Healthier New Jersey Insurance Company d/b/a Braven Health

2021 Quality Improvement Program Description

1. Purpose of the Quality Improvement (QI) Program

The purpose of the Healthier New Jersey Insurance Company d/b/a Braven Health QM Program is to systematically monitor, assess, track, trend and continuously improve the quality of care, service, health status and safety of its members. The QI Program is designed to be comprehensive and to have the necessary resources, infrastructure, and authority to meet the program's goals and objectives. The program also monitors targeted accomplishments, including clinical standards to be developed, medical care evaluations to be completed, and other key quality assurance activities to be completed, including Medicare related quality activities. Braven Health has engaged Horizon BCBSNJ to operate the QI Program, leveraging the medical policy, quality, and service functions of Horizon BCBSNJ.

2. Program Scope

The scope of the QI Program encompasses the clinical and service aspects of the care its members receive. The QI Program implements Braven Health's efforts to monitor and improve preventive, acute, chronic, behavioral and rehabilitative aspects of care. The QI Program also reviews the Plan's initiatives and outcomes related to member and provider satisfaction, member and provider education, access and availability of care, disparities in health care, continuity and coordination of care, member appeals/grievances, quality of care concerns, clinical and service quality metrics and the credentialing of providers. The QI Program is also charged with effectuating changes to improve Braven Health's performance on Healthcare Effectiveness Data and Information Set (HEDIS), Stars, Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes Survey (HOS). Future Accreditation efforts and audits completed by the Quality Management Department and other Horizon departments are also reviewed as part of the QI Program. The following Quality Assurance Activities are also developed and monitored on an ongoing basis:

- Adoption of clinical guidelines for the management of selected common conditions and basic health maintenance, and distribution of all standards, protocols, and guidelines to all providers and upon request to enrollees and potential enrollees.
- Medical policies addressing the diagnosis, treatment and management of clinical conditions, which allow for the application of clinical judgment and professional discretion based on the

unique circumstances of an enrollee's medical condition, level of functioning, and contributing family and social factors.

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

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

- 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 CMS Guidelines.

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

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

- 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 due process for appeal.

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

- 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.

- Tracking of emergency care utilization and follow-up actions, including individual counseling, to promote appropriate use of urgent and emergency care settings.

- Establishment of Medical Policies addressing New technology and new uses for existing technologies including medical procedures, drugs, devices, assistive devices, and durable medical equipment which are based on scientific evidence.

- 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

- Collecting data and acting on opportunities to improve collaborative care between behavioral health and medical health care for members.

3. QI Program Objectives/Goals

The Braven Health 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 Braven Health:

- Promotes health care that is medically necessary with an emphasis on the maintenance and improvement of health in an safe, effective and efficient manner
- Assesses the appropriateness and timeliness of the care and services being provided
- Promotes members' ability to maintain themselves in the least restrictive, most integrated setting of their choice
- Optimizes care delivery for members with special and/or complex care needs
- Identifies members' needs and coordinates care to address the needs of the member
- Focuses on the quality of medical and behavioral health care and services provided to all members
- Works to identify and reduce health care disparities [related to race, ethnicity and other demographic and socio-demographic factors within its membership
- Strives to improve member and provider satisfaction with access to health care and the effectiveness of care

- Maintains oversight of delegated entities
- Maintains oversight of the credentialing and re-credentialing of providers
- Works to improve plan performance on HEDIS, Stars, CAHPS, HOS and Chronic Care Improvement Program (CCIPs)

3.1 Program Evaluation

The QI Program is evaluated annually. This evaluation is performed by the Horizon Quality Management Department, which is engaged by Braven Health to staff and operate its Quality Management Program under the direction of the Quality Improvement Committee (QIC) overseen by the Braven Health Board's Quality Subcommittee. The format of the QI Program Evaluation parallels the QI Program's Work Plan and includes:

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

The QI Program Evaluation is presented annually to the QIC for review, comments, and approval. The Vice President and Chief Medical Officer, or a designee, annually presents the QI Program Evaluation to the Braven Health Quality Committee which, in turn presents this Program Evaluation to the Braven Health Board.

4. Structure of the QI Program

4.1 Governing Body

The Quality Improvement Program of the Healthier New Jersey Insurance Company d/b/a Braven Health is a coordinated and comprehensive program with the goal to optimize the health status of the Company's members by promoting improvements in health care delivery and customer service intended to yield meaningful outcomes in health status and satisfaction.

The Company's Board of Directors ("Braven Health Board") holds the final authority and accountability for the Quality Improvement Program (the "Program"). The Braven Health Board has delegated the oversight of the Program to the Braven Health Quality Committee, a subcommittee of

the Braven Health Board. Braven Health has engaged Horizon BCBSNJ to operate the Braven Program with a Quality Improvement management committee ("QIC") regularly reporting to the Committee.

The responsibilities, basic structure and operation of the Committee is outlined in the Braven Quality Committee charter. The Committee shall annually review this charter and recommend any changes to the Braven Health Board for approval. Braven Health procures the staff and other services from Horizon Healthcare Services, an experienced and accredited operator of Medicare Advantage health plans to operate its Quality Management Program.

The Braven Health Board retains ultimate responsibility for the oversight of the Program, and reviews and approves reports of the Braven Health Quality Committee. The Braven Quality Committee will draft and present for approval the Quality Improvement Program Description(s), Work Plan(s) and Evaluation(s) annually. The QIC provides reports to the Braven Quality Committee on a timely basis monitoring performance of the Program, status of the Workplan and analyses necessary to evaluate the Program.

Committee Structure: There shall be five (5) members of the Quality Committee, including the Chair. Each Committee member shall serve until the next annual meeting of the Healthier New Jersey Insurance Company (dba Braven Health) Board. Any vacancies shall be filled by a majority vote of the Healthier New Jersey Insurance Company Health Board. The Committee members shall consist of the key individuals, identified by the Healthier New Jersey Insurance Company.

4.2 Committees

The organizational structure of Braven Health Quality committee supports the implementation of the QI Program by engaging the Horizon Healthcare Services Quality Improvement Committee and its subcommittees. Each subcommittee has a charter that outlines its purpose, scope, meeting frequency, and composition. Below are descriptions of the Quality Improvement Committee and subcommittees that report to the QIC.

Quality Improvement Committee (QIC)

The QIC's purpose is to oversee all Braven Health QI activities. The QIC is a multidisciplinary committee that meets on a regular basis, at least 6 times per year. This frequency is sufficient to demonstrate that the committee is following up on all findings and required actions. The role,

structure, and function of the committee are specified in its charter. Annually, the charter is revised as needed and approved by the committee. Recorded meeting minutes document the committee's activities, findings, recommendations and actions.

The QIC is accountable to the Braven Health Quality Committee. On a Quarterly basis, the activities, findings, recommendations and actions of the QIC are reported to the Quality Committee. There is active participation on the QIC from network providers. At least one participating provider attends all QIC meetings.

- **Physician Advisory Committee (PAC)**

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

- **Delegated Vendor Oversight Committee (DVOC)**

  The DVOC is an interdisciplinary subcommittee that provides oversight of delegated vendors performing services as Horizon BCBSNJ's resource in operating the Braven Health Quality Program for both health care and non-health care contracts. The committee meets at least eight times per year.

- **Medicare Star Rating & HEDIS Subcommittee**

  The Medicare Star Rating Subcommittee is an interdisciplinary committee that meets ten times per year and oversees efforts aimed to improve the quality and cost effectiveness of the care and services Braven Health provides to its Medicare beneficiaries. The subcommittee coordinates efforts that focus on improving the plan's Medicare Star Rating and CAHPS scores. The subcommittee also provides oversight for efforts aimed at improving the quality and cost effectiveness of the care and services Braven Health provides to all members. The subcommittee also coordinates efforts focused on improving the plan's Medicare and HEDIS performance.

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

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

- **Administrative Policy Approval (APA) Subcommittee**

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

- **Quality Peer Review Committee (QPRC)**

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

- **Member Services Satisfaction Committee (MSSC**)

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

- **Community Health Advisory Committee (CHAC)**

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

- **Provider Service Satisfaction Committee (PSSC)**

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

- **Credentials Committee**

  The Credentials Committee is a committee within the Horizon BCBSNJ Quality Improvement Committee (QIC), established to implement and oversee credentialing, re-credentialing, certification, and/or re-certification of physicians, health care professionals, facilities and ancillary providers. The Credentials Committee is empowered by Horizon Healthcare Services, Board of Directors, acting on Braven Health's behalf, and the QIC with decision-making authority on

matters pertaining to provider credentialing and re-credentialing. This committee meets at least 10 times per year.

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

  The Medicare P&T Committee is responsible for clinical support of the Medicare Pharmacy Program. 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 Healthcare Services Medicare Pharmacy Program acting as a delegated service provider to Braven Health. The Medicare P&T Committee meets at least quarterly.

4.3 Inclusion of Participating Providers in the QI Program

Participating providers are included as voting members of the QIC. Participating providers are also voting members of the Horizon Utilization Management/Case Management Committee, Pharmacy and Therapeutics Committees, and Quality Peer Review Committee. These Committees provide input to the Quality Program operated by Horizon BCBSNJ, which operates a Quality Program as a delegated service provider to Braven Health. Participating physicians and other providers are kept informed about the written QI Program Description available in provider newsletters and on the plan's website at www.bravenhealth.com. Providers can also access information in the Provider Administrative Manual about how they can be included in the design, implementation, and review and follow up of Braven Health QI activities.

4.4 Quality Program Organizational Structure

See the following attachments to gain insight into the Horizon Governance Structure that will administer the Braven Health Quality Program: Attachment 1, Braven Health JV, Insurance Company & CMS Contract Structure, Attachment 2, Business Performance Management Governance – Medicare Advantage, and Attachment 3, 2021 Braven/Horizon Committee Organization Chart, Attachment 4.

4.5 QI Program's Resources

The Braven Health QI Program has the full support of Healthier New Jersey Insurance Company d/b/a Braven Health executive leadership. To demonstrate this support, all departments

within the division collaborate and contribute to the success of the QI Program through their focus on quality in their daily activities and their participation in the QIC.

Braven Health has engaged Horizon to operate and staff the QI Program. The 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, the QI Program monitors all current and planned initiatives to assess current and future staffing needs. This opportunity ensures that the appropriate staff is in place to adequately address the needs of the quality improvement efforts. Below are descriptions of the key roles within Horizon that provides support to the Braven Health QI Program.

QI Programs Staffing:

Vice President and Chief Medical Officer (VP/CMO)

The VP & Chief Medical Officer of Horizon is a board-certified New Jersey licensed physician experienced in health insurance, health care consulting, NCQA accreditation and pharmacy benefit management. The VP/CMO is responsible for the adoption and implementation of the QI Program. The VP/CMO will be an active participant in providing quarterly reports from the QIC, including the quality-related activities of Braven Health in 2021 to the Braven Health Board's Quality Subcommittee. This reporting may be delegated to the Medical Director and/or Quality Director assigned to the Quality Management Department.

Executive Medical Directors

The Horizon 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 Braven Health lines of business. The executive medical directors establish and implement utilization standards, provide overall medical expertise to ensure continuous quality improvement, work to ensure that cost-effective services are provided to members, maintain effective provider relations and develop clinical innovations.

Senior Medical Directors/Medical Directors/Dental Director

The Horizon 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 Braven Health including, but not limited to, clinical practice guidelines, grievances, and quality of care referrals, HEDIS/Stars/CAHPS/HOS initiatives and corrective action plans (CAP).

Director, Quality Management Performance Improvement and Reporting

The Director of the Horizon Quality Management Department acting as Horizon BCBSNJ's resource in operating the Braven Health Quality Program reports to the VP & Chief Medical Officer. The Director has experience leading HEDIS and Star Rating initiatives for large health plans as well as coordinating quality transformation efforts within institutions and provider groups. The Director is responsible for assisting in the planning and direction of the QI Program and Quality Management Department functions. The Director is also responsible for the oversight and function of the business areas within the Quality Management Department including Star Rating/HEDIS/CAHPS/HOS, pay for performance and population health. The Director develops departmental reports and presents these reports, along with the medical director, to the Horizon leadership team directly and through the committee reporting structure. The Director represents the Horizon Quality Management Department on 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 Horizon Quality Management Clinical Operations acting as Horizon BCBSNJ's resource in operating the Braven Health Quality Program reports to the Medical Director of the Quality Management Department. The Director is a licensed professional registered nurse and has experience in health plan management for UM, CM and appeals. The Director is responsible for assisting in the planning and direction of the QI Program and Quality Department functions specific to clinical operations. The Director is also responsible for the oversight and function of the business areas within the Quality Management Department including medical UM appeals audits, and quality of care referrals and quality of care. The Director develops departmental reports and presents these reports, along with the Medical Director, to the Horizon leadership team directly and through the

committee reporting structure. The Director represents the Quality Management Department on Horizon 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 Horizon Quality Management Improvement Operations Department acting as Horizon BCBSNJ's resource in operating the Braven Health Quality Program reports to the VP & Chief Medical Officer. The Director has experience in Continuous Quality Improvement (CQI) methodology, state contractual requirements, and NCQA, DMAHS and CMS quality standards. The Director has a master's degree in business administration, with concentrations in management information systems and risk management. The Director is responsible for design, development, and implementation of on-going improvement and maintenance of quality improvement initiatives necessary for attaining NCQA accreditation, and meeting CMS and DMAHS contractual requirements. The Director provides leadership for implementing, monitoring and evaluating the Quality Improvement Program for Braven Health. 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 Horizon committees and also serves as the Quality Management Medical Director's co-chair.

Director Clinical Behavioral Health Services

The Director of Horizon Clinical Behavioral Health Services acting as Horizon BCBSNJ's resource in operating the Braven Health Quality Program reports directly to the Vice President of Behavioral Health. The Director has a doctoral degree in social work and is a licensed clinical social worker. The Director monitors the effectiveness of behavioral health care services including utilization management, Medicare Case Management and all Quality Management activities related to behavioral health. Internal management of behavioral health services allows Braven Health to be in a stronger position to work directly with providers and health systems to improve integration of physical and behavioral health care for our members.

Quality Management Department Managers

Horizon Quality Management Department managers, acting as Horizon BCBSNJ's resource in operating the Braven Health Quality Program, reports to the Director within the Quality Management Department. The Quality managers are comprised of nurses, social workers and non-clinicians with backgrounds in quality assurance, compliance, analytics and State Health Department operations. Managers are responsible for routine operations within their scope of accountability. Managers have specific business areas within the Quality Management Department that they oversee including member and provider grievances and appeals quality peer review, audits, HEDIS/Star Rating performance, quality policy revisions, accreditation, quality assurance and quality related compliance.

Quality Management Department Supervisors

Supervisors within the Horizon Quality Management Department acting as Horizon BCBSNJ's resource in operating the Braven Health Quality Program reports to Managers and/or Directors. Quality Management Department supervisors include both clinicians (RNs and LPNs) and non-clinicians. The Supervisors are responsible for ensuring that the Quality Management Department's staff completes daily operations as outlined within policies and procedures.

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

Accreditation Specialists

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

PIP Specialists

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

Health Data Analysts

Health data analysts perform research, analysis, programming, implementation and coordination to ensure accurate and timely reporting for the Quality Management Department acting as Horizon BCBSNJ's resource in operating the Braven Health Quality Program. 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 Braven Health Medicare (Star Rating) HEDIS member and provider outreach, engagement and intervention. This position is also responsible for assisting the manager of Outreach & Interventions in operationalizing all initiatives to improve HEDIS performance by working with internal and external stakeholders.

Additionally, the QI program pursues an integrated approach to achieving ongoing improvements in the quality of care and service delivered to members. Horizon Staff in the Quality Department acting as Horizon BCBSNJ's resource in operating the Braven Health Quality Program work closely with the following departments:

Network Operations & Contracting 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 member's rights and responsibilities and treat enrolled members accordingly.

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

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

4.6 External Quality Review

4.6.1 Centers for Medicare & Medicaid Services (CMS)

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

Additionally, CMS performs a full-program audit every four years. This full-program audit evaluates ODAG function including "clinical decision making." Program Audit Results are compared against other Medicare Advantage health plans. All Medicare Advantage health plans that are below the top 25 percent are subject to adverse action on behalf of CMS.

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

4.7. Behavioral Health

The Horizon Behavioral Health (BH) Program is committed to providing quality services to help Braven Health members manage all aspects of their health. Effective January 1, 2021, Braven Health will maintain a fully integrated BH program. Behavioral Health Case Management services are available to the Braven Health Medicare membership. Case managers provide assessment, development and implementation of individualized plans of care; and offer coordination of medical and behavioral health care services for members and their families. The Behavioral Health Program utilizes the Care Radius medical management system to support delivery and documentation of the case management process.

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

5. QI Program's Function

The function of the QI Program is to coordinate, oversee, guide, and assess Braven Health 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 Braven Health QI Program has the ability, through the QIC, to add additional areas on which to focus its attention.

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

5.1 Member Safety

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

To promote safety for hospitalized members and in accordance with the CMS guidelines and NJ state law, Horizon, in operating the Braven Health Quality Program, has policies to address quality of care and service, hospital acquired conditions and serious adverse events. The Quality Management Department reviews CMS regulations, applicable state laws, national clinical practice

and other guidelines at least annually. Policies are reviewed and approved every year including the list of selected hospital-acquired conditions and serious adverse events.

Additional activities occurring within the Quality Management Department and QIC that focus on enhancing member safety include: assisting in the reporting of quality indicators to the provider network, monitoring and follow up on corrective action plans required from delegated vendors and/or network providers who identified care and/or service deficiencies, conducting quality of care reviews focused on member safety issues, designing quality improvement projects targeted at at-risk populations, researching grievances related to member safety issues, analyzing under and over utilization data, and when appropriate, coordinating Braven Health 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. To address the multiplicity of the needs of the membership, the Braven Health QI Program will continue to work on identifying and addressing disparities in health outcomes among different member populations. The goal of this program is the implementation of interventions and community health events, which reduce disparities between differing member populations.

5.2.1 Complex Health Needs

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

medical management system to support both the delivery and documentation of the case management process.

Additionally, the Network Operations & Contracting Departments review geographic access reports to address the adequacy of the provider network. Reporting indicates sufficiency of PCP 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

Medicare Grievances

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

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

is identified on a case-by-case basis. Quarterly grievance reports are presented to the appropriate committees for review. Please note that grievances may also be referenced as complaints.

5.3.2 Quality of Care and Service

Within the Horizon Quality Management Department acting as Horizon BCBSNJ's resource in operating the Braven Health Quality Program, a team exists which is focused on quality of care issues. This team provides ongoing education to personnel regarding potential quality of care concerns and serious adverse events. This education includes the definitions/categories for quality-of-care referrals with direction on how staff can refer potential quality of care issues to the Quality Management Department for investigation, and to the medical director for review. All instances where a quality-of-care issue and/or serious adverse events, hospital acquired, or provider preventable event may exist are presented to the Quality Peer Review Committee (QPRC) for discussion, determination of departure from quality standards and guidelines, and possible practitioner sanctioning.

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

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

Quality of Care Referrals are captured by a Tableau Report which is a comprehensive report of quality of care referrals and grievances. This report is updated daily, and follows all

lines of products, including Medicare Advantage. Information obtained from Tableau is used for monthly monitoring of total cases referred, closed, and outstanding.

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

Monthly data is reviewed for trends and outliers. In the event a quality of care indicator persists, referrals are made to Horizon Network Operations & Contracting. The network team reports the results of its investigation to the Provider and Member Services Satisfaction Committees, which report into the QIC.

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

5.3.3 Audits and Reports

The Braven Health QI Program has oversight of audits and reports completed by multiple business areas. There are several reasons that audits and reports are performed. Audits and reports are required by the External Quality Review Organization (EQRO), necessary to meet accreditation requirements, and they provide Braven Health with insights as to how processes, providers and systems are performing. A selection of the audits and reports that are performed and then reviewed by the QIC is listed below:

- Geo Access Reports
- 24-hour Access Audit
- Appointment Availability Audit
- Office Manager Satisfaction Survey
- Behavioral Health Clinical and Quality Performance Measures
- Vendor Oversight Audit

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

5.4 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 relevant Braven Health policies are maintained on a SharePoint site. The site allows staff access to all current Braven Health policies. Monitoring of compliance requirements is coordinated with the Regulatory Affairs and Compliance Departments. Any policies requiring external approval are submitted to the Regulatory Affairs and Compliance Departments for submission to the State. Such policies which require external review and approval require an approval stamp on the policy*.*

5.5 Delegation Oversight

Delegated managed care entities that administer health care services and/or provide services covered under Braven Health'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, diagnostic imaging services, pharmacy benefit management, laboratory services, vision services, dental services, telemedicine, post-acute skilled nursing facility (SNF) and rehab care services, durable medical equipment, grievances, customer service and claims processing.

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

It is Braven's responsibility to ensure monitoring and oversight activities are performed to ensure delegate/vendor compliance and to promote the delivery of and access to quality and cost-effective health care and services to members. The Delegate Vendor Oversight Committee is responsible for the following: assessing on-going monitoring and evaluation activities performed collaboratively and independently by Horizon business units acting as Horizon BCBSNJ's resource in operating the Braven Health Quality Program; evaluation of delegate/vendor performance results to ensure business goals and outcomes are achieved to further the delivery of quality health goals and outcomes for our members and; ensuring subcontractor compliance with contractual provisions, regulatory requirements, and applicable accreditation guidelines.

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

5.6 Compliance with State and Federal Regulatory and CMS Guideline Requirements

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

- Confidentiality

  Braven Health processes address sensitive protected health information about members and physicians. Documents that are created and reviewed as part of the process are confidential and privileged. The information is maintained in compliance with appropriate federal and state regulations, the Health Insurance Portability and Accountability Act (HIPAA) and all applicable accreditation standards. All employees, participating physicians, vendors and consultants must maintain the Braven Health 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 acting as Horizon BCBSNJ's resource in operating the Braven Health Quality Program involving the use, disclosure or receipt of private health information. These third parties are business associates of Braven Health, which performs administrative functions for Braven Health and enter into formal Business Associate Agreements to protect the privacy and safeguard the security of such private information when assisting with administrative functions or providing services in operating the Braven Health Quality Program.

- Member Rights, Responsibilities and Patient Engagement

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

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

- Regulatory Compliance

The QI Program through the QIC:

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

- Ethics

The Braven Health QI program functions as a key component in promotion of integrity and values found in the care and services provided to Braven Health members. As outlined in the

Corporate Code of Business Conduct and Ethics, Braven Health is committed to maintaining the highest legal and ethical standards in the conduct of its businesses. In maintaining these standards, Braven Health places heavy reliance on individual good judgment, honesty and character. This commitment applies without exception to all activities.

5.7 *Credentialing and Re-credentialing*

Braven Health credentialing and re-credentialing activities are administered by the Horizon BCBSNJ Credentialing Department. Horizon BCBSNJ's credentialing and re-credentialing process determines whether physicians, other health care professionals, and organizational providers of services meet all applicable state licensing standards, participation and credentialing criteria, and are qualified to provide the care or services for which they have been contracted. Oversight of the credentialing and re-credentialing activities is managed through the QIC. In addition, the QPRC (see 5.3.2 above) 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.

5.8 Clinical Practice Guidelines (CPGs)

CPGs are evidenced-based practice standards promoted by Horizon in operating the Braven Health Quality Program. They are used to assist staff in making appropriate recommendations and to inform members and providers about making educated health care decisions. Topics addressed by CPGs include, but are not limited to, preventive health, asthma, diabetes, maternity, EPSDT, behavioral health and geriatric care. The CPGs are based on nationally recognized medical association standards and medical references. The guidelines are reviewed and updated at a minimum of every two years, or as needed, and they are presented to the UM/CM Committee for approval. Information about Braven Health CPGs is made available to providers through the Braven Health Provider Administrative Manual, provider and newsletters. Additionally, Braven Health will follow Horizon BCBSNJ's policies and procedures, including its medical policies. Providers may visit HorizonBlue.com/Braven Health for policy and CPG information. Guidelines are available to members through the website, member newsletters, and/or a copy can be requested by calling the Member Services Department.

5.9 Cultural Competency and Health Literacy

Braven Health recognizes the cultural diversity and health literacy needs of its health plan members. The Plan is committed to promoting cultural competency, increasing health literacy, and decreasing health care disparities, regardless of gender, gender identity or sexual orientation. Braven Health 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. Braven Health produces member-related materials which are easily understood and in languages that meet member needs.

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

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

In evaluating cultural and linguistic needs, Horizon, in operating the Braven Health Quality Program, performs the following:

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

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

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

5.10 *Fraud, Waste, and Abuse*

The Fraud, Waste and Abuse Prevention Plan documents the organization's comprehensive approach to prevent, detect, investigate, recover, and report cases of fraud, waste, and abuse in the Medicare Advantage Programs. The plan supplements all Braven Health 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:

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

Braven Health may routinely discover 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. Braven has engaged the Horizon BCBSNJ's Medicare Special Investigations Unit (SIU) to coordinate fraud waste and abuse activities with all state and federal agencies. If a potential issue is identified, the information is reported to Horizon SIU acting as Horizon BCBSNJ's resource in operating the Braven Health Quality Program for evaluation and further action.

5.11 Program Performance

In its role administering the Braven Health Quality Management Program, Horizon BCBSNJ dedicates resources across the organization, and specifically within the Quality Management Department, to focus on Braven Health Quality Performance. This work is guided by the QI program and included in the QI program Work Plan. The QIC as directed by the Braven Health Board's Quality Subcommittee, which has oversight of this work including the planning, monitoring and evaluation of the outcomes of these efforts.

5.11.1 QI Program Work Plan

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

5.11.2 Performance Improvement Projects (PIPs)

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

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

5.11.2.1 Medicare PIPs (CMS PIPs/CCIPs)

Braven Health will participate in ongoing quality improvement programs for each contract in place. The purpose of the QI program is to ensure that Braven Health 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 active MA contracts and have a three-year project cycle. Braven Health is not required to submit updates for its Medicare CCIPs to CMS, but rather monitors CCIPs internally and submits an attestation that confirms the projects are in place.

5.11.3 Healthcare Effectiveness Data and Information Set (HEDIS)

Braven Health HEDIS measures are evaluated and analyzed monthly. Initiatives are developed, changed, and/or enhancements to initiatives and outreach activities are discussed in the HEDIS subcommittee meetings. HEDIS performance results are reported annually to the QIC, NCQA and reported at the Quality Committee board meeting through review of the QI Program Evaluation.

Annually, Horizon in its role administering the Braven Health Quality Program creates a new work plan to address HEDIS measures that fall below 50th percentile. Existing initiatives and outreach areas are evaluated for their impact and, if needed, are enhanced to improve measure performance. The results and outcomes of initiatives and outreach are monitored monthly and shared in HEDIS subcommittee meetings held ten times per year.

5.11.4 Star Ratings

The Braven Health Medicare Star Rating measures are monitored monthly. Star Rating measures are assigned to business owners who develop strategies, initiatives and outreach activities to maintain and/or improve performance. Star Rating progress is reported to the QIC on a quarterly basis. Star Rating measure performance results are reported to the QIC, NCQA and at the Quality Committee board meeting through review of the QI Program Evaluation.

5.11.5 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS survey captures accurate and complete information about member-reported experiences and how well the Plan and providers are meeting members' expectations and goals. The Horizon Quality Management Department in its role

administering the Braven Health Quality Program coordinates efforts to improve CAHPS scores for Braven members. 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. Braven Health will determine in 2021, which opportunities exists to develop efforts to yield positive results on key 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.

5.11.6 Health Outcomes Survey (HOS)

The Health Outcomes Survey (HOS) provides an assessment of how Braven Health members describe changes in their health status over time. Horizon BCBSNJ's Customer Experience team acting as Horizon BCBSNJ's resource in operating the Braven Health Quality Program 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 HOS survey results. Review of the HOS survey results is included in QI Program Work Plan.

5.12 New Initiatives & Opportunities for Continued Improvement

In 2021, Horizon acting in its role administering the Braven Health Quality Program will track opportunities for improvements which will be presented to the Braven Health QC and prioritized for 2022. Opportunities for improvement that are identified in the 2021 QI Program Evaluation are incorporated into the following year's QI Program activities for implementation and monitoring by the QIC. These opportunities will require new initiatives to be developed that will yield a positive impact on the quality of care and service Braven Health provides its members, and will have direct monitoring by the QI program because of their scope and impact on members and providers. Horizon, in operating the Braven Health Quality Program, will track these opportunities for improvement in 2021 and include updates to activities in the QI Program Evaluation for future Braven Health Success.

Braven Health will pursue these opportunities for improvement in 2022 and include updates to activities in the QI Work Plan to monitor, track and trend progress toward goals.

Attachments to Program Description

Attachment 1, Braven Health JV, Insurance Company & CMS Contract Structure

Attachment 2, Business Performance Management Governance – Medicare Advantage

Attachment 3, 2021 Braven/Horizon Committee Organization Chart

Government Programs 2021 Quality Improvement Program Description

Approvals

_____ _____

Date

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Date