Horizon Healthcare Services, Inc.

Horizon Blue Cross Blue Shield of New Jersey

Government Programs

2020 Quality Improvement Program Description

Attachments to Program Description

Attachment 1 – 2018-2019 Medicaid Managed Long Term Services & Supports (MLTSS) Program Description

Attachment 2 – 2019 FIDE-SNP Care Management and Quality Management Program Description

Attachment 3 – 2019 GP Committee Organizational Chart

Attachment 4 - GP Executive Organizational Chart

Attachment 5 - Quality Management Organizational Chart

1. Purpose of the Quality Improvement (QI) Program

The purpose of the Horizon Blue Cross Blue Shield of New Jersey's Government Programs (GP) QM Program is to systematically monitor, assess, track, trend and continuously improve the quality of care, service, health status and safety of its members. The QI Program is designed to be comprehensive and to have the necessary resources, infrastructure, and authority to meet the program's goals and objectives. The program also monitors targeted accomplishments, including clinical standards to be developed, medical care evaluations to be completed, and other key quality assurance activities to be completed, including Medicaid, Medicare, Managed Long Term Services & Supports (MLTSS) and FIDE-SNP related quality activities.

2. Program Scope

The Government Programs' QI Program applies to all of Horizon BCBSNJ's Government Programs lines of business.[1] The membership served by the QI Program includes: Horizon NJ Health (Medicaid & MLTSS), Horizon NJ TotalCare (HMO D-SNP), Medicare Supplement and Medicare Advantage HMO and PPO plans.

The scope of the QI Program encompasses the clinical and service aspects of the care its members receive. The QI Program has oversight of GP's efforts to monitor and improve preventive, acute, chronic, behavioral and rehabilitative aspects of care. The QI Program also reviews the Plan's initiatives and outcomes related to member and provider satisfaction, member and provider education, access and availability of care, disparities in health care, continuity and coordination of care, member appeals/grievances, quality of care concerns, clinical and service quality metrics and the credentialing of providers. The QI Program is also charged with effectuating changes to improve GP's performance on Healthcare Effectiveness Data and Information Set (HEDIS), Stars, Consumer Assessment of Healthcare Providers and Systems (CAHPS) and

[1] As a result of incongruent State and Federal requirements and timelines, Horizon BCBSNJ's Government Programs QI Program description acts as an overarching guide while allowing individual lines of business to meet their specific contractual and regulatory requirements through the creation of line of business specific QI programs when necessary. These line of business specific program descriptions are reviewed and approved by the QIC. This structure allows individual lines of business (MLTSS for example) to meet their varied filing submission dates while ensuring each line of business' QI Program information is captured within the overall Horizon Government Programs QI Program description. See Attachment 1 for the MLTSS Program Description. See Attachment 2 for the FIDE-SNP Care Management and Quality Management Program Description.

Health Outcomes Survey (HOS). Accreditation efforts and audits completed by the Quality Management Department and other GP departments are also reviewed as part of the QI Program. The following Quality Assurance Activities are also developed and monitored on an ongoing basis:

- Guidelines for the management of selected diagnoses and basic health maintenance, and distribution of all standards, protocols, and guidelines to all providers and upon request to enrollees and potential enrollees.

- Treatment protocols, which allow for adjustments based on the enrollee's medical condition, level of functioning, and contributing family and social factors.

- Procedures for monitoring the quality and adequacy of medical and behavioral health care including: 1) assessing use of the distributed guidelines and 2) assessing possible over-treatment/over-utilization of services and 3) assessing possible under-treatment/under-utilization of services.

- Evaluation of procedures for focused medical care evaluations to be employed when indicators suggest that quality may need to be studied, including procedures for conducting problem-oriented clinical studies of individual care.

- Procedures for prompt follow-up of reported problems and grievances involving quality of care issues. Timeframes for prompt follow-up and resolution which follow the standard described in Article 5.15B.

- Hospital Acquired Conditions and Provider–Preventable Conditions including the implementation of a no payment policy and a quality monitoring program consistent with the Centers for Medicare and Medicaid Services (CMS) that addresses Hospital Acquired Conditions and Provider-Preventable Conditions according to federal regulations.

- Data Collection Procedures for gathering and trending data including outcome data.

- Mortality rates review of inpatient hospital mortality rates of its enrollees.

- Corrective action procedures for informing subcontractors and providers of identified deficiencies or areas of improvement, conducting ongoing monitoring of corrective actions, and taking appropriate follow-up actions, such as instituting progressive sanctions and appeal processes.

- Discharge planning procedures to ensure adequate and appropriate discharge planning, including coordination of services for enrollees with special needs.

- Ethical Issues monitoring of providers for compliance with state and federal laws and regulations concerning ethical issues, including but not limited to, advance directives; family planning services for minors; and other issues as identified. Reports are submitted annually or within thirty (30) days to DMAHS with changes or updates to the policies.

- Emergency care methods to track emergency care utilization and to take follow-up action, including individual counseling, to improve appropriate use of urgent and emergency care settings.

- New medical technology policies and procedures for criteria which are based on scientific evidence for the evaluation of the appropriate use of new medical technologies or new applications of established technologies including medical procedures, drugs, devices, assistive technology devices, and durable medical equipment.

- Informed consent, which requires that all participating providers comply with the informed consent forms and procedures for hysterectomy and sterilization as specified in 42 C.F.R. Part 441, Sub-part F, and shall include the annual audit for such compliance in its quality assurance reviews of participating providers.

- Continuity of care system which includes a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for enrollees with special needs

- Collects data and acts on opportunities to improve collaborative care between behavioral health and medical health care for all members receiving case management services.

3. QI Program Objectives/Goals

The GP QI Program is designed to produce prospective, concurrent, and retrospective analyses of the Plan's activities in order to improve the quality of care and service members receive. The specific goals of the QI Program are to ensure that GP:

- Provides health care that is medically necessary with an emphasis on the promotion of health in an safe, effective and efficient manner
- Assesses the appropriateness and timeliness of the care and services being provided
- Promotes members' ability to maintain themselves in the least restrictive, most integrated setting of their choice
- Optimizes care delivery for members with special and/or complex care needs
- Identifies members' needs and coordinates care to address the needs of the member
- Focuses on the quality of medical and behavioral health care and services provided to all members
- Works to identify and reduce health care disparities within its membership
- Strives to improve member and provider satisfaction
- Maintains oversight of delegated entities
- Maintains oversight of the credentialing and re-credentialing of providers
- Meets current National Committee for Quality Assurance (NCQA) Health Plan Accreditation requirements
- Works to improve plan performance on HEDIS, Stars, CAHPS, HOS and Performance Improvement Projects (PIPs)
- Monitors and ensures the appropriateness of Utilization Management decision-making through the medical appeal process

3.1 Program Evaluation

The QI Program is evaluated annually. This evaluation is coordinated by the Quality Management Department with input from all business areas represented on the Quality Improvement Committee (QIC). The format of the QI Program Evaluation parallels the QI Program's Work Plan and includes:

- A description of completed and ongoing QI activities that address quality of clinical care and quality of service
- Evaluation and assessment of patient safety activities
- Tracking and trending of data to assess program performance in measures of quality of care and quality of service
- An analysis of improvements in quality of care and service to members
- A critical assessment of barriers to achieving goals and root cause analysis
- An evaluation of the overall effectiveness of the QI Program

The QI Program Evaluation is presented annually to the QIC for review, comments, and approval. The Vice President and Chief Medical Officer of Government Programs, or a

designee, annually presents the QI Program Evaluation to the Horizon Healthcare of New Jersey Board of Directors.

4. Structure of the QI Program

4.1 Governing Body

Horizon Healthcare Services Inc.'s (the "Parent") subsidiary companies report into the Parent organization. The Parent and its subsidiary companies have administrative service agreements with each other wherein the subsidiaries utilize staff, policies and procedures and other items from the Parent. The subsidiary companies that comprise the Government Programs division include Horizon Healthcare of New Jersey, Inc. and Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey. Horizon Healthcare Services is the contracting entity for the Medicare Supplemental, Medicare Advantage HMO, MA PPO and Part D product lines. Horizon Healthcare of New Jersey is the contracting entity for the FIDE-SNP HMO and Medicaid HMO product lines.

The Parent's Board of Directors (the "Board") is the governing body of the Horizon BCBSNJ enterprise, and is accountable for the GP QI Program. The Quality Committee of the board reviews and approves the GP QI Program Description annually.

The board has assigned responsibility for the QI Program to the Executive Vice President, Government Programs & Operations who has assigned responsibility to the Vice President and Chief Medical Officer (VP/CMO) of Government Programs. The VP/CMO has the authority over and responsibility for the development and implementation of the QI Program. The Government Programs Medical Director assigned to support the Quality Management Department, who reports to the VP/CMO, has direct oversight of the development and implementation of the QI Program. The VP/CMO has delegated the chairmanship of the QIC to the Government Programs medical director assigned to support the Quality Management Department. The QIC is responsible for the day-to-day approval, monitoring and evaluation of the GP QI Program.

4.2 Committees

The organizational structure of GP committees supports the implementation of the QI Program. Each committee has a charter that outlines the purpose, scope, meeting frequency, and

composition. Below are descriptions of the Quality Improvement Committee and subcommittees/workgroups that report to the QIC.

Quality Improvement Committee (QIC)

The QIC's purpose is to oversee all GP QI activities. The QIC is a multidisciplinary committee that meets on a regular basis, at least 6 times per year. This frequency is sufficient to demonstrate that the committee is following up on all findings and required actions. The role, structure, and function of the committee are specified in its charter. Annually, the charter is revised as needed and approved by the committee. Recorded meeting minutes document the committee's activities, findings, recommendations and actions.

The QIC is accountable to the Quality Board of Horizon BCBSNJ. Quarterly, the activities, findings, recommendations and actions of the QIC are reported to the Quality Board. There is active participation on the QIC from network providers. At least one participating provider attends all QIC meetings.

- Healthcare Disparities Workgroup

  The Healthcare Disparities Workgroup meets at least 6 times per year. The purpose of this workgroup is to reduce health care disparities within its membership. The workgroup brings together a cross-functional team that reviews data, develops and implements interventions, conducts barrier analysis and measures the impact of interventions put in place to decrease health care disparities.

- Physician Advisory Committee (PAC)

  The PAC meets quarterly. The purpose of this committee is to identify issues of concern to the physician community and identify opportunities for optimizing patient care. The PAC meetings are combined with the Utilization Management/Case Management Committee.

- Dental Committee (Special Needs and Oral Advisory)

  This committee advises on and reviews issues pertinent to the delivery of oral health care services to special needs members. This committee advises GP of changes and advances in the treatment of oral health care issues that are unique or prevalent with this population. The committee advises and reviews benefits and services GP provides to its special needs members as well as new or existing policies. This may or may not involve quality of care issues. This committee meets quarterly.

- Delegated Vendor Oversight Committee (DVOC)

  The DVOC is an interdisciplinary subcommittee that provides oversight of delegated vendors performing services on GP's behalf for both health care and non-health care contracts. The committee meets at least eight times per year.

- Medicare Star Rating Subcommittee

  The Medicare Star Rating Subcommittee is an interdisciplinary committee that meets ten times per year and oversees efforts aimed to improve the quality and cost effectiveness of the care and services GP provides to Medicare beneficiaries. The committee coordinates GP efforts that focus on improving the plan's Medicare Star Rating and CAHPS scores.

- HEDIS Workgroup

  The HEDIS workgroup is an interdisciplinary team that provides oversight for efforts aimed at improving the quality and cost effectiveness of the care and services GP provides to all members. The workgroup coordinates GP efforts focused on improving the plan's Medicare and Medicaid HEDIS performance. This workgroup meets six times per year.

- Utilization Management/Case Management Committee (UM/CM)

  The purpose of the UM/CM committee is to ensure high-quality, cost-effective health care for all GP members. The committee is responsible to review the management of Medicare and Medicaid health services to support GP's vision of improving quality and enhancing the member experience. The UM/CM Committee meets at least ten times per year.

- Managed Long Term Services & Supports Committee (MLTSS)

  The purpose of the MLTSS committee is to provide oversight to the Horizon NJ Health MLTSS Quality Program. The committee reviews the program's progress toward its goals to systematically monitor, assess, track, trend and improve the quality of care, service, health status and safety of MLTSS members. The committee meets at least on a quarterly basis.

- Fully Integrated Dual Eligible Special Needs Plan Committee (FIDE-SNP)

  The purpose of the FIDE-SNP committee is to provide oversight to the Horizon NJ TotalCare (HMO D-SNP) Quality Program. The committee reviews the program's progress towards its goals to systematically monitor, assess, track, trend and improve the quality of care, service, health status and safety of the FIDE-SNP members and ensure compliance with stated program activities according to the Centers for

Medicare & Medicaid Services' (CMS) FIDE-SNP Model of Care (MOC). The FIDE-SNP Committee meets at least four times per year.

- MLTSS & FIDE-SNP Community Advisory Committee (MLTSS & FIDE-SNP CAC)

  The MLTSS & FIDE-SNP CAC is comprised of MLTSS and FIDE-SNP leadership as well as providers from the communities that serve GP MLTSS and FIDE-SNP membership. CAC meetings allow GP to share information about the operations and performance of the MLTSS and FIDE-SNP programs with community providers, while allowing them to share their experiences related to the programs with GP. The MLTSS & FIDE-SNP CAC meets at least four times per year.

- Administrative Policy Approval (APA) Subcommittee

  The APA Subcommittee meets monthly, and the purpose of the committee is to review and approve all GP Administrative Policies and Procedures.

- Quality Peer Review Committee (QPRC)

  The goal of the QPRC is to ensure members receive quality health care and excellent service. QPRC meets at least six times per year - and on an ad hoc basis - to review potential quality of care and service issues involving GP members.

- Member Services Satisfaction Committee (MSSC)

  The MSSC is a multidisciplinary committee, focusing on issues related to member satisfaction in order to create proactive action plans to address the identified barriers to providing GP members with the highest quality experience. The MSSC reviews reports focused on call center performance, member grievances, and claims as well as appeals associated with these issues. The MSSC reviews CAHPS results and other member satisfaction survey results so that the committee can coordinate interventions aimed at improving member experience. The committee also determines areas of service with the greatest effect on member satisfaction, and identifies areas of opportunity to increase quality of care through quality initiatives. This committee meets at least quarterly.

- Community Health Advisory Committee (CHAC)

  The purpose of the CHAC is to provide a vehicle for community review and advice on matters related to health care education, outreach, and promotion affecting GP members. Meetings are held in both English and Spanish. The CHAC meets quarterly.

- Provider Service Satisfaction Committee (PSSC)

The purpose of the PSSC is to oversee and ensure provider satisfaction with GP. The PSSC committee reviews grievance and appeal data and specific issues related to provider satisfaction. The committee meets on a quarterly basis.

- Credentials Committee

  The Credentials Committee is a committee within the Horizon BCBSNJ Quality Improvement Committee (QIC), established to implement and oversee credentialing, re-credentialing, certification, and/or re-certification of physicians, health care professionals, facilities and ancillary providers. The Credentials Committee is empowered by Horizon Healthcare Service's, Board of Directors and the Horizon Healthcare of New Jersey Board of Directors, the management of GP and the QIC with decision-making authority on matters pertaining to provider credentialing and re-credentialing. This committee meets at least 10 times per year.

- Pharmacy and Therapeutics (P&T) Committee (Medicaid)

  The Medicaid P&T Committee is responsible for clinical support of the Horizon NJ Health Medicaid Pharmacy Program. The P&T Committee is comprised of primary care and specialty physicians, pharmacists and other health care professionals. The Medicaid P&T Committee provides input on pharmaceutical management procedures and on developing, managing, updating and administering the Drug Formulary System. The Medicaid P&T Committee meets at least quarterly.

- Pharmacy and Therapeutics (P&T) Committee (Medicare)

  The Medicare P&T Committee is responsible for clinical support of the Horizon BCBSNJ Medicare Pharmacy Program, including FIDE-SNP. The P&T Committee is comprised of primary care and specialty physicians, pharmacists and other health care professionals. The Medicare P&T Committee provides input on pharmaceutical management procedures and on developing, managing, updating and administering the Medicare Formulary. The Medicare Formulary development and maintenance is delegated to the Pharmacy Benefit Manager, Prime Therapeutics, and is overseen by the Prime P&T Committee with active participation by the Horizon BCBSNJ Medicare Pharmacy Program. The Medicare P&T Committee meets at least quarterly.

4.3 Inclusion of Participating Providers in the QI Program

Horizon BCBSNJ providers are included as voting members of the QIC. Participating providers are also voting members of GP Utilization Management/Case Management Committee, Physician Advisory Committee, Pharmacy and Therapeutics Committees, Dental Advisory Committee and Quality Peer Review Committee. Participating physicians and other providers are kept informed about the written QI Program Description available in provider newsletters and on the plan's website at **horizonNJhealth.com/for-providers**. Providers can also access information in the Provider

Administrative Manual about how they can be included in the design, implementation, review and follow up of GP QI activities.

4.4 GP Organizational Chart

See Attachment 3 2019 GP Committee Organization Chart, Attachment 4 for the GP Executive Organizational Chart and Attachment 5 for the Quality Management Department's Organizational Chart. Due to the expansion of the Quality Management Department, the Quality Management Clinical Operations Organizational Chart, the Quality Management Performance Improvement and Reporting and the Quality Management and Administration Organizational Chart are reported separately. In October 2019, the Commercial Quality team members merged with the GP Quality Management Operations Division. In doing so, the teams can share best practices and also leverage resources that will yield positive outcomes for Horizon BCBSNJ members.

4.5 QI Program's Resources

The GP QI Program has the full support of GP's executive leadership. To demonstrate this support, leadership approved an expansion in staffing and a reorganization of the Quality Management Department, which occurred in 2019. In addition to the support provided by GP executive leadership, all departments within the division contribute to the success of the QI Program through their focus on quality in their daily activities and their participation in the QIC.

With the expansion and reorganization of the Quality Management Department, continuing into 2020, and the existing GP health services structure, the QI Program will have sufficient material resources and staff with the necessary education, experience and/or training to effectively carry out the QI Program's activities. In addition, the Quality Management Department has access to consultants who provide activities such as statistical analysis, business process improvement recommendations, quality related education and accreditation preparation support. To maintain and improve quality performance, Horizon BCBSNJ monitors all current and planned initiatives to assess current and future staffing needs. This opportunity ensures that the appropriate staff is in place to adequately address the needs of the quality improvement efforts. Below are descriptions of the key roles within GP that support the QI Program.

QI Programs Staffing:

Vice President and Chief Medical Officer (VP/CMO)

The VP/CMO of GP is a board-certified New Jersey licensed physician with a master's degree in public health, experienced in health insurance, health care consulting, NCQA accreditation and pharmaceutics. The VP/CMO is responsible for the design and implementation of the QI Program. The VP/CMO provides quarterly reports to the Quality Subcommittee of the Horizon Healthcare of New Jersey Board of Directors, which details the quality-related activities of GP and the QIC. This reporting may be delegated to the medical director of the Quality Management Department.

Executive Medical Directors

The executive medical directors provide senior level leadership and direction, and contribute to Quality Management initiatives, including Accreditation and CMS Star programs, as well as furnishing strategic and UM oversight of GP lines of business. The executive medical directors establish and implement utilization standards, provide overall medical expertise to ensure continuous quality improvement, work to ensure that cost-effective services are provided to members, maintain effective provider relations and develop clinical innovations.

Senior Medical Directors/Medical Directors/Dental Director

The Senior Medical Directors, Medical Directors and Dental Director provide support to the QI Program and the Quality Management Department. They are involved in the evaluation of the clinical and service functions of GP including, but not limited to, clinical practice guidelines, grievances, and quality of care referrals, HEDIS/Stars/CAHPS/HOS initiatives and corrective action plans (CAP).

Quality Management Coordinator

The Quality Management Coordinator is a board-certified New Jersey licensed physician who has a master's degree in public health. The coordinator has experience in UM, Quality Management, managed care operations, MLTSS, Medicare and Fully Integrated Dual Eligible Special Needs Programs. The QM coordinator reports to the GP VP/CMO and is responsible for the creation and execution of the QI Program Description, work plan, and annual evaluation, as well as all the functions carried out by the Quality Management Department. The QM Coordinator or designee chairs the QIC and is a voting member of select QIC subcommittees. The QM Coordinator's representation and voting rights on QIC subcommittees may be delegated to medical directors within GP or a director within the Quality Management Department.

Director, Quality Management Performance Improvement and Reporting

The Director of the Quality Management Department reports to the executive medical director of the Quality Management Department. The Director has experience leading HEDIS and Star Rating initiatives for large health plans as well as coordinating quality transformation efforts within institutions and provider groups. The Director is responsible for assisting in the planning and direction of the QI Program and Quality Management Department functions. The Director is also responsible for the oversight and function of the business areas within the Quality Management Department including Star Rating/HEDIS/CAHPS/HOS, pay for performance and population health. The Director develops departmental reports and presents these reports, along with the medical director, to the GP leadership team directly and through the committee reporting structure. The Director represents the Quality Management Department on GP committees and may serve as the Quality Management Medical Director's designee when the Medical Director is not present.

Director Quality Management Clinical Operations

The Director of Quality Management Clinical Operations reports to the Medical Director of the Quality Management Department. The Director is a licensed professional registered nurse and has experience in health plan management for UM, CM and appeals. The Director is responsible for assisting in the planning and direction of the QI Program and Quality Department functions specific to clinical operations. The Director is also responsible for the oversight and function of the business areas within the Quality Management Department including medical UM appeals audits, and quality of care referrals and quality of care. The Director develops departmental reports and presents these reports, along with the Medical Director, to the GP leadership team directly and through the committee reporting structure. The Director represents the Quality Management Department on GP committees and may serve as the Quality Management medical director's designee when the medical director is not present.

Director Quality Management Improvement Operations

The Director of the Quality Management Improvement Operations Department reports to the Executive Medical Director of the Quality Management Department. The Director has experience in Continuous Quality Improvement (CQI) methodology, state contractual requirements, and NCQA, DMAHS and CMS quality standards. The Director has a master's degree in business

administration, with concentrations in management information systems and risk management. The Director is responsible for design, development, and implementation of on-going improvement and maintenance of quality improvement initiatives necessary for attaining NCQA accreditation, and meeting CMS and DMAHS contractual requirements. The Director provides leadership for implementing, monitoring and evaluating the Quality Improvement Program for GP. The Director also leads and directs processes and overall quality improvement activities that produce better patient care and more efficient operations. They also develop programs to review and evaluate patient care and outcomes. The Director represents the Quality Management Department on GP committees and may serve as the Quality Management Medical Director's co-chair.

Director Clinical Behavioral Health Services

The Director of Clinical Behavioral Health Services reports directly to the Vice President of Behavioral Health. The Director has a doctoral degree in social work and is a licensed clinical social worker. The Director is responsible for GP's transition from delegated behavioral health services to internal management of services and benefits beginning January 1, 2020. The Director monitors the effectiveness of behavioral health care services including utilization management, Medicare Case Management and all Quality Management activities related to behavioral health. Internal management of behavioral health services allows GP to be in a stronger position to work directly with providers and health systems to improve integration of physical and behavioral health care for our members.

Quality Management Department Managers

Quality Management Department managers report to the Director or Medical Director of the Quality Management Department. GP Quality managers are comprised of nurses, social workers and non-clinicians with backgrounds in quality assurance, compliance, analytics and State Health Department operations. Managers are responsible for routine operations within their scope of accountability. Managers have specific business areas within the Quality Management Department that they oversee including member and provider grievances and appeals quality peer review, audits, HEDIS/Star Rating performance, quality policy revisions, accreditation, quality assurance and quality related compliance.

Quality Management Department Supervisors

Supervisors within the Quality Management Department report to Managers or Directors. GP Quality Management Department supervisors include both clinicians (RNs and LPNs) and non-clinicians. The Supervisors are responsible for ensuring that the Quality Management Department's staff completes daily operations as outlined within policies and procedures.

Quality Management Department Subject Matter Experts, examples include but are not limited to;

Accreditation Specialists

The accreditation specialists support the Quality Management Department's goal of improving the quality of health care for its members through ongoing monitoring of compliance with accreditation standards and regulatory requirements. The specialists work with all business areas, as well as with delegated vendors, to ensure that their work and reporting supports all applicable NCQA Health Plan Accreditation Standards.

PIP Specialists

There is a dedicated team responsible for assisting in the design, implementation, execution, analysis, and reporting of State and CMS required PIPs. They lead the Quality Management Department, as well as other GP departments and external collaborators, in the work required to successfully achieve the goals of each of QI project.

