Horizon Blue Cross Blue Shield of New Jersey
Horizon Healthcare of New Jersey, Inc.
Horizon Insurance Company

2015 Quality Improvement Program Description
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I. INTRODUCTION AND BACKGROUND

Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey, an independent licensee of the Blue Cross and Blue Shield Association traces its history back to 1932 when The Associated Hospitals of Essex County, Inc. was formed as a multi-hospital prepayment plan.

Horizon Blue Cross Blue Shield of New Jersey is the oldest and largest health insurer in the state, serving over 3.6 million members. Horizon BCBSNJ is headquartered in Newark with offices in Wall and Mt. Laurel.

Horizon Healthcare of New Jersey, Inc. is a licensed Health Maintenance Organization incorporated in October, 1985.

Horizon Insurance Company is a licensed Insurance Company in the State of New Jersey, incorporated in October 2012.

Horizon BCBSNJ provides a broad array of health and dental insurance products and services for individuals as well as small and large companies, including national companies headquartered in New Jersey.

II. MISSION STATEMENT

Our mission is to make health care work by improving the health care experience for our members and the communities we serve.

Horizon provides access to high quality health care, options for financing health care costs, and information and services to help our members make the best decisions about managing their health.

III. VISION STATEMENT

Our vision is to be the best health plan, both locally and nationally, by helping our members become and stay healthy.

We will achieve our vision by working with the business, government and medical communities to improve the health care experience for our members and ensure they receive the appropriate care at the best price.

Core Values
Caring
Excellence
Integrity

IV. PURPOSE

The Quality Improvement Program of Horizon Healthcare Services, Inc, the parent corporation, Horizon Insurance Company, and Horizon Healthcare of New Jersey, Inc., the enterprise’s HMO subsidiary company (hereinafter collectively referred to as “Horizon”) is a coordinated and comprehensive program designed to monitor, assess and improve the quality and appropriateness of care and services provided to members/covered persons within their respective lines of business. This is accomplished by creating an infrastructure and set of business processes to make the achievement of high quality outcomes and service an integral part of the way Horizon does business. This document serves as a summary description of the Horizon Quality Improvement Program; more detailed descriptions of program components are described in other Policies, Procedures, and Workflows. The Quality Improvement Program is revised as needed and reviewed at least annually. It is available for review by the regulatory and accreditation entities (i.e. – Department of Banking and Insurance and Centers for Medicare and
V. PROGRAM GOALS AND OBJECTIVES

The Quality Improvement Program monitors the availability, accessibility, continuity and quality of care and services on an ongoing basis.

A. Goal:
Monitor the quality of care and services provided by participating providers, practitioners, and independently contracted delegates to Horizon.

Objectives:

- Evaluate and maintain a high quality provider network through a formalized credentialing and recredentialing process.
- Maintain a structured, ongoing oversight process for quality improvement functions performed by practitioners, providers, and independently contracted delegates.
- Implement activities to monitor and address continuity and coordination of care between medical and behavioral health specialties and within the medical care system.
- Establish long-term collaborative relationships with the provider network to consistently improve the quality and cost effectiveness of care and service delivered to our members.
- Specify standards of care, criteria and procedures as well as assess compliance with such standards and adequacy and appropriateness of health care resources utilized.
- Monitor member satisfaction with quality of care and services received by network providers, practitioners and delegates.

B. Goal:
Maintain a systematic approach to monitor, evaluate, improve and ensure provider and member access to utilization management services.

Objectives:

- Assure that adequate resources are arranged to provide available, appropriate, accessible and timely health care services to all members according to evidence based rules.
- Evaluate new medical technology and the new application of existing technologies and determine their coverage status in the context of Horizon’s benefit packages.
- Continually monitor, evaluate, and improve Horizon’s performance using benchmarks and goals based on local and national data.
- Ensure appropriate coordination of care between clinical settings.

C. Goal:
Act on opportunities for improvement of the health status of members through the development and implementation of health promotion, preventive health education, and disease and case management programs.

Objectives:

- Continually identify and outreach members at risk and/or with gaps in care.
- Identify healthcare disparities in order to develop appropriate intervention tools including staff cultural competency education.
- Establish programs focused on the chronic conditions of our members in order to empower members to actively participate in and take responsibility for their own health through the provision of education, counseling, and access to quality health care providers and tools.
Expand planned interventions in existing health management programs and strengthen coordination between clinical and behavioral health management activities, and appropriate discharge planning.

Develop, distribute and maintain preventive health guidelines that are: age, gender, culture, and risk status appropriate; describe the prevention or early detection interventions along with the recommended frequency and conditions under which the interventions are required; document the source upon which it is based, review and update bi-annually or as needed.

Develop population based wellness programs and promote engagement/participation.

D. Goal:
Maximize safety and quality of health care delivered to members through the continuous quality improvement process.

Objectives:
- Provide members with semiannual publications and access to a website that contain information to improve their knowledge about clinical safety issues.
- Collaborate with providers and practitioners to establish a means of promoting and maintaining safe clinical practices.
- Address patient safety through continuous review of quality care issues and require corrective action from providers involved.
- Evaluate and reward provider (physicians and hospitals) performance with respect to the quality of care delivered to members.
- Establish evidence based practice guidelines, monitor and assess the extent to which members receive care consistent with the guidelines.
- Provide members with 24/7 access to clinical staff for informational questions and help with assessing their basic health care needs.
- Evaluate patient safety through continuous monitoring of polypharmacy utilization.
- Assess the over and under-utilization of services.

E. Goal
Maintain a high level of satisfaction in members, providers and customers on the services provided by Horizon.

Objectives:
- Ensure easy and timely access to accurate information through customer service representatives, phone lines, internet or website.
- Resolve inquiries, complaints and appeals in a timely manner.

F. Goal:
Maintain compliance with local, state, and federal regulatory requirements and accreditation standards.

Objectives:
- Monitor and update workflows and processes to continuously meet regulatory requirements for quality improvement and compliance as needed.
- Initiate and monitor quality improvement activities which meet or exceed accreditation standards.
- Fulfill the quality related reporting requirements of applicable state and federal statutes and regulations, as well as standards developed by independent external review and accreditation.
VI. PROGRAM SCOPE

The Quality Improvement Program provides a mechanism for the coordination of both quality improvement and quality management activities. The scope of this program includes the objective and systematic monitoring of the quality and safety of health care services provided to Horizon members. In an effort to improve organization performance, collaborative and specific indicators of both processes and outcomes of care are developed, measured and assessed by all appropriate departments in a timely manner.

The membership served by the Quality Improvement Program is from the following product lines: Commercial including Qualified Health Plans (HMO, POS, Direct Access, EPO, PPO) Medicare Advantage SHBP, FEHBP, and self-funded accounts. It does not include Horizon NJ Health.

The program has two major components: clinical and service. The range of the clinical activities is extensive, encompassing preventive care, acute care, chronic care, and care provided for special populations. It monitors provider credentialing and compliance, member education, health outcomes, screening, practice guidelines, delegation and medical record documentation. The service component of the program monitors accessibility of care, member/provider satisfaction, and member/provider complaints and appeals.

VII. AUTHORITY AND ACCOUNTABILITY

The Horizon Healthcare Services, Inc., Horizon Insurance Company and Horizon Healthcare of New Jersey, Inc. Boards of Directors hold the final authority and accountability for the quality of care and service provided to Horizon members. The Boards of Directors of Horizon Healthcare Services, Inc. and Horizon Insurance Company delegate quality improvement responsibility and authority to the Quality Committee of the Horizon Healthcare of New Jersey, Inc. Board. The Quality Committee of the Horizon Healthcare of New Jersey, Inc. Board meets on a quarterly basis and provides oversight to the Quality Improvement Program through reviewing and approving annually, the Quality Improvement Program Description, Work Plan, and Evaluation. In turn, the Board of Directors of the companies, Horizon Healthcare Services, Inc., Horizon Insurance Company and Horizon Healthcare of New Jersey, Inc., will likewise review and approve annually the Quality Improvement Program Description, Work Plan and Evaluation. The Quality Committee of the Horizon Healthcare of New Jersey, Inc. Board has designated full responsibility for the Horizon Quality Improvement Program to the Quality Improvement Committee (QIC). The QIC provides oversight and evaluation of the Quality Improvement Program.

VIII. ORGANIZATIONAL STRUCTURE

An organizational chart of the QIC is available in Attachment A.
An organizational chart of the Quality Management Department is available in Attachment B.

Quality Committee of the Board

The Quality Committee of the Horizon Healthcare of New Jersey, Inc. Board is chaired by the VP and Chief Medical Officer, who has full responsibility and authority for the quality of care provided to Horizon members. The Quality Committee of the Horizon Healthcare of New Jersey, Inc. Board meets on a quarterly basis and provides oversight to the Quality Improvement Program through reviewing and approving annually, the Quality Improvement Program Description, Work Plan and Evaluation. The
Quality Committee of the Horizon Healthcare of New Jersey, Inc. Board reports to the Board of Directors of Horizon Healthcare of New Jersey, Inc. Annually, the Boards of Directors of Horizon Healthcare Services, Inc., Horizon Insurance Company and Horizon Healthcare of New Jersey, Inc. review and approve the Quality Improvement Program Description, Work Plan and Evaluation. The Quality Committee of the Horizon Healthcare of New Jersey, Inc. Board has delegated full responsibility for Horizon’s Quality Improvement Program to the QIC.

Quality Improvement Committee

1. Function

The QIC is an interdisciplinary committee that reviews, analyzes, recommends and approves all Quality Improvement activities for Horizon Healthcare Services, Inc., Horizon Insurance Company and Horizon Healthcare of New Jersey, Inc. (collectively “Horizon”) relating to their respective lines of business: Commercial HMO, POS, Direct Access, PPO, Medicare Advantage all products, including SHBP, FEHBP, self-funded accounts and Horizon’s Exchange Products, but excluding contract, regulatory requirements, and accreditation standards.

The QIC reports quarterly to the Quality Committee of the Horizon Healthcare of New Jersey, Inc. Board of Directors. The Boards of Directors of the Horizon companies have the ultimate final authority and accountability for all Quality Improvement activities relating to the health plans mentioned above that are operated under their direction.

The Chief Medical Officer (CMO) of Horizon Blue Cross Blue Shield of New Jersey, or his designee, serves as Chairperson. The CMO has designated the Executive Medical Director, Quality Management, to chair the Quality Improvement Committee.

2. Committee Composition

The Committee consists of the Chairpersons of the reporting Committees and Directors from functional areas involved in service and clinical quality improvement initiatives. At a minimum, this includes:

A. Executive Medical Director, Quality Management (tie breaker).

B. Chairpersons of all reporting Committees (up to 12 voting members). Chairpersons must be Medical Directors or at the Director level or above to be members of the QIC. If a Committee Chairperson is not at the Director level, that Chairperson’s Director is the designated voting member for the QIC.

C. Participating Physicians (up to 5 Participating Physicians as voting members).

D. Director, Quality Management (1 voting member).

E. Director, Service Operations (1 voting member)

F. Director, Market Business Units (1 voting member)

G. Director, Clinical Operations (1 voting member)

H. Vice President, Pharmacy (1 voting member)

I. External Physician Representing Hospital Administration (1 voting member)

J. Assistant General Counsel (non-voting member)

K. Director, Compliance Services (1 voting member)
3. **Terms of Office**

The QIC Chairperson appoints Committee members to serve a one (1) year term of office. All prospective members are subject to approval by a majority vote of the current members. Members will be re-appointed annually.

4. **Others Attending**

Other medical and non-medical personnel and consultants may attend and participate without vote as needed. Participating physicians, as necessary, will be invited on a regular basis to ensure involvement of the medical community.

5. **Frequency of Meetings/Voting/Quorum**

The QIC meets quarterly. Attendance records are maintained. Committee meetings are scheduled by the Chairperson. Voting privileges will not be assigned to alternates attending in place of Committee members. A majority of the Committee’s membership must be present to meet the quorum (50% + 1). Members not in attendance at four (4) pre-scheduled meetings in any twelve month period may be removed / replaced through action by the Chairperson. Action is taken by the majority vote of members present.

6. **Minutes/Agenda**

Minutes are recorded under the direction of the Chairperson. Copies of the minutes are distributed to Committee members. All preliminary research on agenda items is completed prior to the meeting and documentation released with the agenda one week in advance of the meeting. Members review all materials prior to the meeting date. The approved actions are forwarded to the Quality Committee of the Board of Directors. Approved Committee minutes are maintained in a binder and in an on-line database.

7. **Confidentiality**

Member, physician and provider confidentiality is maintained. All external, non-employee members of the QIC must sign a confidentiality agreement annually. All internal members must comply with Horizon policies annually.

8. **Responsibilities:**

   A. The QIC is responsible for the annual development and implementation of the Quality Improvement Program, oversight of the QI Work Plan (QIWP) and analysis and approval of the QI Program Evaluation.

   B. The QIC monitors on a quarterly basis the QIWP which details goals and objectives with established time tables and criteria for completion. These goals will involve specific medical policy, practice guidelines, health care evaluation and utilization, clinical and service quality
assessments, as per applicable regulatory and accreditation requirements and in alignment with Horizon’s quality metrics.

C. The QIC conducts a more focused review of any topics that it deems is warranted and as measured by tracking and trending by performance indicators.

D. The QIC is responsible for annual approval of the Quality Improvement and Medical Management Program Descriptions, Work Plans and Program Evaluation.

E. The QIC serves as the coordinating body that reviews and approves the recommendation of the Committees that report to it: Clinical Policy Committee, Quality Case Review Committee, Medical Management Committee, Provider Appeals Committee, Member Appeals Committee, Delegate and Vendor Oversight Committee, Credentials Committee, Member Appeals Committee-Benefit Issues Committee, Pharmacy and Therapeutics Committee, and Member Provider Service Satisfaction Committee.

F. The QIC is responsible for approval of all Committee actions, whether submitted on an annual work plan or in the quarterly reports. The QIC may request or recommend action plans from the Committee as needed.

G. The Committees will report to QIC on a quarterly basis. Items requiring action on a more frequent basis will be presented to the QIC as needed.

H. The QIC delegates the approval of policies, procedures, workflows and guidelines to the respective Committees.

I. The QIC directs and evaluates all statewide ongoing activities pertaining to the quality of clinical care, services to members and utilization of resources.

J. The QIC recommends, approves and oversees new Quality Improvement activities.

K. The QIC ensures that Horizon is in compliance with appropriate accrediting organizations and regulatory requirements.

The following represents a list and description of the committees:

**Quality Case Review Committee**

1. **Function**

The Quality Case Review Committee reports to the QIC. The Committee conducts reviews and determines practitioner, facility and ancillary provider competence, identifies improvement opportunities and develops strategies to measure practitioner compliance and performance, including monitoring of individual occurrences of poor service and clinical care leading to potential quality of care issues. The Quality Case Review Committee is responsible for ensuring the findings, conclusions, and recommendations, for actions to be taken to improve provider performance, are communicated in confidence to appropriate Horizon departments or parts of the QIC committee structure implicated for action. The Committee’s voting membership consists of Executive Medical Director, Quality Management (tie breaker voting member), Horizon Medical Directors (up to 2 voting members), and Participating Physicians not employed by Horizon (3-4 voting members).

2. **Accountability**
   - Investigate, evaluate, report and respond to quality of care complaints and clinical referrals.
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- Develop, approve and maintain for recommendation to the QIC the Quality Case Review Process Policy and Member Quality of Care Complaints Policy which includes the following components;
  - Confidentiality
  - Record/Data Requirement
  - Indicators/Review Criteria and Procedure
  - Education of Participating Providers
  - Maintenance of Member Quality of Care Complaints and Case Review Databases
  - Tracking reports to Provider Affairs and Credentialing

3. Frequency of Meetings

The Quality Case Review Committee holds quarterly meetings. Special meetings may be held if the chairperson determines it to be necessary and appropriate.

Medical Management Committee

1. Function

The Medical Management Committee serves as a supporting committee to the QIC. This Committee is responsible for reviewing, analyzing and trending Horizon Medical Management and Complex Case Management data and their respective lines of business, Commercial (HMO, POS, Direct Access, PPO, Indemnity), Horizon’s Exchange Products, Medicare Advantage (all products), SHBP, FEHBP and self-funded accounts that elect to participate in the Medical Management and Complex Case Management Programs, but excluding Horizon NJ Health. The Committee’s voting membership consist of Senior Medical Director, Health Affairs (Chairperson and tie breaker), Medical Director, Medical Management (1 voting member), Medical Director, Network Management (1 voting member), Director, Quality Management (1 voting member), Senior Medical Director, Medical Policy (1 voting member), Director, Medical Management Appeals (1 voting member), Directors, Health Affairs with UM/CM/Prior Authorization (3 voting members), Medical Director, Behavioral Health (1 voting member), Representative for Corporate Compliance (1 voting member), Director, Clinical Initiatives (1 voting member), and External Physicians (1-2 voting members).

2. Accountability

The responsibilities of the Medical Management Committee include, but are not limited to:

- Annual approval of the Medical Management Program Description, Program Evaluation and Work Plan, including the Complex Case Management Program.
- Annual evaluation of the Medical Management Work Plan.
- Annual approval of the Pharmacy Medical Management Program Description and Evaluation.
- Approval of Medical Management Programs and Program Evaluations as applicable to the delegates.
- Annual review of clinical criteria.
- Monitoring of inpatient hospitalization data.
• Annual review of administrative policies pertaining to Medical Management/Case management (MM/CM).
• Monitoring of appeals data.
• Monitoring of utilization data, including patterns of over and underutilization.
• Review of program and/or product specific initiatives (e.g. – FEP).
• Selection and monitoring of MM and CM initiatives.
• Monitoring of the Prior Authorization Process.
• Evaluation of Physician, Nurse, and Physical Therapist Inter-rater reports.
• Monitoring of Delegate utilization data.
• Monitoring of Case Management Program outcomes.
• Monitoring of MM and CM compliance with external accreditation standards and regulatory requirements.
• Assessment of member/covered person and provider satisfaction with the Medical Management and Complex Case Management process.
• Identification and referral of data, policy, and quality issues, as appropriate, to the Quality Improvement Committee, Appeals Subcommittee, Clinical Issue Subcommittee, Medical Policy Subcommittee, Delegate and Vendor Oversight Subcommittee, Quality Case Review Subcommittee and/or Credentialing Subcommittee.
• Follow-up for Medical Management and Complex Case Management activities, as appropriate.

