Click or tap to enter a date.

«Signatory\_Contact\_Name»

«Signatory\_Contact\_Title»

«hospital\_name»

«Hospital\_Street»

«Hospital\_City», NJ «Hospital\_Zip»

Dear New Jersey Department of Health (DOH),

«hospital\_name» intends to participate in the Quality Improvement Program – New Jersey (QIP-NJ) Measurement Year (MY) 4 starting on January 1, 2024 and continuing through December 31, 2024. «hospital\_name» intends to participate in the following portion(s) of QIP-NJ:

Behavioral Health (BH)

Maternal Health

By intending to participate, «hospital\_name» acknowledges and agrees to the following conditions:

1. The participating hospital acknowledges that DOH is actively working with the Centers for Medicare and Medicaid Services (CMS) to renew QIP-NJ for another one-year period, starting January 1, 2024.
2. Hospital participation in QIP-NJ is voluntary. Hospitals that elect not to participate in MY4 or hospitals that withdraw from participation in MY4 and choose to rejoin the program will be required to submit performance data in order for DOH to determine their baseline and performance target for subsequent MYs in which they are participating.
3. Continued funding of QIP-NJ is subject to receipt of any additional approvals from CMS as well as annual budget appropriations by the State of New Jersey.
4. Calculation of hospital payments and the rules governing payments for QIP-NJ are solely determined by CMS and DOH.
5. Hospitals that participate in the maternal portion of QIP-NJ must maintain their labor and delivery unit for the full MY.
6. The participating hospital will submit accurate and complete data to support performance and payment calculations and any other documents, as required by DOH. Failure to submit these documents in accordance with DOH guidance and timeframes may result in loss of payment.
7. The participating hospital will submit non-claims-based (chart/electronic health record (EHR)) measures in accordance with the guidance specified in the most recent version of the QIP-NJ Measurement Specifications and Submission Guidelines (Databook) available on the QIP-NJ website [here](https://qip-nj.nj.gov/Home/resources). Failure to submit the non-claims-based measures in accordance with the Databook will result in loss of payment for the MY.
8. The participating hospital attests by checking the box near Table 2 below that the Medicaid ID and billing provider National Provider Identifiers (NPIs) on file are appropriate and complete to calculate the hospital’s attribution for MY3 (January 1, 2023 through December 31, 2023). Any corrections to the Medicaid ID and/or billing provider NPIs are reflected in Table 2 below. The participating hospital further attests to notify DOH in writing within 30 days of any changes to any of these IDs.
9. In addition to data submitted to assess performance on state-selected quality measures, the participating hospital may also be required to provide additional qualitative or quantitative data to DOH, as directed, to support the program evaluation process.
10. The participating hospital agrees to receive programmatic updates, as necessary, in the form of emails, newsletters, and phone calls.
11. The participating hospital will complete Table 1 below and update DOH on any changes to hospital leadership within 30 days of the change.
12. Hospitals must email QIP-NJ@pcgus.com following submission to ensure receipt of the files.

***Table 1. Hospital Contact Information – this table is to be used only for corrections. If no corrections, please check the box below.***

By checking this box, «hospital\_name» attests that no corrections are needed to DOH’s current list of contact information.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **QIP-NJ Role** | **Name** | **Title** | **Email** | **Phone** |
| Hospital Signature Authority | «Signatory\_Contact\_Name» | «Signatory\_Contact\_Title» | «Signatory\_Contact\_Email» | «Signatory\_Contact\_Phone» |
| Additional  Hospital  Signature Authority | «Signatory\_Contact\_2\_Name» | «Signatory\_Contact\_2\_Title» | «Signatory\_Contact\_2\_Email» | «Signatory\_Contact\_2\_Phone» |
| Hospital Team Lead | «Primary\_Contact\_Name» | «Primary\_Contact\_Title» | «Primary\_Contact\_Email» | «Primary\_Contact\_Phone» |
| Additional Hospital Primary Contact | «Primary\_Contact\_2\_Name» | «Primary\_Contact\_2\_Title» | «Primary\_Contact\_2\_Email» | «Primary\_Contact\_2\_Phone» |
| Additional Hospital Primary Contact | «Primary\_Contact\_3\_Name» | «Primary\_Contact\_3\_Title» | «Primary\_Contact\_3\_Email» | «Primary\_Contact\_3\_Phone» |
| Hospital Government Contact |  |  |  |  |

