

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW JERSEY DID NOT PROVIDE
ADEQUATE OVERSIGHT OF ITS
MEDICAID DELIVERY SYSTEM REFORM
INCENTIVE PAYMENT PROGRAM**

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March 2019
A-02-17-01007

Office of Inspector General

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: March 2019

Report No. A-02-17-01007

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

As of 2016, New Jersey and eight other States had implemented or received approval for Delivery System Reform Incentive Payment (DSRIP) programs with Federal Medicaid funding totaling \$26 billion. New Jersey's DSRIP program provides incentive payments to hospitals for providing quality health care to Medicaid beneficiaries and uninsured patients.

Under New Jersey's 5-year DSRIP demonstration program, hospitals received incentive payments for meeting performance indicators (goals). New Jersey measured hospitals' progress toward meeting certain performance goals by using Medicaid claims data and patients' health records information. New Jersey was approved for Medicaid funding totaling \$923 million (\$462 million Federal share) for its DSRIP program. From this amount, it made "pay-for-performance" incentive payments totaling \$182 million (\$91 million Federal share) to 49 hospitals. New Jersey extended the program through June 2020 with additional funding totaling \$500 million (\$250 million Federal share).

Our objective was to determine whether New Jersey claimed Medicaid reimbursement for certain DSRIP program payments in accordance with Federal and State requirements.

How OIG Did This Review

We reviewed approximately \$51 million (\$25 million Federal share) in pay-for-performance incentive payments made to five hospitals during the fourth and fifth years of the demonstration program.

New Jersey Did Not Provide Adequate Oversight of Its Medicaid Delivery System Reform Incentive Payment Program

What OIG Found

We could not determine whether New Jersey appropriately claimed Medicaid reimbursement for pay-for-performance incentive payments to five selected hospitals. Specifically, we could not determine if the hospitals met performance goals calculated from Medicaid claims data. In addition, the hospitals did not report patients' health records information consistent with performance measure criteria. As a result, we could not determine what portion of pay-for-performance incentive payments, totaling approximately \$51 million (\$25 million Federal share), that New Jersey made to the five selected hospitals based on determinations from New Jersey's DSRIP program contractor was appropriate.

This occurred because New Jersey did not ensure that the DSRIP program contractor maintained Medicaid claims data to support the achievement of performance goals and did not provide adequate guidance to the hospitals regarding how they should report patients' health records information.

What OIG Recommends and New Jersey's Comments

We recommend that New Jersey work with its DSRIP manager and program contractor and the five selected hospitals to determine whether the approximately \$51 million (\$25 million Federal share) in pay-for-performance incentive payments to the hospitals was appropriate. New Jersey should also work with its DSRIP manager and program contractor and the 44 hospitals not selected for review to determine whether the approximately \$132 million (\$66 million Federal share) in remaining pay-for-performance incentive payments was appropriate. We also recommend that New Jersey improve its oversight of the DSRIP program to ensure compliance with Medicaid requirements.

In written comments to our draft report, New Jersey disagreed with our findings and did not indicate concurrence or nonconcurrence with our recommendations. However, it described steps that it has taken to improve its oversight of the DSRIP program. After reviewing New Jersey's comments, we maintain that our findings and recommendations are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

Delivery System Reform Incentive Payment (DSRIP) programs allow States to receive Medicaid reimbursement for incentive payments made to providers for meeting performance goals. As of 2016, New Jersey and eight other States had implemented or received approval for DSRIP programs with Federal funding totaling approximately \$26 billion. New Jersey's DSRIP program provides incentive payments to hospitals for providing quality health care to Medicaid beneficiaries and uninsured patients. We decided to review certain DSRIP program payments made to selected hospitals for meeting performance goals.

This review is the first in a series of reviews to determine whether selected States adhered to Federal and State requirements when claiming Medicaid reimbursement for DSRIP program payments.

OBJECTIVE

Our objective was to determine whether the New Jersey Department of Human Services (State agency) claimed Medicaid reimbursement for certain DSRIP program payments in accordance with Federal and State requirements.

BACKGROUND

Medicaid Delivery System Reform Incentive Payments

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. In New Jersey, the State agency administers the Medicaid program.

CMS has approved Medicaid DSRIP initiatives as part of broader Section 1115 Waiver programs.¹ Under the DSRIP program, States are able to secure significant Federal funding to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries. The DSRIP program varies significantly from State to State, but generally DSRIP initiatives are performance-based incentive programs that require providers to meet process or outcome measures to qualify for program payments. Therefore, to take part, States must establish data collection and reporting requirements that adequately measure provider performance.

¹ Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program. The purpose of these projects, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

New Jersey’s Delivery System Reform Incentive Payment Program

New Jersey’s DSRIP program is part of its Comprehensive Medicaid Waiver (Medicaid waiver) approved by CMS in October 2012. The New Jersey Department of Health (DOH), which uses a contractor to collect and process hospital performance data, manages the State agency’s DSRIP program.