3. Frequency of Meetings
The Medical Management Committee meets no less than six (6) times per year.

Provider Appeals Committee

1. Function
The Committee review is the final authority within Horizon in setting facility appeals related to medical necessity/appropriateness. The Committee’s voting membership consists of Medical Director (tie breaker), Manager or designee, Utilization Management Appeals representatives (2 voting members).

2. Accountability
• The Provider Appeals Committee issues a determination and communicates the decision within 30 calendar days of receipt of the level two (2) appeals provided the Committee does not require additional medical information. If the Committee does require additional medical information, a letter to this effect must be sent to the appellant within five (5) business days from the presentation at the Provider Appeal Committee.
• The Provider Appeals Committee reports quarterly to the QIC. The report includes a statistical summary on all written appeals filed, procedures used and dispositions handed down.
• The Provider Appeals Committee convenes at least once each year to evaluate and update its role, procedures and effectiveness.
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DESCRIPTION

- The Provider Appeals Committee complies with any applicable state or federal regulations and/or accreditation requirements.

3. Frequency of Meetings

The Provider Appeals Committee meets at least once a month. Additional meetings will be scheduled on an as needed basis.

Member Appeals Committee

1. Function

The Committee reviews Stage 2 medical appeals brought by members/covered persons pursuant to Horizon’s Member Medical Appeals policy. The Committee’s voting membership consists of a Chairperson (tie breaker), Participating Physicians who are board certified with valid unrestricted licensure to practice in New Jersey (up to 3 voting members), at least two (2) but no more than four (4) Community representatives/non-Horizon employees or providers; a minimum of 1 must be a Horizon member (2-4 voting members), Participating Physicians practicing in the appropriate specialties, as needed (non-voting members).

2. Accountability

- The member, provider acting on behalf of a member with the member’s consent, and/or duly authorized representative receives notice of a final determination and confirmation, in writing, within the timeframes provided for in the Member Appeals policy and procedure. The written notification documents the reasons for the decision and advises members on how they can file an external appeal, if applicable.
- Prospective, urgent medical appeals are reviewed by the Expedited Member Appeals Committee and communicated via telephone to the Appellant. Written confirmation will follow. The whole process does not exceed the timeframes set forth in the Member Medical Appeals policy and procedure.
- The Member Appeals Committee reports quarterly to the QIC.
- The Member Appeals Committee convenes at least once each year to evaluate and update its role, procedures and effectiveness. The Chairperson will forward a statistical summary on all written appeals filed, procedures used and dispositions handed down.
- The Member Appeals Committee complies with any state or federal regulations and/or requirements.
- The Committee chair or his/her designee appoints committee members to serve a one (1) year term of office. The members may be re-appointed annually. All prospective members are subject to approval by a majority vote of current members.

3. Frequency of Meetings

The member Appeals Committee meets at least once a month. Additional meetings will be scheduled as needed.

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Delegate and Vendor Oversight Committee

1. Function

The Delegate and Vendor Oversight Committee (DVOC) of the QIC is an interdisciplinary Committee that provides oversight of healthcare contracts and selected non-healthcare contracts. The Delegate and Vendor Oversight Committee reports quarterly to the QIC. The Committee’s voting membership consists of Manager, Delegate and Vendor Oversight (tie breaker), Horizon Medical Director III (1 voting member), Manager, Service (1 voting member), Director, Utilization Management Operations (1 voting member), Manager, Healthcare Management Finance (1 voting member), Manager, Healthcare Services (1 voting member), Manager, Pharmacy Management (1 voting member), Manager, Quality Management (1 voting member), Manager, Major Accounts (1 voting member), Manager, HCM Compliance (1 voting member), Director, Sourcing & Supplier Management (1 voting member), and Medicare Compliance (1 voting member).

2. Accountability

- The annual CQI work plan approved by the QIC may include action items assigned to the Delegate and Vendor Oversight Committee. The Committee is then responsible for the creation of a Committee work plan that will include the QIC assignments and other issues identified within the Committee. Updates to this plan are given to the QIC on a quarterly basis, as needed.
- The Committee is responsible for the annual review of policies that fall within its scope of responsibility.
- The Committee ensures that all new delegates have received a pre-delegation review.
- The Committee ensures that all delegates have agreements that comply with regulatory and accreditation standards and executed Business Associate Agreements, as applicable.
- The Committee reviews, makes recommendations and votes to approve or disapprove the annual program description and Continuous Quality Improvement plan from each Delegate for each delegated function and for vendors and providers as appropriate.
- The Committee reviews, makes recommendations and votes to approve or disapprove quarterly reports for each delegated function (i.e. Continuous Quality Improvement, Utilization Management, Case Management, Customer Service and Provider Credentialing activities) and for vendors and providers as appropriate.
- The Committee reviews annual on-site audits of the delegates’ clinical and administrative policy and procedures manuals, committee minutes, Quality Improvement studies and corrective action plans, operational results (claims, correspondence, complaints and customer service), and periodically participates in the delegate’s quality meetings.
- The Committee is the primary body charged with carrying out the Delegate and Vendor Oversight Policy. Recommendations, including corrective action plans made by the Committee, will be addressed by the Delegate and Vendor Oversight Department. In addition, the Committee is responsible for ensuring that all delegates comply with external accreditation standards, are compliant with State and Federal regulations, and meet contractual performance measures.
- The Committee reviews, makes recommendations and votes to approve or disapprove reports submitted by contracted Delegates, certain Vendors, and certain Ancillary Providers as defined in the Delegate and Vendor Oversight Policy.
- The Committee reviews, makes recommendations and votes to approve or disapprove quarterly reports of certain non-healthcare and healthcare vendors with whom Horizon contracts. The vendor oversight process will monitor vendor performance and compliance with contractual and regulatory requirements on an enterprise-wide basis. Supplier Management will monitor quarterly
reports submitted by internal contract owners to ensure all requirements are met and/or corrective action plans are established. Supplier Management will report vendor non-compliance to the Senior Vice President of the division responsible for the specific contract.

3. Frequency of Meetings

The Delegate and Vendor Oversight Committee meets quarterly throughout the year.

Credentials Committee

1. Function

The Credentials Committee is a Committee of the QIC established for the purpose of implementation and oversight of a program for credentialing, re-credentialing, certification, and/or re-certification of physicians, healthcare professionals, facilities, and ancillary providers who fall under the scope and authority of the Credentials Committee. The Credentials Committee is empowered by Horizon Healthcare Services, Inc.’s Board of Directors, Horizon Insurance Company’s Board of Directors and the Horizon Healthcare of New Jersey, Inc. Board of Directors and the Horizon Healthcare of New Jersey, Inc. Board of Directors, the Management of Horizon NJ Health and the QIC with decision making authority on matters pertaining to provider credentialing and re-credentialing. Voting members consist of the Executive Medical Director, Quality Management (tie breaker), Physicians and/or other healthcare professionals that are participating in the Horizon Managed Care and/or Horizon PPO Networks (up to 4 voting members), Medical Directors (3 voting members), Medical Director, Horizon NJ Health (1 voting member), Medical Director, Horizon Casualty Services (1 voting member), Medical Director, Magellan (1 voting member).

Consultant voting members of the Credentials Committee may be appointed, as necessary, to conduct the business of the Credentials Committee with regards to the credentialing and re-credentialing, certification and re-certification of specialist physicians, healthcare professionals and ancillary providers and facilities.

2. Accountability

A. The Credentials Committee reports to the QIC regarding credentialing and re-credentialing decisions which are made, and advises and makes recommendations to the QIC with respect to the following:
   - The establishment of criteria for participation in Horizon Managed Care, Horizon PPO, Horizon NJ Health and Horizon Casualty Services Networks (collectively “Networks”).
   - The establishment of guidelines for submission and review of initial and renewal applications for participation in the Networks.
   - The establishment and annual review of policies and procedures as may be appropriate for the Credentials Committee to carry out its purpose and function.
   - Monitoring of Credentialing and Re-credentialing compliance with accreditation and regulatory requirements.

B. The Credentials Committee establishes criteria and reviews and makes recommendations to the Chairperson, or his/her designee, with respect to the participation of providers in the Horizon Independent Medical Evaluation (IME) Panel.

C. The Credentials Committee engages in other activities designated by the QIC and/or as may be necessary for the Credentials Committee to carry out its responsibilities.
D. The Credentials Committee determines the eligibility of initial applicants and renewal applicants for participation in the Networks, and certification and/or re-certification as required by Horizon.

E. The Credentials Committee provides guidance to organization staff on the overall direction of the credentialing program.

F. The Credentials Committee evaluates and reports to organization management on the effectiveness of the credentialing program.

3. Frequency of Meetings

The Credentials Committee meets no less than ten (10) times per year, at least every 45 days.

Member Appeals Committee-Benefit Issues/Complaints Committee

1. Function

The role of the Member Appeals Committee-Benefit Issues Complaints (MAC-BIC) relates to the review of a Member appeal regarding a benefits based adverse benefit determination. The MAC-BIC is an interdisciplinary Committee that reviews unresolved benefit-related appeals received by Horizon. Committee composition consists of any combination of the following: Chairperson (attendance required/tie breaker), a Manager from Service Operations, a Provider Affairs or Provider Services Representative, a Medical Staff representative (Medical Director), and a Utilization Management Nurse Supervisor. The Committee may also contract with up to three (3) external consumer advocates.

