

Horizon Healthcare Services, Inc.
Horizon Blue Cross Blue Shield of
New Jersey
Government Programs

2019 Quality Improvement
Program Description

- 1. Purpose of the Quality Improvement (QI) Program 4**
- 2. Program Scope 4**
- 3. QI Program Objectives/Goals 7**
 - 3.1 Program Evaluation 7**
- 4. Structure of the QI Program 8**
 - 4.1 Governing Body 8**
 - 4.2 Committees 9**
 - 4.3 Inclusion of Participating Providers in the QI Program13**
 - 4.4 GPOrganizational Chart13**
 - 4.5 QI Program’s Resources13**
 - 4.6 External Quality Review19**
 - 4.6.1 Department of Medical Assistance and Health Services (DMAHS)/Island Peer Review Organization (IPRO) 19
 - 4.6.2 Centers for Medicare & Medicaid Services (CMS) 20
 - 4.7. Behavioral Health20**
- 5. QI Program’s Function21**
 - 5.1 Member Safety21**
 - 5.2 Disparities in Health.....22**
 - 5.2.1 Complex Health Needs..... 23
 - 5.3 Quality Assurance23**
 - 5.3.1 Grievances and Appeals..... 23
 - 5.3.1.1 Medicaid Grievances 23
 - 5.3.1.2 Medicare Grievances..... 24
 - 5.3.1.3 Appeals..... 25
 - 5.3.2 Quality of Care and Service..... 26
 - 5.3.2.1 Quality of Care and Service 27
 - 5.3.2.1.1 Mortality Data 28
 - 5.3.2.2 Programs for the Elderly and Disabled..... 28
 - 5.3.2.3 Population Health 29
 - 5.3.3 Audits and Reports..... 29
 - 5.3.4 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) - Lead Screening..... 30
 - 5.4 Policy Management31**
 - 5.5 Delegation Oversight31**
 - 5.6 Compliance with State and Federal Regulatory and NJ Medicaid Managed Care Contract Requirements32**
 - 5.7 Accreditation33**

5.8	Credentialing and Re-credentialing	34
5.9	Clinical Practice Guidelines (CPGs)	34
5.10	Cultural Competency and Health Literacy	34
5.11	Fraud, Waste, and Abuse	36
5.12	Program Performance	36
5.12.1	QI Program Work Plan	36
5.12.2	Performance Improvement Projects (PIPs)	37
5.12.2.1	Medicaid PIPs (State PIPs)	37
5.12.2.2	Medicare PIPs (CMS PIPs/CCIPs)	38
5.12.3	Healthcare Effectiveness Data and Information Set (HEDIS)	38
5.12.4	Stars	39
5.12.5	Consumer Assessment of Healthcare Providers and Systems (CAHPS)	39
5.12.6	Health Outcomes Survey (HOS)	39
5.13	New Initiatives	40
5.14	Opportunities for Continued Improvement	40

Attachments to Program Description

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

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

Attachment 3 – 2019 GP Committee Organization Chart

Attachment 4 - GP Executive Organizational Chart

Attachment 5 - Quality Management Department’s Organizational Chart

1. Purpose of the Quality Improvement (QI) Program

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

2. Program Scope

The Government Programs (GP) QI Program applies to all of Horizon Government Programs lines of business.¹ The membership served by the QI Program includes: Horizon NJ Health (HNJH) Medicaid & MLTSS, Horizon NJ TotalCare (FIDE-SNP), Medicare Supplemental and Medicare Advantage HMO and PPO.

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

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

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

- Guidelines for the management of selected diagnoses and basic health maintenance, and distribution of all standards, protocols, and guidelines to all providers and upon request to enrollees and potential enrollees.
- Treatment protocols, which allow for adjustments based on the enrollee's medical condition, level of functioning, and contributing family and social factors.
- Procedures for monitoring the quality and adequacy of medical care including: 1) assessing use of the distributed guidelines and 2) assessing possible over-treatment/over-utilization of services and 3) assessing possible under-treatment/under-utilization of services.
- Evaluations procedures for focused medical care evaluations to be employed when indicators suggest that quality may need to be studied, including procedures for conducting problem-oriented clinical studies of individual care.
- Procedures for prompt follow-up of reported problems and grievances involving quality of care issues. Timeframes for prompt follow-up and resolution which follow the standard described in Article 5.15B.
- Hospital Acquired Conditions and Provider-Preventable Conditions-Implementation of a no payment policy and a quality monitoring program consistent with the Centers for Medicare and Medicaid Services (CMS) that addresses Hospital Acquired Conditions and Provider-Preventable Conditions and according to federal regulations.
- Data Collection Procedures for gathering and trending data including outcome data.
- Mortality Rates review of inpatient hospital mortality rates of its enrollees.
- Corrective Action procedures for informing subcontractors and providers of identified deficiencies or areas of improvement, conducting ongoing monitoring of corrective actions, and

taking appropriate follow-up actions, such as instituting progressive sanctions and appeal processes.