The State agency implemented its DSRIP program as a 5-year demonstration program from July 2012 through June 2017, with each demonstration year (DY) beginning in July. For DY 1 and the first half of DY 2, the State agency made “transition payments”² to 63 hospitals it deemed program-eligible.³ For the second half of DY 2, 55 DSRIP program-eligible hospitals received payments for approved DSRIP plans to carry out projects designed to improve the cost and quality of care for populations diagnosed with prevalent chronic conditions.⁴ Of these 55 hospitals, 49 elected to participate in the DSRIP program. During DYs 3 through 5, the State agency made incentive payments to those 49 hospitals for meeting performance indicators (goals) related to project reporting requirements and clinical performance measures.⁵

For the State agency’s 5-year DSRIP demonstration, CMS approved Medicaid funding totaling \$923 million (\$461.5 million Federal share). From this amount, the State agency made incentive payments totaling \$182.4 million (\$91.2 million Federal share) to hospitals for meeting pay-for-performance goals. At the conclusion of the 5-year demonstration, the State agency received approval from CMS to extend the program an additional 3 years.⁶

² “Transition payments” were not contingent on hospitals meeting any performance goals (Medicaid waiver, Special Terms and Conditions (STC) #91a, amended February 11, 2016).

³ Program-eligible hospitals were New Jersey Medicaid providers that received supplemental Medicaid payments under the Medicaid State plan (Medicaid waiver, STC #91a). The State agency made supplemental payments to hospitals that served low-income patient populations.

⁴ The State agency offered hospitals a choice of 17 predefined projects for eight prevalent chronic conditions—asthma, behavioral health, cardiac care, substance abuse, diabetes, HIV/AIDS, obesity, and pneumonia (Medicaid waiver, STC #92b, DSRIP Planning Protocol, Attachment 1, Section III).

⁵ The State agency categorized performance goals as pay-for-reporting, project-specific pay-for-performance, and population-focused pay-for-performance. Pay-for-reporting goals included reporting on clinical performance measures and on the progress of hospital project activities. Pay-for-performance goals included meeting or improving on clinical performance measure targets.

⁶ The demonstration renewal secured an additional \$499.8 million (\$249.9 million Federal share) in Medicaid funding from July 2017 through June 2020 (Medicaid waiver, STC #51, amended October 31, 2017).

New Jersey's Hospital Performance Goals

In New Jersey, DSRIP incentive payments are contingent on participating hospitals implementing quality initiatives within their community and meeting performance goals.⁷ The State agency created a *DSRIP Performance Measurement Databook* that detailed its selected performance measures. The *DSRIP Performance Measurement Databook* establishes the criteria that hospitals must use to measure and satisfy their performance goals. The State agency measured hospitals' progress toward meeting performance goals by using Medicaid claims data and patients' health records information for the New Jersey Low Income Population.⁸ During DY 3, the State agency's contractor calculated baseline performance measurements for each hospital's performance goals. Hospitals received incentive payments during DYs 4 and 5 if they met the performance goals described in their DSRIP plans. Hospitals that did not meet their performance goals forfeited some or all of their incentive funding to a performance pool that distributed incentive payments to hospitals based on population-focused clinical performance measures.⁹

Federal and State Requirements

States must maintain records to assure that claims for Federal funds meet applicable Federal requirements.¹⁰ Requirements for New Jersey's DSRIP program are detailed in the State agency's CMS-approved Medicaid waiver, which requires the State agency to make available appropriate supporting documentation for CMS to determine the allowability of DSRIP program payments. The State agency may not claim reimbursement for payments made for the 5-year demonstration until both the State agency and CMS have concluded that the hospitals met the performance goals tied to each payment.¹¹ Appendix B contains the details on Federal and State requirements for the DSRIP program.

⁷ Hospitals' performance goals were established using performance measures developed by measure stewards (organizations that develop and maintain performance measures used by hospitals and health care providers). These performance measures are not exclusive to the State agency's DSRIP program.

⁸ The "New Jersey Low Income Population" is defined as New Jersey Medicaid, Children's Health Insurance Program, and Charity Care populations (*New Jersey DSRIP Performance Measurement Databook, § 1, "General Overview,"* page 5).

⁹ All incentive payments funded under the performance pool were based on hospitals maintaining or improving on a specific set of 12 population-focused clinical performance measures.

¹⁰ 42 CFR § 433.32.

¹¹ Hospital reports must contain sufficient data and documentation to allow the State agency and CMS to determine if the hospital met a specific performance goal, and hospitals must have available for review all supporting data and backup documentation (Medicaid waiver, STC #93(c)). Supporting documentation must be made available for CMS to determine the allowability of the payments (Medicaid waiver, STC #90(e).) Also, the State must use documentation described in the DSRIP Program Funding and Mechanics Protocol to support claims for federal financial participation (Medicaid waiver, STC #93(d), #92(f)(vii)).

HOW WE CONDUCTED THIS REVIEW

We reviewed incentive payments totaling \$50,920,788 (\$25,460,394 Federal share) made to five selected hospitals¹² for meeting pay-for-performance goals during DYs 4 and 5.¹³ We selected these hospitals because the State agency allocated 37 percent of all “target funding” to them for DYs 4 and 5.¹⁴ Table 1 summarizes the pay-for-performance incentive payments to the five selected hospitals.

