ATTACHMENT A
Delivery System Reform Incentive Payment (DSRIP) Program
Renewal Request

Background

The New Jersey Department of Health (DOH) operates the Delivery System Reform Incentive Payment (DSRIP) program as required by Section 93(e) of the Special Terms and Conditions (STCs) for New Jersey's 1115(a) Medicaid and Children's Health Insurance Program (CHIP) Comprehensive Waiver. DSRIP program requirements are detailed in the Planning Protocol (PP) and Funding and Mechanics Protocol (FMP). CMS approved these protocols on August 8, 2013.

DSRIP is designed to result in better care for individuals (including access to care, quality of care and health outcomes), better health for the population, and lower costs by transitioning hospital funding to a model where payment is contingent on achieving health improvement goals. Hospitals may qualify to receive incentive payments for implementing quality initiatives within their community and achieving measurable, incremental clinical outcome results demonstrating the initiatives' impact on improving the New Jersey health care system.

The DSRIP program supports the Healthy New Jersey 2020 vision: "For New Jersey to be a state in which all people live long, healthy lives."

As described in the Planning Protocol, New Jersey's described goals include:

- Improve care processes
- Improve patient satisfaction
- Improve patient adherence to their treatment regimen
- Reduce unnecessary admissions/ readmissions
- Reduce unnecessary emergency department visits

Hospitals were offered a menu of 17 pre-defined projects with activities that were identified and developed by the Department and the hospital industry because they represented realistic and achievable improvement opportunities for New Jersey. In order to focus the DSRIP incentive budget and resources, New Jersey was seeking to improve the cost and quality of care for eight prevalent or chronic conditions. The 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

Based on the requirements of these protocols, 55 hospital applications were submitted and approved on May 6, 2014. 11 of the projects were selected representing 7 of the focus areas.

Since that time, 49 hospitals have continued their participation in the program and completed implementation of Stage 1 and Stage 2 infrastructure activities, and Stage 3 and Stage 4 performance measurement.

–Stage 1 – Infrastructure Development

–Stage 2 – Piloting and redesign of chronic and preventive care models

–Stage 3 – Quality improvement measurements specific to clinical performance of the Hospital's DSRIP project

–Stage 4 – Population-focused improvement measurement across several domains of care

New Jersey DSRIP Initial Demonstration Program

DSRIP programs are different from other payment programs because it begins a migration from fee-for-service as a method of payment to pay for performance as a method of payment to a population health payment design. This migration requires a series of foundation steps that needed to be built to create a successful program.

There have been a number of program design, implementation, and industry engagement issues that needed to be constructed as foundational steps. The initial planning and implementation has been over a protracted time period attributed to the complexities of the DSRIP program design. Since hospitals and states have never been part of a DSRIP program before the entire program needed to be built from the ground up. Below is a list that includes some of the first time ever efforts undertaken by NJ hospitals and the State. Also there is not a significant body of work nationally NJ could draw from in creating the NJ DSRIP program.

State of NJ DSRIP Tasks	**NJ Hospitals DSRIP Tasks**
• **Designed Protocols, the Databook and** **Other resources used in the DSRIP program and updated documents based on program changes and experience. Final Protocol design was not completed until the start of DY2.**	• **Participate in the design of the DSRIP program including stage 3 and stage 4 clinical and process measures.**
• **Design project activities and**	• **Develop their DSRIP project**

milestones, project specific measures, universal measures and a payment methodology.	**including an application submitted to the State and CMS, build program infrastructure, and design internal data collection systems and processes for EHR/Chart measures.**
• **Review and "coach" hospitals to develop project applications based on state and CMs reviews. Project applications were not approved until the end of DY2**	• **Engage project partners including the design of systems to collect data and share measure performance results.**
• **Design the attribution algorithm used in patient assignment for hospitals, and, then hospital project partners. The attribution algorithm and project partner requirement was completed in DY3.**	• **Engage hospital medical staff and other members of leadership in understanding the DSRIP program and performance results.**
• **Develop project measure improvement target goals including benchmarks and expected improvement target goals.**	• **Participate in learning collaboratives including making presentations on successes and challenges of DSRIP projects.**
• **Educate NJ hospital providers and project partners in their specific expected improvement target goals. NJ hospitals have never had a significant amount of payments linked to clinical and process measures and never for the low income population. This task was completed in DY4.**	• **For many NJ hospitals the DSRIP program has been the introduction to using attribution as a method of assigning patients.**
	• **Realign internal information systems and processes to capture and analyze measure data.**