Health Data Analysts

Health data analysts perform research, analysis, programming, implementation and coordination to ensure accurate and timely reporting for the Quality Management Department. The responsibilities include, but are not limited to, analyze reporting, development of databases and reports that are responsive to department needs, review and coordinate all data requests to ensure data consistency and accuracy, utilize various software packages to extract and analyze data, provide support and education to all Health Services departments on data requirements and needs for quality activities.

Quality Outreach Specialists

Quality Outreach Specialists are responsible for the coordination, implementation and monitoring of all Medicaid and Medicare (Star Rating) HEDIS member and provider outreach, engagement and intervention. This position is also responsible for assisting the manager of Outreach

& Interventions in operationalizing all initiatives to improve HEDIS performance by working with internal and external stakeholders.

Additionally, the QI program pursues an integrated approach to achieving ongoing improvements in the quality of care and service delivered to members. Staff in the Quality Department work closely with the following departments:

Provider Contracting & Strategy (PC&S) works with Quality Management to ensure that the tools to assess the access and availability of practitioners and providers are adequate, that practitioners/providers comply with the QI program, that clinical materials distributed to practitioners are understandable and useful, and that practitioners understand members rights and responsibilities and treat enrolled members accordingly.

Clinical Services Operations includes Care, Case and Disease Management and UM. Care, Case Disease Management staff identifies and refers potential quality issues to the Quality Management Department for investigation, recommends benefit enhancement, approves clinical practice guidelines and participates in the QIC.

Delegate Vendor Oversight (DVO) and Quality Management staff work collaboratively in the review of Quality Management initiatives with delegates and ensures compliance with the NCQA standards. In addition, DVO provides oversight of the activities and responsibilities of delegated vendors to ensure quality health care is provided to members.

4.6 External Quality Review

4.6.1 Department of Medical Assistance and Health Services (DMAHS) and the Island Peer Review Organization (IPRO)

On behalf of the New Jersey DMAHS, IPRO conducts oversight activities of Horizon NJ Health and Horizon TotalCare (HMO D-SNP). Annually, IPRO conducts an assessment of Horizon BCBSNJ operations to determine if Horizon BCBSNJ has implemented and operationalized State-mandated contractual requirements. The Quality Management Department is responsible for Horizon BCBSNJ's preparation, the submission of documentation and the coordination of the onsite assessment. After the annual assessment is completed and Horizon BCBSNJ receives feedback from DMAHS/IPRO, corrective action

plans are created and executed to address the opportunities for improvement that were highlighted in IPRO's report. These corrective actions are monitored by the QIC through their completion.

Additionally, as a follow up to the annual assessment, the plan receives a Quality Technical Report (QTR) each year from IPRO that aggregates and analyzes relevant data to draw conclusions on quality, timeliness and access to Medicaid managed care services. IPRO is required to make improvement recommendations as a part of its external quality review activities and then discuss how the managed care organization addressed those recommendations in the next annual QTR.

DMAHS/IPRO also has oversight of additional Horizon BCBSNJ activities including focused studies, audits to evaluate the quality of care received by the publicly insured enrolled in managed care, HEDIS performance, CAHPS performance and evaluation of Horizon BCBSNJ's Performance Improvement Projects (PIPS).

In addition to the external quality reviews performed by the State, GP undergoes quality reviews/audits performed by CMS and NCQA. Horizon BCBSNJ ensures CMS required QIPs and CIPS are approved by CMS. Horizon BCBSNJ maintains compliance with NCQA Health Plan Accreditation standards and the plan's Medicaid and Medicare lines of business are assessed by NCQA as part of the health plan accreditation process.

4.6.2 Centers for Medicare & Medicaid Services (CMS)

CMS evaluates Organizational Determinations, Appeals and Grievances (ODAG) annually in two specific reviews. Those reviews are entitled "Timeliness Review" and "Part C and Part D Data Validation Audit." The former looks at specific period in the previous year and the later looks at the entire previous year. The focus is to evaluate timeliness of performing ODAG functions. These results are compared against all other Medicare Advantage Plans to identify health plans that are considered "outliers." The health plans determined to be "outliers" would be subject to adverse action on behalf of CMS.

Additionally, CMS performs a full-program audit every four years. This full-program audit evaluates ODAG function including "clinical decision making." Program Audit Results are

compared against other Medicare Advantage health plans. All Medicare Advantage health plans that are below the top 25 percent are subject to adverse action on behalf of CMS.

Monthly monitoring of these functions, combined with workflows that include regulations, support a state of readiness for the above outlined audits.

4.7. Behavioral Health

The Behavioral Health Program is committed to providing quality services to help members manage all aspects of their health. Effective January 1, 2020, GP transitioned from delegation of behavioral health services from Beacon Health Options to fully integrating services into current GP programs. Behavioral Health Case Management services are available to the Medicare membership and a specific subgroup of the Medicaid membership. The benefits provided through Medicaid are limited to the enrollees in the Division of Developmental Disabilities (DDD), MLTSS and FIDE-SNP programs. Case managers provide assessment, development and implementation of individualized plans of care; and offer coordination of medical and behavioral health care services for members and their families. The Behavioral Health Program utilizes the Care Radius medical management system to support delivery and documentation of the case management process.

The Director of Behavioral Health Services reports into QIC and a behavioral health practitioner participates on the QIC, UM/CM, P&T and FIDE-SNP Committees to provide information and guidance on mental health/substance use disorder topics and related quality initiatives and activities. Additionally, the Provider Contracting & Strategy and Network Operations Departments review geographical access reports that address the adequacy of the behavioral health provider network. Deficiencies are acted on to reduce barriers to access and ensure continuity of care for members.

5. QI Program's Function

The function of the QI Program is to coordinate, oversee, guide, and assess GP efforts to ensure that continuous quality improvement is being pursued throughout the organization. The following sections highlight the functions of the QI Program. In addition to focusing on these functions, the GP QI Program has the ability, through the QIC, to add additional areas on which to focus its attention.

Each year the QI Program Description is reviewed and revised as necessary. Annually, a QI Work Plan is developed and implemented to guide the execution of the QI Program. At the conclusion of each year, a QI Program Evaluation is completed to assess the success of the QI Program and guide the creation of the following year's QI Program Description and Work Plan looking at those areas where goals were not met and will continue to be monitored into the next calendar year. The work plan is monitored, reviewed and updated on a quarterly basis and new initiatives are added as needed.

5.1 Member Safety

Promoting safety for its membership is a key focus for Horizon BCBSNJ and involves a wide range of activities. The QI Program, as well as the Quality Management Department, are central contributors and coordinate the member safety initiatives performed throughout the organization.

To promote safety for hospitalized members and in accordance with the CMS guidelines, state law, and the State Medicaid Managed Care Contract, GP has policies to address quality of care and service, hospital acquired conditions and serious adverse events. The Quality Management Department reviews the State Medicaid Managed Care contract, CMS regulations, applicable state laws, national clinical practice and other guidelines at least annually. Policies are reviewed and approved every year including the list of selected hospital-acquired conditions and serious adverse events.

Additional activities occurring within the Quality Management Department and QIC that focus on enhancing member safety include: assisting in the reporting of quality indicators to the provider network, monitoring and follow up on corrective action plans required from delegated vendors and/or network providers who identified care and/or service deficiencies, conducting quality of care reviews focused on member safety issues, designing quality improvement projects targeted at at-risk populations, researching grievances related to member safety issues, analyzing under and over utilization data, and when appropriate, coordinating GP response to potential urgent/immediate member safety threats.

5.2 Disparities in Health

Disparities in health reduce the overall quality of care provided within the health care system while adding to overall health care costs. In 2020, to address the multiplicity of the needs of the membership, the QI Program will continue to work on identifying and addressing disparities in health

outcomes among different member populations. GP programs to reduce disparities in health will be driven by discussions held during Disparities Workgroup and QIC meetings, as well as recommendations made by the QIC. The interventions selected to reduce health care disparities in clinical and service areas will be instituted during 2020 and will be included on the 2020 QI Work Plan. Current topics under review include breast cancer screening (BCS), cervical cancer screening (CCS), depression in the elderly FIDE-SNP population, colorectal cancer screening (COL), prostate cancer screening, social determinants of health and childhood obesity. Horizon BCBSNJ's ongoing efforts to reduce disparities will be coordinated and monitored through the QIC.

The goal of this program is the implementation of interventions and community health events, which reduce disparities between differing member populations. New interventions for social determinants of health and childhood obesity will launch in 2020. Ongoing interventions from 2018 for depression in the elderly FIDE-SNP population BCS, CCS, COL and prostate cancer screening will continue through 2020.

5.2.1 Complex Health Needs

The QI program is dedicated to addressing the needs of members with complex health issues. The Complex Case Management Program resides within the Medicaid Case Management and Medicare Advantage (MA) Care Management teams (product line specific) and integrates all components of case management and coordination to support access to care for members with complex diseases (including transplantation, HIV/AIDS, oncology and behavioral health) and chronic conditions. Members are identified and referred for Complex Case Management using a variety of methods, such as data provided from utilization/concurrent review, predictive modeling tools, physician or member referrals and health information lines. The assigned case manager coordinates care with members, their families, and providers as appropriate to assist in assessment, development and implementation of individualized plans of care to meet the identified needs of the member across multiple settings. Case Management and Medicare Advantage Care Management utilize the Care Radius medical management system to support both the delivery and documentation of the case management process.

Additionally, the Provider Contracting & Strategy and Network Operations Departments review geographical access reports to address the adequacy of the provider

network. Reporting indicates sufficiency of PCP, Ob/Gyn, and high volume and high impact specialties required to treat the membership. Deficiencies in the network are acted upon to reduce barriers to care and to ensure continuity of care for members.

5.3 Quality Assurance

5.3.1 Grievances and Appeals

5.3.1.1 Medicaid Grievances

Horizon BCBSNJ is committed to improving the efficiency and quality of how the Plan manages appeals and grievances. In 2019, all grievance analysts were provided with additional training to ensure grievances were handled timely and efficiently, and will continue to be monitored in 2020 to initiate additional trainings where needed. The training included review of the process for identifying quality of care issues and making outbound calls to providers. In addition, 100 percent of all grievances receive a quality review prior to closure. This added step ensures that member and provider grievances are addressed appropriately.

The GP grievance resolution teams address member and provider grievances within the mandated timeframes required by the NJ State Medicaid Contract, CMS Health Maintenance Organization (HMO) regulations, and in accordance with standards set forth by an applicable accrediting body of NCQA. The staff receives grievances through telephone calls coming into the member/provider services areas, State referrals, CMS referrals, internal and external direct calls, written correspondence, GP websites and the electronic internal complaint form. The internal processes provide the opportunity for all employees within the organization to document any grievance that was received during an interaction with a member and/or provider. The grievance staff is the liaison between the member/provider, Horizon BCBSNJ, and the delegate or vendor for grievances related to any delegate or vendor. As necessary, the team participates in monthly meetings with delegates and vendors to ensure grievances are processed within compliance contractual agreements and service level agreements and also discuss any issues that may arise.

Grievance data is analyzed monthly and submitted to the appropriate committees for review and discussion. At least quarterly, member, provider and delegated vendor grievance data is presented to the QIC. After presentation at the QIC, the information is presented at the Quality Committee of the Horizon Healthcare of New Jersey Board for review and discussion. As required by the NJ State Medicaid Managed Care Contract and CMS regulations, grievance reports are prepared and submitted to the state and CMS.

The Horizon NJ Health appeals staff handles all member and provider Utilization Management appeals in accordance with the NJ State Medicaid Managed Care contract requirements, applicable CMS regulations, and accreditation standards. Please note that grievances may also be referenced as complaints.

5.3.1.2 Medicare Grievances

CMS provides stringent guidelines related to the intake and resolution of grievances received by Medicare enrollees. In order to meet the requirements, a dedicated grievances team exists within the organization to resolve grievances. The focus of the team is to review and resolve grievances regardless of where they originate within the organization. The grievances staff receives referrals by telephone calls, written correspondence, internal referrals or legislative referrals. Grievances received by **1-800-Medicare** are also handled within the grievances team.

All grievances are reviewed in detail to identify the root cause of the issue. There is continuous collaboration within various departments within the organization to review and resolve grievances. All grievances are handled within the CMS designated timeframe and follow all CMS guidelines as outlined in the Managed Care Manual Chapter 13; Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs), collectively referred to as Medicare Health Plans. The staff member serves as a liaison between the member/provider, delegated vendors, and regulatory bodies, and follows the grievance until completion. Grievance inventory is monitored on a daily basis in order to ensure grievances are acknowledged and resolved in a timely manner. The overall outcomes

are reviewed on a monthly basis in order to identify trends and any corrective action is identified on a case-by-case basis. Quarterly grievance reports are presented to the appropriate committees for review. Please note that grievances may also be referenced as complaints.

5.3.1.3 Appeals

The Quality Management Department has a team dedicated to processing appeals across all GP lines of business. The Appeals Department is comprised of non-clinicians, registered nurses, medical directors and a leadership team focused on ensuring compliance with NCQA standards and state /federal regulations. External MD specialty match consultants are used when appropriate to provide expertise to the input of a medical necessity review. This ensures member and provider appeals are managed in accordance with nationally recognized criteria to render determinations based on medical necessity.

The quality improvement initiatives continue in the Appeals Department with ongoing education and monitoring for effective administration of medical necessity appeals. Leadership and staff have been structured to create subject matter experts to support the Medicaid, Medicare and FIDE-SNP lines of business. There continues to be a refocus on data driven outcomes via diversified reporting through the business analyst's support. The result is tracking, trending and identifying opportunities for improvements in production. Operationally, monitoring tools such as the appeals dashboard helps create and modify department policies/procedures and workflows to support compliance with CMS and State contractual timeframes.

5.3.2 Quality of Care and Service

Within the Quality Management Department, a team exists which is focused on quality of care issues. This team provides ongoing education to GP personnel regarding potential quality of care concerns and serious adverse events. This education includes the definitions/categories for quality-of-care referrals with direction on how staff can refer potential quality of care issues to the Quality Management Department for investigation, and to the medical director for review. All instances where a quality-of-care issue and/or serious adverse events, hospital acquired, or provider preventable event may exist are presented to

the Quality Peer Review Committee (QPRC) for discussion, determination of departure from quality standards and guidelines, and possible practitioner sanctioning.

QPRC sanction determinations are forwarded to the Credentialing Committee for inclusion in the provider's credentialing file. Quality-of-care referrals as well as provider sanctions are tracked and trended by the QPRC. Entities that receive sanctions may be monitored by the PC&S team through telephonic and medical record audits, as well as onsite visits. When the QPRC issues sanctions against providers, the QPRC may require the provider to create and implement corrective action plans (CAPs). These CAPs are reviewed by the QPRC for completeness. The QPRC reports quality-of-care concerns (QOC), hospital-acquired conditions (HAC) and serious adverse events (SAE) to the QIC.

The Quality Management Clinical Operations RN staff provides quarterly education sessions regarding quality of care referral categories. These information sessions are conducted in office and via WebEx (to accommodate staffs who work from home). In addition to structured reviews of the criteria, the Quality Management staff provides support to all referring staff to ensure that referrals and grievances are created correctly.

Quality of Care Referrals are captured by a Tableau quality report that was developed in 2017. The Tableau report is a comprehensive report of quality of care referrals and grievances. This report is updated daily, and follows all lines of Government Programs business. Information obtained from Tableau is used for monthly monitoring of total cases referred, closed, and outstanding.

Readmission monitoring for quality-of-care indicators are reviewed prior to proceeding with the UM appeal process. Working with the Medical Directors, cases are reviewed and quality-of-care indicators are validated. If no quality-of-care indicators are identified, the UM appeal process will commence.

Monthly data is reviewed for trends and outliers. In the event a quality of care indicator persists, referrals are made to Horizon NJ Health's Provider Contracting & Strategy (PC&S) team. PC&S reports the results of its investigation to the Provider and Member Services Satisfaction Committees, which report into the QIC.

The QI Program is designed to maintain and enhance high quality of care and service in an era of high expectations from our members and providers.

5.3.2.1 Quality of Care and Service

The Clinical Quality Operations team has the ability to monitor and track quality of care grievances and quality-of-care referrals for all lines of business including MLTSS and FIDE-SNP. Data regarding these lines of business is reported to the Government Programs QIC committee. In addition, tracking of cases for members defined as aged, blind and disabled (ABD), Division of Developmental Disabilities (DDD) and elderly are reported to the QPRC committee. Potential quality of service issues identified for MLTSS, FIDE-SNP, ABD, DDD, and elderly during the investigation of a quality of care issue will be referred to the appropriate area for review and investigation.

5.3.2.1.1 Mortality Data

Another function of the Quality Management Department is the tracking of mortality data for Medicaid, FIDE-SNP and MLTSS members. The mortality data is also stratified by special populations as defined by the New Jersey Medicaid HMO contract. These categories include aged, blind, disabled (ABD), Division of Developmental Disabilities (DDD) and elderly members. On an annual basis, the analysis is presented to the QPRC committee for review and approval.

5.3.2.2 Programs for the Elderly and Disabled

Horizon BCBSNJ continues to focus on the care of all members. In doing so, Horizon BCBSNJ has segmented the population to address the needs of the most critical members, which include a focus on elderly members aged 65 years and older and members with disabilities. The elderly and disabled population is managed by various programs including Care, Case and Disease Management and Quality Management Programs. They are designed to outreach, engage and educate both members and providers on the importance of preventive visits and communication to providers on outcomes of care.

For elderly and disabled enrollees, GP monitors, evaluates and reports on member outcomes at least annually. GP tracks and reports on each population separately. Horizon BCBSNJ's program includes functional standards to evaluate outcomes of care; as well as measurement and distribution of outcome reports to providers. The program includes a process for communicating measurement standards to providers and evidence that the process is implemented.

The results are included in the QI Program Evaluation. GP includes quality indicators of potential adverse outcomes and provides appropriate education, outreach, case management and other activities as outlined in the Medicaid Contract.

5.3.2.3 Population Health

GP manages Medicaid and Medicare members through multiple programs to increase member satisfaction, improve health outcomes and reduce cost, known as the Triple Aim. GP utilizes a data-driven approach to population health management of its member population. This approach includes stratifying the population into four quadrants (Healthy, Rising Risk, Complex Care and Safety and Outcomes). In addition, the population is also segmented by location (zip code, city or county), age and gender.

The objectives of the GP Population Health Management Program are to improve the overall health and wellness of the population through programs that encourage preventive health services, health and disease maintenance programs and appropriate utilization of practitioner and other provider services. Through population analysis, interventions are designed to meet the needs of the target population, as well as have an understanding of their needs and barriers. The Population Health Program is available to all active enrolled members, with the option to opt out via a telephone call, at which time they are placed on a do not contact list.

5.3.3 Audits and Reports

The QI Program has oversight of audits and reports completed by multiple business areas. There are several reasons that audits and reports are performed. Audits and reports

are required by the State, necessary to meet accreditation requirements, and they provide GP with insights as to how processes, providers and systems are performing. A selection of the audits and reports that are performed and then reviewed by the QIC is listed below:

- MLTSS Quarterly Audit
- FIDE-SNP Audits
- Geo Access Reports
- 24-hour Access Audit
- Medical Record Review Audit
- Appointment Availability Audit
- Office Manager Satisfaction Survey
- Behavioral Health Clinical and Quality Performance Measures
- EPSDT Audit
- Lead Report
- Vendor Oversight Audit

These audits are incorporated into the QI Program Work Plan. As part of the QI program, the QIC uses the work plan to track the completion of these audits. The QIC provides the business area completing each audit/report with recommendations about how it can be modified to improve its usefulness.

5.3.4 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) - Lead Screening

Lead screening using blood lead level determination must be done for every Medicaid-eligible and NJ FamilyCare child between nine (9) months and eighteen (18) months of ages, preferably at twelve (12) months of age and a second time between 18-26 months, preferably at twenty-four (24) months of age. Testing should be done on any children between twenty-seven (27) to seventy-two (72) months of age not previously tested. GP provides a screening program for the presence of lead toxicity in children, which consists of two components; a verbal risk assessment and blood lead testing. The verbal risk assessment is given to providers to perform at every periodic visit between the ages of six (6) months and seventy-two (72) months. Monthly data reports are reviewed for the 9-18 month and 18-26 month age groups. Those between 27-72 months that have not previously been tested are also included on this report. Those members that have been tested and have an abnormal rate above 5 ug/dl are handled by the Case Management Department for management and follow up. Additionally,

the health plan has various lead monitoring methods and interventions in place to increase lead screening rates plan-wide. Primary and secondary prevention methodologies have been adopted to ensure lead screening takes place earlier, rather than later, in the applicable age groups. These interventions include, but are not limited to, member mailings, provider mailings, call campaigns, provider onsite education, provider webinars, member gap-detail analysis and community events.

In 2020, GP will continue to monitor initiatives to increase lead screening awareness and lead testing. In addition to our interventions targeted towards all of our members and providers, we have interventions specific to our hard-to-reach members who appear on the annual member work plan. There are also specific interventions in place and developed each year specific to providers falling under 80% lead testing compliance for two-consecutive, six month periods. Those providers who are on this "under compliance" list are monitored throughout the year and reported to the Quality Peer Review Committee in the case that they are unable to increase their rate to 80% or higher. Providers that are placed on a CAP are notified in April following the measurement year (i.e. letters are sent out in April 2020 for providers under 80% for two consecutive, six month periods in 2019) via letter and fax. They are advised that they have been placed on a CAP and their lead screening performance will be monitored throughout the year (i.e. 2020 for 2019 non-compliance). In August of the following year (August 2020 for 2019 non-compliance), providers who are still under 80% compliance are notified via fax as a reminder that they have until year-end to increase their lead screening rates. If their lead screening compliance is still below 80% by year-end, they are referred to QPRC to determine further corrective action.

While provider compliance is key and monitored closely, there are a number of interventions underway that support providers to increase their lead testing rates. These efforts are proactive and ongoing throughout the year to maintain compliant rates and also to improve low rates.

5.4 Policy Management

Annual policy review is conducted and presented to the QIC or the applicable subcommittee or workgroup of the QIC, by the department responsible for each policy. All policies are reviewed to comply with the Corporate Policy and Procedure Development Policy and include the effective date,

most recent revision and most recent review dates. In addition, policies are reviewed for applicable regulatory and accreditation content.

All GP policies are maintained on a SharePoint site. The site allows staff access to all current GP policies. Monitoring of state compliance requirements is coordinated with the Regulatory Affairs Department. Any policies requiring state/DMAHS approval are submitted to the GP Regulatory Affairs Department for submission to the State. Such policies which require State/DMAHS review and approval require a DMAHS stamp on the policy**.**

5.5 Delegation Oversight

Delegated managed care entities that administer health care services and/or provide services covered under GP's benefit plans are subject to review and oversight under the QI Program. These services include, but are not limited to, activities/functions relating to utilization review/management, case management, quality improvement, credentialing/re-credentialing, utilization management appeals, HEDIS gap closures, radiology services, pharmaceutical services, laboratory services, vision services, dental services, telemedicine, post-acute skilled nursing facility (SNF) and rehab care services, durable medical equipment, grievances, customer service and claims processing.

Contracted delegates/vendors are obligated to provide and administer services in accordance with contractual terms and conditions, applicable state and federal laws & statutes, including but not limited to, regulations set forth by the New Jersey Department of Banking and Insurance (DOBI), New Jersey DMAHS Managed Care Contract provisions, the Health Claims Authorization, Processing and Payment (HCAPP) Act, CMS regulations, Horizon BCBSNJ policies and procedures, and current-year NCQA standards and guidelines. GP remains accountable for the quality, integrity and appropriateness of delegated functions and services provided by subcontractors for Horizon BCBSNJ's MLTSS, FIDE-SNP and Medicare Advantage members.

It is Horizon BCBSNJ's responsibility to ensure monitoring and oversight activities are performed to ensure delegate/vendor compliance and to promote the delivery of and access to quality and cost-effective health care and services to members. The Delegate Vendor Oversight Committee is responsible for the following: assessing on-going monitoring and evaluation activities performed collaboratively and independently by GP business units; evaluation of delegate/vendor performance results to ensure business goals and outcomes are achieved to further the delivery of quality health

goals and outcomes for our members and; ensuring subcontractor compliance with contractual provisions, regulatory requirements, and applicable accreditation guidelines.

A quarterly subcommittee report summarizing items and issues reviewed and discussed at DVOC meetings must be submitted and presented to the QIC and the Horizon Quality Committee Board (HQCB). A summarized overview on delegate/vendor oversight activities must also be submitted to the Compliance and Ethics (C&E) Committee. Committee reports must include, but not be limited to, delegate/vendor performance statistics, the status of delegate/vendor CAP (when applicable) and, oversight monitoring reports and; must highlight matters of importance and/or that require the attention of the QIC, HQCB or C&E Committee.

