Environmental Triggers other than tobacco smoke (dust mites, cats, dogs) – DSRIP #65
  - Percent of patients who have had a visit to an Emergency Department for asthma in the past six months (5-18, Total) – DSRIP #66
  - Asthma Medication Ratio – DSRIP #90

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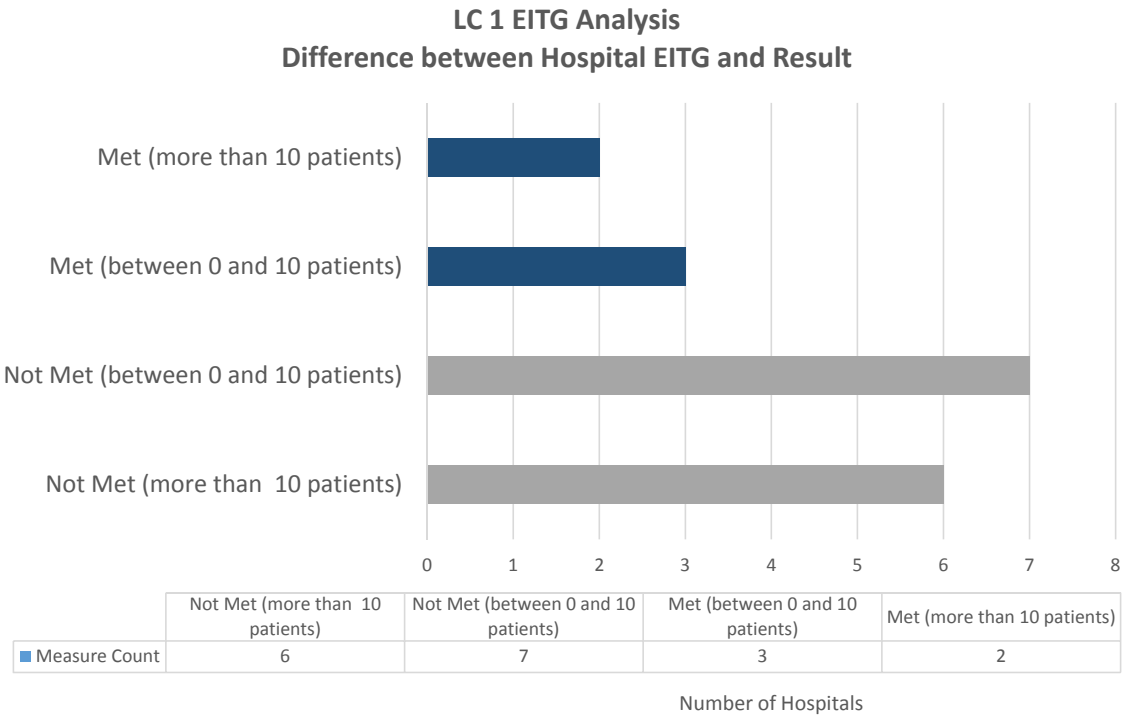
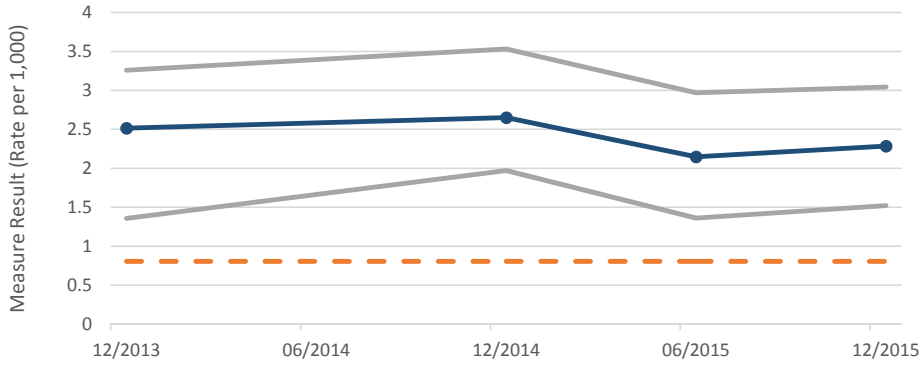
Performance Achievement – Learning Collaborative 1



Performance Achievement – Learning Collaborative 1

Asthma admission rate
LC 1 - DSRIP 13 - Improvement Direction ↓

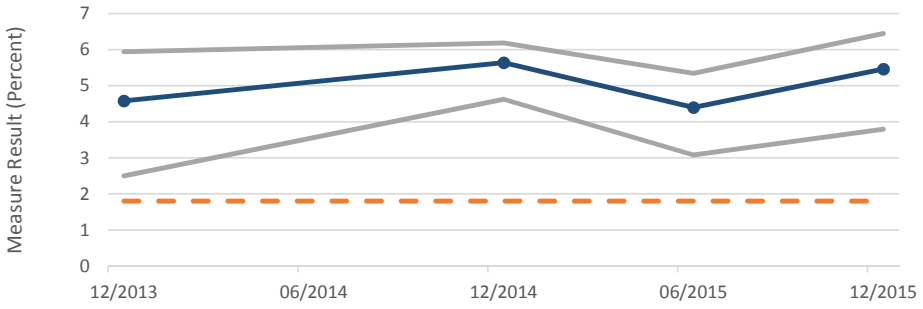


	12/2013	12/2014	06/2015	12/2015
Min	1.357	1.97	1.361	1.521
Max	3.258	3.531	2.969	3.043
Avg	2.515	2.650	2.147	2.285
ITG	0.806	0.806	0.806	0.806

Performance Period (Half Calendar Year)

Min Max Avg ITG

Percent of patients who have had a visit to an Emergency Department for asthma in the past six months, Age 5 through 18 years
LC 1 - DSRIP 66 - Improvement Direction ↓



	12/2013	12/2014	06/2015	12/2015
Min	2.498	4.625	3.078	3.796
Max	5.942	6.184	5.342	6.446
Avg	4.582	5.640	4.399	5.462
ITG	1.802	1.802	1.802	1.802

Performance Period (Half Calendar Year)

Min Max Avg ITG

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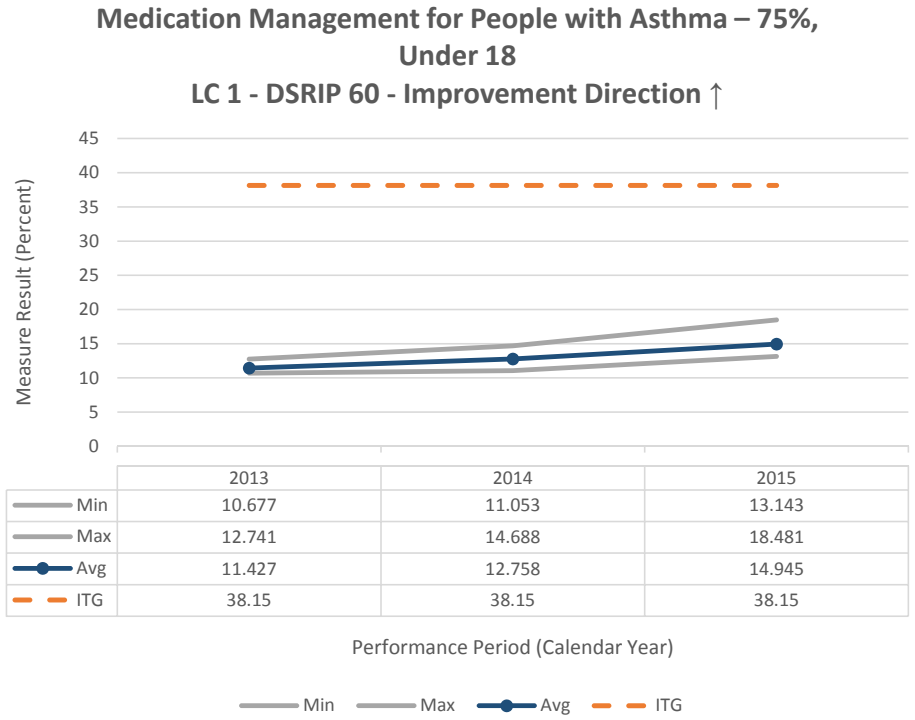
Performance Achievement – Learning Collaborative 1



Performance Achievement – Learning Collaborative 2

Focus	Project #	Project	Hospital Count
Behavioral Health	Project 3	Integrated Health Home for the Seriously Mentally Ill (SMI)	2
Behavioral Health	Project 5	Electronic Self-Assessment Decision Support Tool	2
Chemical Addiction/ Substance Abuse	Project 9	Hospital-Wide Screening for Substance Use Disorder	5

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Performance Achievement – Learning Collaborative 2

- 9 Hospitals in LC

- P4P Measures
  - Antidepressant Medication Management – Effective Acute Phase Treatment– DSRIP #11
  - Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use – DSRIP #15
  - Breast Cancer Screening – DSRIP #16
  - Chlamydia Screening in Women – DSRIP #28
  - Depression Remission at 12 Months – DSRIP #33
  - Engagement of alcohol and other drug treatment –DSRIP #38
  - Follow-up After Hospitalization for Mental Illness – 7 days post discharge –DSRIP #41
  - Initiation of alcohol and other drug treatment – DSRIP #52
  - Diabetes Monitoring for People with Diabetes and Schizophrenia – DSRIP #92
  - Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications – DSRIP #94

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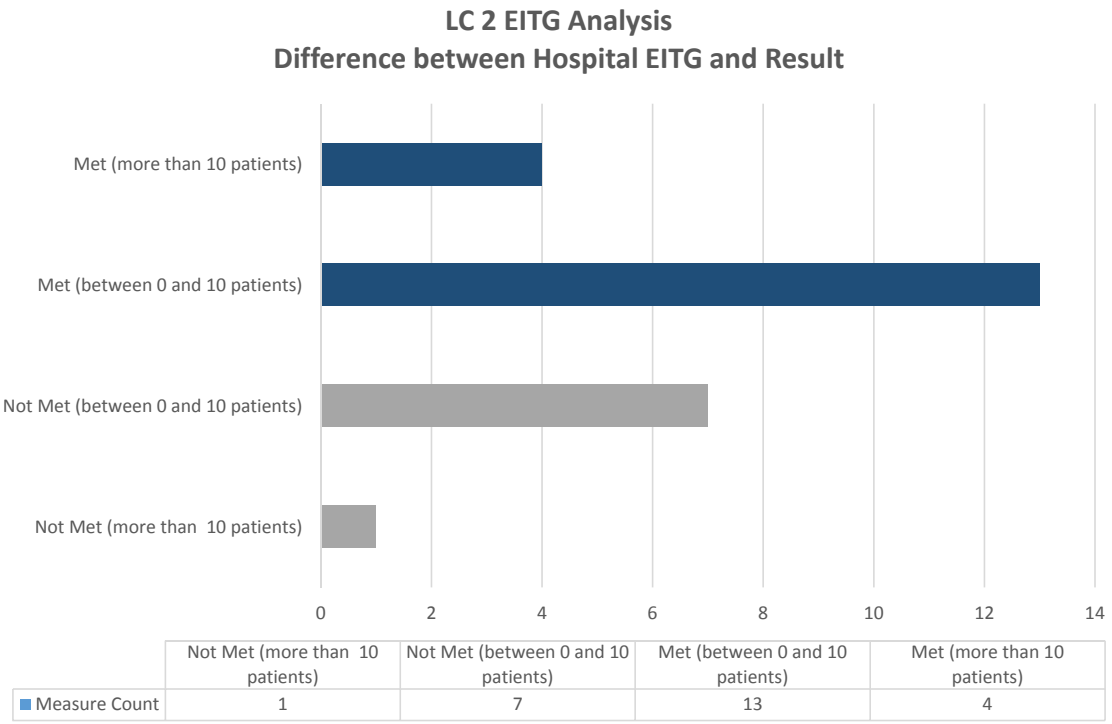
Performance Achievement – Learning Collaborative 2



	Not Met (more than 10 patients)	Not Met (between 0 and 10 patients)	Met (between 0 and 10 patients)	Met (more than 10 patients)
Measure Count	1	7	13	4

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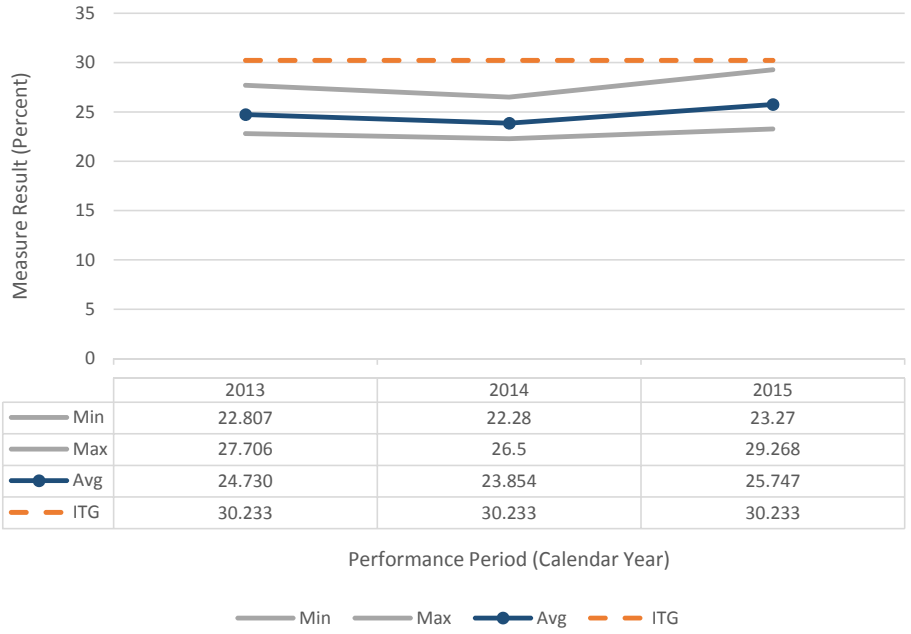
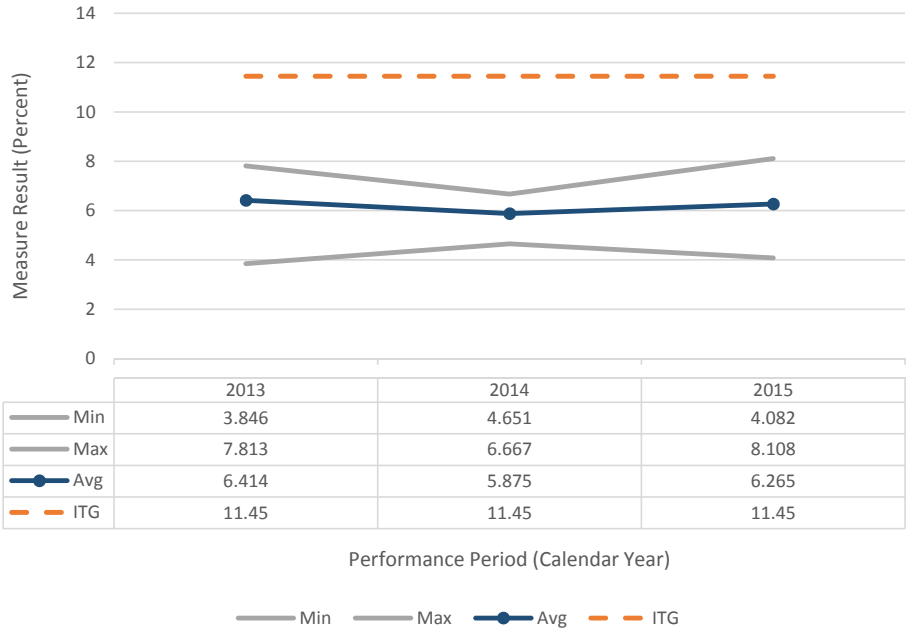
Performance Achievement – Learning Collaborative 2

Initiation of alcohol and other drug treatment
LC 2 - DSRIP 52 - Improvement Direction ↑



	2013	2014	2015
Min	22.807	22.28	23.27
Max	27.706	26.5	29.268
Avg	24.730	23.854	25.747
ITG	30.233	30.233	30.233

Engagement of alcohol and other drug treatment
LC 2 - DSRIP 38 - Improvement Direction ↑



	2013	2014	2015
Min	3.846	4.651	4.082
Max	7.813	6.667	8.108
Avg	6.414	5.875	6.265
ITG	11.45	11.45	11.45

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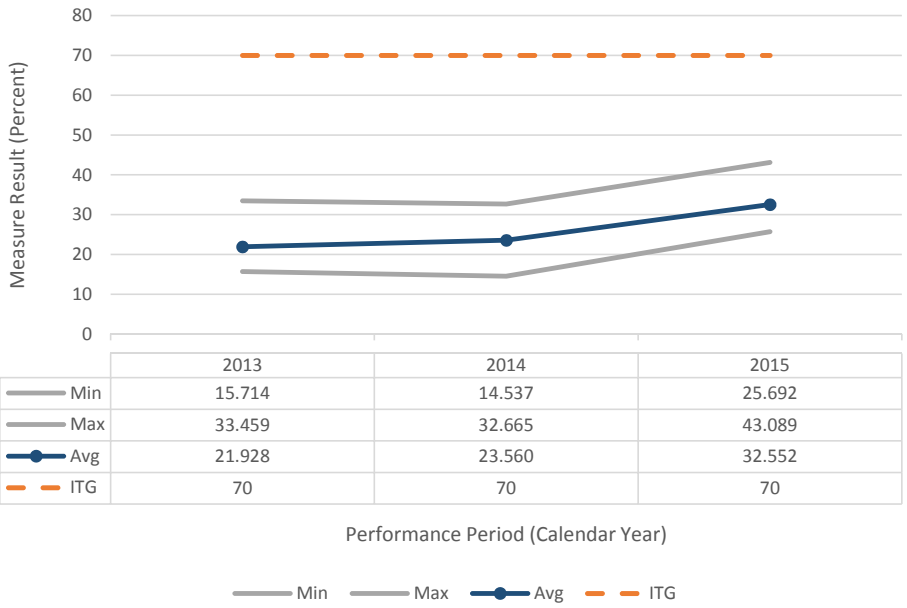
Performance Achievement – Learning Collaborative 2

