# Quality Improvement Program – New Jersey Measurement Year 4 Letter of Intent

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» does **not** intend to participate in either the behavioral or maternal health components of the Quality Improvement Program – New Jersey (QIP-NJ) Measurement Year 4 (MY4), starting on January 1, 2024. By declining to participate, «hospital\_name» acknowledges and agrees to the following:

1. The 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. By not participating in MY4 of QIP-NJ, the hospital will not receive payments for MY4.
3. If the hospital elects to participate in QIP-NJ in a subsequent MY, the hospital must provide: (1) the necessary baseline data to determine performance targets and payment calculations and (2) a completed Letter of Intent confirming participation and agreeing to program conditions. The hospital also agrees that if it elects to participate in subsequent MYs, it will be required to close 50% of the performance gap from all prior MYs in addition to the full gap of the MY in which the hospital joins as a participant.
4. 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.
5. The hospital will update DOH on any changes to hospital leadership, as contained in Table 1 below, within 30 days of the change.
6. The hospital confirms 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.
7. 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, «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» |
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| «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, «hospital\_name» does **not** intend 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

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Signature