2. Accountability

The MAC-BIC Committee hears benefit appeals per the procedures described in the Members/Covered Persons Inquiries, Complaints and Appeals Policy. The member/covered person or authorized representative receives a final determination following the MAC-BIC Committee meeting. The written notification documents the reason for the decision and advises members of their additional rights. If the above participated in the meeting via teleconference or in-person, they will be informed via telephone call of the decision. On a quarterly basis, summaries and activities of the Committee’s determinations are submitted to the QIC.

3. Frequency of Meetings

The MAC-BIC Committee meets at least once a month, with additional meetings scheduled as needed.

Pharmacy and Therapeutics Committee

1. Function

The Pharmacy and Therapeutics Committee (the "P&T Committee") of Horizon is a multidisciplinary committee of health care professionals that is charged with identifying opportunities for quality improvement and cost-effectiveness by reviewing therapeutic classes of drugs and new drug therapies, developing medical guidelines and a process to work with those practitioners licensed to prescribe in achieving quality appropriate prescribing patterns within the health plans underwritten or administered by Horizon. The P&T Committee also makes tiering decisions. There must be at least ten (10) voting members excluding the Chairperson and Co-Chair (tie breaker) including a practicing doctor of pharmacy. Of these members, at least two-thirds (2/3) of the P&T Committee shall be practicing physicians and pharmacists.
2. **Accountability**

- The P&T Committee objectively reviews the medical usefulness of all available pharmaceuticals for safety and effectiveness and provides input into drug utilization review activities and the analysis of adverse reactions of drug therapy. Cost analysis of the available pharmaceuticals must also be considered. In addition, when requested by Horizon, the P&T Committee will provide input on recommendations Horizon may make to the Horizon BCBSNJ physician networks regarding the appropriate use of pharmaceuticals, methods to measure the quality of drug prescribing and educational programs for Horizon members and providers.

- All actions of the P&T Committee are reported to the Quality Improvement Committee on a quarterly basis.

3. **Frequency of Meetings**

The P&T Committee holds quarterly meetings. Special meetings may be held if the chairperson determines it to be necessary and appropriate.

**Member Provider Service Satisfaction Committee**

1. **Function**

The Member Provider Service Satisfaction Committee (MPSSC) reports to the QIC and reviews, approves and oversees improvement activities that have an impact on provider and member services and satisfaction. The committee consists of at least 15, but not more than 20 members. The MPSSC reports quarterly to the QIC.

2. **Accountability**

   **A.** The Committee focus is oversight and direction of enterprise-wide improvement service initiatives. The Committee:

   - Monitors provider and member service quality data.
   - Identifies quality improvement opportunities
   - Conducts root cause analyses and barrier analyses.
   - Measures and analyzes results with respect to overall goals.
   - Develop service QI goals and activities.
   - Monitors ongoing QI activities for improvement and recommends revisions as necessary

   **B.** The Committee oversees collection, reporting and trending of member and provider service quality data including but not limited to the following:

   - NCQA, URAC and other accreditation information.
   - Focus is on HMO, POS/DA, PPO, Medicare Advantage and Horizon’s Exchange Products.
   - Member and provider contact volume.
   - Member and provider call Average Speed of Answer rates.
   - Member and provider call abandonment rates.
   - Member complaints and appeals volume, status and turnaround time.
   - Provider complaints and appeals volume, status and turnaround time.
2015 QUALITY IMPROVEMENT PROGRAM
DESCRIPTION

- Annual and on-going member and provider satisfaction data (CAHPS – Office Managers-Member Experience – First Call Resolution – Member Touchpoint Measures).
- Claims accuracy and timeliness

C. The Committee reviews all activities pertaining to member/provider service quality issues, except clinical care issues. A quarterly summary of actions, recommendations and process improvement activities are reviewed and approved.

D. The Committee reviews recommended activities and reports submitted and appoints appropriate staff or workgroup from:
   - Service Division
   - HealthCare Management
   - Market Business Units
   - Information Systems

E. The Committee ensures appropriate resources are assigned and accountable for approved and recommended activities.

F. The co-Chairpersons of the Committee appoint work teams to develop action plans and proposals related to specific issues.

G. The Committee annually oversees and approves all policies and procedures related to compliance with regulatory and accreditation requirements related to member’s Rights and Responsibilities and recommends changes as appropriate.

3. Frequency of Meetings

The MPSSC meets quarterly throughout the year.

Clinical Policy Committee

1. Function

The Committee identifies, prioritizes and develops medical policies for Horizon and its subsidiaries and affiliates. It provides medical expertise and experience in policy development. It assists in researching medical issues, obtaining specialty consultations and feedback from the medical community on policy issues. Also reviews and advises on the clinical content, validity and appropriateness of Medical and Pharmacy policies. Voting members consist of Medical Director III, Medical Policy or his/her designee (tie breaker voting member), Medical Director (2-4 voting members), Participating Providers (3-6 voting members), Medical Director of a Major/National Account (1 voting member), Director of Utilization Management-Review & Appeals (1 voting member), and Pharmacy Management-Clinical Pharmacist (1 voting member). The Clinical policy Committee (CPC) reports to the QIC.

2. Accountability

A. Review and advise on the content and quality of medical and pharmacy policies including but not limited to:
   - Evidence based data from clinical trials, studies and articles, published in peer-reviewed literature.
   - Accessibility to health care for members.
   - Utilization and medical necessity, indication or appropriateness of medical services.
• Provider and member education.

B. The Clinical Policy Committee shall also have the accountability for the following:

• To develop medical policies that reflect evidence-based best medical practice, promote high standard of quality care, promote efficient and appropriate use of resources, and minimize risk to our members.

• Evaluates emerging and new technologies.

• Identify services that result in improved clinical outcomes.

• Assist in the education of internal and external customers regarding medical policy.

3. Frequency of Meetings

The Clinical Policy Committee meets no less than ten (10) times per year.

**HHI Quality Advisory Committee**

1. Function

The HHI Quality Advisory Committee (QAC) is comprised of members representing various disciplines within Horizon Blue Cross Blue Shield of New Jersey, participating network physicians and other professionals whose diverse knowledge will provide clinical expertise representation from all specialties relating to the development of HHI value based initiatives and programs. The committee consists of Director, PCMH who serves as the Chair; Director – EOC who serves as the Vice-Chair; Director – Medical Leadership; Medical Director – Health Affairs; Medical Director – Medical Policy; Director – ACO Models; Director QM; Manager – QM (non-voting); Manager – Partner Contracting Outcomes and Relationship Specialists (non-voting); Partnership Outcomes and Relationship Specialists (non-voting); and two (2) external physicians.

2. Accountability

• Assesses and advises the organization’s value based metrics.

• Review and monitor quality performance of HHI partners including but not limited to recommending corrective action plans if appropriate

• Reporting all actions to Horizon’s Quality Improvement Committee following all QAC meetings.

• Forming a QAC sub-committee when necessary for the efficient functioning of the HHI QAC to meet project deadlines or as otherwise directed.

3. Frequency of Meetings

The HHI Quality Advisory Committee Team will meet on a quarterly basis, additional communications may occur as required.
IX. QUALITY IMPROVEMENT PROCESS

Detailed processes and methodology are used to determine the overall efficacy of performance improvement activities and programs. The monitoring of specific indicators is designed, measured and assessed by all appropriate departments, disciplines and services to reveal trends and performance improvement opportunities in an effort to improve organizational performance. These indicators are objective, measurable, based on current scientific knowledge and clinical experience, broadly recognized in the industry and are structured to produce statistically valid performance measures of care and services provided.

Methodology:

- Identification of important issues that reflect significant aspects of care and service.
- Selection and/or development of adequate metrics.
- Selection of goals and/or benchmarks for each measure/metric.
- Measurement, tracking and trending.
- Identification of opportunities for improvement based available data.
- Root cause analysis.
- Implementation of interventions or corrective actions referring to the identified opportunities for improvement.
- Re-measure to determine the effectiveness of the interventions based on statistical significant improvement and/or reaching a goal or benchmark.

X. DATA SOURCES

Horizon collects, stores, groups, analyzes and uses the following data in order to identify opportunities for improvement, and track and measure process, outcomes and overall effectiveness. These data sources include, but are not limited to:

- Annual HEDIS® reports
- Member Satisfaction Survey (CAHPS®)
- Member health status surveys (HOS®)
- Provider satisfaction surveys (Office Manager/Physician)
- Hospital acquired conditions
- Member and provider files
- Medical record review data
- Access and availability data (GeoAccess)
- Continuity and coordination of care processes and data
- Clinical and preventive guidelines
- Credentialing and re-credentialing data and files
- Marketing information
2015 QUALITY IMPROVEMENT PROGRAM
DESCRIPTION

- Member quality of care complaints
- Member complaints and appeals
- Provider complaints and appeals
- Chronic care program data and files
- Case management data and files
- Utilization management data and files
- Delegated entities’ performance data
- Internal audits of Quality Improvement processes data and reports
- Pharmacy utilization data
- Phone statistics (ASA, CAR)
- Employer satisfaction survey
- Concurrent review database
- 24/7 nurse line data and reports
- Online interactive tools/HRA data and reports
- Feedback from external regulatory and accrediting agencies
- Office site visits reports

All data is stored in Horizon’s electronic systems. Utilization and member/provider data is stored, updated and maintained in an Enterprise Data Warehouse that is backed up daily. Data resulting from surveys, interaction with members, mandatory reporting and specific analysis and monitoring are stored in independent databases supported by the enterprise IT Department which in turn ensures data confidentiality in compliance with HIPAA regulations.