Table 1: Summary of Pay-for-Performance Incentive Payments to Five Selected Hospitals (Total Medicaid Dollars)

Payment Type*	Hospital 1	Hospital 2	Hospital 3	Hospital 4	Hospital 5
DY 4 Project-Specific	\$2,785,974	\$1,592,399	\$1,223,370	1,401,482	\$4,021,265
DY 4 Population-Focused	1,545,861	1,854,226	0	500,767	2,691,667
DY 5 Project-Specific	1,755,866	501,806	0	1,766,574	3,379,214
DY 5 Population-Focused	6,476,790	4,859,628	4,170,494	3,755,335	6,638,070
Total	\$12,564,491	\$8,808,059	\$5,393,864	\$7,424,158	\$16,730,216

* Hospitals earned project-specific payments for achieving performance measures related to their selected DSRIP projects and population-focused payments for meeting a specific set of 12 population-focused performance measures.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

¹² The five hospitals were Bergen Regional Medical Center; St. Joseph’s Regional Medical Center; Newark Beth Israel Medical Center; Trinitas Regional Medical Center; and University Hospital, Newark.

¹³ The State agency made incentive payments totaling \$131,511,277 (\$65,755,639 Federal share) to the 44 hospitals not selected for review for meeting pay-for-performance goals during DYs 4 and 5.

¹⁴ The State agency established target funding amounts for each hospital on the basis of State fiscal year 2013 Hospital Relief Subsidy Fund (HRSF) amounts. New Jersey’s DSRIP program replaced its HRSF, from which payments to hospitals were made based on the amount of care they provided to Medicaid beneficiaries and uninsured patients. Target funding amounts based on HRSF payments were established to ensure that hospitals were able to manage their finances with reasonable stability during the 5-year DSRIP demonstration.

FINDINGS

We could not determine whether the State agency appropriately claimed Medicaid reimbursement for pay-for-performance incentive payments for five selected hospitals under its DSRIP program. Specifically, we could not determine if hospitals met pay-for-performance goals calculated using Medicaid claims data because the State agency's DSRIP program contractor did not maintain the data to support the results of its calculations. In addition, the hospitals did not report patients' health records information¹⁵ that was consistent with the performance measure criteria used to determine whether certain pay-for-performance goals were met. As a result, we could not determine what portion of DSRIP pay-for-performance incentive payments, totaling \$50,920,788 (\$25,460,394 Federal share), that the State agency made to the five selected hospitals was appropriate.¹⁶

The State agency did not provide adequate oversight of its DSRIP program. Although the State agency reviewed the contractor's results before submitting them to CMS for approval of incentive payments, it did not ensure that the DSRIP program contractor maintained Medicaid claims data to support its determinations for whether hospitals met Medicaid claims-related pay-for-performance goals. In addition, the State agency did not provide effective guidance to the hospitals regarding how they should report patients' health records information used to measure whether hospitals met certain pay-for-performance goals.

NO DOCUMENTATION SUPPORTING ACHIEVEMENT OF MEDICAID CLAIMS-RELATED PERFORMANCE GOALS

States must maintain records to assure that claims for Federal funds meet applicable Federal requirements (42 CFR § 433.32). The State agency is required to maintain documentation to support its DSRIP program payments (Medicaid waiver, STC #90e, 92(f), 93(c), 93(d)).

The DSRIP program contractor did not maintain the original data (e.g., source summary data and results of queries) it used to determine whether hospitals met pay-for-performance goals for which hospital performance was measured using Medicaid claims data.¹⁷ Further, the contractor stated that any attempt to replicate its original results would produce variances because the data it used to determine if hospitals met these goals had changed over time. As described in Example 1, we could not replicate or audit the contractor's results for the selected

¹⁵ Patient health record information included medical diagnoses, procedures, history, outcomes, and lengths of inpatient stay.

¹⁶ All forfeited DSRIP funds for DYs 3 through 5 were added to the program's performance pool. The State agency redistributed amounts in the performance pool to all participating hospitals if they met certain population-focused performance goals. When hospitals forfeit funds, the State agency must recalculate payments to all hospitals. As a result, if the hospitals not selected for review failed to meet their performance goals, the redistribution of forfeited funds would affect payments to the five hospitals we reviewed.

¹⁷ The State agency provided the DSRIP program contractor with Medicaid claims data from New Jersey's Medicaid Management Information System.

hospitals because the contractor used the State agency’s Medicaid claims database, which is updated quarterly, and did not maintain any summary data or results of queries used in measuring the hospitals’ performance.

Example 1: Heart Failure Admission Rate

Among its pay-for-performance goals, the State agency measured the rate at which the New Jersey Low Income Population aged 18 or older were admitted to a hospital with a principal diagnosis of heart failure.¹⁸ The hospitals met this performance goal when their admission rates for heart failure decreased during DYs 4 and 5. The program contractor used Medicaid claims data, which the State agency updates quarterly, to measure the hospitals’ performance. For DY 4, the contractor’s initial calculations inadvertently counted certain heart failure patients who were not eligible for the measure because of a diagnosis of hypertension, kidney disease, or both. The contractor recalculated its results for all five selected hospitals to correct its error. However, because the contractor did not maintain summary data or the results of its queries for its initial calculations and recalculations, we could not replicate the results.

HOSPITALS REPORTED INFORMATION INCONSISTENT WITH PERFORMANCE MEASURE CRITERIA

Hospitals’ DSRIP reports must contain sufficient data and documentation to allow the State agency and CMS to determine if they fully met specific performance goals, and hospitals must have available for review all supporting data and back-up documentation (Medicaid waiver, STC #93(c)). DSRIP payments to a hospital are contingent on the hospital’s meeting performance measure criteria and satisfying a target level of improvement (Medicaid waiver, STC #92(g), 93(d)).

All of the five selected hospitals reported information that did not meet performance measure criteria. Hospitals reported this information based on their patients’ health records to the DSRIP program contractor, which used the information to measure whether the hospitals met certain pay-for-performance goals. The information reported did not meet performance measure criteria for elements such as the number of patients¹⁹ or patient-days. This information was used in the contractor’s calculation of measurements and resulted in the contractor erroneously determining that the hospitals met some pay-for-performance goals.

¹⁸ *New Jersey DSRIP Performance Measurement Databook*, § IV, “Heart Failure Admission Rate DSRIP Code 45,” page 215.

¹⁹ The selected hospitals reported information for patients who were not eligible for the measurements because of demographic or clinical factors—including age, certain diagnoses, and past medical history—that were required criteria in the performance measures.

In addition, four of the selected hospitals reported the information for one measurement in a manner that was not consistent with DSRIP program requirements. As described in Example 2, we could not audit the information that these four hospitals reported for this one measure because they had no system in place to count only those patient-days that were eligible for the measurement.

Example 2: Central Line-Associated Bloodstream Infection Event

Hospitals were required to report information on the rate at which patients in the New Jersey Low Income Population developed an infection that occurs when germs enter the bloodstream through a central line, which is an intravascular line that terminates at or close to the heart or in a major blood vessel.²⁰ The rate is calculated as the number of infection events over the number of patient-days during which the beneficiary had a central line. Although the electronic health record systems used by the five selected hospitals were able to calculate the number of patient-days with a central line, four of the five hospitals had no system in place to count only those patient-days for the New Jersey Low Income Population. The fifth hospital developed a manual process to properly count patient-days for the measure. However, based on instructions from the DSRIP program contractor, the other four hospitals reported all patient-days with a central line for the measure, including ineligible patient-days for those who were not in the New Jersey Low Income Population.

STATE AGENCY DID NOT PROVIDE ADEQUATE PROGRAM OVERSIGHT

The State agency did not provide adequate oversight of its DSRIP program. Although the State agency reviewed the contractor's results before submitting them to CMS for approval of incentive payments, the State agency or DOH did not issue specific guidance to the contractor regarding how hospitals' performance should be measured or require that supporting data be maintained. Further, neither the State agency nor DOH verified the contractor's calculations. As a result, the State agency did not ensure that the DSRIP program contractor maintained data to support its determinations for whether hospitals met Medicaid claims-related pay-for-performance goals.

Hospitals reported information inconsistent with the performance measure criteria to the DSRIP program contractor, in part, due to a lack of adequate program oversight. Specifically, the State agency, DOH, and the contractor did not have a process to verify patients' health records information reported by the hospitals and to identify errors in the hospitals' submissions. Further, the State agency, DOH, and the contractor did not provide effective guidance to the hospitals regarding how they should report information used to measure whether they met certain pay-for-performance goals.

²⁰ *New Jersey DSRIP Performance Measurement Databook*, § IV, "Central Line-Associated Bloodstream Infection Event DSRIP Code 21."

RECOMMENDATIONS

We recommend that the State agency:

- work with DOH, the DSRIP program contractor, and the five selected hospitals to determine whether the \$50,920,788 (\$25,460,394 Federal share) in pay-for-performance incentive payments to the five hospitals was appropriate;
- work with DOH, the DSRIP program contractor, and the 44 hospitals not covered by this review to determine whether the \$131,511,277 (\$65,755,639 Federal share) in pay-for-performance incentive payments to those hospitals was appropriate; and
- improve its oversight of the DSRIP program to ensure that (1) its contractor maintains the Medicaid claims data necessary to support its determinations for whether hospitals qualify for pay-for-performance incentive payments and (2) hospitals report information consistent with the performance measure criteria to the DSRIP program contractor.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with our findings and did not indicate concurrence or nonconcurrence with our recommendations.²¹ It also took issue with the title of our report. However, the State agency described steps that it has taken to improve its oversight of the DSRIP program. The State agency also provided documentation to support its comments on our draft report in the form of memoranda from the DSRIP program contractor during our audit period and the vendor with which it contracted in 2018 to manage the DSRIP program.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. The State agency's comments are included as Appendix C.²²

NO DOCUMENTATION SUPPORTING ACHIEVEMENT OF MEDICAID CLAIMS-RELATED PERFORMANCE GOALS

State Agency Comments

The State agency stated that the achievement of performance goals by hospitals was sufficiently documented. Specifically, the State agency expressed that it is confident that the DSRIP program contractor can produce the documentation needed to support the calculation of

²¹ The State agency forwarded our draft report to DOH and provided DOH's written comments on it. The State agency indicated that DOH is primarily responsible for implementing the DSRIP program. We refer to DOH's written comments as the State agency's comments on our draft report.

²² We did not include the supporting documentation (i.e., memoranda) included in the State agency's comments because neither DSRIP program contractor was the subject of our audit.

Medicaid claims-related performance goals and provided a memorandum from the contractor indicating its capacity to provide all source claims data used to calculate the performance measures. According to the State agency, the contractor asserted that it could produce all DSRIP program source files by reverting to a “point in time” view of its source data and that query scripts for performance measure analysis are saved and available. The State agency acknowledged that claims adjustments could yield variances in the performance results but asserted that these adjustments would not prevent an accurate calculation of performance measure achievement.

The State agency also stated that in 2018, it contracted with a new DSRIP program contractor that will maintain all originally extracted Medicaid claims data and queries used for calculating claims-based performance measures and provided a memorandum from the contractor attesting to this.

Office of Inspector General Response

We maintain that the DSRIP program contractor did not maintain the original data it used to determine whether hospitals met pay-for-performance goals for which hospital performance was measured using Medicaid claims data. We requested the original data from the DSRIP program contractor on multiple occasions and were informed that the data were not maintained. Further, the contractor has not produced the source files to support its calculation of Medicaid claims-related performance goals. We also note that, in its written comments, the State agency confirmed that any attempt to replicate the original results would produce variances.

We acknowledge the State agency’s commitment to ensure that its new DSRIP program contractor will maintain all originally extracted Medicaid claims data and queries used for calculating claims-based performance measures.

HOSPITALS REPORTED INFORMATION INCONSISTENT WITH PERFORMANCE MEASURE CRITERIA

State Agency Comments

The State agency stated that we applied an administrative expectation that CMS does not require in New Jersey’s implementation of the DSRIP program. Rather, the State agency indicated that it and the DSRIP program contractor were obliged to adhere to protocols approved by CMS and included in the *DSRIP Performance Measurement Databook*. According to the State agency, per CMS’s approval of the protocols, the State agency and the contractor were required to accept patients’ health records information submitted by hospitals and were not allowed to accept resubmission of corrected information. In addition, the State agency asserted that audit capability was not required in New Jersey’s DSRIP program under the CMS-approved protocols. The State agency concluded that for data that was collected from electronic health records, the State agency and the contractor had no ability to verify patients’

health records information reported by hospitals or to identify errors in the hospitals' submissions.

The State agency stated that it is working with CMS to develop a DSRIP "successor program" slated to begin in mid-2020. For this program, the State agency indicated that it is reconsidering the use of patients' health records information for performance measures, given its inability to audit the source data under its DSRIP program.

Office of Inspector General Response

We maintain that hospitals reported information that did not meet performance measure criteria, including the criteria included in the *DSRIP Performance Measurement Databook*. As described in Example 2 on page 7, the DSRIP program contractor instructed four of the selected hospitals to report information for one measurement that was not consistent with the *DSRIP Performance Measurement Databook*. Further, as we described in our findings, hospitals' DSRIP reports must contain sufficient data and documentation to allow the State agency and CMS to determine if the hospitals met specific measures, and hospitals must have available for review all supporting data and back-up documentation (Medicaid waiver, STC #93c).

We met with CMS finance and program officials to discuss the State agency's statement that "audit capability was not required in New Jersey's DSRIP program under the CMS-approved protocols." The officials informed us that New Jersey's DSRIP program was subject to Medicaid audit requirements because such requirements were not expressly waived or identified as not applicable in the State's CMS-approved protocols or Medicaid waiver. Specifically, the CMS officials referred us to the Federal requirements for New Jersey's Comprehensive Medicaid Waiver which state that "all requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver, apply to the demonstration."²³ Therefore, New Jersey's DSRIP program was subject to Medicaid audit requirements.

STATE AGENCY DID NOT PROVIDE ADEQUATE PROGRAM OVERSIGHT

State Agency Comments

The State agency stated that it collaborated with CMS "in crafting the various protocols guiding the administration of" the DSRIP program and that the State agency and the DSRIP program contractor adhered to the program's CMS-approved guidance on how hospitals' performance should be measured. According to the State agency, this did not include the State agency independently verifying the contractor's calculations, performing site audits of individual hospitals, or reviewing patients' health records. The State agency also stated that it worked

²³ Medicaid waiver, STC #2.

cooperatively with CMS and the contractor to provide information, review results, and render decisions throughout the operation of the DSRIP program.

The State agency also took issue with the title of our audit report and stated that it is not supported by our findings. According to the State agency, we did not have sufficient information to definitively assess New Jersey's management of the DSRIP program.

Office of Inspector General Response

We maintain that the State agency did not provide *adequate* oversight of its DSRIP program. Although the State agency, DOH, and the DSRIP program contractor had frequent meetings and worked with CMS to craft how New Jersey would administer its DSRIP program, neither the State agency nor DOH verified the DSRIP program contractor's calculations or ensured that the contractor maintained data to support its determinations for whether hospitals met Medicaid claims-related pay-for-performance goals. In addition, the State agency, DOH, and the contractor did not have a process to verify patients' health records information reported by the hospitals and to identify errors in the hospitals' submissions. If they had a process for verifying this information, the State agency and DOH could have ensured that hospitals accurately reported information used to determine whether they met performance goals.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed incentive payments totaling \$50,920,788 (\$25,460,394 Federal share) made to five selected hospitals for meeting pay-for-performance goals during DYs 4 and 5. We selected these hospitals because the State agency allocated 37 percent of all target funding to them for DYs 4 and 5.

We limited our review of the State agency's internal controls over the DSRIP program to those applicable to pay-for-performance incentive payments because our objective did not require an understanding of all internal controls over the program.

In October 2017, the State agency substituted a performance goal for one of the selected hospitals. We did not review the substituted performance goal during our fieldwork at the hospital. As of February 2018, the State agency had not yet finalized incentive payments for DY 5. We based our findings on the performance goal information available for review during our fieldwork and the incentive payment information available in January 2018.