Follow-up After Hospitalization for Mental Illness – 7 days post discharge

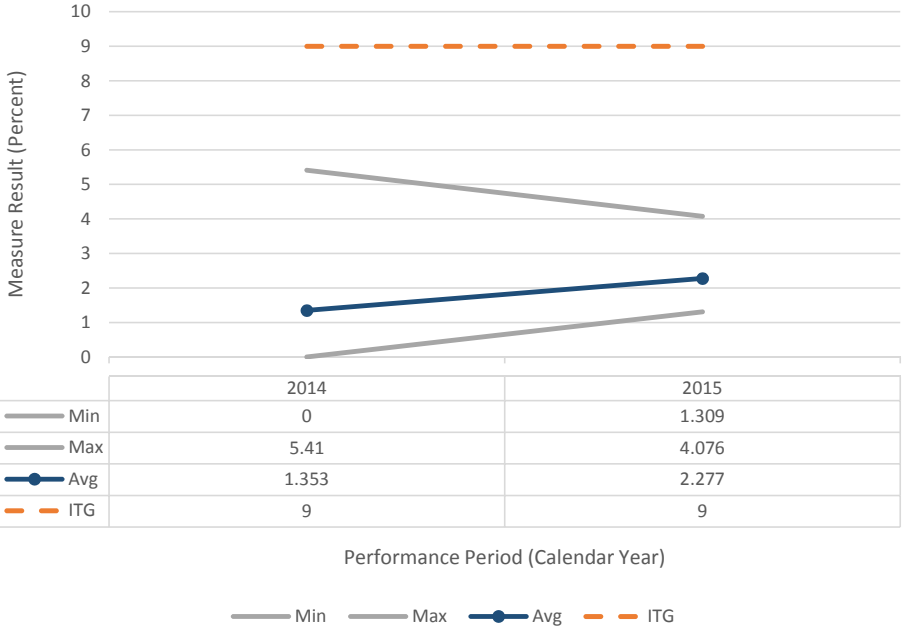
LC 2 - DSRIP 41 - Improvement Direction ↑



	2013	2014	2015
Min	15.714	14.537	25.692
Max	33.459	32.665	43.089
Avg	21.928	23.560	32.552
ITG	70	70	70

Depression Remission at 12 Months

LC 2 - DSRIP 33 - Improvement Direction ↑



	2014	2015
Min	0	1.309
Max	5.41	4.076
Avg	1.353	2.277
ITG	9	9

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Performance Achievement – Learning Collaborative 3 & 4

Focus	Project #	Project	Hospital Count
Cardiac Care	Project 6	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	11
Cardiac Care	Project 7	Extensive Patient CHF-Focused Multi-Therapeutic Model	4
Cardiac Care	Project 8	The Congestive Heart Failure Transition Program (CHF-TP)	6

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Performance Achievement – Learning Collaborative 3 & 4

- 21 Hospitals

- P4P Measures
  - 30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization – DSRIP #1
  - 30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization – DSRIP #3
  - Breast Cancer Screening – DSRIP #16
  - Cervical Cancer Screening – DSRIP #22
  - Chlamydia Screening in Women – DSRIP #28
  - Controlling High Blood Pressure – DSRIP #31
  - Diabetes Long-Term Complications Admission Rate (PQI 3) – DSRIP #34
  - Diabetes Short-Term Complications Admission Rate (PQI 1) – DSRIP #36
  - Heart Failure Admission Rate – DSRIP #45
  - Hypertension Admission Rate – DSRIP #48
  - Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C Control <100mg/dL – DSRIP #55
  - Post-Discharge Appointment for Heart Failure Patients – DSRIP #73
  - Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention – DSRIP #76
  - Timely Transmission of Transition Record – DSRIP #80
  - Adherence to Chronic Medications for People with Diabetes Mellitus: Hypoglycemic agents – DSRIP #97

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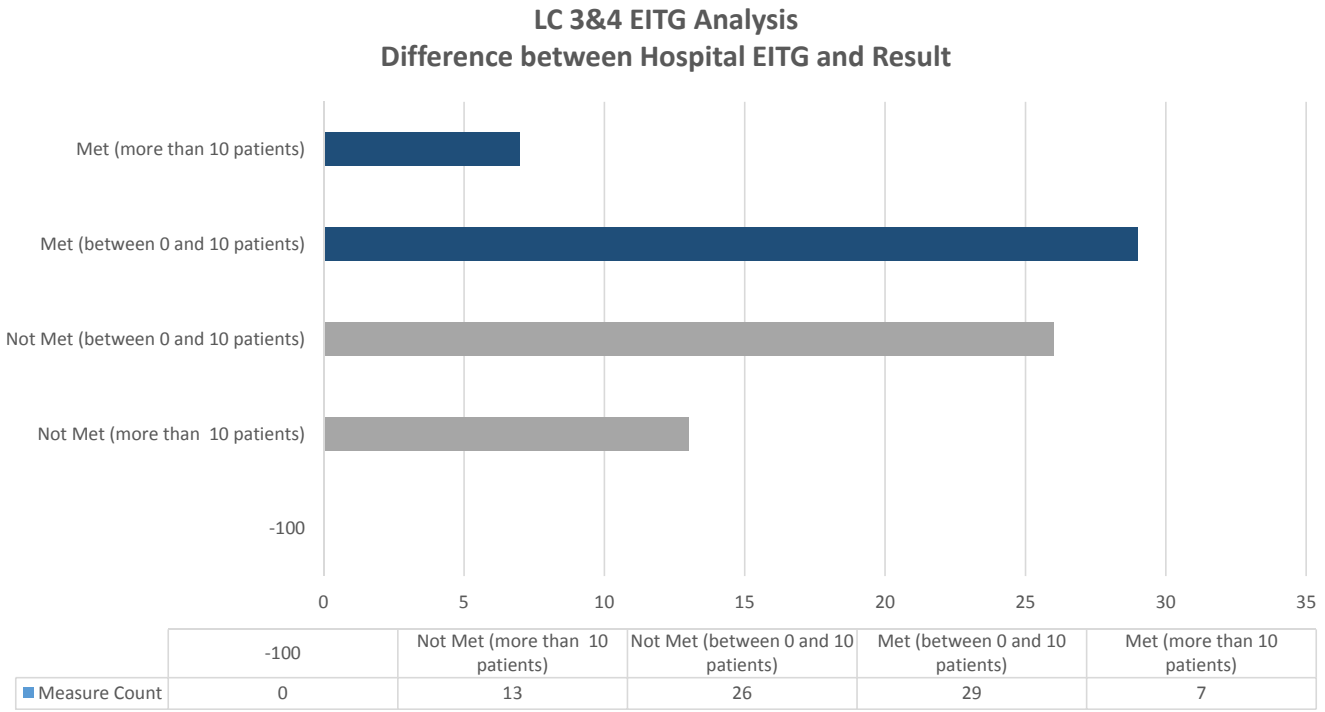
Performance Achievement – Learning Collaborative 3 & 4



	-100	Not Met (more than 10 patients)	Not Met (between 0 and 10 patients)	Met (between 0 and 10 patients)	Met (more than 10 patients)
Measure Count	0	13	26	29	7

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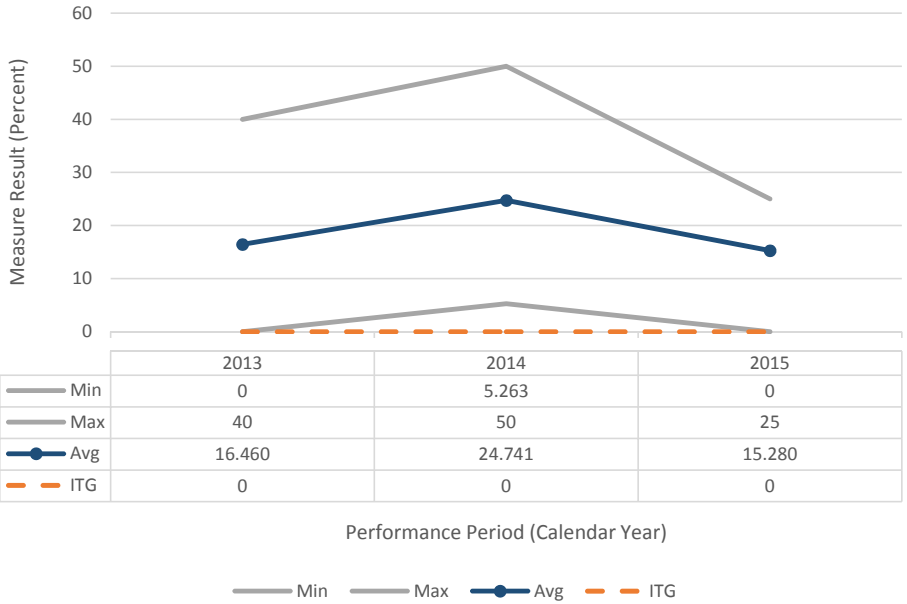
Performance Achievement – Learning Collaborative 3 & 4

30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization

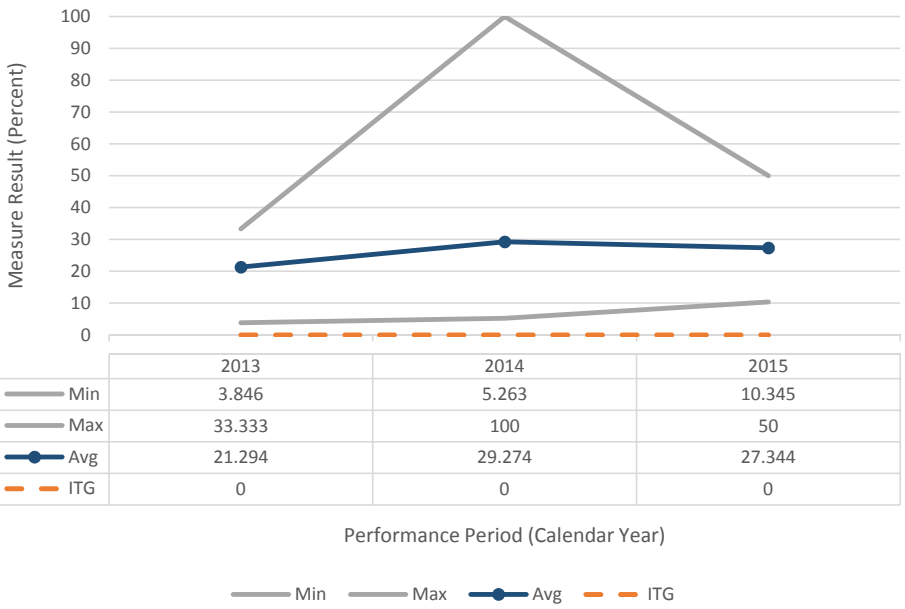
LC 3&4 - DSRIP 1 - Improvement Direction ↓



	2013	2014	2015
Min	0	5.263	0
Max	40	50	25
Avg	16.460	24.741	15.280
ITG	0	0	0

30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization

LC 3&4 - DSRIP 3 - Improvement Direction ↓



	2013	2014	2015
Min	3.846	5.263	10.345
Max	33.333	100	50
Avg	21.294	29.274	27.344
ITG	0	0	0

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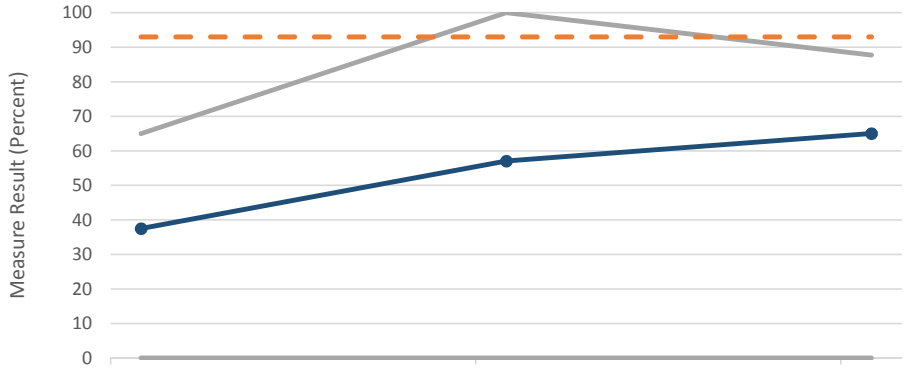
Performance Achievement – Learning Collaborative 3 & 4

Timely Transmission of Transition Record
LC 3&4 - DSRIP 80 - Improvement Direction ↑

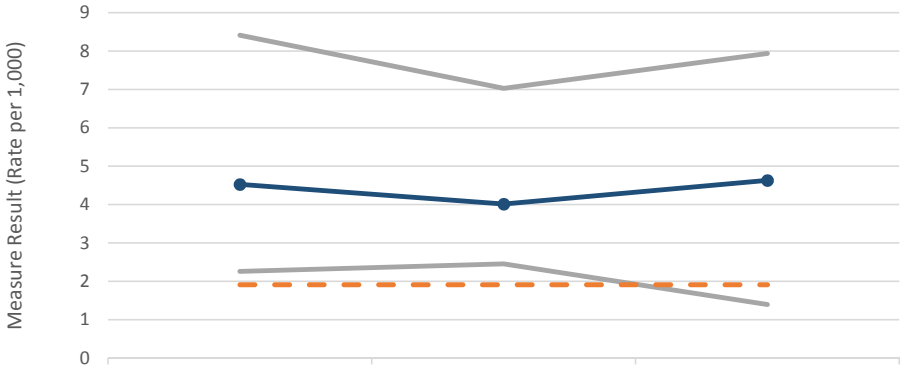


	12/31/2014	6/30/2015	12/31/2015
Min	0	0	0
Max	65	100	87.719
Avg	37.499	57.057	65.034
ITG	93	93	93

Performance Period (Half Calendar Year)

Min Max Avg ITG

Heart Failure Admission Rate
LC 3&4 - DSRIP 45 - Improvement Direction ↓



	2013	2014	2015
Min	2.257	2.454	1.395
Max	8.415	7.029	7.938
Avg	4.528	4.013	4.629
ITG	1.91	1.91	1.91

Performance Period (Calendar Year)

Min Max Avg ITG

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Performance Achievement – Learning Collaborative 5

Focus	Project #	Project	Hospital Count
Diabetes	Project 11	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	7
Diabetes	Project 12	Diabetes Group Visits for Patients and Community Education	6
Obesity	Project 15	After School Obesity Program	1

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Performance Achievement – Learning Collaborative 5

- 14 Hospitals

- P4P Measures
  - Children Age 6-17 Years who Engage in Weekly Physical Activity – DSRIP #26
  - Chlamydia Screening in Women –DSRIP #28
  - Controlling High Blood Pressure – DSRIP #31
  - Diabetes Long-Term Complications Admission Rate (PQI 3) – DSRIP #34
  - Diabetes Short-Term Complications Admission Rate (PQI 1) – DSRIP #36
  - Hypertension Admission Rate – DSRIP #48
  - Uncontrolled Diabetes Admission Rate (PQI 14) – DSRIP #81
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents – DSRIP #87
  - Adherence to Chronic Medications for People with Diabetes Mellitus: Statins – DSRIP #96
  - Adherence to Chronic Medications for People with Diabetes Mellitus: Hypoglycemic agents – DSRIP #97
  - Medical attention for nephropathy – DSRIP #98
  - Diabetes Mellitus: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes and Ischemic Vascular Disease – DSRIP #100

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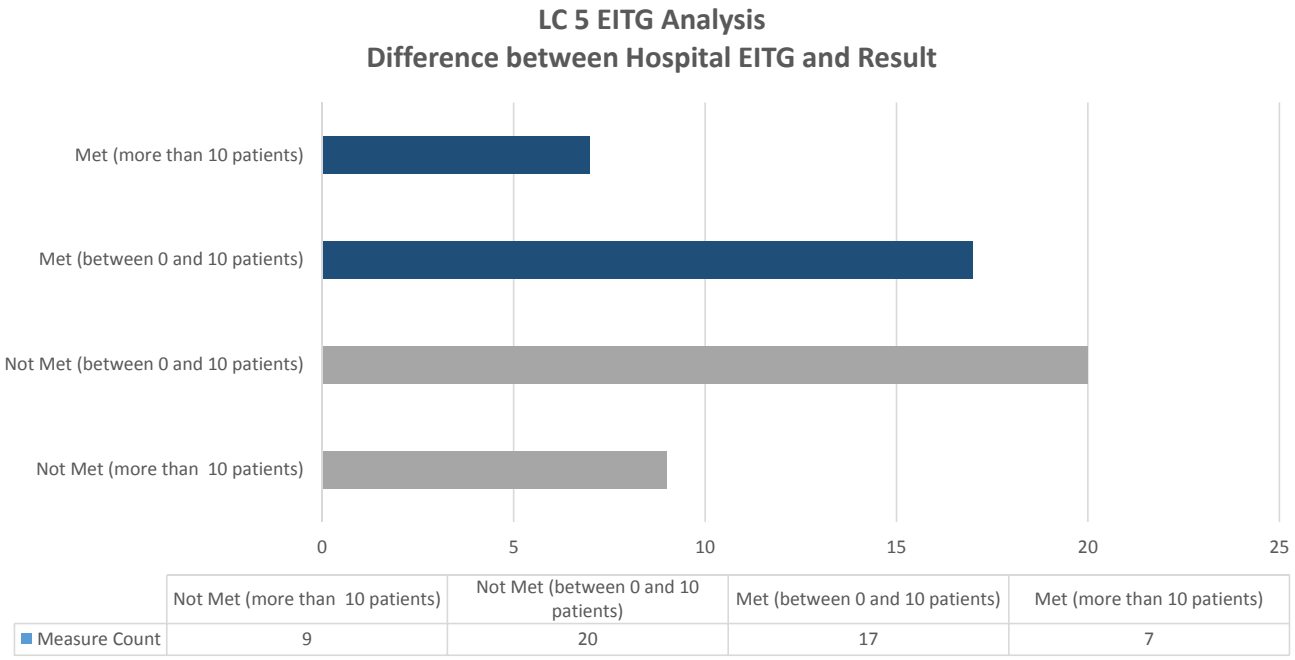
Performance Achievement – Learning Collaborative 5



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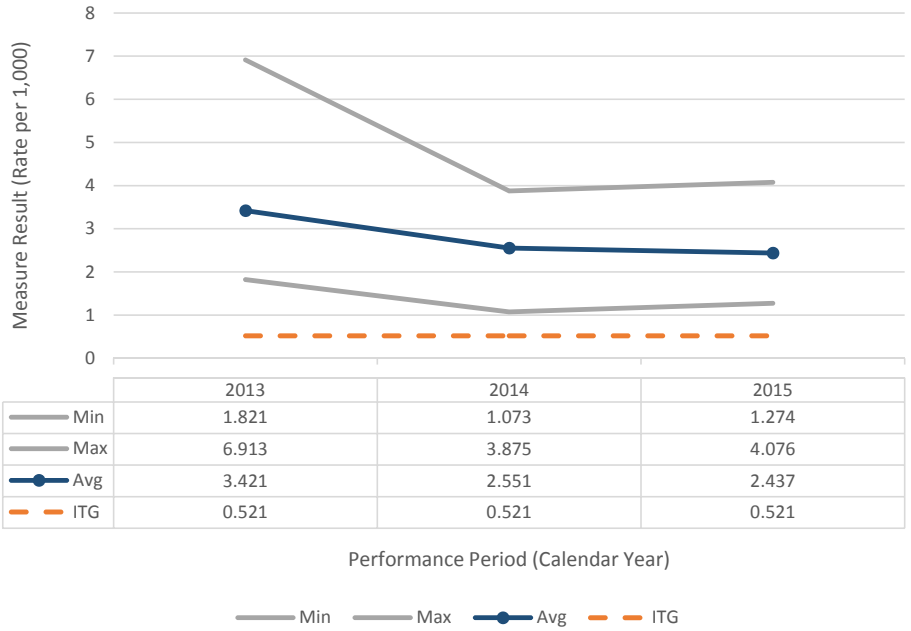
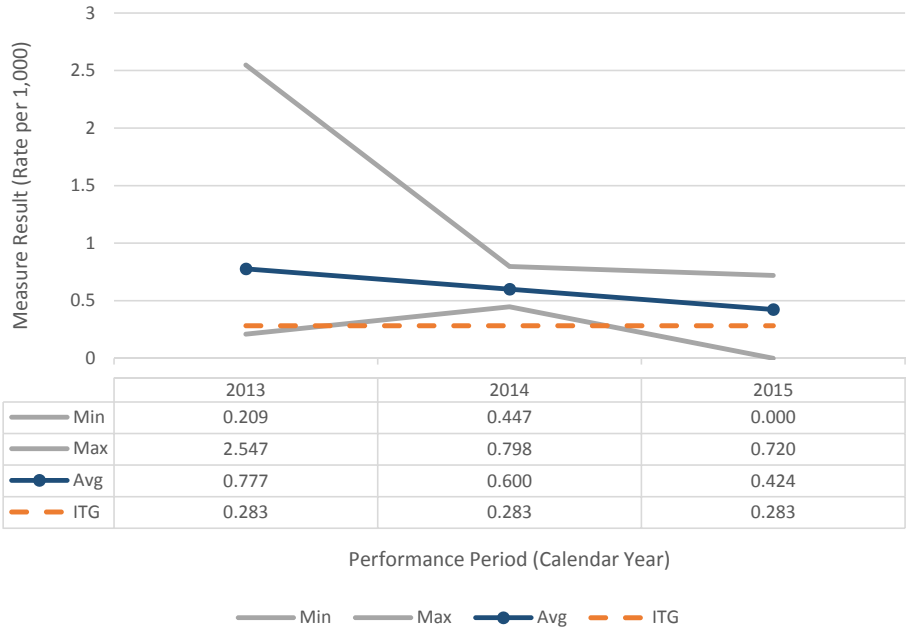
Performance Achievement – Learning Collaborative 5

Diabetes Long-Term Complications Admission Rate
LC 5 - DSRIP 34 - Improvement Direction ↓



	2013	2014	2015
Min	1.821	1.073	1.274
Max	6.913	3.875	4.076
Avg	3.421	2.551	2.437
ITG	0.521	0.521	0.521

Uncontrolled Diabetes Admission Rate
LC 5 - DSRIP 81 - Improvement Direction ↓



	2013	2014	2015
Min	0.209	0.447	0.000
Max	2.547	0.798	0.720
Avg	0.777	0.600	0.424
ITG	0.283	0.283	0.283

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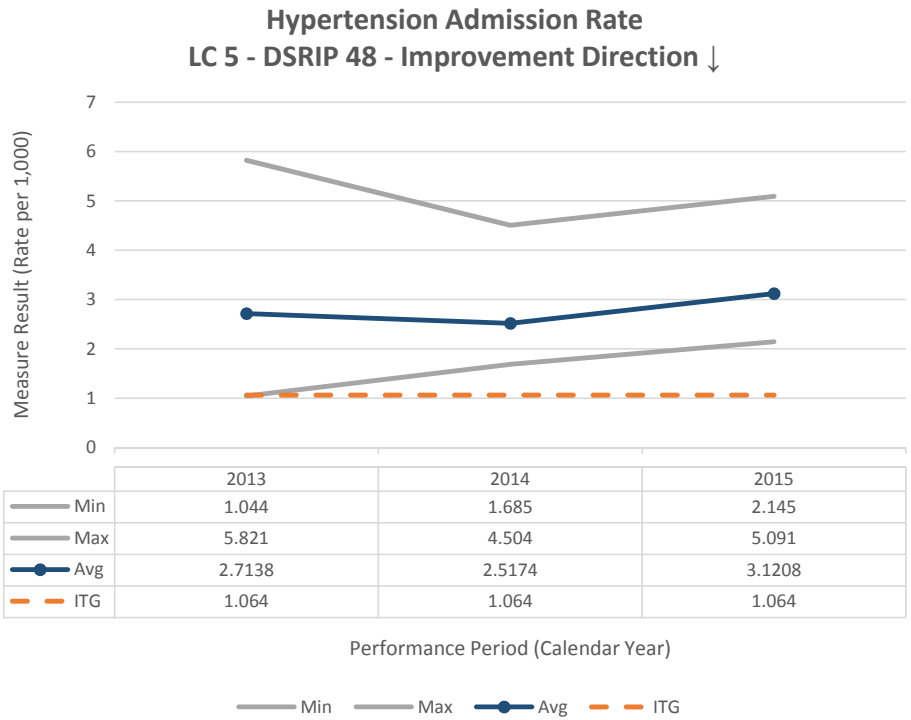
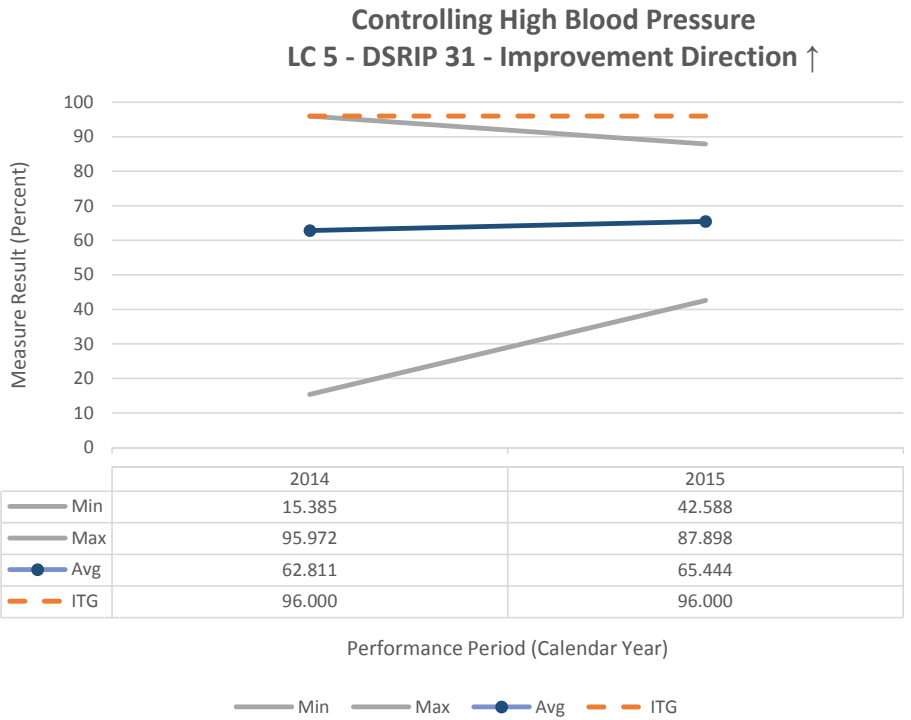
Performance Achievement – Learning Collaborative 5



	2013	2014	2015
Min	1.044	1.685	2.145
Max	5.821	4.504	5.091
Avg	2.7138	2.5174	3.1208
ITG	1.064	1.064	1.064



	2014	2015
Min	15.385	42.588
Max	95.972	87.898
Avg	62.811	65.444
ITG	96.000	96.000

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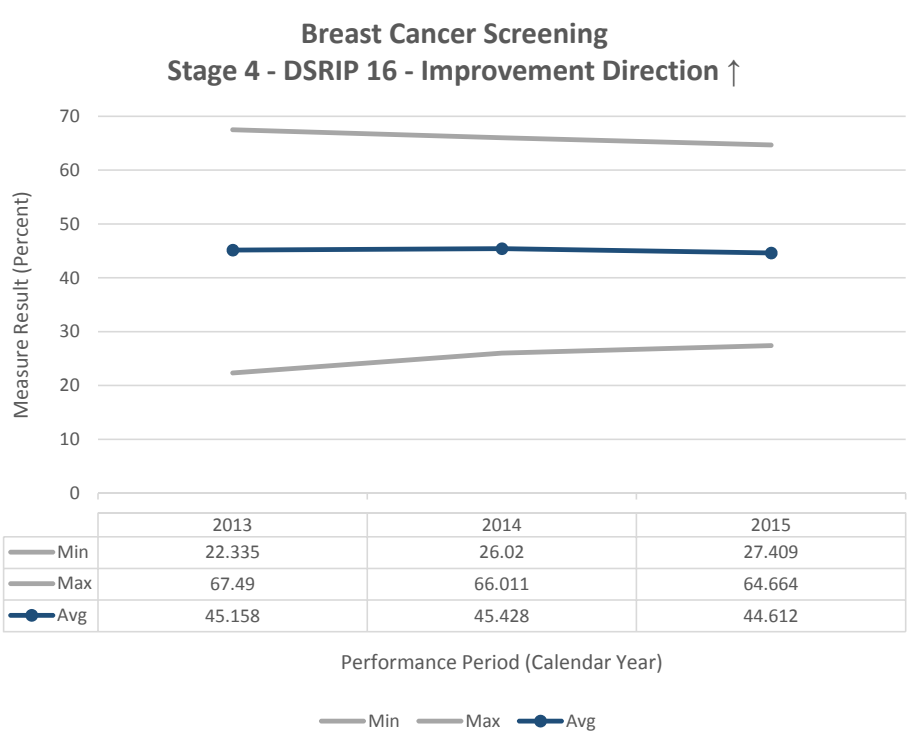
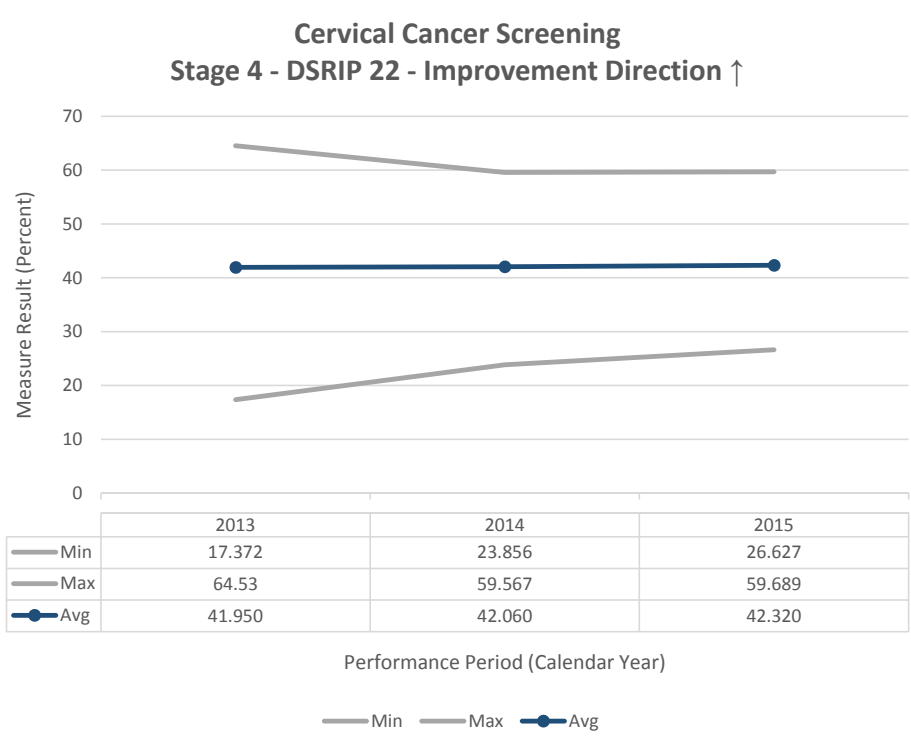
Performance Achievement – Stage 4





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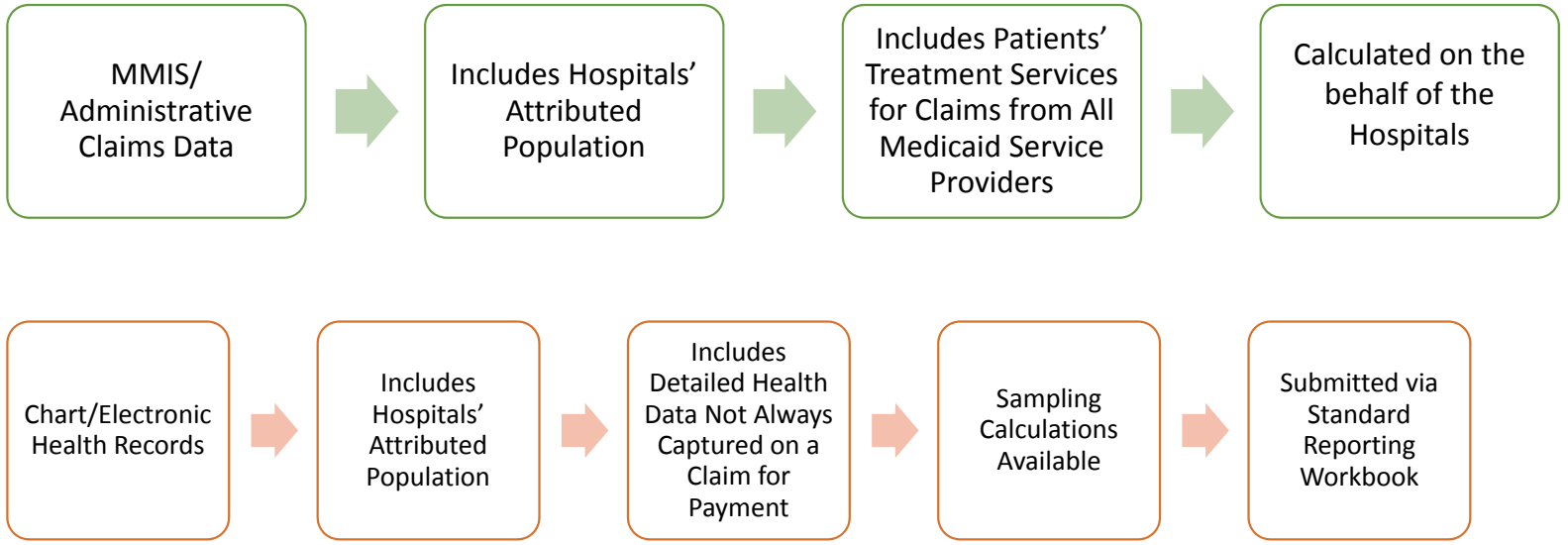
Performance Measurement – Collection, Calculation and Reporting Processes

Performance Measurement – Collection, Calculation and Reporting



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Attribution

Attribution Period	Performance Period	Roster
Jan 2012 – Dec 2013	Jan 2013 – Dec 2013	Preliminary Roster; Jan 2015
Jan 2013 – Dec 2014	Jan 2014 – Dec 2014	Feb 2015
Jan 2014 – Dec 2015	Jan 2015 – Dec 2015	Feb 2016
July 2014 – June 2016	January 2016 – June 2016	October 2016
Jan 2015 – Dec 2016	Jan 2016 – Dec 2016	Feb 2017

- Patient Rosters are uploaded to SFTP.
- Separate files are created per hospital and per reporting partner.
- Download and save the file immediately. The documents on the SFTP site auto-delete from the folder within fourteen days.
- Webinar 7 - Attribution Patient Roster Layout offers detailed training related to the patient roster to support patient-matching by hospitals.

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Attribution Review – Hospital Example

Patient Roster
Sent Feb. 2015

Date Of Service	2013	2014	2015
	Patient A	Patient A	
	Patient B		

Patients A and B included in hospital's roster.

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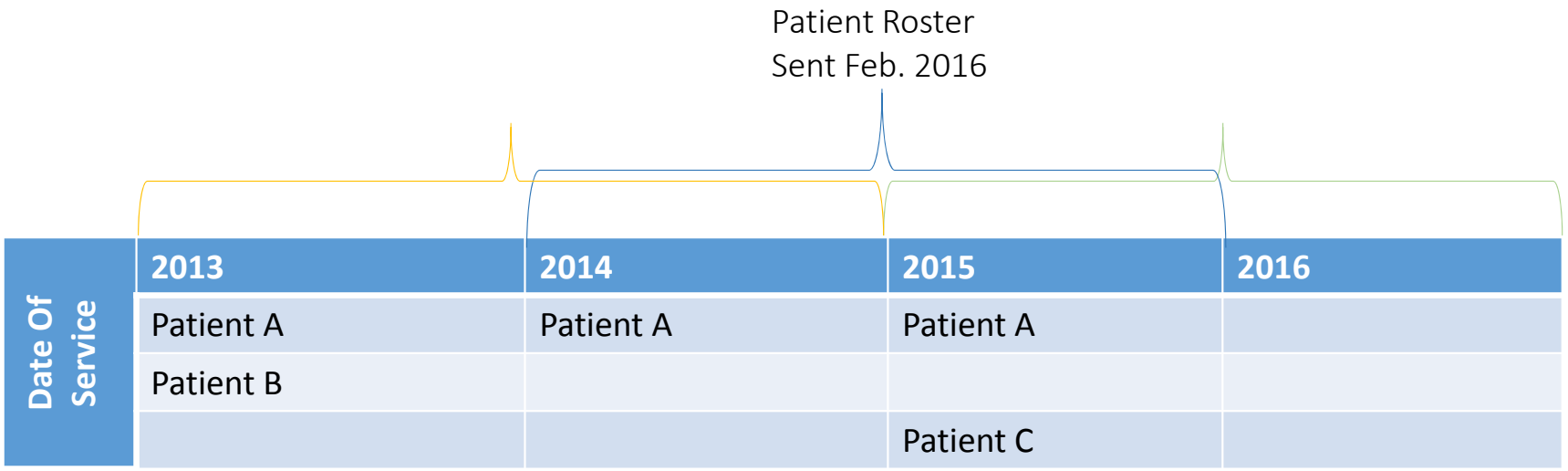
Attribution Review – Hospital Example



Date Of Service	2013	2014	2015	2016
	Patient A	Patient A	Patient A	
	Patient B			
			Patient C	

Patient A: Patient continues to have the greatest relationship with hospital and remains on patient roster.