Data accuracy is assessed through periodic audits such as medical record reviews for performance monitoring and reporting, sharing of performance data with providers and other internal audit processes.

Data collection, management and analysis is carried out by Horizon’s staff such as nurses, business analysts, reporting analysts and clinical auditors with the appropriate background and qualifications required by the task such as data management, computer programming, data analysis and clinical expertise.

A comprehensive data recovery process is in place to ensure continuity of business in the event of a major adverse event. All data is backed-up daily and stored in an outside location. A recovery site is located 40 miles from corporate headquarters in Newark where Horizon’s technology (telephone and computers) can be rerouted in the event of a major disruption of business. Horizon has a work-at-home policy and several locations which contribute to a fast restoration of services in the event of a major adverse event.

All data, documents, reports, materials, files and committee minutes are kept for a period of years (according to various regulatory, state and federal requirements), whether on site or achieved in a secured site. Horizon has a corporate policy “Records Management Policy” reviewed annually that clearly describes processes.

XI. PROCESS AND OUTCOME MEASURES

The following process and outcome measures are collected and reported with various frequencies from monthly to annually depending on the nature of the indicator as per what it measures and the availability of data.
These measures are collected, analyzed and reported by a team of professionals with knowledge in data management, analysis and clinical expertise. Benchmarks and/or goals are developed for all measures. For those publicly reported measures, national and regional benchmarks are utilized and then goals set based on differences between the plan’s performance and benchmarks. For internal developed measures or measures with no benchmarks available, goals are set based on plan’s trends and objectives.

Results are presented at various committees (see section VIII Organizational Structure) and shared with members and providers as appropriate via newsletter and the member and provider portal.

A. HEDIS®

Annually, Horizon participates in HEDIS® reporting for its Combined HMO/POS/DA, PPO, and Medicare Advantage products. Data is collected, analyzed, evaluated, and compared to regional and national benchmarks. Based on the results and comparison against national benchmarks, Horizon, through the Health Outcomes Work Group is able to recognize areas of strength as well as identify opportunities for quality improvement.

HEDIS® (Healthcare Effectiveness Data & Information Set) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. The performance measures in HEDIS® are related to many significant public health issues such as cancer, heart disease, smoking, asthma and diabetes. HEDIS® is sponsored, supported and maintained by the National Committee for Quality Assurance (NCQA).

Horizon’s staff collects, consolidates and reports HEDIS hybrid and administrative rates. It contracts with an NCQA certified software vendor, GDIT (General Dynamics Information Technology to report HEDIS data through the use of their MedMeasures tool. Relevant data are extracted by experienced trained nurses using VIPS’ MedCapture data collection tool. Using GDIT’s tools (MedCapture), all HEDIS measures are reported.

Upon completion of all relevant chart audits, MedCapture has measure-specific logic to automatically consolidate data from multiple chart reviews and administrative data to determine a member’s compliance to a measure or whether the member should be excluded from the denominator.

To ensure Structure and Process measures are accurately reported, data files and documentation are reviewed by an NCQA certified auditor. The Quality Management team then reviews and finalizes survey tool prior to submission to NCQA.

HEDIS rates are then calculated and reported via the IDSS (Interactive Data Survey System) to NCQA and/or CMS. In addition, Medicare Advantage member level data is uploaded and sent to CMS.

B. CAHPS®

CAHPS® (Consumer Assessment of Healthcare Providers and Systems) is a member satisfaction survey as well as a major component of HEDIS®. The CAHPS® survey is a measurement tool, used for all products which ask members to report and evaluate their experiences with health care in areas of customer service, access to care, claims processing and provider interactions. The products for CAHPS® surveys are grouped as HMO/POS, PPO, and Medicare Advantage. The Direct Access product is considered a POS product and is included in one sample under the HMO/POS. The survey is conducted by an NCQA and CMS certified vendor.

C. HOS®

HOS® (Health Outcomes Survey) is a member health status survey collected by a CMS certified survey vendor annually for the Medicare Advantage members. A random sample of 1200 (or maximum
available) Medicare members is drawn by product and surveyed each spring. The survey is administered to a different baseline cohort each year and then two years later, the same cohort is surveyed again.

Based on performance comparison with national performance and changes over 2 years, areas for improvement are selected, prioritized as per severity, ease to change and available interventions by the Quality Management Department.

D. MEDICARE STAR PROGRAM

As part of the Medicare Advantage program Horizon participates in the Medicare Star program. The Star program was initiated by CMS to determine Quality Bonus Payments (QBP) for high performing plans, to assist in identifying poor performing plans for compliance actions and to provide Medicare beneficiaries information they may consider when choosing a plan. Annually Horizon submits HEDIS data (Effectiveness of Care Measures, and CAHPS) to CMS on the Medicare Advantage membership. Specific measures from the Health Outcomes Survey are also utilized to measure plans.

In addition CMS evaluates plans against specific CMS developed measures, related to operations, complaint, appeals, call center performance and medication adherence.

There are approximately 48 measures divided into 2 areas; Part C related to clinical and administrative issues and Part D, pharmacy. The measures are divided into 5 Domains:

1. Staying Healthy: Screening Tests and Vaccines
2. Managing Chronic (Long Term) Conditions
3. Rating of Plan Responsiveness and Care
4. Member Complaints, Problems Getting Services and Choosing to Leave the Plan
5. Health Plan Customer Service

Data is collected and submitted to CMS annually and results are released fourth quarter. Star measure results are monitored and compared to goals and benchmarks on an ongoing basis throughout the year to measure program performance and identify areas for quality improvement projects.

E. OTHER PROCESS/OUTCOME MEASURES

Examples of other measures that would be utilized to assess effectiveness of the quality of care and services provided to Horizon members include the following:

- Percent completion of Medicare Health Risk Assessments (total number of completed HRA/total number of new members)
- Member satisfaction with Chronic Care Program
- Percent of referred members engaged in any form of behavioral health treatment
- Percent of members with Depression that showed improvement in the Patient Depression Questionnaire-9.
- ALOS
- Readmission rate 30 and 60 days
2015 QUALITY IMPROVEMENT PROGRAM
DESCRIPTION

- ER/1,000 members
- Admits/1,000 members
- Average number of primary and specialty visits per member per year
- Percent of Medicare Advantage members included in the Medication Treatment Management Program
- Drug treatment adherence (percent of members refilling specific prescriptions)
- ASA/Call abandonment rate for Customer Service phone unit
- Timeliness of member appeals
- Percent member appeals upheld

XII. QUALITY IMPROVEMENT PROGRAM COMPONENTS

The following are brief descriptions of the various components of the Quality Improvement Program. For a full description of the programmatic elements as well as to which lines of Horizon’s business they apply, see the relevant administrative policies relating to that function.

A. Preventive Health and Wellness

The goal of Horizon’s preventive health and wellness activities is to improve the quality of health by encouraging members to pursue healthy lifestyles and maintain optimal wellness. A key component of this is to help assure that the members/covered persons obtain needed immunizations and screening tests. Educating Horizon members on preventive health care can result in the reduction of illness, disease and accidents and promote the early detection of potential illnesses. The plan uses a variety of reminder techniques for this purpose such as automated reminder telephone calls, health risk appraisals and interactive tools through the member portal, newsletters targeted to a specific populations, mailings, and preventive health calendars. The aim is to reach members in a manner to which they can easily relate.

Horizon’s Preventive Health Program is based on preventive health care guidelines that are developed and maintained by Horizon. These guidelines were adopted from nationally known organizations such as the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the American Academy of Family Physicians, the Agency for Health Care Policy and Research, American Cancer Society and the American Diabetes Association. The guidelines are age, gender, and risk-status specific that describe the prevention or early detection interventions recommended along with frequency and conditions under which the interventions are required. Areas targeted through preventive health activities include childhood and adult immunizations, women’s health needs, nutrition, high blood pressure, smoking cessation, and depression.

Internal users who utilize Clinical Practice Guidelines (CPG’s) access information through the Lotus Notes database. Horizon distributes the preventive health guidelines and any updates to participating physicians and members via newsletters. Providers can also access information via the provider portal.

B. Care Management

Care Management consists of Chronic Care (CC) and Case Management (CM) programs.

1. Chronic Care Program
Horizon’s Chronic Care Programs promote the well-being of members by empowering them to actively participate and take responsibility for their own chronic disease health care needs through the provision of education, counseling, coaching, and access to quality health care. The programs seek to enable members and caregivers to make independent, informed health care decisions that result in an optimal, realistic level of wellness and functionality. There are currently six (6) chronic care programs offered by Horizon.