***Table 2. Hospital Medicaid IDs and Billing Provider NPIs – This table is to be used only for corrections. If no corrections, please check the box below.***

By checking this box, Enter Hospital Name attests that no corrections are needed to DOH’s current list of Medicaid IDs or billing provider NPIs.

|  |  |  |
| --- | --- | --- |
| **Hospital Name** | **Medicaid ID** | **Billing Provider NPI** |
| «hospital\_name» | «MY3\_Medicaid\_ID\_1» | «MY3\_NPI\_1» |
| «MY3\_Medicaid\_ID\_2» | «MY3\_NPI\_2» |
| «MY3\_Medicaid\_ID\_3» | «MY3\_NPI\_3» |
| «MY3\_Medicaid\_ID\_4» | «MY3\_NPI\_4» |
| «MY3\_Medicaid\_ID\_5» | «MY3\_NPI\_5» |
| «MY3\_Medicaid\_ID\_6» | «MY3\_NPI\_6» |
| «MY3\_Medicaid\_ID\_7» | «MY3\_NPI\_7» |
| «MY3\_Medicaid\_ID\_8» | «MY3\_NPI\_8» |
| «MY3\_Medicaid\_ID\_9» | «MY3\_NPI\_9» |
| «MY3\_Medicaid\_ID\_10» | «MY3\_NPI\_10» |
| «MY3\_Medicaid\_ID\_11» | «MY3\_NPI\_11» |
| «MY3\_Medicaid\_ID\_12» | «MY3\_NPI\_12» |
| «MY3\_Medicaid\_ID\_13» | «MY3\_NPI\_13» |
| «MY3\_Medicaid\_ID\_14» | «MY3\_NPI\_14» |
| «MY3\_Medicaid\_ID\_15» | «MY3\_NPI\_15» |
| «MY3\_Medicaid\_ID\_16» | «MY3\_NPI\_16» |
| «MY3\_Medicaid\_ID\_17» | «MY3\_NPI\_17» |
| «MY3\_Medicaid\_ID\_18» | «MY3\_NPI\_18» |
| «MY3\_Medicaid\_ID\_19» | «MY3\_NPI\_19» |
| «MY3\_Medicaid\_ID\_20» | «MY3\_NPI\_20» |
| «MY3\_Medicaid\_ID\_21» | «MY3\_NPI\_21» |
| «MY3\_Medicaid\_ID\_22» | «MY3\_NPI\_22» |
| «MY3\_Medicaid\_ID\_23» | «MY3\_NPI\_23» |
| «MY3\_Medicaid\_ID\_24» | «MY3\_NPI\_24» |
| «MY3\_Medicaid\_ID\_25» | «MY3\_NPI\_25» |
| «MY3\_Medicaid\_ID\_26» |  |
| «MY3\_Medicaid\_ID\_27» |  |
| «MY3\_Medicaid\_ID\_28» |  |
| «MY3\_Medicaid\_ID\_29» |  |
| «MY3\_Medicaid\_ID\_30» |  |

In signing this letter, Enter Hospital Name intends to participate in QIP-NJ, starting on January 1, 2024, and attests this letter has been completed fully and accurately by an authorized hospital representative.

Enter Name of Hospital Click or tap to enter a date.

Name of Hospital Date

Enter Name of Signatory Enter Title of Signatory

Printed Name of Signatory Title of Signatory

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature