MVP Health Care®

2024 Quality Improvement Program Description

Table of Contents

INTRODUCTION...3

***PURPOSE*...4**

***SCOPE*...4**

***PRIORITIES AND GOALS*...7**

***CONFIDENTIALITY*...8**

CULTURAL COMPETENCY AND HEALTH EQUITY...9

AUTHORITY...11

QUALITY PROGRAM STRUCTURE...13

QI PROGRAM RESOURCES: INFRASTRUCTURE AND DATA ANALYTICS...53

DOCUMENTATION CYCLE...555

***PERFORMANCE MEASUREMENT*...58**

PROMOTING MEMBER SAFETY AND QUALITY OF CARE...59

***MEMBER ACCESS TO CARE*...61**

POPULATION HEALTH MANAGEMENT...65

***PROVIDER SUPPORTS*...66**

PERFORMANCE IMPROVEMENT ACTIVITIES...7171

GRIEVANCE AND APPEAL SYSTEM...76

REGULATORY COMPLIANCE AND REPORTING...76

NCQA HEALTH PLAN ACCREDITATION...77

***DELEGATED SERVICES*...77**

INTRODUCTION

The MVP Health Care® (MVP) Quality Improvement (QI) Program Description provides the framework to improve the quality, safety, and efficiency of clinical care, enhance satisfaction, and improve the health of MVP members and the communities it serves. The QI Program Description defines the authority, scope, structure, and content of the QI Program, including the roles and responsibilities of committees and individuals supporting program implementation.

MVP is a quality-driven organization that adopts continuous quality improvement as a core business strategy for the entire health plan. MVP develops and implements a quality management strategy that is embedded within every staff role and department function, approaching quality assurance, quality management, and quality improvement as a culture, integral to all daily operations. Each MVP operational area has defined performance metrics with accountability to the Quality Improvement Committee (QIC) and Board of Directors.

MVP acknowledges its obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate setting. MVP provides for the delivery of quality care with the primary goal of improving the health status of members by supporting providers, who know what is best for their patients.

The MVP leadership team is committed to focusing clinical, network, and operational processes towards improving the health of members (including all demographic groups and those with special health care needs), enhancing each member's experience of care and service, lowering the per capita cost of their health care, and improving the work life of Participating Providers and their staff, as well as their experience and satisfaction.

MVP's QI Program utilizes the Continuous Quality Improvement Cycle (Plan, Do, Check, Act [PDCA]) as an agile approach to measure quality and is part of *The MVP Way*. MVP embraces this philosophy as a critical component of the quality approach. Discipline is necessary to apply the PDCA cycle to MVP's quality program. When initiatives are being considered, it is essential to understand who the intervention is intended to impact, the resources necessary for the intervention, and the estimated effectiveness of the intervention. Interventions will be monitored against expectations and will be modified as necessary to improve results. When there is considerable uncertainty about the variables, it is preferred to pilot the intervention on a smaller scale and then expand once the impact is more defined. Pilots are developed with the same discipline as full initiatives; however, it is equally important to move the pilots forward as quickly as possible so information obtained can be analyzed to determine if the intervention should be expanded.

In addition, the annual quality plan sets expectations to allow MVP to use the PDCA cycle effectively.

The QI Department maintains strong inter/intradepartmental working relationships, with support integrated throughout MVP to address the priorities and goals of the QI Program and assess its effectiveness. Collaborative activities include development of department objectives and plans, coordination of activities to achieve department goals, and participation on quality committees as needed to support the QI Program. The QI Department collaborates across MVP with several functional areas including, but not limited to, Case Management, Provider Relations, Population Health Management, Network/Contracting, Customer Care, Corporate Compliance, and Clinical Quality and Risk Management.

PURPOSE

MVP is committed to the provision of a well-designed and well-implemented QI Program. MVP's culture, systems, and processes are structured around the purpose and mission to improve the health of all members which includes a focus on health outcomes as well as health care process measures, and member and provider experience.

The QI Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members. Whenever possible, the MVP QI Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of its members. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services by addressing both medical and non-medical drivers of health and promoting health equity.

MVP provides for the delivery of quality care with the primary goal of improving the health status of MVP members. When a member's condition is not amenable to improvement, MVP implements measures to prevent any further decline in condition or deterioration of health status or provides for comfort measures as appropriate and requested by the member.

To fulfill its responsibility to members, the community and other key stakeholders, and regulatory and accreditation agencies, the MVP Board of Directors has adopted the following QI Program Description. The program description is reviewed and approved at least annually by the QIC and MVP Board of Directors.

SCOPE

The scope of the QI Program is comprehensive and addresses both the quality and safety of clinical care and quality of services provided to MVP members including medical, behavioral health, dental, and vision care as applicable to MVP's benefit package. MVP incorporates all demographic groups, lines of business, benefit packages, care settings, and services in its quality management and improvement activities. Areas addressed by the QI Program include:

- Preventive health
- Emergency care
- Acute and chronic care
- Population health management (PHM)

- Health disparity reduction
- Behavioral health
- Episodic care
- Long-term services and supports (LTSS)
- Ancillary services
- Continuity and coordination of care
- Patient safety
- Social determinants of health (SDOH)
- Administrative, member, and network services as applicable

The MVP QI Program includes the following activities:

- Identification of priorities and goals aligning with MVP's mission and the health priorities defined by the Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), New York State Department of Health (NYSDOH), National Committee for Quality Assurance (NCQA), Vermont (VT) Department of Financial Regulation (DFR), New York State Department of Financial Services (DFS), National Institutes of Health (NIH), and other regulatory bodies
- Conducting quality activities, including peer review activities, in accordance with all applicable state and federal confidentiality laws and regulations and taking conflicts of interest into consideration when conducting peer review activities
- A focus on cultural competency and health equity, including the identification of interventions to improve health disparities based on age, race, ethnicity, preferred gender, primary language, etc. and by key population group
- Assessment and identification of interventions to address health disparities at a statewide and regional level, including identifying internal priorities for disparity reduction, quality measure improvement, and addressing inequalities
- A robust QIC structure, including subcommittees and additional ad hoc committees as applicable, to meet the needs of MVP, members, and providers
- Allocation of personnel and resources necessary to:
    - Support the QI Program, including data analysis and reporting
    - Meet the educational needs of members, providers, and staff relevant to quality improvement efforts
    - Meet all regulatory and accreditation requirements
- The technology infrastructure and data analytics capabilities to support goals for quality management and value include health information systems that provide data collection, integration, tracking, analysis, and reporting of data that reflects performance on standardized measures of health outcomes
- An ongoing documentation cycle that includes the QI Program Description, the QI Work Plan, and a QI Annual Report; these documents demonstrate a systematic process of quality assessment, identification of opportunities, action implementation as indicated, and ongoing evaluation

- Collecting and submitting all quality performance measurement data per state, federal, and accreditation requirements, including robust performance management tracking and reporting such as:
    - The annual Consumer Assessment of Health Care Providers and Systems (CAHPS®):
        - CAHPS is a Qualified Health Plan (QHP) Enrollee Experience survey for the Medicare, Medicaid, Commercial, and Marketplace lines of business
    - The annual Health Outcomes Survey (HOS):
        - HOS is a CMS-developed survey tool which assesses a health plan's ability to maintain or improve the physical and mental health of Medicare members over time
    - Healthcare Effectiveness Data and Information Set (HEDIS®) results for members:
        - HEDIS is an established set of performance measures developed and maintained by NCQA
    - Developing additional standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time
    - Administering an annual provider satisfaction survey and identifying improvement activities based on identified areas of provider need/dissatisfaction
- Monitoring, assessing, and promoting patient safety including efforts to prevent, detect, and remediate quality of care and critical incidents and a peer review process that addresses deviations in the provision of health care and action plans to improve services
- Ensuring member access to care in areas such as network adequacy, availability of services, timely appointment availability, transitions of coverage, coordination, and continuity of care, etc.
- Encouraging providers to participate in quality initiatives and giving support to providers, including a provider analytics system that delivers frequent, periodic quality improvement information to Participating Providers to support them in their efforts to provide high quality health care, and adoption and distribution of evidence-based practice guidelines
- Conducting and assessing quality improvement activities and Performance Improvement Projects (PIPs) based on demonstration of need and relevance to the population served, with improvement initiatives aligned with identified health priorities, state/federal requirements, and applicable member population(s)
- Developing and implementing a Chronic Care Improvement Program (CCIP) for Medicare, focused on improving care and health outcomes for members with chronic conditions
- Monitoring utilization patterns by performing assessment of utilization data to identify potential over-and under-utilization issues or practices using various data sources such as medical, behavioral health, pharmacy, dental, and vision claim/encounter data to identify patterns of potential or actual inappropriate utilization of services
- A PHM strategy focused on four key areas of member health needs (keeping members healthy, managing members with emerging health risk, patient safety/outcomes across settings, and managing multiple chronic illnesses) that offers interventions to address member needs in all stages of health and across all health care settings

- Serving members with complex health needs, including members needing complex care management
- Achieving/maintaining NCQA accreditation and/or other applicable accreditations for appropriate products
- Monitoring for compliance with all regulatory and accreditation requirements
- Collaboration with Corporate Compliance and other applicable departments concerning oversight of delegated functions and services, including approval of the delegate's programs, routine reporting of key performance metrics, and ongoing evaluation to determine whether the delegated activities are being carried out according to health plan and regulatory requirements, and accreditation standards

PRIORITIES AND GOALS

MVP's primary goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving the quality of care and services delivered. The QI Program focuses on the health priorities defined by a combination of the CDC, NIH, and other evidence-based sources. Performance measures are aligned to specific priorities and goals used to drive quality improvement and operational excellence.

The MVP QI Program's priorities and goals support MVP's purpose to ***be the difference for the customer, be curious, and be humble*** and its mission to ***improve health, provide peace of mind, and create healthier communities.***

To improve health, provide peace of mind, and create healthier communities.		
Focus on Individuals	**Whole Health**	**Active Local Involvement**
Priorities	**Priorities**	**Priorities**
• Well-coordinated, timely, accessible care delivery • Member tools and resources to help make healthy decisions • Home and community connection • Right care, right place, right time • Member engagement • Provider engagement • High value care • Member satisfaction with provider and health plan	• Meaningful use of data • Prevent and manage top chronic illnesses • Manage co-morbid physical and behavioral health diagnoses • Manage episodic illnesses • Manage rare chronic conditions • Screen for unmet needs • Remove barriers to care; make it simple to get well/stay well/be well • Coordination of care across the health care continuum	• Local partnerships • Population health improvement • Preventive health and wellness • Maternal-child health care • Prevent and manage obesity • Tobacco cessation • Opioid misuse prevention and treatment • Address SDOH • Health equity/disparity reduction • Multi-cultural health

To improve health, provide peace of mind, and create healthier communities.		
Focus on Individuals	**Whole Health**	**Active Local Involvement**
Priorities	**Priorities**	**Priorities**
	• Behavioral health integration • LTSS quality of life	

CONFIDENTIALITY

Confidential information is defined as any data or information that can directly or indirectly identify a member or provider. MVP and all Participating Providers and subcontractors comply with the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), and all applicable federal and state privacy laws. The QIC and its subcommittees have the responsibility to review quality of care and resource utilization, as well as conduct peer review activities as appropriate. The QIC and related peer review committees conduct such proceedings in accordance with MVP's bylaws and applicable federal and state statutes and regulations.

The proceedings of the QIC, its subcommittees, work groups, and/or any ad hoc peer review committees are considered "Privileged and Confidential" and are treated as such. In this regard, all correspondence, worksheets, quality documents, minutes of meetings, findings, and recommendations for the programs are considered strictly confidential and therefore not legally discoverable.

Confidential quality findings are accessible only to the following individuals/groups:

- Board of Directors
- President and Chief Executive Officer (CEO)
- Chief Medical Officer; Vice President, Health and Pharmacy Management; Director, Accreditation and Quality Regulatory Compliance; and designated Quality Department staff
- Peer Review Committee (PRC)
- External regulatory agencies, as mandated by applicable state/federal laws
- MVP legal executives
- Corporate Compliance leadership

QIC correspondence and documents may be made available to another health care entity's PRC, and/or any regulatory body as governed by law, for the purpose of carrying out or coordinating quality improvement/peer review activities; this may include a Quality and/or Credentialing Committee of a health plan-affiliated entity or that of a contracted medical group/independent physician association.

MVP has adopted the following confidentiality standards to ensure quality proceedings remain privileged:

- Confidentiality policies and procedures comply with applicable state statutes that address protection of peer review documents and information
- Committee members and employees responsible for Quality, Health Management, Credentialing, and Pharmacy program activities are educated about maintaining the confidentiality of peer review documents
- The Confidentiality and Conflict of Interest Disclosure Agreement is distributed and required for all committee participants annually
- The Director, Accreditation and QI Regulatory Compliance designates Quality Department staff responsible for taking minutes and maintaining confidentiality
- For quality studies coordinated with, or provided to outside PRCs, references to members are coded by identification number rather than a protected health information (PHI) identifier such as medical record number or ID number, with references to individual providers by provider code number
- Records of review findings are maintained in secured files, which are made available only as required by law or specifically authorized in writing by the CEO, Chief Medical Officer, Chief Legal Officer and General Counsel, Vice President, Health and Pharmacy Management, or the Board of Directors Chair

CONFLICT OF INTEREST

MVP defines conflict of interest as participation in any review of cases when objectivity may not be maintained. No individual may participate in a quality of care or medical necessity decision regarding any case in which he or she has been professionally involved in the delivery of care. Peer reviewers may not participate in decisions on cases where the reviewer is the consulting provider or where the reviewer's partner, associate, or relative is involved in the care of the member, or cases in which the provider or other consultant has previously reviewed the case. When a provider of any committee perceives a conflict of interest related to voting on any provider-related or peer review issue, the individual in question is required to abstain from voting on that issue.

CULTURAL COMPETENCY AND HEALTH EQUITY

MVP strives to meet the needs of all members with sensitivity to cultural needs and the impact of cultural differences on health services and outcomes. MVP is guided by requirements set by each respective state/federal contract and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) developed by the Office of Minority Health. Specifically, the QI Program identifies and addresses clinical areas of health disparities. MVP assures communications are culturally sensitive, appropriate, and meet federal and state requirements. Information provided to members promotes the delivery of services in a culturally competent manner to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, or disabilities and regardless of gender, sexual orientation, or gender identity. PHM initiatives are reviewed to assure cultural issues and SDOH are identified, considered, and addressed. Additionally, MVP is committed to improving disparities in care as an approach to improving HEDIS measures, reducing utilization costs, and delivering locally tailored, culturally relevant care. As such, MVP

has developed a health equity approach that identifies and highlights disparities, prioritizes projects, and collaborates across the community to reduce disparities by targeting member, provider, and community interventions. Disparity analysis includes analyzing HEDIS and utilization data by eligibility category, race, ethnicity, limited English proficiency, disability, age, gender, and geography to identify priority populations and interventions for targeting disparity reduction.