- Diabetes
- Asthma
- Coronary Artery Disease (CAD)
- Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Kidney Disease (CKD)

Through the promotion of education, support and positive reinforcement, Horizon encourages member adherence to provider recommended treatment regimes, thereby improving one’s quality of life and preventing unnecessary complications resulting in hospitalization. By means of Horizon’s comprehensive Chronic Care Programs, the following goals can be achieved:

- To educate members and providers on health management based on nationally recognized standards of care.
- To promote an optimal, realistic level of wellness and functionality for our members.
- To promote behavior modification and facilitate member and provider communication.
- To assure the patient, family and providers appropriate coordination of health care services and benefits.
- To achieve cost-effective utilization of financial and human resources.
- To enable the patient/family to make independent, informed health decisions.
- To provide prevention and wellness education programs that will improve the quality of health for our members.
- To reduce the cost of care by reducing inpatient admissions and emergency room visits.
- To improve overall member and provider satisfaction with Horizon Blue Cross Blue Shield of New Jersey.
- To optimize care coordination.
- To identify needs that follow an acute care episode and assist with interventions for long term health problems.

### a. Behavioral Health (BH) Integrated Programs

The mission of the Horizon Blue Cross Blue Shield of New Jersey Chronic Care Program is to promote the well-being of our members by empowering them with the tools they need to better manage their disease and lead a better quality of life. The BH Integrated Program provides members with education about behavioral health conditions such as but not limited to depression, anxiety, alcohol and other substance abuse, eating disorders, schizophrenia, and bipolar disorder. The program encourages the member to actively participate and take responsibility for his/her own health. Through the provision of education, support and motivation, we encourage member adherence to provider recommended treatment regimens, thereby improving member quality of life and preventing
unnecessary complications. Horizon Blue Cross Blue Shield of New Jersey supports and partners with the interdisciplinary health team and employers to ensure access to high quality, cost effective behavioral health management programs.

The BH Integrated Programs include the following goals:

- Providing Behavioral Health coaching or consultation for members that are identified at risk or with diagnosis of depression, anxiety, bipolar, schizophrenia, alcohol abuse or dependence, other substance abuse or dependence, eating disorders. Also identifying members with chronic medical conditions with symptoms that complicate adherence to prescribed treatment plan and self-management of their conditions.
- Assisting members with outpatient behavioral health referrals by linking them to network providers.
- Transitioning members that are in medical inpatient units to behavioral health services as appropriate.
- Assisting members with primary or secondary diagnosis of substance abuse or dependence with appointments within 14 days of diagnosis, establishing initiation of treatment and two (2) subsequent appointments (HEDIS Substance Abuse Treatment Initiation and Engagement).
- Providing a Pediatric Behavioral Health specialist to assist with treatment collaboration for members with ADHD.
- Improving community tenure, functioning and treatment compliance for members with behavioral health issue through intensive case management (ICM).
- Decreasing excessive use of the ER for behavioral health reasons through proactive identification and providing assistance with referrals to specialty programs, appropriate authorizations and community resources.
- Improving communications between primary care providers and behavioral health providers.
- Providing education and support for families of children with autism spectrum disorders, including referrals to community resources, helping build self-management skills, and facilitating ongoing coordination of care.
- Collaborating with Pharmacy Psychotropic Drug Management Screening high risk members enrolled in all chronic care programs for complications associated with depression and substance abuse.
- Performing diagnostic assessment of symptoms to determine the severity of the conditions (Patient Health Questionnaire).
- Providing all enrolled members with education about behavioral health conditions.
- Assisting members with depression and other behavioral health conditions to overcome barriers to treatment.
- Focus on behavioral health conditions as barrier to adherence with self-management.
- Monitoring the member’s condition through assessment of treatment response.
- Collaborating with the member’s consent, routinely with the PCP and behavioral health specialist as needed.
- Providing a concurrent disease prevention and wellness education program that will improve the quality of health for our members with behavioral health conditions.
- Identifying and promoting an optimal, realistic level of an individual’s wellness and functionality.
• Improving overall member and provider satisfaction with Horizon Blue Cross Blue Shield of New Jersey.

• Identifying needs following an acute care episode and assisting with interventions for long term health problems.

• Provide support to Horizon PCPs and pediatricians to improve the identification, evaluation and treatment of behavioral health conditions such as depression, anxiety and bipolar disorders. PCPs are afforded access to telephonic consultations with a behavioral health medical director (psychiatrist) to consult on psychotropic medication management and appropriateness of their Horizon member’s current behavioral treatment plan.

Offerings vary by line of business.

1.1 Operations
The Chronic Care Program services are primarily telephonic, with on-site services provided at the discretion of the Chronic Care program management team. The team includes Registered Nurses, Registered Dieticians, Managed Care Coordinators and Medical Directors. The Chronic Care Program is an “opt-out” program and participation is voluntary.

1.2 Member Identification
Members are identified for participation from the following sources:

- Horizon’s own clinical identification algorithms based on medical, laboratory and pharmacy claims data.

- Health Risk Assessment survey

- Member self/ caregiver/ Practitioner referral

- Hospital discharge data

- 24/7 Nurse line referral

- Internal Horizon referral

- Facility Case Managers

- Employer Group referrals

1.3 Member Interventions
The methods of interventions include: educational mailings, telephonic educational coaching, assessing member readiness to change, assisting the member understands treatment options, appropriate use of medications, appropriate nutrition, avoid disease exacerbations, better communication with his/her physician, and connecting members with community resources.

1.4 Provider Interventions
The Chronic Care Program staff is dedicated to supporting the treating physician’s efforts to improve health status and interact with the physician on behalf of the member by informing them of the member’s participation in the program through phone, mail, e-mail and or fax including the member’s decision to opt out of the program or when the member denies the disease. The CM/CS will involve the provider in determining mutually agreed upon goals for the members enrolled in the program and to request clinical metrics to support any identified gaps in care for the member. Participating physicians are encouraged to use the physician-restricted online portal of Horizon BCBSNJ’s website that provides them access to Clinical Practice Guidelines that are developed based on national standards of care and also provides information about the Chronic Care Program as well as resources for their members.
1.5 Outcomes

Clinical outcomes metrics may include but are not limited to objective clinical findings such as lab results, immunization rates, and prescription filling/use of disease-specific medications. Clinical outcome metrics are specific to each Chronic Care Program and are measured quarterly and annually using medical, pharmacy claims, HEDIS and assessment collected data.

An annual assessment of the program is conducted, including a review of all clinical and operational metrics including member satisfaction and provider feedback. Feedback on the program including need for program revisions or new/revised clinical practice guidelines is evaluated. Improvement areas are identified and actions are developed. Ongoing monitoring is conducted quarterly/biannually and plans are reviewed for improvement or revision.

2. Case Management

Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet a member’s medical and psychological needs. Its primary focus is the coordination of appropriate quality health care in the most cost-effective manner for members with complex medical conditions. The intensity of case management activities varies based on a multitude of factors including, but not limited to:

- Clinical features of the individual case as reported by a member or attending/treating provider.
- Evaluation/treatment setting resources available.
- The member’s clinical needs and situation; and
- The opportunity for case management intervention to modify the situation.

Case Management activities and the result of these activities are summarized and reported to the Medical Management Committee.

The objectives of the Case Management Program are as follows:

- To assure timely patient access to the appropriate type and level of care as early as possible.
- To manage health care benefits as effectively as possible.
- To identify needs that allow an acute care episode and assist with interventions for long-term health problems.
- To identify members who may benefit from educational programs, materials and other services that can be offered, including community services.
- To identify members who might benefit from participation in Chronic Care programs, if eligible under their contracts.
- To achieve optimum cost efficiency while assuring quality of care.

C. Medical Management

The Medical Management (MM) Program evaluates clinical necessity, access, appropriateness, and efficiency of services including, but are not limited to the following programmatic components: prior authorization, concurrent review, discharge planning and retrospective review. The MM Program also generally seeks to coordinate, when possible, emergent, urgent and elective health care services. The MM Program evaluates overall utilization such as ER, admission and readmission rates, coordination of services, over and underutilization, and evaluation of new technology. In addition, oversees all Medical Managed delegated functions. Refer to Medical Management (MM) Program Description for more detailed information.
D. **Pharmaceutical Management**

The purpose of the Pharmacy Utilization Management Program is to identify different patterns of medication utilization and identify variables in treatment patterns for different disease states. The goal of this program is to improve patient outcomes and to utilize various interventions, including physician and member education, to ensure medically appropriate cost-effective prescription drug therapy. The pharmacy department implements educational interventions designed to improve clinical outcomes, optimize patient compliance, and maximize safety.

An integral part of the process is constituted by the Medication Therapy Management program (MTM) with targeted interventions focusing mainly on safety for Medicare Part D members with pharmacy services. This program focuses, for example, on duplicate therapy, drug interactions, gaps in therapy, and adherence to therapy. The interventions can vary from individual outreach to providers, pharmacies and members. The Pharmacy Services, Medication Therapy Management program offers Spanish language materials for those Spanish-speaking Medicare members. Comprehensive Medication Review telephonic counseling is available in any language through translation services. A Health Literacy Consultant is also contracted to review all member materials distributed to ensure the messages conveyed to members are clear and understandable. There is a Motivational Interviewing Training session for pharmacy staff to understand how to effectively communicate with members.

Goals of the Pharmacy Utilization Management Program are as follows:

- To assure that adequate and appropriate resources are available to provide accessible health care services.
- To design interventions that improve clinical outcomes, optimize patient compliance, and maximize safety.
- To provide pertinent education to members, physicians and healthcare professionals.
- To identify medication utilization issues.
- To identify patterns of inappropriate prescribing based on recommended prescribing guidelines.
- To evaluate the impact of interventions.
- To augment the drug selection process for formulary inclusion.
- To further integrate Pharmacy Utilization Management activities with Medical Utilization Management and Quality Improvement processes.
- To audit retail pharmacies and the pharmacy benefit manager to ensure appropriate utilization and reporting.
- To review quarterly utilization reports to monitor drug use patterns.
- To perform outcomes research based on pharmacy, medical and laboratory data.

E. **Credentialing and Re-credentialing**

A significant part of Horizon’s Quality Improvement Program is the appropriate and regular credentialing of providers. The Credentials Committee establishes standards for identifying competent physicians and other providers in accordance with regulatory requirements and accreditation standards. The Committee uses the standards to determine eligibility for participation in one or more of Horizon’s networks. The goal is to develop a network of participating physicians and providers that demonstrates Horizon’s commitment to continuously improve the quality of health care delivered to its members.

All physicians and providers participating with the health plan must submit their qualifications for review and approval by the Credentials Committee. Qualifications for physicians include, but may not be limited to, current licensure, education and training, board certification, hospital/facility privileges, and malpractice history.
Re-credentialing is performed on every network physician (excluding those to whom credentialing is not applicable per the Credentialing and Re-credentialing policy) and provider every three years. To ensure the quality and safety of care between credentialing cycles, the program performs continuous monitoring for sanctions, limitations on licensure, potential quality of care issues including member complaints and compliance with Horizon’s performance standards, such issues are brought to the Credentials Committee, which takes action as warranted.

F. Network Management

Network Management focuses on exploring and implementing opportunities to improve member access to care and services. Data is continuously gathered and analyzed throughout the Horizon organization to ensure that our Network(s) meet these needs and is able to deliver quality healthcare to our members.

Some examples of analysis include but are not limited to the following: Our Blue Physician Recognition Program, which is designed to identify and recognize the highest quality participating physicians for their contribution in delivering quality care to our members. This program rewards certain physicians through acknowledgement as well as an enhanced fee schedule on an annual basis. Horizon also conducts quarterly geo-access reporting that identifies any potential network deficiencies that we would need to recruit into our network(s). We also conduct an appointment availability analysis to ensure that members have access to needed providers and that they are getting desired appointments within the required timeframes.

G. Customer Service

Horizon Member Services seeks to establish and maintain effective communication with members in order to deliver the highest level of care and service. Member satisfaction is evaluated from data which includes phone performance, member complaint handling, and member/provider satisfaction surveys (CAHPS and other internally developed surveys). Survey data is reviewed monthly, and continuous process improvements are developed to optimize service levels in areas such as first call resolution, Average Speed of Answer, information accuracy and content of written materials (health literacy).

Member satisfaction, complaint and appeal information are used to identify opportunities for improvement, review root cause / "end to end" processes and develop action plans as warranted.

H. Delegate Oversight

The Delegate and Vendor Oversight Department performs the formal process by which Horizon monitors, directs, and evaluates a set of activities by contractors who are responsible for the performance and/or implementation of any of Horizon’s quality improvement activities. Horizon maintains oversight responsibility of delegated activities and retains the right to modify or withdraw the nature of the contractual relationship, including the termination of the contract and/or the delegation of activities as specified in the relevant contract or delegation agreement.

The Delegate and Vendor Oversight Committee also seeks to ensure that the vendor or delegate’s activities adhere to regulatory and accreditation standards and/or meets performance goals as required in the relevant contract or delegation agreement. In the event of not meeting performance goals, the committee requires improvement and monitors corrective action plans.

I. Patient Safety

Horizon has a dedicated commitment to patient safety; it is of the utmost importance to Horizon and its membership. Promoting patient safety encompasses a wide range of activities in the Quality Improvement domain:
2015 QUALITY IMPROVEMENT PROGRAM

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- Drug-Drug Interaction Reject (DDIR) Program to identify potential serious drug interactions.
- Reducing prescribing errors by encouraging and supporting e-prescribing.
- Retrospective analysis and evaluation of clinical data through Drug Utilization Reviews (DUR) Program.
- Identification of potential drug-drug interactions through Point of Service edits.
- Daily identification of members who have filled medications with a potential drug-drug interaction to intervene within 24 hours of being dispensed.
- Prior Authorization Program for certain prescription drugs that require Horizon’s prior authorization before the drug can be dispensed.
- The Medication Therapy Management (MTM) program implements targeted interventions focusing mainly on safety for Medicare Part D beneficiaries with pharmacy services.
- Providing members information on “questions to ask when you visit your doctor” and how to be safe at home in particular for Medicare members.
- Dose Optimization Program to encourage the use of higher strengths once a day and to discourage the use of lower strengths that require multiple dosing. This will improve the likelihood of patient compliance.
- Drug Recalls, Black Box Warnings and Safety Alerts. When a drug is withdrawn / recalled from the market or when a drug has a new black box warning, Horizon’s Pharmacy Benefit Manager on behalf of Horizon BCBSNJ Pharmacy Services, will notify participating providers and affected members.
- Duplicate Therapy: Members who are receiving duplicate medication therapy regimens are identified and the prescribing physicians are notified through intervention letters.
- Narcotic Management Program, to reduce inappropriate prescribing and utilization through case based reviews.
- Horizon BCBSNJ maintains a website with available patient safety brochures, drug to drug interaction tool and a drug database that informs members regarding drug therapy, how to take drugs, potential side effects, etc.
- Pharmacy related topics are published in the member and provider newsletters on various drug information including drug interactions alerts, herbal medications, drug recalls, etc.
- Gaps in Care Program promote appropriate drug therapy and improve quality of life for our members through avoidance of medical complications and slowing disease progression.
- The use of HEDIS and Medicare Stars results to identify areas for improvement and to ensure that our members are continuously receiving safe and appropriate care particularly with regards to Diabetes treatment, Rheumatoid Arthritis, Adherence and High Risk Medications.
- Maintaining a safety conscious provider network through diligent credentialing.
- Preparing and distributing a hospital report card and providing incentives to Leapfrog participating high performing hospitals. Peer review of suspected instances of substandard quality health care delivery.
- Monitoring continuity of care across treatment sites and between medical and behavioral health.
• Monitoring adherence to clinical practice guidelines at the provider level.
• Supporting hospitals in the implementation of hospital acquired infections control

J. Behavioral Health

Horizon works collaboratively with its delegated Managed Behavioral Health Organization to monitor and improve the quality of behavioral health care delivered to its members. Such delegated functions are overseen by Horizon’s Delegate Vendor Oversight and Medical Management Committees. The quality improvement process begins with the development of an annual work plan, which includes core performance indicators, monitoring and intervention activities designed to improve the safety of members’ quality of care and services, and coordination of care. Work plan goals are evaluated annually with achievements and opportunities for improvement specified in the behavioral health organization’s annual program evaluation.

The Behavioral Health Organization manages mental health/substance abuse services in a variety of settings delivered by providers from several disciplines. Behavioral health activities are based on the goals and objectives outlined in the organization’s annual program description and work plan.

The behavioral health organization has guidelines for density and geographic distribution of its providers, based on the membership and distribution of the covered populations.

K. Education and Training

A team of nurses from the Outcomes and Performance Management department within Quality Management, with experience in the development of education modules and training is in charge of developing all education materials to be delivered in either a classroom format or via WebEx. Education is related to the process of care management, health literacy and cultural competency, accreditation, and quality reporting. Training is conducted for new employees and education is carried out across Health Affairs. All courses are reviewed annually to ensure current information is available. All education modules include a post test to assess the degree of learning.

L. Cultural Competency

New Jersey is a diverse state and so is the membership at Horizon Blue Cross Blue Shield of New Jersey. Horizon collaborates with numerous institutions, community centers, hospitals and practitioners implementing programs to decrease health care disparities, training staff on cultural competency and developing programs on health literacy. The Horizon Foundation, through the yearly award of grants, helps to demonstrate our compassion, social responsibility and commitment to New Jersey.

As part of the on-boarding for all new Horizon employees, cultural diversity, cultural competency and health literacy are key components of the mandatory curriculum.

Members speaking a language other than English have access to the AT&T language line whenever they need to interact with Horizon, and they can look for a provider speaking their language in the provider directory. In a state in which approximately 18 percent of residents are of Hispanic descent, Horizon Blue Cross Blue Shield of New Jersey has a bilingual service initiative and website dedicated to reaching out to Spanish-speaking members.

The initiative, “Tu Seguro Azul” (Your Blue Insurance), features a dedicated customer toll-free number and website (www.HorizonAzul.com), available in both Spanish and English, to help Spanish-speaking members with Individual and Small Group policies manage their benefits, find network physicians and providers, and access relevant health information for the Hispanic community.
All members and those specifically enrolled in Case Management and Care Management Programs have translation services and materials available in Spanish, which is the predominant non-English language among Horizon’s members.

Individual areas of the company are addressing the issue of health literacy, and in particular the Pharmacy Division is working with the Medicare population.

The Health Literacy work team goals include:

- Catalog all literacy-related activities in the organization.
- Share information about literacy activities throughout the company.
- Improve employee understanding on how their health plans work and apply it during customer communication.
- Agree on a scope document.
- Coordinate all literacy activities.
- Have governance over activity.