5.6 Compliance with State and Federal Regulatory and NJ Medicaid Managed Care Contract Requirements

Government Programs places the utmost importance on compliance with regulatory and contract requirements. This is particularly important as it relates to member safety, the handling of private health information and the integrity with which the Plan cares for its members.

- Confidentiality

GP processes address sensitive protected health information about members and physicians. Documents that are created and reviewed as part of the process are confidential and privileged. The information is maintained in compliance with appropriate federal and state regulations, the Health Insurance Portability and Accountability Act (HIPAA) and all applicable accreditation standards. All employees, participating physicians, vendors and consultants must maintain the Horizon BCBSNJ standards of ethics and confidentiality regarding both member information and proprietary information. All employees and non-employees are required to sign a confidentiality statement, as well as any consultant or business associate that may need to access confidential member information. In addition, certain business associates perform certain business functions on behalf of GP involving the use, disclosure or receipt of private health information. These third parties are business associates of GP and will sign a GP Business Associate Agreement to protect the privacy and safeguard the security of such private information when assisting with administrative functions or providing services for or on behalf of GP.

- Member Rights, Responsibilities and Patient Engagement

GP is committed to maintaining a mutually respectful relationship with its members that promotes effective health care. GP makes clear its expectation for the rights and responsibilities of members and sets a structure for cooperation among members, practitioners and the health plan. GP recognizes that members must establish a dynamic partnership in the management of their care, which includes the members' family and their health care practitioner.

When care does not meet the member's expectations, GP assures members of their right to voice grievances (complaints) and to appeal any decisions with which they do not agree.

- Regulatory Compliance

The QI Program through the QIC:

  - Monitors regulatory requirements for quality management and compliance;
  - Ensures that the appropriate actions are taken when areas of quality management non-compliance are identified; and
  - Ensures GP quality management reporting system provides adequate information for meeting the regulatory external review and accreditation requirements of mandatory and voluntary review bodies.

- Ethics

The QI program functions as a key component in promotion of integrity and values found in the care and services provided to GP members. As outlined in the Horizon BCBSNJ Corporate Code of Business Conduct and Ethics, Horizon BCBSNJ is committed to maintaining the highest legal and ethical standards in the conduct of its businesses. In maintaining these standards, Horizon BCBSNJ places heavy reliance on individual good judgment, honesty and character. This commitment applies without exception to all activities.

5.7 Accreditation

GP Medicare and Medicaid lines of business are accredited by the NCQA. The Quality Management Department, through the QI program, continuously monitors all applicable GP business areas to ensure their compliance with the most current NCQA Health Plan Accreditation standards and guidelines. The QI Accreditation Team provides education, assessment and feedback to business areas for continual readiness in between reaccreditation cycles. The Accreditation Team monitors compliance with standards on an ongoing basis and reports the status of accreditation activities at least quarterly to the QIC.

5.8 *Credentialing and Re-credentialing*

GP's credentialing and re-credentialing activities are managed by the Horizon BCBSNJ Credentialing Department. Horizon BCBSNJ's credentialing and re-credentialing process determines whether physicians, other health care professionals, and organizational providers of services meet all applicable state licensing standards, participation and credentialing criteria, and are qualified to provide the care or services for which they have been contracted. GP maintains oversight of the credentialing and re-credentialing activities through the QIC. In addition, the QPRC provides reports to the Credentialing Committee on quality of care and service sanctions that are issued by the QPRC. This information is taken into account when providers are evaluated for re-credentialing.

5.9 Clinical Practice Guidelines (CPGs)

CPGs are evidenced-based practice standards promoted by GP. They are used to assist staff in making appropriate recommendations and to inform members and providers about making educated health care decisions. Topics addressed by GP CPGs include, but are not limited to, preventive health, asthma, diabetes, maternity, EPSDT, behavioral health and geriatric care. The CPGs are based on nationally recognized medical association standards and medical references. The guidelines are reviewed and updated at a minimum of every two years, or as needed, and they are presented to the UM/CM Committee for approval. Information about GP CPGs is made available to providers through the GP Provider Administrative Manual, provider newsletters and the Horizon NJ Health website. Guidelines are available to members through the website, member newsletters, and/or a copy can be requested by calling the Member Services Department.

5.10 Cultural Competency and Health Literacy

Horizon BCBSNJ recognizes the cultural diversity and health literacy needs of its health plan members. The Plan is committed to promoting cultural competency, increasing health literacy, and decreasing health care disparities, regardless of gender, gender identity or sexual orientation. GP utilizes data from multiple sources to develop and implement policies and programs to increase cultural competency and health literacy. Education is provided to staff and participating providers to enhance the provision of culturally competent and linguistically appropriate care. Language assistance services, including bilingual staff and interpreter services, are offered and provided to members at no cost. GP produces member-related materials which are easily understood and in languages that meet member needs.

The objective of GP cultural competency and health literacy efforts are to improve materials and communications by:

- Increasing the cultural sensitivity of employees and providers
- Gaining a better understanding of the needs of our members through solicitation of member feedback
- Optimizing members' experience with the health plan
- Enhancing the provision of quality care to members with diverse values, beliefs and behaviors
- Encouraging the development of more effective strategies for communication with members
- Identifying and overcoming barriers most likely to inhibit the advancement of health care for diverse groups

In evaluating cultural and linguistic needs, GP performs the following:

- Identifies linguistic needs and cultural backgrounds of members, by using U.S. Census data, enrollment data and member feedback
- Identifies languages of practitioners in provider networks to assess whether they meet members' linguistic needs and preferences

The data from these reports is analyzed and used by GP to adjust the practitioner network if the current practitioner network does not meet members' language needs and preferences. Where there is a deficiency, efforts are made to recruit providers and practitioners to meet the needs of the underserved groups.

Additionally, case managers identify member cultural, physical, auditory, vision and linguistic barriers to care as a part of the Complex Needs Assessment process. Member needs are assessed and barriers are addressed throughout the continuum of care.

5.11 *Fraud, Waste, and Abuse*

The Fraud, Waste and Abuse Prevention Plan documents the organization's comprehensive approach to prevent, detect, investigate, recover, and report cases of fraud, waste, and abuse in the Medicare Advantage, Medicare Advantage Part D, Medicaid, FIDE-SNP and NJ FamilyCare Programs. The plan supplements all Horizon BCBSNJ and Horizon NJ TotalCare (HMO D-SNP) policies and workflows on fraud, waste and abuse prevention, and provides a framework for monitoring compliance with the following fraud waste and abuse-related requirements including:

- NJ Medicaid Managed Care Contract
- Federal Program Fraud Civil Remedies Act, New Jersey False Claims Act
- New Jersey Anti-Fraud Prevention and Detection Plan Protocol, (N.J.A.C. 11:16-6.7)

GP routinely discovers issues that require intervention and analysis. The various methods employed to aid in monitoring and identifying fraud, waste and abuse include daily queries, the SAS analytical software package, referrals from internal departments, external referrals (i.e. State Medicaid Fraud Unit, pharmacy audit vendors, and fraud hotline) and media publications. Horizon BCBSNJ's Medicaid and Medicare Special Investigations Unit (SIU) coordinates fraud waste and abuse activities with all state and federal agencies. If a potential issue is identified, the information is reported to Horizon BCBSNJ's Medicaid and Medicare SIU for evaluation and further action.

5.12 Program Performance

Horizon BCBSNJ dedicates resources across the organization, and specifically within the Quality Management Department, to focus on GP Quality Performance. This work is guided by the QI program and included in the QI program Work Plan. The QIC has oversight of this work including the planning, monitoring and evaluation of the outcomes of these efforts.

5.12.1 QI Program Work Plan

Annually, the Quality Management Department creates the QI program Work Plan. The work plan is presented to the QIC in the first quarter of the year. The QIC provides recommendations for revisions and the committee approves the work plan. The QI program Work Plan is designed to be inclusive of all aspects of the QI program's responsibilities. The work plan is updated as needed during the year to incorporate recommendations that are identified through the completion of the QI Program Evaluation and/or by recommendations made by the QIC. The QIC reviews the work plan at least quarterly to ensure that the activities outlined within the work plan are being addressed by the appropriate business owners, and to ensure progress is being made toward the stated goals. If the QIC determines that progress is not being made toward goals, the committee is tasked with providing recommendations to assist the business area in identifying barriers and developing interventions to overcome the barriers. The 2020 QI Work Plan will identify items applicable to behavioral health services, which were previously delegated to Beacon Health Options.

5.12.2 Performance Improvement Projects (PIPs)

A performance improvement project (PIP) is a concentrated effort on a specific problem within the health plan. Information is systematically collected for the clarification of issues or problems, which are then the focus of improvement. Improvements are made via the development of interventions. The Plan develops and conducts PIPs to examine and improve care or services in areas that have been deemed as containing deficiencies. Deficiencies are determined via the analysis of data against a specific standard.

The Quality Improvement Operations team is responsible for assisting in the design, implementation, execution, analysis, and reporting of GP state and CMS-required PIPs and Chronic Care Improvement Projects (CCIPs). Plan Do Study/Check Act cycle in addition to Lean Six Sigma methodologies are used to develop and ensure continuous quality improvement throughout the entirety of each PIP.

5.12.2.1 Medicaid PIPs (State PIPs)

Horizon NJ Health conducts four performance improvement projects (PIPs) specific to its State/Medicaid membership. The topics for these PIPs are determined by DMAHS. The current topics include: (1) MLTSS reducing admissions, readmissions

and gaps in service for members with congestive heart failure in the Horizon NJ Health MLTSS Medicaid population; (2) Increasing Developmental Screening and Early Intervention; (3) FIDE-SNP reducing admissions, readmissions and Emergency Room (ER) visits in members with asthma; (4) MCO Adolescent Risk Behavior and Depression Collaborative. Twice per year, Horizon NJ Health submits reports to the State detailing Horizon NJ Health's efforts and outcomes related to each PIP. This takes place in April and August. In addition to semi-annual submissions, Horizon BCBSNJ monitors intervention implementation timeliness and effectiveness along with all other PIP-related activities to ensure positive results.

5.12.2.2 Medicare PIPs (CMS PIPs/CCIPs)

GP participates in ongoing quality improvement programs for each contract in place. The purpose of the QI program is to ensure that GP has the necessary framework and infrastructure to coordinate care, promote quality, performance, and efficiency on an ongoing basis. The guidelines followed and incorporated into the QI programs are based on the 42 CFR§ 422.152 regulation. Each Chronic Care Improvement Project (CCIP) applies to the three MA contracts in place. Currently, there are three CCIPs in place for each contract with a focus on promoting effective management of chronic disease. The CCIPs in place have a three-year project cycle. GP is no longer required to submit updates for its Medicare CCIPs to CMS, but rather monitors CCIPs internally and submits an attestation that confirms the projects are in place.

5.12.3 Healthcare Effectiveness Data and Information Set (HEDIS)

GP Medicare, FIDE-SNP and Medicaid HEDIS measures are evaluated and analyzed monthly. Initiatives are developed, changed, and/or enhancements to initiatives and outreach activities are discussed in the HEDIS workgroup meetings. HEDIS performance results are reported annually to the State, QIC, NCQA and reported at the Quality Committee board meeting through review of the QI Program Evaluation.

Annually, GP creates a new work plan to address State HEDIS measures that fall below 50th percentile with the exception to the Lead Screening Measure, which is added if it falls below the 75th percentile. This work plan is provided to DMAHS on or before August 15

annually. Existing initiatives and outreach areas are evaluated for their impact and, if needed, are enhanced to improve measure performance. The results and outcomes of initiatives and outreach are monitored monthly and shared in HEDIS workgroup meetings held four times per year.

5.12.4 Star Ratings

GP Medicare Star Rating measures are monitored monthly. Star Rating measures are assigned to business owners who develop strategies, initiatives and outreach activities to maintain and/or improve performance. Star Rating progress is reported to the QIC on a quarterly basis. Star Rating measure performance results are reported annually to the State (FIDE-SNP product only), to the QIC, NCQA and at the Quality Committee board meeting through review of the QI Program Evaluation.

5.12.5 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS survey captures accurate and complete information about member-reported experiences and how well the Plan and providers are meeting members' expectations and goals. The Quality Management Department coordinates Government Programs' efforts to improve CAHPS scores for Medicare, Medicaid and FIDE-SNP for adults and children. The planning, work and results of these efforts are reported to QIC directly. Specific CAHPS work plans are created to manage each line of business. Government Programs has determined that in 2020, opportunity exists to continue efforts to improve on all measures. These are all drivers of customer satisfaction and impact the Plan's overall ratings. The QI Program Work Plan will incorporate the QIC's oversight of CAHPS improvement efforts.

5.12.6 Health Outcomes Survey (HOS)

The Health Outcomes Survey (HOS) provides an assessment of how Horizon BCBSNJ's members describe changes in their health status over time. Horizon BCBSNJ's Customer Experience team analyzes the results of the HOS survey and this analysis is presented to the QIC for discussion and recommendations for interventions that can be put in place to improve Horizon BCBSNJ's HOS survey results. Review of the HOS survey results is included in QI Program Work Plan.

5.13 New Initiatives

In 2020, GP will be embarking on multiple new initiatives. While all of GP's new initiatives have the potential to impact the quality of care and service GP provides its members, the following specific initiatives require direct monitoring by the QI program because of their scope and impact on members and providers.

- "Lost" Post Service Appeals

  In collaboration with the Operations Service Center (OSC), internal compliance teams, legal and facility management, we will continue efforts to eliminate the post service third party vendor facility appeals that have USPS tracking numbers but never arrive at the UM appeal department for processing. The OSC improvement activities include hiring additional staff and securing a scanning tool to validate receipt of forwarded USPS mail with tracking.

- Mortality Reporting

  In 2019 the QM Department established a Tableau report for self-service mortality reporting capabilities for Government programs and the commercial lines of business. In 2020, expansion of the use of mortality reports will move forward in collaboration with other Horizon BCBSNJ clinical departments.

- Behavioral Health (BH) and Substance Use Disorder (SUD) Appeal Management

  Medical necessity management for BH and SUD appeals will be transitioned to Horizon BCBSNJ. The GP Appeals Team has three additional staff who will have specific education to manage these appeal types. In addition, a supervisor with extensive BH experience will oversee the team.

5.14 Opportunities for Continued Improvement

Opportunities for improvement that are identified in the QI Program Evaluation are incorporated into the following year's QI Program activities for implementation and monitoring by the QIC including but not limited to:

- Health Care Disparities – identification of opportunities for improvement health care disparities to improve member support and engagement
- Appeals – Complexity of the appeal process for Medicare and FIDE-SNP members
- Reduce "lost post-service facility appeals" sent with USPS tracking
- Misroutes of grievances to the Quality of Care team
- Hospital Acquired Conditions and Serious Adverse Event Management
- Readmission quality of care reviews

- Star Rating and CAHPS – focused implementation of improvement initiatives
- Lead – improve screening rates across all counties
- Reducing admissions, readmissions and gaps in services for members with Congestive Heart Failure in the Horizon NJ Health MLTSS Medicaid population
- Dental provider network deficiencies in Atlantic County
- MLTSS provider network deficiencies in several counties
- Improve timeliness of grievance processing
- Continued focus on GP CAHPS - to ensure that member satisfaction is achieved. Addressing opportunities identified within the HEDIS & CAHPS Performance to achieve NCQA Commendable status for the Medicaid and Medicare products

GP will pursue these opportunities for improvement in 2020 and include updates to activities in the QI Work Plan to monitor, track and trend progress toward goals.

Attachments to Program Description

Attachment 1 – 2019-2020 MLTSS Program Description

2019-20 MLTSS Program Description.p

Attachment 2 – 2020 FIDE-SNP Care Management and Quality Management Program Description

2020 SNP Care Management and Qua

Attachment 3 – 2020 GP Committee Organization Chart

2020 Horizon GP Committee Organizatic

Attachment 4 - GP Executive Organizational Chart

Horizon GP Executive Organizational Chart

Attachment 5 - Quality Management Department's Organizational Chart

QM Org Chart January 2020.pdf

Government Programs 2020 Quality Improvement Program Description

Approvals

_____ ___2/26/20_____

Roberta McNeill, MD **Date**
Medical Director
Chairperson Designee, Quality Improvement Committee

_____ __2/26/20_____

Donald Liss, MD **Date**
Vice President & Chief Medical Officer