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New Jersey's Approach to the Next Generation DSRIP Program

Because pay for performance for project specific measures begins in DY4 [SFY 2016] and extends through DY5 [SFY 2017] the NJ concepts for developing the next generation DSRIP program are shown below.

1. Extend the NJ DSRIP program by two [2] additional years to June 30, 2019. A two year extension to the current program provides a more complete and comprehensive term to evaluate performance and enabling NJ to develop an enhanced DSRIP program going forward.

    a. Consider based upon input from CMS and the hospital industry creating a stronger link between payment and performance by establishing minimum expected improvement target goals, minimum attributed Medicaid enrollees and Charity care recipients.

    b. Consider introducing new substitute project measures and/or new measures provided the number of measures and data collection is a reasonable undertaking for hospitals.

    c. NJ anticipates stable program funding similar to the present annual funding of $166.6 million.

    d. A stronger link to project return on investment.

    e. Initiate program enhancements as described below:

        i. Increase the detail of patient-level information provided to hospitals.

        ii. Increase the amount and timeliness of performance measurement (e.g. increasing trending frequency, comparing participating and non-participating hospitals, etc.).

        iii. Encourage increased health information technology capabilities to receive more real-time data regarding admissions, transfers, discharges, emergency department and primary care visits.

        iv. Encourage increased health information exchange to support increased provision of data-informed patient care.

        v. Establish a coordinated plan with Managed Care Organizations (MCOs) to support DSRIP-specific project and statewide reform goals.

vi. Create administrative efficiency for the state and CMS by establishing operating parameters which require either state-only, or both state and federal review and approval.

These enhancements will strengthen capacity of the health care industry to more effectively coordinate care and become accountable for population health. This will reinforce the expectations CMS has expressed to continue to build hospitals' partnerships with the broader community in order to manage the needs of all residents in the right setting at the right time.

2. NJ to propose a design for a new DSRIP demonstration program expansion by June 30, 2018 to begin on July 1, 2019 and extend through June 30, 2022 with an option for renewal term of an additional two years if mutually agreed to by NJ and CMS. It is anticipated the new NJ DSRIP demonstration program will incorporate the following enhancements leading to more targeted performance improvement and a return on investment:

    a. Lessons learned in NJ from the project specific pay-for-performance outcomes including measures to be discontinued and new measures.

    b. Analysis of the low income population high users of services and high cost services with a focus on addressing high utilization and high cost services.

    c. Consideration for developing provider networks into long-term sustainable medical delivery systems serving the low income population focused on delivering the right care in the right setting at the right cost leading to population health.

    d. Developing a low income population recipient incentive program to actively participate in preventive care programs.

<u>Demonstration and Renewal Periods</u>

The original five year demonstration program was separated between a transition payment period and DSRIP implementation payment periods. The transition period allowed the DSRIP program to fully reimburse all hospitals at historical rates during the development of the program. As of January 2014, reimbursement was limited to participating DSRIP hospitals based on DSRIP stage funding allocation. DY 5 is the final year of the current DSRIP program and will serve as the transition year to the proposed two year extension and next generation DSRIP program.

Demonstration Year	**Implementation Period**	**Dates**
Demonstration Year 1	Transition Period	July 2012 – June 2013

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Demonstration Year 2	Transition Period	July 2013 – December 2013
	DSRIP Implementation	January 2014 - June 2014
Demonstration Year 3	DSRIP Implementation	July 2014 – June 2015
Demonstration Year 4	DSRIP Implementation	July 2015 – June 2016
Demonstration Year 5	DSRIP Implementation: Note 1	July 2016 – June 2017
Renewal Year 1	DSRIP Extension	July 2017 – June 2018
Renewal Year 2	DSRIP Extension	July 2018 – June 2019
Renewal Year 3	DSRIP Expansion	July 2019 – June 2020
Renewal Year 4	DSRIP Expansion	July 2020 – June 2021
Renewal Year 5	DSRIP Expansion	July 2021 – June 2022

For the renewal years 1 and year 2, it is proposed that funding allocations continue similar to DY 5 funding amounts and allocations to the Universal Performance Pool (UPP) including a UPP carve out for project partner participation payments, Stage 1 and 2, Stage 3, and Stage 4.