We performed our fieldwork at the State agency's office in Hamilton, New Jersey; the DSRIP program contractor's office in Indianapolis, Indiana; and the five selected hospitals' offices located throughout New Jersey from February 2017 through March 2018.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- met with CMS regional financial and program management officials to gain an understanding of and to obtain information on New Jersey's DSRIP program;
- met with State agency and DOH officials to discuss their administration and monitoring of the DSRIP program;
- met with DSRIP program contractor representatives to discuss the contractor's role and responsibilities in the State agency's DSRIP program;
- selected for review five hospitals that were allocated 37 percent of all target funding for DYs 4 and 5;
- interviewed the DSRIP project teams at the five selected hospitals to gain an understanding of their projects and the data and documentation available to support

performance goal information reported to the DSRIP program contractor for DYs 4 and 5;

- obtained data and documentation from the DSRIP program contractor and the selected hospitals to support performance goal calculations reported to DOH for DYs 4 and 5, including the rosters of patients attributed to the selected hospitals and patients' health records information:
 - for each Medicaid claims-related performance goal reported by the DSRIP program contractor to DOH, requested from the contractor Medicaid claims data (e.g., source summary data and results of queries) to support calculations of hospitals' achievement of the performance goal; and
 - for each performance goal measured using patients' health records information reported to the DSRIP program contractor, reviewed with the hospital's clinical staff applicable medical charts and electronic health records and determined whether the hospital reported information consistent with the performance measure criteria;
- determined whether pay-for-performance incentive payments to the selected hospitals for DYs 4 and 5 complied with Federal and State requirements; and
- summarized the results of our review and discussed these results with State agency and DOH officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: FEDERAL AND STATE REQUIREMENTS FOR DELIVERY SYSTEM REFORM INCENTIVE PAYMENTS

New Jersey's Comprehensive Medicaid Waiver Special Terms and Conditions

In October 2012, CMS approved New Jersey's Medicaid Waiver under the authority of section 1115(a)(2) of the Social Security Act. The Medicaid waiver STC, as amended in February 2016, establish the requirements for the DSRIP program.

The State agency is required to maintain documentation to support its DSRIP program payments. It must make available appropriate supporting documentation for CMS to determine the allowability of the payments. Supporting documentation may include, but is not limited to, summary electronic records containing all relevant data fields (Medicaid waiver, STC #90(e)).

The State agency may not claim Medicaid reimbursement for program payments until it and CMS have determined that the hospitals have met the performance goals for each payment. Hospitals' DSRIP reports must contain sufficient data and documentation to allow the State agency and CMS to determine if the hospital met specific measures, and hospitals must have available for review all supporting data and back-up documentation (Medicaid waiver, STC #93(c)). The State must use documentation described in the DSRIP Program Funding and Mechanics Protocol to support claims for federal financial participation (Medicaid waiver, STC #93(d), #92(f)(vii)).

The State agency must develop and submit to CMS for approval a DSRIP Planning Protocol, a DSRIP Program Funding and Mechanics Protocol, and each hospital's DSRIP plan. The three documents provide guidance for the requirements of the DSRIP program for each hospital (Medicaid waiver, STC #92e, f, and g). In addition, the DSRIP Planning Protocol requires that the State agency develop a *DSRIP Performance Measurement Databook* that provides the specifications for the DSRIP clinical performance measures (Medicaid waiver, STC #92e, and DSRIP Planning Protocol, §§VI and VII).

DSRIP payments for each hospital are contingent on the hospital fully meeting the performance goals defined in its approved hospital DSRIP plan. To receive incentive funding related to any performance measure, the hospital must submit all required reporting, as outlined in the DSRIP Program Funding and Mechanics Protocol (Medicaid waiver, STC #92f).²⁴

Payment of funds allocated in a hospital DSRIP plan to population-focused improvements may be contingent on the hospital reporting clinical performance measures to the State agency and CMS, on the hospital meeting a target level of improvement in the performance measure relative to baseline, or both. At least some of the funds so allocated in DY 3 and DY 4, and all

²⁴ In March 2014, the State agency submitted and CMS approved the DSRIP Program Funding and Mechanics Protocol. In June 2017, the State agency amended the document effective through DY 5.

such funds allocated in DY 5, must be contingent on meeting a target level of improvement (Medicaid waiver, STC #92g).

APPENDIX C: NEW JERSEY COMMENTS



**State of New Jersey
Department of Human Services**

P.O. BOX 700
TRENTON NJ 08625-0700

PHILIP D. MURPHY
Governor

Carole Johnson
Commissioner

Sheila Y. Oliver
Lt. Governor

November 30, 2018

Brenda M. Tierney
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Service, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Dear Ms. Tierney:

The Department of Human Services (DHS) is in receipt of the Office of Inspector General's draft audit report regarding New Jersey's Delivery System Reform Incentive Payment (DSRIP) program during the first five years of implementation, July 2012 through June 2017. Thank you for the opportunity to comment on the draft report. The Department of Health is primarily responsible for implementing the DSRIP program. Accordingly, DHS forwarded the draft audit report to the Department of Health. The Department of Health's response is enclosed.

Sincerely,

A handwritten signature in black ink, appearing to read "Carole Johnson".

Carole Johnson
Commissioner

c: Shereef Elnahal, Commissioner
Robin Ford, Executive Director
Meghan Davey, Assistant Commissioner
Sarah Adelman, Deputy Commissioner
Mark Talbot, Director



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Governor

SHEILA Y. OLIVER
Lt. Governor

SHEREEF M. ELNAHAL, MD, MBA
Commissioner

November 30, 2018

Brenda M. Tierney
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, New York, 10278

Dear Ms. Tierney,

This letter is in response to Audit Report Number A-02-17-01007 received by the State of New Jersey on October 1, 2018. The audit report detailed the findings and conclusions of the Office of the Inspector General's (OIG) review of New Jersey's Delivery System Reform Incentive Payment (DSRIP) program during the first five years of its implementation.

Although the audit period occurred under the prior administration, the new administration will continue to look for opportunities to improve the program and has already begun to implement changes in the current DSRIP program per the suggestions in the audit. To that end, the Department has already clarified with its new DSRIP vendor that the vendor will maintain all originally extracted Medicaid Management Information System (MMIS) data files in a static data warehouse for auditing purposes.

Additionally, the Department of Health is currently developing a DSRIP Successor program, in conjunction with CMS and the State Department of Human Services, which is slated to start in mid-2020. The selection of performance measures for the DSRIP Successor program will be made ensuring oversight of hospital submissions, subject to CMS approval.

The Department of Health will continue to perform due diligence and oversight of the vendor through ongoing project management meetings and progress reports, including quality assurance checks. The Department and the vendor will also continue to inform and educate hospitals on DSRIP related procedures through in-person and virtual meetings and CMS approved materials.

DSRIP is a demonstration project designed to result in better care, better population health, and lower costs by transitioning hospital funding to a model where payment is contingent on achieving health improvement goals. The DSRIP program has served as an opportunity to reinforce a culture of quality and collaboration across the State's hospital partners. DSRIP started as a five-year pilot program as part of the Section 1115 Medicaid Comprehensive Waiver in 2012 and was approved for a three-year

extension in 2016. New Jersey worked collaboratively with the Centers for Medicare and Medicaid Services (CMS) on the design and implementation of DSRIP.

Below lists each of the OIG findings, followed by the Department of Health's response.

OIG Finding

"No Documentation Supporting Achievement of Medicaid Claims-Related Performance Goals."

Response

The Department of Health (Department) respectfully does not concur with the OIG finding. The Department engaged with contractor, Myers and Stauffer LC, (vendor) from 2013 to 2018 to provide project management, analytical support, operational support, and technical assistance to participating DSRIP hospitals, including the calculation of performance measure achievement. The Department believes that the vendor can produce the documentation needed to support the calculation of Medicaid-claims related performance goals.

Throughout the operation of the program, the Department met with the vendor multiple times per week, providing continuous oversight of the program's progress. The Department also performed quality assurance checks on the performance results calculated by the vendor. Participating hospitals were given an opportunity to participate in a yearly appeals process about the measure calculations. The Department informed CMS of all initial performance results that the vendor calculated, as well as all appeal results. CMS provided approvals on a continual basis throughout the program's administration.

The Department is confident that the vendor can replicate the calculations to demonstrate performance measure achievement. The vendor has asserted that it can produce all source files used in the performance of the NJ DSRIP project by reverting to a "Point in Time" view of the source data.¹ The vendor has also confirmed that the query scripts used to conduct the performance measure analysis are saved and available. As is the nature of the claims adjudication process, claims adjustments could yield some variances in the performance results if recreated many years after the initial run because claims may have been adjusted after the point in time being reviewed. However, the Department believes that these adjustments would not prevent an accurate calculation of performance measure achievement.

While the Department maintains that the achievement of performance goals was sufficiently documented during the audit period, it has ensured that documentation will be preserved moving forward. The Department contracted with a new NJ DSRIP vendor in 2018. The Department has ensured that its new vendor will maintain all originally extracted MMIS data files used for calculating claims-based performance measures in a static data warehouse for auditing purposes. The query scripts used to calculate these measures will also be saved and made available to any qualified entity requesting them for the purposes of validating calculations or auditing of results.²

OIG Finding

"Hospitals Reported Information Inconsistent with Performance Measure Criteria"

*

¹ NJ DSRIP Close Out Letter_09-14-2018.pdf, attached

² PCG Data Storage Memo 11_20_2018, attached

*** Office of Inspector General Note:** We did not include attachments to the State agency's comments because neither the DSRIP program contractor during our audit period nor the vendor contracted in 2018 to manage the DSRIP program was the subject of our audit.

Response

The Department respectfully does not concur with the OIG finding because this conclusion applies an administrative expectation that CMS does not require in the State's implementation of this program, per CMS' approval of the program. The Department and the vendor developed program implementation protocols that provided hospitals with instructions on how to report information consistent with the performance measure criteria. These protocols were reviewed and approved by CMS; the Department and the vendor were obliged to adhere to the protocols as approved and included in the DSRIP Databook.³ In addition to the formal program implementation documents, the Department and the vendor provided guidance through several different platforms so that hospitals clearly understood how they should report measure information for the program. The Department and the DSRIP vendor established a Learning Collaborative, which included monthly online and quarterly in-person meetings, engaged with leadership from the hospital industry groups monthly, held frequent webinars, published online resources on the DSRIP website, and managed a support email and telephone.

While the vast majority of data was reported through MMIS, certain measures required hospitals to submit patients' health information to the vendor through patient charts/electronic health records (EHR). Per CMS' approval of the NJ DSRIP protocols, the vendor (and de facto the Department) was required to accept these records and was not allowed to accept resubmission of corrected records during appeal. In addition, audit capability was not required in the NJ DSRIP program under the CMS-approved plan. Therefore, for the minority of data which was submitted through EHR rather than MMIS, the Department and the vendor had no ability to verify patients' health records information reported by the hospitals or to identify errors in the hospitals' submissions.

Thus, this OIG finding applies an administrative expectation that CMS does not require in the State's implementation of this program, per CMS' approval of the program.

OIG Finding

"State Agency Did Not Provide Adequate Program Oversight"

Response

Respectfully, the Department does not concur with OIG's finding that it did not provide adequate oversight of its DSRIP program. The State worked collaboratively with CMS in crafting the various protocols guiding the administration of this program. The State and the vendor adhered to these CMS-approved protocols on how hospitals' performance should be measured, all of which are publicly posted and available.⁴ The Department contracted with the vendor to calculate performance of each individual hospital and to maintain the supporting data. The vendor complied with these requirements. As stated above, the administration of the DSRIP program did not include the Department independently verifying the vendor's calculations or performing site audits of individual hospitals, including review of patient charts or EHRs.

³ <https://dsrip.nj.gov/Resources.html>

⁴ <https://dsrip.nj.gov/Resources.html>

The vendor established a system to analyze each hospitals' performance results and reported these results to the Department. The Department conducted quality assurance checks on the performance results calculated by the vendor, engaged in weekly meetings to analyze the results, solicited feedback on any questions that arose, and received written and verbal responses from the vendor on these questions. After the Department approved the performance results and the planned payments, these were forwarded to CMS for review. Only after CMS review and approval were the payments released to the hospitals. The timeline following hospitals' receipt of the payments was as follows:

- The participating hospitals were given thirty days to appeal the measure calculations
- The vendor subsequently had thirty days to investigate the appeals
 - The Department and the vendor would meet often during these thirty days. Weekly meetings were required, and daily updates were often given.
- After the thirty-day appeal investigation, the results were sent to CMS for final review and approval.

The Department and the vendor also held meetings and exchanged information with stakeholders including: monthly CMS meetings; monthly hospital group meetings; and a Learning Collaborative, which included monthly online and quarterly in-person meetings, intermittent webinars, published online resources on the DSRIP website, and managed a support email and telephone hotline.

Thus, throughout the operation of the DSRIP program, the Department, CMS and the vendor worked cooperatively to provide information, review results and render decisions. The program design and review methodology were approved by CMS.

Title of OIG Report

"New Jersey Did Not Provide Adequate Oversight of Its Medicaid Delivery System Reform Incentive Payment Program"

Response

The Department believes that the title is not supported by the findings described in the body of the report. The report notes several instances where OIG did not have sufficient information to definitively assess the State's management of the program. The Department is confident it provided adequate oversight of the NJ DSRIP program, consistent with protocols agreed upon with CMS and reviewed above, and therefore the report's title is not consistent with the findings in the body of the report.

OIG Recommendation

"RECOMMENDATIONS

We recommend that the State agency:

- work with DOH, the DSRIP program contractor, and the five selected hospitals to determine whether the \$50,920,788 (\$25,460,394 Federal share) in pay-for-performance Incentive payments to the five hospitals was appropriate;"

- work with DOH, the DSRIP program contractor, and the 44 hospitals not covered by this review to determine whether the \$131,511,277 (\$65,755,639 Federal share) in pay-for-performance Incentive payments to those hospitals was appropriate; and
- Improve its oversight of the DSRIP program to ensure that (1) its contractor maintains the Medicaid claims data necessary to support its determinations for whether hospitals qualify for pay-for-performance incentive payments and (2) hospitals report information consistent with the performance measure criteria to the DSRIP program vendor.”

Response

The Department appreciates OIG’s recommendations. The Department will continue to oversee the performance of the new vendor through ongoing project management meetings, progress reports and quality assurance checks. It will perform due diligence and oversight of the vendor, including the previously stated assurance from the current vendor that it will maintain the necessary Medicaid claims data. The Department will also continue to educate hospitals on reporting information consistent with performance measures through the distribution of CMS-approved support documents, peer-to-peer learning opportunities via webinars, as well as the vendor’s support of an email and phone helpline. The Department will continue to review results and work within the parameters established by CMS.

The Department, in conjunction with CMS, is developing a DSRIP Successor program that is slated to start in mid-2020. New Jersey’s multi-year experience with the DSRIP program, as well as OIG’s findings, are informing the design of this next program. For example, the Department is considering whether to continue to use patient chart/EHR performance measures. The Department will weigh the use of such measures in the absence of the ability to audit the data from these sources, as the current DSRIP program had been designed with CMS approval.

The Department and its vendor both strive to balance supporting hospitals in their continued learning through tailored opportunities and technical assistance, while also advancing hospital performance accountability so that New Jersey residents receive safe and high-quality care.

Sincerely,



Shereef M. Elnahal, MD, MBA
Commissioner