M. Horizon Healthcare Innovations (HHI)

HHI is a division of Horizon Blue Cross Blue Shield of New Jersey HBCBSNJ with the following goals:

- To improve the quality and health of the population.
- To achieve a sustainable trajectory in health care spend, and approximating the Consumer Index.
- To establish a more positive and collaborative provider relationships.

To establish goals, HHI aligned to focus on five major areas:

- Redefining care delivery and health management.
- Creating accountable consumers and purchasers.
- Building information exchange and clinical quality standards.
- Catalyzing care delivery system alignment and regulatory support.
- Building support among community stakeholders.

HHI Models

- Patient-Centered Medical Homes (PCMH) - A designated provider assumes responsibility for managing a comprehensive care plan for patients and coordinates care across providers. Registered Nurse Population Care Coordinators work within the primary care medical offices.
  - The goal is to provide active management of chronic and complex conditions to optimize treatment plan, drive care coordination and ensure patient compliance.

- Episodes of Care - An acute care model where participating providers lead patient care across the entire episode. In return, they accept a risk-adjusted bundled payment for procedure or medical event. They collaborate on improving quality while reducing costs.
The goal is to improve clinical outcomes and the patient experience, enable more informed choices by both customers and physicians, reducing wasteful spend, thereby improving the total cost of care for a particular episode.

- Accountable Care Organizations (ACO) - An organization of health care providers agrees to assume joint accountability for a patient’s entire care.
  
  - The goal is to achieve measured quality improvement and increase affordability for the provider’s patient population.

XIII. QUALITY IMPROVEMENT PROJECTS

Annually, a Quality Improvement Project for the Medicare Advantage population is identified, developed, implemented, monitored and reported to CMS.

Quality improvement projects are selected based on a set of criteria: prevalence in the population, severity of complications/consequences, high hospitalization/cost, member complaints, satisfaction issues, and ease of inflicting change.

Member selection for participation is based on administrative data (claims/encounters, lab and pharmacy) or it would include the whole population or a particular geographic area.

Outcome measures selected are easy to obtain, reliable and consistent. Preferably existing nationally recognized indicators with available national/regional benchmarks are utilized.

Measurement cycles are quarterly or at least annually. Goals are re-assessed once attained and timeliness of interventions is closely monitored in order to clearly evaluate effectiveness. Statistical analyses are utilized when applicable.

Interventions are based on direct member communication, coordination of care with treating practitioners or discharge planning, practitioner communication, practitioner reward, system improvements.

XIV. RESOURCES

Resources available to the Program that contribute to the Quality Improvement function include various Horizon departments, including Quality Management, Medical Management (Utilization Management, Case Management and Care Management Programs), Marketing, Service, Communications, Operations, Information Systems, Credentialing, Service Quality, Pharmacy and Network Management. Organizational charts provide a more comprehensive description of the resources available within each department.

Roles and Responsibility-Individual

President and CEO

The President and CEO is responsible for the overall operations of the Quality Improvement Program.

Chief Medical Officer (CMO)

The Chief Medical Officer reports to the Executive VP of Healthcare Management, chairs the Quality Committee of the Board and is responsible for design and implementation of the Quality Improvement Program. He/she ensures that quality activities are prioritized based on membership needs and integrates the Medical Management and Credentialing programs with the Quality Improvement Program.
Vice President and Chief Pharmacy Officer

The Chief Pharmacy Officer plans and directs pharmacy benefit management activity, including specialty pharmacy management. This includes oversight of the P&T Committee, clinical development activity, utilization and quality management and medication safety, benefit administration, operations, sales and marketing support and business development. The Chief Pharmacy Officer is responsible for the contracted PBM. Performance measurement is managed in conjunction with the Delegate and Vendor Oversight Committee which is part of the Quality structure and reports to the Quality Improvement Committee.

Executive Medical Director for Quality Management

The Executive Medical Director is the designated physician with substantial involvement in the Quality Improvement Program. The Executive Medical Director chairs the Quality Improvement Committee, the Quality Case Review Committee the P&T Committee and the Credentials Committee. His/her roles include, overseeing the implementation of the QI program that involve or affect clinical care, patient safety, and the overall development and evaluation of the QI program.

Medical Directors

The Medical Directors are responsible for conducting peer and utilization management review, and may be delegated to chair various committees.

Behavioral Healthcare Medical Director

The Behavioral Health Services Board of Directors has designated the National Quality Council and its Committees to provide corporate oversight of the QI program. The Medical Director of QI and Compliance is the designated behavioral health care practitioner who is actively involved in the behavioral health care aspects of the QI program. Some of his/her activities include coordination of the development of the Quality Improvement Program Description, Quality Work Plan, mid-year Quality Work Plan Update, and annual QI Program Evaluation. The Medical Director is responsible for the coordination of quality improvement activities, QIC minutes, agenda, data reporting, analysis, implementation and review of the behavioral health safety program and adherence to corporate compliance policies and procedures.

Quality Management Director

The Quality Management Director plans and directs the quality improvement activities. The Director, in conjunction with the Delegate and Vendor Oversight Committee, oversees the delegates' compliance with the quality improvement program. The director oversees initiatives related to all quality improvement programs as well as the provider quality improvement process including provider credentialing. The Director oversees the development of an annual quality improvement work plan and is responsible for the annual quality improvement program evaluation. He/she reviews and revises the Quality Improvement Program Description annually, and is a member of the Quality Improvement Committee, Medical Management Committee, Member Provider Service Satisfaction Committee, Credentials Committee, and the Delegate and Vendor Oversight Committee.

Team Quality Managers

The Team Quality Managers who oversee the day-to-day operations of the Quality Improvement programs. Specifically they manage medical record reviews, clinical quality complaints, HEDIS® training and quality audits, and accreditation.
XV. ANNUAL QI WORKPLAN & EVALUATION

An annual Quality Improvement (QI) Work Plan is developed and approved by QIC. The purpose of the QI Work Plan is to focus on the specific activities that Horizon will undertake to meet established goals planned for the year. The annual work plan includes time frames for monitoring and completing quality improvement activities, clearly defined and measurable objectives for the year, individuals responsible for those activities’ time frames for monitoring and completing each activity, and serves as an action plan for previously identified issues. The Quality Improvement Committee annually presents an evaluation of the QI Work Plan and the Quality Improvement Program to the Quality Committee of the Board, and in turn to the Board of Directors of Horizon Healthcare Services, Inc., Horizon Insurance Company and Horizon Healthcare of NJ, Inc. Updates to the work plan are presented quarterly or as needed, based on the effectiveness of the program and the ability to reach established goals and objectives, membership demographics and utilization experience. The QI work plan allows tracking of activities over the calendar year.

The program evaluation includes information about the following:

- Review of progress and status of annual goals.
- Monitoring of previously identified issues.
- Evaluation of the effectiveness of each quality improvement activity.
- Review of trends of clinical and service quality indicators.
- Evaluation of the improvements occurring as a result of quality improvement efforts.
- Evaluation of the overall effectiveness of the Quality Improvement Program.
- Evaluation of adequacy of staff resources.
- Evaluation of program structure and processes.
- Goals and recommendations for the work plan for the following year.

Policies and procedures supporting the Quality Improvement Program are reviewed and approved annually by the appropriate committee and updated as needed. Based on the annual program evaluation, the prior year’s QI Work Plan is revised, and a new QI Work Plan for the coming year is developed to guide and focus the work for the next year.

XVI. CONFIDENTIALITY

Horizon is committed to ensuring that its practices regarding the privacy and security of Private Information comply with industry norms and as applicable, all federal and state laws and regulations including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) standards for privacy of individually identifiable health information. Consequently, Horizon is committed to maintaining privacy policies, administrative structure, reporting procedures, due diligence procedures, training programs and other methodologies of an effective compliance program relative to the use and disclosure of its members’ private information.

Horizon has in place appropriate administrative, technical and physical safeguards to protect the privacy of its Members’ Private Information and to reasonably attempt to prevent any intentional or unintentional Use or Disclosure of Private Information in violation of Horizon’s privacy policies and procedures or other applicable state or federal law. Safeguards may include but are not limited to:

- Shredding documents containing Private Information prior to disposal.
- Locking cabinets, drawers and rooms that house Private Information, especially member medical information.
Limiting which personnel is authorized to have keys or pass-codes to locked areas containing Private Information, as well as which have access to all forms of Private Information based on the roles and functions said personnel perform for Horizon.

All Users who gain access to Information Assets shall be uniquely identified and properly authenticated.

Placing computers in areas not accessible to the general public or in high-traffic areas; shielding computer screens so that information is not viewable by others who are near the computer; encouraging the use of secure passwords for systems access to information.

Making certain that computers are turned off at night, at lunch or during other times of prolonged nonuse; making certain that Private Information that is used off site is subject to procedures for safeguarding that information.

Using secured methods of electronically transmitting Private Information such as data encryption.

In addition, all new and existing employees, other persons on Horizon’s Workforce, and others, as determined by Horizon, will be trained as to Horizon’s privacy policies and procedures and applicable state and federal privacy law in accordance with Horizon’s Employee Training on information Privacy Policy.

All privacy policies and procedures are maintained and updated at least bi-annually by Horizon’s Privacy Officer and available to all employees through the employee portal.

References:
NCQA – Current Standards and Guidelines for the Accreditation of Health Plans
URAC – Current Core Standards