Patient B: Patient drops off hospital's roster.

Patient C: New patient seen by the hospital in 2015. Hospital should ***pro-actively*** identify this individual. This patient will not appear on the hospital's roster until potentially 2017 if the greatest relationship exists with this hospital.

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Substitution Measures – Active Pay for Performance Measurement

- Converted P4R to P4P:
  - 2014 and 2015 data results are available.
    - Controlling High Blood Pressure - ITG set for diabetes projects at 96.000
    - Post Discharge Appointment for Heart Failure Patients - process measure that could have ITG set at 90%

- Utilized Low performing MMIS Stage 4 measures.
  - Cervical Cancer Screening
  - Chlamydia Screening
  - Breast Cancer Screening

- Zero Denominator Results Received Pay for Reporting – Met Result due to inability to measure. No penalty applied to hospital.

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Performance Measurement – Collection, Calculation – MMIS Validation Steps

Data integrity –

- Data integrity is based on the successful information flow from hospital to managed care organization (MCO) to fiscal agent to data warehouse to MSLC.
- DSRIP participating providers have provided the data used to compute measure results.
- Unless specifically noted otherwise, Myers and Stauffer's procedures are limited to confirming that data are loaded correctly.
- Measurement results are a function of the measure steward specifications, definitions and underlying data, and are not intended to imply or address the accuracy of the underlying data or any facts or findings related to New Jersey health coverage programs.

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Performance Measurement – Collection, Calculation – MMIS Validation Steps

Data Calculation Accuracy –

- MMIS performance measure calculation goes through quality control and validation procedures for every measure for every performance period.
    a. Each measure has undergone thorough review to ensure that the measure has been calculated to the specification detailed in the databook. The source code and the results of each measure are validated against the specification.

    b. Computed measure results are compared for reasonableness against national and state benchmarks, when available, DSRIP participating hospital peers and prior-period performance.

    c. The measures were calculated from the administrative claims data that is collected and adjudicated in the New Jersey Medicaid Management Information System (MMIS).

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Performance Measurement – Collection, Calculation – MMIS Validation Steps

Data Calculation Accuracy –

- The MMIS data contains a broader data set than is available to any participating hospital. Therefore, results calculated by an individual hospital or health system will vary from the results calculated using the broader MMIS data set.

- For example, a recipient may receive health care services from a provider not affiliated with the hospital system to which the recipient is attributed. Claims for these services would be included in the measure calculation, and would not be available to the health system to use in an internal calculation of the measure.

- To increase the transparency of programming steps performed on the behalf of the hospitals, and as a part of the NJ DSRIP databook, the Programming Assumptions document provides specific detail related to requirements and assumptions made to program the measures which use the MMIS claims administration data.

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Chart Collection, Calculation and Reporting Processes

Step 1: The provider receives the attributed patient population list from Myers and Stauffer through the FTP site.

Step 2: The provider runs a query of their EHR or reporting system. The population is limited to the attributed patient population only. This query always first includes looking for the measure-specific denominator (D) criteria as outlined in the DSRIP specification sheet and detailed by the measure steward specifications.

Step 3: The provider compares the initial total population results to the sampling tables to determine the number of patient records that must be abstracted.

Step 4: The provider runs a standard random sampling query to select the specific patient records for abstraction

Step 5: The provider staff reviews the sampled patient records to determine if the numerator (N) criteria have been met.

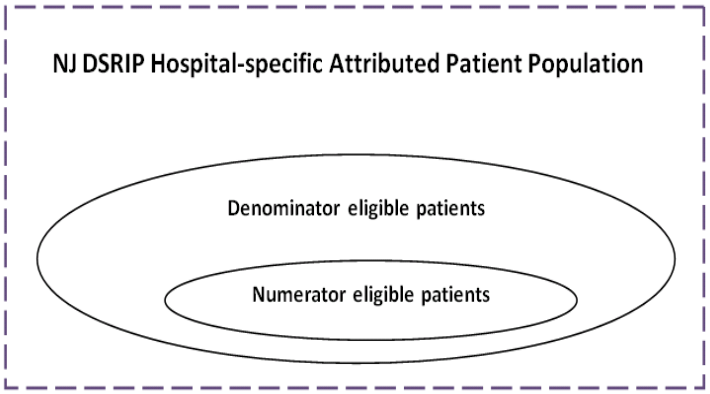

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Chart Collection, Calculation and Reporting Processes

Standard Reporting Workbook

NJ DSRIP Performance Measurement Standard Workbook

Project 5 - Electronic Self-Assessment Decision Support Tool

Focus Area: Behavioral Health

New Jersey Department of Health (NJDOH) Delivery System Reform Incentive Payment (DSRIP)

Project Code	Measure Name	Provider's Name	Provider's Name	Provider's Name	Provider's Name	Provider's Name		
5.2	**Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use**	[Enter the operating name of the reporting entity.]	[Enter the operating name of the reporting entity.]	[Enter the operating name of the reporting entity.]	[Enter the operating name of the reporting entity.]	[Enter the operating name of the reporting entity.]		
	DSRIP #	Provider's NJ Medicaid Identification Number	Provider's NJ Medicaid Identification Number	Provider's NJ Medicaid Identification Number	Provider's NJ Medicaid Identification Number	Provider's NJ Medicaid Identification Number		
	15	[Enter the NJ Medicaid ID that is assigned to the reporting entity.]	[Enter the NJ Medicaid ID that is assigned to the reporting entity.]	[Enter the NJ Medicaid ID that is assigned to the reporting entity.]	[Enter the NJ Medicaid ID that is assigned to the reporting entity.]	[Enter the NJ Medicaid ID that is assigned to the reporting entity.]	Total Counts	
	Initial Patient Total [Enter the total number of patients that meet the denominator criteria.]	0	0	0	0	0	0	
	Denominator [Enter the total number of records that are required to be sampled based off the measure's specification sampling table.]	0	0	0	0	0	0	
	Numerator [Enter the total number of patients that meet the numerator criteria.]	0	0	0	0	0	0	
	Provider's Weighting Factor [The worksheet will calculate the portion of the provider's population compared to the total patient population.]	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
	Provider's Measure Result [The worksheet will calculate the provider's measure result.]	0.00%	0.00%	0.00%	0.00%	0.00%		NJ DSRIP Network Weighted Measure Result Percentage
	Provider's Adjusted Rate [The worksheet will calculate the provider's adjusted rate.]	0.0000	0.0000	0.0000	0.0000	0.0000	**0.0000**	**0.00%**

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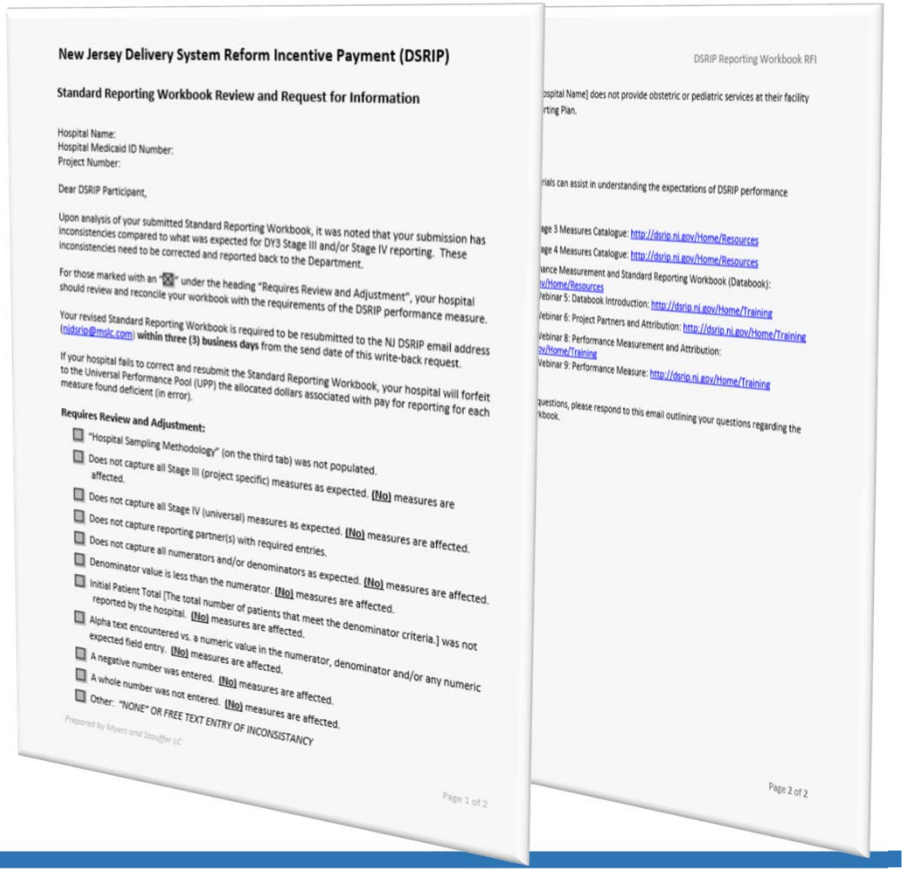
Chart Collection, Calculation and Reporting Processes – Validation Steps

- Validation and Write back Processes Apply to Chart Measures



New Jersey Delivery System Reform Incentive Payment (DSRIP)

Standard Reporting Workbook Review and Request for Information

Hospital Name:
Hospital Medicaid ID Number:
Project Number:

Dear DSRIP Participant,

Upon analysis of your submitted Standard Reporting Workbook, it was noted that your submission has inconsistencies compared to what was expected for DY3 Stage III and/or Stage IV reporting. These inconsistencies need to be corrected and reported back to the Department.