- Discharge Planning procedures to ensure adequate and appropriate discharge planning, and includes coordination of services for enrollees with special needs.
- Ethical Issues monitoring of providers for compliance with state and federal laws and regulations concerning ethical issues, including but not limited to Advance Directives; Family Planning services for minors; and other issues as identified. Reports are submitted annually or within thirty (30) days to DMAHS with changes or updates to the policies.
- Emergency Care methods to track emergency care utilization and to take follow-up action, including individual counseling, to improve appropriate use of urgent and emergency care settings.
- New Medical Technology policies and procedures for criteria which are based on scientific evidence for the evaluation of the appropriate use of new medical technologies or new applications of established technologies including medical procedures, drugs, devices, assistive technology devices, and DME.
- Informed Consent which requires that all participating providers comply with the informed consent forms and procedures for hysterectomy and sterilization as specified in 42 C.F.R. Part 441, Sub-part F, and shall include the annual audit for such compliance in its quality assurance reviews of participating providers.
- Continuity of Care system which includes a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for enrollees with special needs.

3. QI Program Objectives/Goals

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

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

3.1 Program Evaluation

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

- A description of completed and ongoing QI activities that address quality of clinical care and quality of service
- Evaluation and assessment of patient safety activities
- Tracking and trending of data to assess program's performance in measures of quality of care and quality of service
- An analysis of improvements in quality of care and service to members

- A critical assessment of barriers to achieving goals and root cause analysis
- An evaluation of the overall effectiveness of the QI Program

The QI Program Evaluation is presented annually to the QIC for review, comments, and approval. The Vice President and Chief Medical Officer of Horizon GP, or a designee, annually presents the QI Program Evaluation to the Horizon Healthcare of New Jersey Board of Directors.

4. Structure of the QI Program

4.1 Governing Body

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

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

The Board has assigned responsibility for the QI Program to the Executive Vice President, Government Programs & Operations who has assigned responsibility to the Vice President and Chief Medical Officer (VP/CMO) of Government Programs. The VP/CMO has the authority over and responsibility for the development and implementation of the QI Program. The Government Programs Executive Medical Director (EMD) of the Quality Management Department, who reports to the VP/CMO, has direct oversight of the development and implementation of the QI Program. The VP/CMO has delegated the chairmanship of the QIC to the EMD of the Quality Management

Department. The QIC is responsible for the day-to-day approval, monitoring, and evaluation of the GP QI Program.

4.2 Committees

The organizational structure of GP committees supports the implementation of the QI Program. Each committee has a charter that outlines the purpose, scope, meeting frequency, and composition. Below are descriptions of the Quality Improvement Committee and subcommittees/workgroups that report to the QIC.

Quality Improvement Committee (QIC)

The QIC's purpose is to oversee all GP QI activities. The QIC is a multidisciplinary committee that meets on a regular basis, at least 10 times per year. This frequency is sufficient to demonstrate that the committee is following-up on all findings and required actions. The role, structure, and function of the committee are specified in its charter. Annually, the charter is revised as needed and approved by the committee. Meeting minutes are recorded that documents the committee's activities, findings, recommendations and actions.

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

- **Healthcare Disparities Workgroup**

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

- **Physician Advisory Committee (PAC)**

The PAC meets quarterly. The purpose of this committee is to identify issues of concern to the physician community and identify opportunities for optimizing patient care. In 2018 the PAC meetings were combined with the Utilization Management/Case Management Committee.

- Dental Committee (Special Needs and Oral Advisory)

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

- Delegated Vendor Oversight Committee (DVOC)

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

- Medicare Stars Subcommittee

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

- HEDIS Workgroup

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

- Medicaid CAHPS Workgroup

The Medicaid CAHPS workgroup is an interdisciplinary team that provides oversight for efforts aimed at gauging how Horizon NJ Health is meeting its members' expectations. It also determines areas of service with the greatest effect on member satisfaction, and identifies areas of opportunity to increase quality of care through quality initiatives. This workgroup coordinates Horizon NJ Health's efforts that focus on improving the plan's Medicaid CAHPS performance. This workgroup meets monthly.

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

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

- Managed Long Term Services and Supports committee (MLTSS)

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

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

The FIDE-SNP Committee meets at least four times per year. The purpose of the FIDE-SNP committee is to provide oversight to the Horizon NJ TotalCare (HMO SNP) Quality Program. The committee reviews the program's progress towards its goals to systematically monitor, assess, track, trend and improve the quality of care, service, health status and safety of the SNP members and ensure the ongoing state of compliance with stated program activities according to the Center for Medicare and Medicaid (CMS)'s FIDE- SNP Model of Care (MOC).

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

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

- Administrative Policy Approval (APA) Subcommittee

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

- Quality Peer Review Committee (QPRC)

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

- Member Service Satisfaction Committee (MSSC)

The MSSC is a multidisciplinary committee that focuses on issues related to member satisfaction in order to create proactive action plans to address the identified barriers to providing GP members with the optimal experience with the plan. This committee meets at least quarterly. The MSSC reviews reports focused on call center performance, member grievances, and claims as well as appeals associated with these issues. The MSSC reviews CAHPS results and other member

satisfaction survey results so that the committee can coordinate interventions aimed at improving the members' experience.

- Community Health Advisory Committee (CHAC)

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

- Provider Service Satisfaction Committee (PSSC)

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

- Credentials Committee

The Credentials Committee is a Committee of the Horizon-BCBSNJ Quality Improvement Committee (QIC) established to implement and oversee of a program for credentialing, recredentialing, 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 Service's, Board of Directors and the Horizon Healthcare of New Jersey Board of Directors, the management of GP and the QIC with decision making authority on matters pertaining to provider credentialing and recredentialing. It meets at least 10 times per year.

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

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

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

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

4.3 Inclusion of Participating Providers in the QI Program

Horizon Government Programs providers are included as voting members of the QIC. Participating providers are also voting members of GP Utilization Management/Case Management Committee, Physician Advisory Committee, Pharmacy and Therapeutics Committees, Dental Advisory Committee, and Quality Peer Review Committee. Participating physicians and other providers are kept informed about the written QI Program Description through its posting on the provider website (horizonNJHealth.com/for-providers) and in newsletters. GP providers can also look in the Provider Administrative Manual to find out how they can be included in the design, implementation, review and follow-up of GP QI activities.

4.4 GP Organizational Chart

See Attachment 3 2019 GP Committee Organization Chart , Attachment 4 for the GP Executive Organizational Chart and Attachment 5 for the Quality Management Department's Organizational Chart. Due to the expansion of the Quality Management Department, the Quality Management Clinical Operations Organizational Chart, the Quality Management Performance Improvement and Reporting and the Quality Management and Administration Organizational Chart are reported separately.

4.5 QI Program's Resources

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

With the expansion and reorganization of the Quality Management Department continuing into 2019 and the existing GP health services structure, the QI Program will have sufficient material resources and staff with the necessary education, experience, and/or training to effectively carry out the QI Program's activities. In addition, the Quality Management Department has access to consultants who provide activities such as statistical analysis, business process improvement recommendations, quality related education, and accreditation preparation support. To maintain

and improve quality performance, Horizon monitors all current and planned initiative to assess current and future staffing needs. This opportunity ensures that the appropriate staff is in place to adequately address the needs of the quality improvement efforts. Below are descriptions of the key roles within GP that support the QI Program.

QI Programs Staffing:

Vice President and Chief Medical Officer (VP/CMO)

The VP/CMO of GP is a board certified, New Jersey licensed physician with a Master's degree in Public Health and experience in health insurance, health care consulting, NCQA accreditation, and pharmaceuticals. The VP/CMO is responsible for the design and implementation of the QI Program. The VP/CMO provides quarterly reports to the Quality Subcommittee of the Horizon Healthcare of New Jersey Board of Directors which detail the quality related activities of GP and the QIC. This reporting may be delegated to the Executive Medical Director of the Quality Management Department.

Executive Medical Directors

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

Senior Medical Directors/Medical Directors/Dental Director

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

Executive Medical Director, Quality Management

The Executive Medical Director (EMD) of the Quality Management Department is a board certified, New Jersey licensed physician who has a Master's degree in Public Health. The EMD of the Quality Management Department has experience in UM, Quality Management, Managed Care Operations, MLTSS, Medicare and fully-integrated dual-eligible programs. In addition, this Medical Director previously worked for the state's Independent Utilization Review Organization (IURO) as the Medical Director for the IURO's New Jersey contract.

The EMD of the Quality Management Department reports to the GP VP/CMO. The EMD of the Quality Management Department is responsible for the creation and execution of the QI Program description, work plan, and annual evaluation, as well as all the functions carried out by the Quality Management Department. The EMD of the Quality Management Department chairs the QIC and is a voting member of select QIC subcommittees. The EMD's representation and voting rights on QIC subcommittees may be delegated to Medical Directors within GP or a Director within the Quality Management Department.

Director, Quality Management Performance Improvement and Reporting

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

Director Quality Management Clinical Operations

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

Director Quality Management Improvement Operations

The Director of the Quality Management Improvement Operations Department reports to the Executive Medical Director of the Quality Management Department. The Director has experience in Continuous Quality Improvement (CQI) methodology, state contractual requirements, and NCQA, DMAHS, CMS quality standards. The director has a Master's Degree in Business Administration, with concentrations in Management Information Systems and Risk Management. The Director is responsible for design, development, and implementation of on-going improvement and maintenance of quality improvement initiatives necessary for attaining NCQA accreditation, CMS and DMAHS Contract requirements. The Director also directs and provides leadership for implementing, monitoring and evaluating the Quality Improvement Program for the Government Programs. The Director also leads and directs processes and overall quality improvement activities that produce better patient care and more efficient operations. They also develop programs to review and evaluate patient care and outcomes. The Director represents the Quality Management Department on GP committees and may serve as the Quality Management Medical Director's co-chair.

Quality Management Department Managers

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

Quality Management Department Supervisors

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

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

Accreditation Specialists

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

PIP Specialists

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

Health Data Analysts

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

Quality Outreach Specialists

Quality Outreach Specialists are responsible for the coordination, implementation, and monitoring of all Medicaid and Medicare (Stars) HEDIS member and provider outreach, engagement, and intervention. This position is also responsible for assisting the Manager of Outreach & Interventions in operationalizing all initiatives to improve HEDIS performance by working with internal and external stakeholders.

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

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

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

Delegate Vendor Oversight and Quality Management staff work collaboratively in the review of quality management initiatives with delegates and ensures compliance with the NCQA applicable

standards. In addition, Delegate Vendor Oversight supports Quality Management's goal of improving the quality of health care provided to members via the delegated vendor activities and responsibilities by providing oversight of those activities and responsibilities.

4.6 External Quality Review

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

On behalf of the New Jersey DMAHS, IPRO conducts oversight activities of Horizon NJ Health and Horizon TotalCare (FIDE SNP). Annually, IPRO conducts an assessment of Horizon's operations to determine if Horizon has implemented and operationalized State-mandated contractual requirements. The Quality Management Department is responsible for Horizon's preparation, the submission of documentation, and the coordination of the on-site assessment. After the annual assessment is completed and Horizon receives feedback from DMAHS/IPRO, corrective action plans are created and executed to address the opportunities for improvement that were highlighted in IPRO's report. These corrective actions are monitored by the QIC through their completion.

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

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

In addition to the external quality reviews performed by the State, GP undergoes quality reviews/audits performed by CMS and NCQA. Horizon's GP CMS required QIPs and CIPS are approved by CMS. Horizon maintains compliance with NCQA Health Plan

Accreditation standards and the plan's Medicaid and Medicare lines of business are assessed by NCQA as part of the Health Plan Accreditation process.

4.6.2 Centers for Medicare & Medicaid Services (CMS)

Annually, CMS conducts an Organizational Determinations and Reconsiderations (ODR) audit. The focus of the audit is data specific and does not include medical record review.

The Organization Determinations, Appeals and Grievances (ODAG) reporting supports a constant state of readiness in the event of a Medicare audit. Monthly ODAG reports facilitate ongoing monitoring of the appeal teams' compliance with established workflows including regulatory expectations.

4.7. Behavioral Health

To address the needs of members with behavioral health, severe mental illness and substance use disorder conditions, GP provides behavioral and mental health services to the Medicare membership and a specific subgroup of its overall Medicaid membership. The benefits provided through Medicaid are limited to the enrollees in the Division of Developmental Disabilities (DDD), MLTSS and FIDE-SNP programs FIDE-SNP. The behavioral health services are delegated to and provided by Beacon Health Options (formerly Value Options); an NCQA-accredited Managed Behavioral Healthcare Organization.

The GP staff works in collaboration with Beacon Health Options to provide quality care and service to the membership who have the benefit. Beacon employs a board certified behavioral health practitioner that has oversight and accountability for behavioral health aspects of the program.

A behavioral health practitioner participates on the QIC, UM/CM, P&T and FIDE-SNP Committees to provide information and guidance on mental health/substance use topics and related quality initiatives and activities. The DVOD, the Quality Management Department, the Care, Case and Disease Management Department and UM Department provide oversight of Beacon Health Options through reporting activities and monthly meetings. Information related to Beacon Health Options performance is reported to the QIC on at least a quarterly basis. Beacon Health Options presents its

program evaluation and program description annually to the DVOC, which reports in to the QIC. GP approves and adopts the Beacon Health Options Quality Program Description on an annual basis.

As of October 1, 2018, MCOs were required to align DDD, FIDE-SNP and MLTSS behavioral health benefits add additional services for the treatment of substance use orders and be responsible for all general acute care hospital admissions for all Medicaid members regardless of age or diagnosis. GP is addressing steps to ensure all required steps are implemented according to the State-defined timeline to comply with the 2018 and 2019 requirements for behavioral health services.

5. QI Program's Function

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

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

5.1 *Member Safety*

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

To promote safety for hospitalized GP members and in accordance with the CMS guidelines, state law, and the State Medicaid Managed Care Contract, GP has policies addressing quality of care and service, hospital-acquired conditions and serious adverse events. The Quality Management Department reviews the State Medicaid Managed Care contract, CMS regulations, applicable state

laws, national clinical practice and other guidelines at least annually, revising these policies and the list of selected hospital-acquired conditions and serious adverse events.

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

5.2 Disparities in Health

Disparities in health reduce the overall quality of care provided within the health care system while adding to overall health care costs. In 2019, to address the multiplicity of the needs of the membership, GP QI Program will continue to work on identifying and addressing disparities in health outcomes amongst different member populations. GP programs to reduce disparities in health will be driven by discussions held during Disparities Work Group and QIC meetings and recommendations made by the QIC. The interventions selected to reduce health care disparities in clinical and service areas will be instituted during 2019 and will be included on the 2019 QI work plan. Current topics under review include breast cancer screening (BCS), cervical cancer screening (CCS), depression in the elderly SNP population, colorectal cancer screening (COL), prostate cancer screening, social determinants of health, and childhood obesity. GP's ongoing efforts to reduce disparities will be coordinated and monitored through the QIC.

The goal of this program is the implementation of interventions and community health events which reduce disparities between differing member populations. New interventions for social determinants of health and childhood obesity will be launched in the 1st and 2nd quarter of 2019. Ongoing interventions from 2018 for depression in the elderly FIDE-SNP population BCS, CCS, COL and prostate cancer screening will continue through 2019.

5.2.1 Complex Health Needs

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

Additionally, the PC&S and Network Operations departments review geographical access reports to address the adequacy of the provider network. Reporting indicates sufficiency of PCPs, OB/GYNs, and high volume and high impact specialties required to treat the membership. Deficiencies in the network are acted upon to reduce barriers to care and to ensure continuity of care for members.

5.3 *Quality Assurance*

5.3.1 Grievances and Appeals

5.3.1.1 Medicaid Grievances

GP is committed to improving the efficiency and quality of how the Plan manages appeals and grievances. In 2018 Horizon finalized the migration of Medicaid grievances to the Government Programs Appeal and Grievance Resolution Unit.

GP grievance resolution teams address member and provider grievances within the mandated timeframes required by the NJ State Medicaid Contract, CMS

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

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

The NJ Health appeals staff handles all member and provider utilization management appeals in accordance with the NJ State Medicaid Managed Care contract requirements, applicable CMS regulations, and accreditation standards.

5.3.1.2 Medicare Grievances

CMS provides stringent guidelines related to the intake and resolution of grievances received by MA enrollees. In order to meet the requirements, a dedicated grievances team exists within the organization to resolve grievances. The focus of the team is to review and resolve grievances regardless of where they originate within the organization. The grievances staff receives referrals by telephone calls, written

correspondence, internal referrals, or legislative referrals. Grievances received by 1-800-Medicare are also handled within the grievances team.

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

5.3.1.3 Appeals

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

The quality improvement initiatives continue in the Appeals department with reorganization of the appeal teams due to changes in the Medicare MAPPO membership. Leadership and staff have been structured to create subject matter experts to support the Medicaid, Medicare, & SNP lines of business. There continues to be a refocus on data driven outcomes via diversified reporting with the creation of

the Health Data Analyst role. The result is tracking, trending and identifying opportunities for improvements in production. Operationally, monitoring tools such as the Appeals Tableau Dashboard helps create and modify department policies/procedures and workflows to support compliance with CMS and state contractual timeframes.

5.3.2 Quality of Care and Service

Within the Quality Management Department a team exists which is focused on quality of care issues. This team provides ongoing education to GP personnel regarding potential quality of care concerns and serious adverse events. This education includes the definitions/categories for quality of care referrals and how staff can refer potential quality of care issues to the Quality Management Department for investigation and Medical Director for review. All instances where a quality of care issue and/or serious adverse events, hospital acquired, or provider preventable event may exist are presented to the Quality Peer Review Committee QPRC for discussion, determination of departure from quality standards and guidelines, and possible practitioner sanctioning.

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

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

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

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

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

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

5.3.2.1 Quality of Care and Service

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

5.3.2.1.1 *Mortality Data*

Another function of the Quality Management Department is the tracking of mortality data for Medicaid, SNP, and MLTSS members. The mortality data is also stratified by Special Populations as defined by the New Jersey Medicaid HMO contract. These categories include Aged, Blind, Disabled (ABD), Division of Disability (DDD) and Elderly members. On an annual basis the analysis is presented to the QPRC committee for review and approval.

5.3.2.2 *Programs for the Elderly and Disabled*

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

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

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

5.3.2.3 Population Health

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

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

5.3.3 Audits and Reports

The QI Program has oversight of audits and reports completed by multiple business areas. There are several reasons audits and reports are performed. Audits and reports are required by the State, required to meet accreditation requirements, and they provide GP with insights in how processes, providers, and systems are performing. A selection of the audits and reports that are performed and then reviewed by the QIC is listed below:

- MLTSS Quarterly Audit
- FIDE-SNP Audits
- Geo Access Reports
- 24-hour Access Audit
- Medical Record Review Audit
- Appointment Availability Audit
- Provider Satisfaction Survey
- Office Manager Survey
- EPSDT Audit

- Lead Report
- Vendor Oversight Audit

These audits are incorporated into the QI Program work plan. As part of the QI Program, the QIC uses the QI Program work plan to track the completion of these audits and the input the QIC provides the business area completing each audit about how the audit can be modified to improve the audit's usefulness.

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

Lead screening using blood lead level determination must be done for every Medicaid-eligible and NJ FamilyCare child between nine (9) months and eighteen (18) months of ages, preferably at twelve (12) months of age and a second time between 18-26 months, preferably at twenty-four (24) months of age. Any children between twenty-seven (27) to seventy-two (72) months of age not previously tested should be tested. GP provides a screening program for the presence of lead toxicity in children which consists of two components; a verbal risk assessment and blood lead testing. The verbal risk assessment is given to providers to perform at every periodic visit between the ages of six (6) months and seventy-two (72) months. The health plan has various lead monitoring methods and interventions in place to increase lead screening rates plan wide. Primary and secondary prevention methodologies have been adopted to ensure lead screening takes place earlier, rather than later in the applicable age groups. These interventions include, but are not limited to, member mailings, provider mailings, call campaigns, provider on-site education, provider webinars, member gap-detail analysis and community events. In 2019, GP will continue monitoring initiatives to increase lead screening awareness and lead testing.

5.4 Policy Management

Annual policy review is conducted and presented to the QIC or the applicable subcommittee or workgroup of the QIC, by the department responsible for each policy. All policies are reviewed to comply with the Corporate Policy and Procedure Development Policy and include the effective date, most recent revision and most recent review dates. In addition, policies are reviewed for applicable regulatory and accreditation content.

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

5.5 Delegation Oversight

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

GP's contracted delegates/vendors are obligated to provide and administer services in accordance with contractual terms and conditions, applicable state and Federal Laws & Statutes, regulations set forth by the DMAHS New Jersey State Managed Care Contract provisions, the Health Claims Authorization, Processing and Payment (HCAPP) Act, CMS, Horizon Policy and Procedures, and current year standards and guidelines of both the NCQA. GP remains accountable for the quality, integrity and appropriateness of delegated functions and services provided by subcontractors to Horizon MLTSS, FIDE-SNP and MA members.

It is GP's responsibility to ensure monitoring and oversight activities are performed to ensure and delegate/vendor compliance and; to promote the delivery of and access to quality and cost-effective health care and services to Members. The GP DVOC is responsible to assess on-going monitoring and evaluation activities performed collaboratively and independently by GP business units; to evaluate delegate/vendor performance results to ensure business goals and outcomes are achieved to further the delivery of quality health goals and outcomes for our members and; to ensure subcontractor compliance with contractual provisions, regulatory requirements, and applicable accreditation guidelines.

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

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

- Confidentiality

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

safeguard the security of such private information when assisting with administrative functions or providing services for or on behalf of GP.

- Member Rights, Responsibilities and Patient Engagement

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

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

- Regulatory Compliance

The QI Program through the QIC:

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

- Ethics

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

5.7 Accreditation

GP Medicare and Medicaid lines of business are accredited by the NCQA. The Quality Management Department, through the QI Program, continuously monitors all applicable GP business

areas to ensure their compliance with the most current NCQA Health Plan Accreditation standards and guidelines. The QI Accreditation Team provides education, assessment and feedback to business areas for continual readiness in between reaccreditation cycles. The Accreditation Team monitors compliance with standards on an ongoing basis and reports the status of accreditation activities at least quarterly to the QIC.

5.8 *Credentialing and Re-credentialing*

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

5.9 *Clinical Practice Guidelines (CPGs)*

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

5.10 *Cultural Competency and Health Literacy*

GP recognizes the cultural diversity and health literacy needs of its health plan members and is committed to promoting cultural competency, increasing health literacy, and decreasing healthcare

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

The objective of GP Cultural Competency and Health Literacy efforts are to improve the materials and communications by

- Increasing the cultural sensitivity of employees and providers
- Better understanding and meeting the needs of our members which is accomplished through various settings and solicitation of information from members
- Optimizing members' experience with the health plan
- Enhancing the provision of quality care to members with diverse values, beliefs, and behaviors
- Encouraging the development of more effective strategies for communication with patients
- Identifying and overcoming barriers most likely to inhibit the advancement of health care for diverse groups

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

- Identifies language needs and cultural background of members, including prevalent languages and cultural groups, using U.S. Census data, enrollment data, and member feedback
- Identifies languages of practitioners in provider networks to assess whether they meet members' language needs preferences

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

Additionally, Case Managers identify the cultural, physical, auditory, vision and linguistic barriers to care for members as a part of the Complex Needs Assessment process. The needs are addressed and recognized throughout the continuum of care.