For renewal years 3-5, it is proposed that some adjustments occur to allocations to help support additional information technologies needs under this type of program. Additionally, development of targeted measures and improvement will be discussed with stakeholders through a deliberative design phase based on meeting the trigger. Also NJ would like to consider an incentive payment for low income population enrollees practicing targeted preventive care behaviors.

Stages	**Payment Mechanism**		**Allocation Percentage [Beyond RY2 is to be Determined based on the design of the DSRIP expansion years 7/1/2019-6/30/2022]**								
Description		**DY2**	**DY 3**	**DY 4**	**DY 5**	**RY 1**	**RY 2**	**TBD**	**RY3**	**RY 4**	**RY5**
Universal Performance Pool (UPP) Carve Out – all hospitals are eligible to receive monies from a shared performance pool		0%	10 %	15 %	25 %	22 %	20 %		18%	18 %	18%

of funding.											
Community Partner Participation Carve out based on meeting partner requirements as part of UPP						3%	5%		5%	5%	5%
Stages I Project Activities – incentive payment award is based on hospital investments in technology, tools, and human resources	Pay for Achievement	90%	75%	50%	25%	25%	25%		25%	15%	15%
Stage II Project Activities – incentive payment award is based on accomplishing the piloting, testing, and replicating of chronic patient care models.											
Stage III Quality Improvements – incentive payment award is based on either a pay for reporting or pay for performance basis. Clinical performance measures that measure the impact of Stage 1 and 2 activities; number of measures varies by project	Pay for Reporting	5%	15%	-	-	-	-		10%	20%	20%
	Pay for Performance	0%	-	35%	50%	50%	50%		40%	40%	40%
Stage IV Population Focused [UPP] Improvements – clinical performance measures that include reporting performance on measures across domains of care	Pay for Reporting	5%	10%	15%	25%	25%	25%		25%	25%	25%
Low income population preventive care incentive payment if hospital proposal is approved as part of UPP									2%	2%	2%

Initial DSRIP Results

The DSRIP program has begun to successfully meet the high expectations and aims set out for the program in New Jersey including meeting CMS' three-part aims for better care, smarter spending and healthier people. New Jersey has seen improvements in the following:

- Increased infrastructure, health information technology and data analytics
- Enhanced provider collaboration and community engagement
- Improved care processes and services provided
- Improved health outcomes
- Decreased costs

Individual hospitals have shown very impressive preliminary findings. These remarkable improvements have been presented and shared by providers during the New Jersey DSRIP Learning Collaborative.

Increased infrastructure, health information technology and data analytics		
Increased number of chronic condition clinics	Newark Beth Israel Medical Center[i]	Opened The Transitional Care Center (TCC) for high risk patients with medical monitoring and other support until patients are able to get an appointment with their primary care provider.
Increased work force trained and dedicated to system reform	Multiple hospitals	Additional case managers, new asthma educators, addition of peer support specialists, and patient care navigators have been added to the work force.
Attributed patients are being assessed for diagnoses and new linkages of care or social supports	Our Lady of Lourdes Medical[ii]	Transitions RN identifies barriers to therapeutic regimen adherence. Assesses inability to afford prescriptions, no reliable transportation, food, shelter, addiction, mental health issues and then consults with social worker, case managers, and discharge planners to assist with community resource referrals. Hospital is also contracting with transportation vendor.
	Jersey City Medical	Homeless are being linked to the Medical and Social Services for the Homeless (MASSH)

	Center	program. HIV patients are being linked to Center for Comprehensive Care (CCC) program.
Increased population health management preparedness and data analysis	Cape Regional Medical Center[iii]	Detailed analytics have been integrated into hospital workflows quantifying outcomes for an entire patient population instead of a patient sampling. Real-time data feeds occur to each of the hospital and reporting partner practices to provide real-time numerator and denominator data in order to reach out and intervene as clinically necessary.
Increased electronic medical record capabilities and notifications for clinical decision support	Englewood Hospital and Medical Center	New daily inpatient report identifying patients with chronic cardiac conditions with a LACE score greater than 7 with Medicaid, Charity Care, and Self-pay status are enrolled in the program. LACE scores represent the length of stay of the index admission, acuity of admission, co-morbidities of the patient, and number of emergency department visits in the last six months.
Enhanced provider collaboration and community engagement		
Hospital and community partner relationship development and collaboration	Jersey City Medical Center[iv]	More than 100 school nurse relationships, 30 outreach events, 20 back to school events and/or PTO meetings attended.
	Inspira Medical Center Elmer	Quarterly consortiums at Woodbury/Vineland and Monthly calls with Capital and Trinitas are held.
Increased primary care provider collaboration	Jersey City Medical Center	Lunch and Learns held with FQHCs.
	Barnabas Health[v]	In order to secure a reporting partner, agreed to assist Zufall Clinic FQHC patients' with access to specialty services like the OB clinic, orthopedics

		and plastic surgery.
	Our Lady of Lourdes Medical	Transitions RNs using practice offices for follow-up visits.
Improved care processes and services provided		
Increased treatment plan development and follow-up	Newark Beth Israel Medical Center	Percent of patients who had documented outpatient follow-up appointment: Baseline June 2014 data = 17%; Feb-May 2015 data = 4 months with 100% scheduling compliance. "I understand the purpose for taking each of my medications" Baseline =75%; April-June 2015 = 91% "The staff explains my test results so that I know what they mean" Baseline = 80%; April-June 2015 = 91% Model is being spread throughout the medical center for other patient populations.
Increased chronic condition management and services	Barnabas Health	Pulmonary physicians are completing baseline spirometry on all asthma patients
	Inspira Medical Center Elmer[vi]	106 of 116 patients referred for substance abuse consults accepted secondary screenings, others continued into treatment. – Refusal = 35; Brief Education = 24 Inpatient Tx = 17; Brief Intervention = 14

		Intensive Outpatient = 5; Individual/Psychiatrist = 4 12 Step Meetings = 4; Suboxone Maintenance = 1 Acute Detox = 1; Detox = 1
	Our Lady of Lourdes Medical	Home visit is scheduled ideally within 1-3 days post discharge. Coach targets 4 key areas: Medication reconciliation, follow-up appointments, red flags, personal health record completion.
	Monmouth Medical Center Southern Campus[vii]	Community Health Workers are completing home visits to facilitate patient engagement, meeting them in-home or in the community (i.e. coffee shops, church, etc.).
Increased patient engagement and shared decision making	Bergen Regional Medical Center[viii]	Increase in patient experience (5 point scale): – Physician listens to you Baseline (135) = 4.03; Q3 (446) = 4.7 – Physician takes enough time Baseline (135) = 4.04; Q3 (446) = 4.67 – Physician explains what you want to know Baseline (135) = 3.98; Q3 (446) = 4.68 – Physician encourages me to participate Baseline (213) = 4.62; Q3 (466) = 4.66
Increased medication management	CarePoint Health Bayonne Medical Center[ix]	Added Meds to Beds service where the patient's prescription is brought to the OPD Pharmacy and the medication is returned to the patient prior to discharge.
Improved health outcomes		
	Bergen Regional Medical	– Average Quarterly ER Visits per quarter per patient:

	Center	Baseline 2013-2014 = 0.308; Q1-Q2 2015 = .196; Reduction of 159 Visits – Average Quarterly Inpatient Admissions per quarter per patient: Baseline 2013-2014 = 0.114; Q1-Q2 2015 = .096; Reduction of 26 Admissions
	Inspira Medical Center Elmer	– Average Length of Stay: Baseline Aug 2014-Dec 2014 = 4.22; 2015 YTD = 2.98
	University Medical Center of Princeton at Plainsboro[x]	– 6 months Pre enrollment Admissions = 14 6 months Post enrollment Admissions = 5 – 6 months Pre enrollment 30-day Readmissions = 2 6 months Post enrollment 30-day Readmissions = 1 – 6 months Pre enrollment ED visits = 36 6 months Post enrollment ED visits = 30
	Palisades Medical Center[xi]	– 30-day AMI Readmission rate: Baseline Aug 2014-Jan 2015 = 21.9%; Feb 2015-June 2015 = 17.7%
Decreased Cost		
	Barnabas Health	– ER Visits: 2012 Baseline per quarter = 109; DY4 Q1 = 13; 88% Reduction Per visit savings = $358.95 Total quarter savings = $35,459

		– Admissions: 2012 Baseline per quarter = 21; DY4 Q1 = 5; 76% Reduction Per visit savings = $3,900 Total quarter savings = $62,400
	St. Josephs[xii]	– Reduction of 59 Admissions – Reduction of 0.5 days – 20 percent reduction in ED Visits – $1.4 million cost savings

This snapshot of the various successes are exciting and demonstrates the level of commitment by the DSRIP participating hospitals in achieving a new, reformed health system focused on providing the best care possible for all of New Jersey. The DSRIP program supports this emerging transformation. Not only is there commitment from the hospitals, but it is clear that reform is taking place in the delivery of health care. To continue to move towards sustainable transformation, enduring process adoption and commitment at a steady, incremental pace is required.

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[i] Newark Beth Israel Medical Center, The Congestive Heart Failure (CHF) Transition Program. July 9, 2015. https://dsrip.nj.gov/Documents/Newark%20Beth%20Israel%20Med%20Ctr_LC3_4_07.09.2015.pdf
[ii] Our Lady Of Lourdes Medical, CHF Program, October 8, 2015. https://dsrip.nj.gov/Documents/LC%203%20&%204%20Our%20Lady%20of%20Lourdes_10-8-2015.pdf
[iii] Cape Regional Medical Center, "Meaningful Use of Patient-Generated Data." October 8, 2015. https://dsrip.nj.gov/Documents/LC%205%20Cape%20Regional%20Med%20Ctr%20_10-08-2015.pdf
[iv] Jersey City Medical Center – Pediatric Asthma Case Management and Home Evaluation Program, October 8, 2015. https://dsrip.nj.gov/Documents/LC%201%20Jersey%20City%20Medical%20Center_10-8-2015.pdf
[v] Barnabas Health Hospital Presentation, October 8, 2015. https://dsrip.nj.gov/Documents/LC%201%20St.%20Barnabas%20Med%20Ctr_10-8-2015.pdf
[vi] Inspira Medical Center Elmer, October 8, 2015. https://dsrip.nj.gov/Documents/LC%202%20Inspira%20Medical%20Center%20-Elmer_10-8-2015.pdf
[vii] Monmouth Medical Center Southern Campus, Integrated Health Home for the Seriously Mentally Ill, July 9, 2015. https://dsrip.nj.gov/Documents/Monmouth%20Med%20Ctr_Southern%20Campus_LC2_07.09.2015.pdf
[viii] Bergen Regional Medical Center – Shared Decision Making: Electronic Self-Assessment, October 8, 2015. https://dsrip.nj.gov/Documents/LC%202%20Bergen%20Regl%20Med%20Ctr_10-8-2015v2.pdf
[ix] CarePoint Health – Bayonne Medical Center – Cardiac Care- Heart Failure, October 8, 2015. https://dsrip.nj.gov/Documents/LC%203%20&%204%20Bayonne%20Med%20Ctr_10-8-2015.pdf

[x] University Medical Center of Princeton at Plainsboro, Diabetes Group Visits. October 8, 2015. https://dsrip.nj.gov/Documents/LC%205%20University%20Med%20Ctr%20at%20Princeton_10-8-2015.pdf
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[xii] St. Joseph's Healthcare System, Hospital-Based Educators Teach Optimal Asthma Care. July 9, 2015. https://dsrip.nj.gov/Documents/St.%20Joseph%20Regional%20Med%20Ctr_LC1_07.09.2015.pdf