STATE OF NEW JERSEY

Department of Banking and Insurance

Certified Organized Delivery System (ODS)
Annual Report

_____
Name of ODS

December 31, 2024
Year Ending

This report may be submitted to the Department by mail or electronically. Please submit a completed report to the address below:

Barbara Hanlon
Supervising Healthcare Evaluator
New Jersey State Department of Banking and Insurance
Office of Managed Care
P. O. Box 329
20 West State Street, 9th Floor
Trenton, New Jersey 08625-0329

Fax: 609-777-0508
Email: officeofmanagedcare@dobi.nj.gov

Thank you for your cooperation.

Department of Banking and Insurance

Certified Organized Delivery System (ODS)
Annual Report

ODS: _____

Contact Person for
Annual Report: _____
Name Telephone E-mail

1. Identify the services provided by the ODS on behalf of carriers:

   ☐ Network Management, including credentialing/ recredentialing and provider complaints

   ☐ Utilization Management Development

   ☐ Utilization Management Application

   ☐ Utilization Appeals: ☐ Stage 1 only ☐ Stage 1 and Stage 2

   ☐ Member Complaints

2. Complete the chart below identifying each carrier under contract with the ODS and the number of covered lives per carrier for business in **New Jersey**. If the services performed by the ODS differ by carrier, identify the specific services performed for each carrier.

Carrier	Number of Covered Lives	Commercial	Medicaid

3. List all of the states in which the ODS is doing business:

_____

Name of ODS: _____

4. Submit a current organizational chart, identifying the names and titles of the persons responsible for the conduct of the affairs of the ODS. Include the ODS's principal officers and medical director, if applicable.

5. Submit a copy of the ODS' Continuous Quality Improvement Work Plan and Evaluation.

6. During the past year, has the ODS, its affiliates, or persons who are responsible for the conduct of the ODS or affiliates been subject to any administrative, civil or criminal actions and proceedings. If yes, provide a list of the actions and a statement regarding the resolution of such actions.

   YES ☐ No ☐

7. During the past year, has the ODS, or any of its affiliates, failed to meet a carrier's performance measure(s) or been penalized by a carrier? If yes, provide a list of the performance measure(s) and/or penalties.

   YES ☐ NO ☐

8. During the past year, has the ODS been required to submit a Plan of Correction (POC) to a carrier? If yes, provide a list of each POC including the date, brief description of the corrective action and confirm that the POC was accepted by the carrier.

   YES ☐ NO ☐

Changes in Operations

Pursuant to N.J.A.C. 11:24B-2.7 (a) except as set forth in N.J.A.C. 11:24B-2.6, an ODS shall provide the Department with 30 days prior notice of changes to information contained in its certification unless 30 days' prior notice was impossible, in which event, the ODS shall provide notice of the change as soon as possible, but within no more than 30 days following the date of the change. Please identify any change in operations not reported to the Department during 2024.

Certification

As an Officer of the ODS, I certify that all information submitted in this Annual Report gives a full and true statement of the condition of the ODS, according to the best of my information, knowledge and belief. This also certifies that all changes for 2024 as described by N.J.A.C. 11:24B-2.7 have been reported.

Name of CEO Signature Date

Name of ODS: _____

Network Management

I. Network

1. Approved counties: ☐ All 21 NJ counties ☐ Less than 21 counties*

   *If not approved in all 21 counties, identify the names of the counties for which approval has not been obtained: _____

2. Submit current network information using the applicable network tables available at http://www.state.nj.us/dobi/division_insurance/managedcare/mcapps.htm

3. Explain how the ODS maintains and monitors the network of contracted providers to ensure network adequacy. (Attach a separate page)

4. The following questions pertain to the formation of the network via contracting:

   a. Are all providers represented as being in the network under direct contract with the ODS?

   YES ☐ NO* ☐

   *If no, explain how the network is formed and identify the contracts the ODS has entered into for purposes of network formation. Specify whether the ODS maintains responsibility for credentialing these providers? (Attach separate page)

II. Provider Directory

5. Provide the web address of the on-line provider directory, if available to covered persons:

   _____

6. Explain the process for maintaining a current and accurate listing of network providers. Include in the explanation, how frequently provider data information is verified and a description of the verification process.
   Note: This question must be answered regardless of whether the ODS publishes its own directory or the ODS network is incorporated into the carrier's directory.

Name of ODS: _____

III. Provider Complaints

7. Report the total number of provider complaints received during the past year for each carrier contract. Identify the top three (3) categories of provider complaints:

CARRIER	Number of Complaints	Complaint Categories

8. Is provider complaint data reported to carriers? YES ☐ NO ☐

   If yes, include a copy of the data reported to carriers for the most recent year.

IV. Provider Relations

9. Submit a copy of the most recent provider satisfaction survey and the results for each carrier. Identify the number of providers who were sent a survey and the number of providers who responded.

Name of ODS: _____

Complete the following sections of the annual report, if applicable:

V. Claims Payment

10. Does the ODS process and pay claims on behalf of a carrier? YES ☐ NO ☐
If Yes:

a. Submit a copy of the forms used by providers for filing an internal appeal claim determination and for arbitration through the Program for Independent Claims Payment Arbitration (PICPA), pursuant to the Health Claims Authorization Processing and Payment Act (HCAPPA), P.L. 2005, c. 352.

b. Submit a copy of the annualized claim payment data reported to the carrier for the past year in the format prescribed below:

Claim Activity Information				
		Appeal Resolution		
Total # Claims Processed	Total # Appeals Processed	Total # Claims No change to Reimbursement	Total # Claims Additional reimbursement remitted	Total dollar Amount of Interest Paid on Appealed Claims

VI. Utilization Management

A. UM Development

1. Describe how providers access a copy of the ODS' internal UM criteria. (Attach separate page)

2. Have providers submitted written comments on the internal UM criteria? If so, please summarize the nature of the providers' comments. (Attach separate page)

3. Identify the mechanisms used by the ODS to detect under and over utilization of services. (Attach separate page)

Name of ODS: _____

B. UM Application

1. Submit a copy of annual statistics provided to each carrier for the past year showing authorization and denial activity. For each carrier, identify the frequency of reporting, i.e. monthly, quarterly, etc. and submit a copy of such report.

C. UM Appeals

1. Submit a copy of annual statistics provided to each carrier for the past year showing the number of utilization management appeals and the outcome of the appeals. For each carrier, identify the frequency of reporting, i.e. monthly, quarterly, etc. and submit a copy of such report.

2. Identify the name and credentials of each physician who has responsibility for review of UM appeals. (Attach separate page)

VII. Member Complaints

1. Report the number of member complaints received during the past year _____.

2. Identify the top three (3) categories of member complaints.

   a. _____

   b. _____

   c. _____