5.11 *Fraud, Waste, and Abuse*

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

- NJ Medicaid Managed Care Contract
- Federal False Claims Act
- Patient Protection and Affordable Care Act of 2010 Social Security Act
- Federal Program Fraud Civil Remedies Act, New Jersey False Claims Act
- Health Care Claims Fraud Act Conscientious Employee Protection Act

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

5.12 *Program Performance*

In 2018, GP dedicated additional resources across the organization, and specifically within the Quality Management Department, to focus on GP Quality Performance and will continue to add resources as needed in 2019. This work will be guided by the QI Program and included in the QI Program work plan. The QIC will have oversight of this work including the planning, monitoring, and evaluation of the outcomes of these efforts.

5.12.1 QI Program Work Plan

Annually, the Quality Management Department creates the QI Program work plan.

The work plan is presented to the QIC in the first quarter of the year. The QIC provides

recommendations for revisions and the committee approves the work plan. The QI Program work plan is designed to be inclusive of all aspects of the QI Program's responsibilities. The work plan is updated as needed during the year to incorporate recommendations that are identified through the completion of the QI Program evaluation and/or by recommendations made by the QIC. The QIC reviews the QI Program work plan at least quarterly to ensure that the activities outlined within the work plan are being addressed by the responsible business area owners and to ensure progress is being made toward the stated goals. If the QIC determines that progress is not being made toward goals, the committee is tasked with providing recommendations to assist the business area in identifying barriers and developing interventions to overcome the barriers. The 2019 QI work plan will identify items applicable to the elderly and disabled populations and includes a new item for population health.

5.12.2 Performance Improvement Projects (PIPs)

GP leadership has acknowledged State/External Quality Review Organization (EQRO) feedback on its PIPs and the quality improvement manager in addition to the quality team has worked diligently to ensure EQRO feedback is and will continue to be incorporated into each PIP submission. This team is responsible for assisting in the design, implementation, execution, analysis, and reporting of GP state and CMS required PIPs. Plan Do Study/Check Act cycle in addition to Lean Six Sigma methodologies are used to develop and ensure continuous quality improvement throughout the entirety of each PIP.

5.12.2.1 Medicaid PIPs (State PIPs)

Horizon NJ Health conducts five performance improvement projects (PIPs) specific to its State/Medicaid membership. The topics for these QIPs are determined by the DMAHS. The current topics include: MLTSS Recurrent Fall Prevention; MLTSS Reducing admissions, readmissions and gaps in service for members with congestive heart failure in the Horizon NJ Health MLTSS Medicaid population; Increasing Developmental Screening and Early Intervention; and the FIDE-SNP Reducing Admissions, Readmissions and Emergency Room (ER) Visits in Members with Asthma. Twice per year, Horizon NJ Health submits reports to the state detailing Horizon NJ Health's efforts and outcomes related to each PIP. This takes place in April and August. In addition to semi-annual submissions, Horizon NJ Health also monitors

intervention implementation timeliness and effectiveness along with all other PIP related activities to ensure positive results.

5.12.2.2 Medicare PIPs (CMS PIPs/CCIPs)

GP participates in ongoing quality improvement programs for each contract in place. The purpose of the QI program is to ensure that GP has the necessary framework and infrastructure to coordinate care, promote quality, performance, and efficiency on an ongoing basis. The guidelines followed and incorporated into the QI programs are based on the 42 CFR§ 422.152 regulation. Each Chronic Care Improvement Project (CCIP) applies to the three MA contracts in place. Currently there are three CCIPs in place for each contract with a focus on promoting effective management of chronic disease. The CCIPs in place have a three-year project cycle. GP is no longer required to submit updates for its Medicare CCIPs to CMS, but rather monitors CCIPs internally and submits an attestation that confirms the projects are in place. Additionally, following CMS guidance that was released on April 1, 2018, CMS QIPs have been closed out as of December 31, 2018. Final results, best practices and lessons learned have been documented internally.

5.12.3 Healthcare Effectiveness Data and Information Set (HEDIS)

GP Medicare, SNP and Medicaid HEDIS measures are evaluated and analyzed monthly. Initiatives are developed, changed, and/or enhancements to initiatives and outreach activities are discussed in the HEDIS workgroup meetings. HEDIS performance results are reported annually to the state, QIC, NCQA, and to the Quality Committee of the Horizon Healthcare Board.

Annually, GP will create a new work plan to address State HEDIS measures that fall below 50th percentile with the exception to the Lead Screening Measure which will be added if it falls below the 75th percentile. This work plan will be provided to the DMAHS on or before August 15 annually. Existing initiatives and outreach areas will be evaluated for their impact and, if needed, will be enhanced to improve measure performance. The results and outcomes of initiatives and outreaches will be monitored monthly and shared in HEDIS workgroup meetings held 6 times per year.

5.12.4 Stars

GP Medicare Star measures are monitored monthly. Star measures are assigned to business owners who develop strategies, initiatives, and outreach activities to maintain and/or improve performance. Star rating progress is reported to the QIC on a quarterly basis. Star measure performance results are reported annually to the state (FIDE-SNP product only), to the QIC, NCQA, and the Quality Committee of the Horizon Healthcare Board.

5.12.5 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS survey captures accurate and complete information about member-reported experiences and how well the Plan is meeting members' expectations and goals. The Quality Management Department coordinates Government Programs' efforts to improve Medicare, Medicaid, and FIDE-SNP CAHPS results for adults and children. The planning, work, and results of these efforts are reported to QIC directly. Specific CAHPS work plans are created to manage each line of business. Government Programs has determined that in 2019, opportunity exists to improve on all measures. These are all drivers of customer satisfaction and impact the Plan's overall ratings. The QI Program work plan will incorporate the QIC's oversight of CAHPS improvement efforts.

5.12.6 Health Outcomes Survey (HOS)

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

5.13 New Initiatives

In 2019, GP will be embarking on multiple new initiatives. While all of GP's new initiatives have the potential to impact the quality of care and service GP provides its members, the following specific initiatives in 2019 require direct monitoring by the QI Program because of their scope and impact on members and providers.

- Unified Credentialing

Horizon NJ Health is collaborating with the State and other Managed Care Organizations (MCO) in the development of a State sponsored program serving as a single source for the credentialing and re-credentialing of Medicaid providers. The project is expected to go live in 2019. Ensuring that the quality of the credentialing/re-credentialing process is maintained and improving the efficiency and accuracy of the process will be the focus of GP QI Program oversight of this initiative.

- "Lost" Post Service Appeals

In collaboration with the internal compliance teams, legal ,and facility management we are working on efforts to eliminate the post service third party vendor facility appeals that have USPS tracking numbers but never arrive at the UM appeal department for processing.

- Interrater Reliability for Readmission Reviews

The Quality of Care team currently reviews readmissions for quality indicators. Efforts in 2019 will establish an IRR process for the clinical team to standardize the review process and evaluate the understanding and interpretation of the current Horizon UM Readmission policies.

- Mortality Reporting

The QM department is working with the Analytics department to establish a Tableau report for self-service mortality reporting capabilities for Government programs and the commercial lines of business.

5.14 Opportunities for Continued Improvement

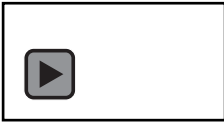
Opportunities for improvement that are identified in the QI Program Evaluation are incorporated into the following year's QI Program activities for implementation and monitoring by the QIC including but not limited to:

- Healthcare Disparities – identification of opportunities for improvement health care disparities to improve member support and engagement
- Appeals –Complexity of the appeal process for Medicare and FIDE-SNP members
- Reduce “lost post service facility appeals” sent with USPS tracking
- Hospital Acquired Conditions and Serious Adverse Event management
- Readmission quality of care reviews
- Star and CAHPS – focused implementation of improvement initiatives
- Lead – improve screening rates across all counties
- Reducing admissions, readmissions and gaps in services for members with Congestive Heart Failure in the Horizon NJ Health MLTSS Medicaid population
- Enhanced reporting and monitoring Mortality Rates at facilities
- Streamlining Programs for the Elderly & Disabled- to ensure all components are met as required by the NJ Family Care contract.
- Development of member and provider newsletters and educational materials for the elderly and/or disabled populations
- Continued focus on GP CAHPS- to ensure that member satisfaction is achieved. Addressing opportunities identified within the HEDIS & CAHPS Performance - to achieve NCQA Commendable status for the Medicaid products

GP will pursue these opportunities for improvement in 2019 and include updates to activities in the QI Work Plan to monitor, track and trend progress toward goals.

Attachments to Program Description

Attachment 1 – 2018-2019 MLTSS Program Description



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



2019 FIDE-SNP Care Management and QM

Attachment 3 – 2019 GP Committee Organization Chart



2019 Horizon GP Committee Organization

Attachment 4 - GP Executive Organizational Chart



Horizon GP Executive Organizational Chart

Attachment 5 - Quality Management Department's Organizational Chart



Government Programs 2019 Quality Improvement Program Description

Approvals

Joshua Ardise, MD, MPH
Executive Medical Director
Chair, Quality Improvement Committee

2/20/19
Date

Paul G. Alexander, MD, MPH
Vice President Horizon Blue Cross Blue Shield New Jersey
Chief Medical Officer Government Programs

2/20/19
Date