For those marked with an "☒" under the heading "Requires Review and Adjustment", your hospital should review and reconcile your workbook with the requirements of the DSRIP performance measure.

Your revised Standard Reporting Workbook is required to be resubmitted to the NJ DSRIP email address (nidsrip@msdc.com) **within three (3) business days** from the send date of this write-back request.

If your hospital fails to correct and resubmit the Standard Reporting Workbook, your hospital will forfeit to the Universal Performance Pool (UPP) the allocated dollars associated with pay for reporting for each measure found deficient (in error).

Requires Review and Adjustment:

- ☐ "Hospital Sampling Methodology" (on the third tab) was not populated.
- ☐ Does not capture all Stage III (project specific) measures as expected. **(No)** measures are affected.
- ☐ Does not capture all Stage IV (universal) measures as expected. **(No)** measures are affected.
- ☐ Does not capture reporting partner(s) with required entries.
- ☐ Does not capture all numerators and/or denominators as expected. **(No)** measures are affected.
- ☐ Denominator value is less than the numerator. **(No)** measures are affected.
- ☐ Initial Patient Total [The total number of patients that meet the denominator criteria.] was not reported by the hospital. **(No)** measures are affected.
- ☐ Alpha text encountered vs. a numeric value in the numerator, denominator and/or any numeric expected field entry. **(No)** measures are affected.
- ☐ A negative number was entered. **(No)** measures are affected.
- ☐ A whole number was not entered. **(No)** measures are affected.
- ☐ Other: *"NONE" OR FREE TEXT ENTRY OF INCONSISTANCY*

Prepared by Myers and Stauffer LC

Page 1 of 2

DSRIP Reporting Workbook RFI

ospital Name] does not provide obstetric or pediatric services at their facility
rting Plan.

rials can assist in understanding the expectations of DSRIP performance

age 3 Measures Catalogue: http://dsrip.nj.gov/Home/Resources
age 4 Measures Catalogue: http://dsrip.nj.gov/Home/Resources
ance Measurement and Standard Reporting Workbook (Databook):
s/Home/Resources
/ebinar 5: Databook Introduction: http://dsrip.nj.gov/Home/Training
/ebinar 6: Project Partners and Attribution: http://dsrip.nj.gov/Home/Training
/ebinar 8: Performance Measurement and Attribution:
ov/Home/Training
/ebinar 9: Performance Measure: http://dsrip.nj.gov/Home/Training

questions, please respond to this email outlining your questions regarding the
kbook.

Page 2 of 2

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Chart Collection, Calculation and Reporting Processes – Validation Steps

- **Step 1- Comparison of Standard Reporting Workbook to Hospitals Data Reporting Plan (DRP)**
  - Verify capture of all Stage 3 measures populated as expected.
  - Verify capture of all Stage 4 measures populated as expected.

- **Step 2- Completeness Check**
  - To ensure a report is complete, the reviewer will perform the following:
  - Verify the project selected by the hospital is the project tab populated by the hospital.
  - Verify both of the Universal Measures tabs are populated by the hospital.
  - If a hospital does not provide a service that is monitored for Stage IV and did not report it on their Data Reporting Plan, the hospital included a rationale for omission of the measure data in the comments section of the cover sheet.

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Chart Collection, Calculation and Reporting Processes – Validation Steps

- **Step 3- Data Entry Check**
  - Verify “Hospital Sampling Methodology” was populated.
  - Verify reporting partner captured with required entries, for those hospitals with project partner(s).
  - Verify capture all numerators and/or denominators in workbook cells as expected.
  - Verify the denominator value is NOT less than the numerator.
  - Verify the hospital populated the In-Patient Total.
  - Verify there is NO alpha text encountered, vs. a numeric value, in the numerator and/or denominator entry.
  - Verify there are NO negative numbers entered.
  - Verify only whole numbers are entered.

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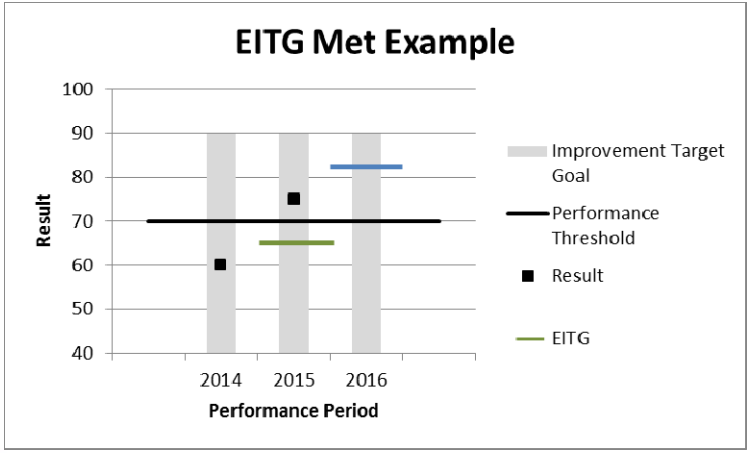
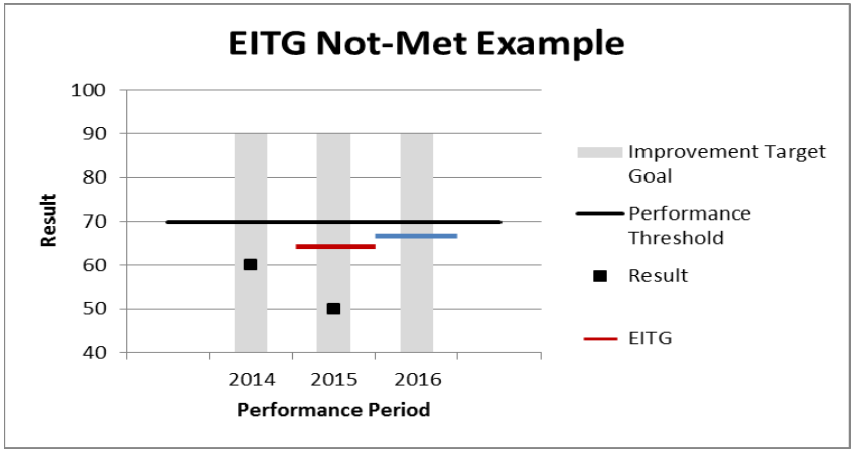
Performance Measure Result Reminders

When an EITG is met.
Next year's EITG is calculated on last result.

When an EITG is not met for a performance period.
Next EITG calculated from last EITG.





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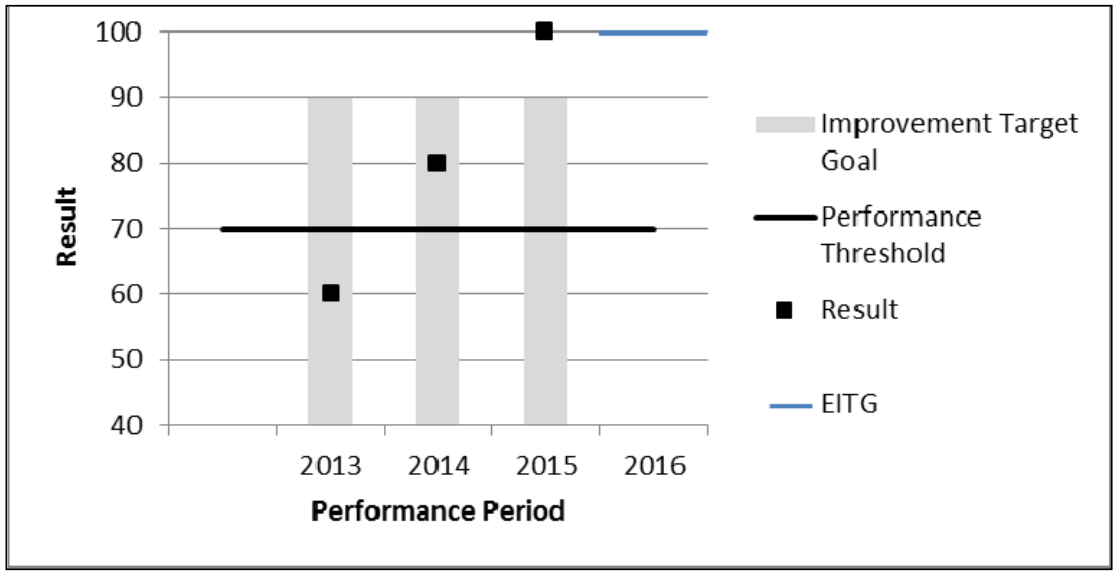
Performance Measure Result Scenarios

If ITG is exceeded, performance is expected to be maintained.



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