Serving a Culturally and Linguistically Diverse Membership

The following outlines MVP's strategy to monitor cultural and linguistic needs of its membership and maintain compliance as defined by Section 15.10 of the New York State (NYS) Medicaid Model Contract and current NCQA Health Plan Accreditation (HPA) Standards:

1. MVP promotes and ensures the delivery of services in a culturally competent manner to all members, including but not limited to those with limited English proficiency, diverse cultural and ethnic backgrounds, as well as members with diverse sexual orientations, gender identities, and members of diverse faith communities. Cultural competence means having the capacity to function effectively within the context of the cultural beliefs, behaviors, and needs presented by members and their communities across all levels of the organization.
2. To comply with this section:
    a. The MVP Network Management Department maintains an inclusive culturally competent provider network. In accordance with Section 21 of the NYS Medicaid Model Contract, the Network also includes a culturally competent network of Behavioral Health (BH) providers, individual BH providers, community-based providers, and peer-delivered services.
    b. MVP policies and procedures incorporate the importance of honoring members' beliefs, sensitivity to cultural diversity, fostering respect for members' culture and cultural identity, and eliminating cultural disparities.
    c. The Accreditation and Quality Regulatory Compliance team maintains a cultural competence component in the MVP Internal Quality Assurance program, referenced in Section 16.1 (d) of the NYS Medicaid Model Contract.
    d. The MVP comprehensive cultural competence plan is based on National CLAS Standards of the US Department of Health and Human Services, Office of Minority Health, the most current NCQA HPA standards, and managed through the MVP Internal Quality Assurance Program.
    e. MVP performs internal cultural competence activities including, but not limited to:
        i. Organization-wide cultural competence self-assessment led by Talent Management.
        ii. Community needs assessments to identify threshold populations in each Service Area in which MVP operates.
        iii. Quality improvement projects to improve cultural competence and reduce disparities, informed by such assessments and National CLAS Standards.
    f. Talent facilitates annual training in cultural competence for all MVP staff members:

i. All elements of the curriculum are consistent with and/or reflects National CLAS Standards.
ii. The MVP cultural competence training materials are subject to the review and approval by NYS.

g. The MVP Network Management Department ensures the cultural competence of its provider network by requiring Participating Providers to attest, annually, the completion of a cultural competence training curriculum, including training on the use of interpreters, for all Participating Providers' staff who have regular and substantial contact with members. NYS makes available cultural competence training materials for Article 31 of the New York State Mental Hygiene Law governed by the Office of Mental Health (OMH) and Article 32 of the New York State Mental Hygiene Law governed by the Office of Addiction Services and Supports (OASAS) facilities on their website(s).

For 2024, these cultural and linguistic items will be tracked and monitored by the appropriate business area and reported up to the Service Improvement Committee (SIC), Clinical Quality Committee (CQC), and the QIC, as appropriate.

AUTHORITY

The MVP Board of Directors has authority and oversight of the development, implementation, and evaluation of the QI Program and is accountable for oversight of the quality of care and services provided to members. The Board of Directors supports the QI Program by:

- Adopting the initial and QI Annual Report which requires regular reporting (at least annually) to the Board of Directors, and establishes mechanisms for monitoring and evaluating quality, utilization, and risk
- Supporting QIC recommendations for proposed quality studies and other quality initiatives and actions taken
- Providing the resources, support, and systems necessary for optimum performance of quality functions
- Designating a senior staff member as the MVP senior quality executive
- Designating a BH professional to provide oversight of the behavioral health aspects of care to ensure appropriateness of care delivery and improve quality of service
- Evaluating the QI Program Description and QI Work Plan annually to assess whether program objectives were met and recommending adjustments when necessary

MVP Board of Directors delegates the operating authority of the QI Program to the QIC. MVP executive management, clinical staff, and Participating Providers including, but not limited to, primary, specialty, behavioral, dental, and vision health care providers, are involved in the implementation, monitoring, and directing of the relative aspects of the QI Program through the QIC, which is directly accountable to the Board of Directors.

The Chief Medical Officer, or designated by the MVP President/CEO, serves as the senior quality executive and is responsible for:

- Compliance with state, federal, and accreditation requirements and regulations

- Chairing the QIC, or designating an appropriate alternate Chair, and participating as appropriate
- Monitoring and directing quality activities among personnel and among the various subcommittees reporting to the QIC
- Coordinating the resolution of outstanding issues with the appropriate leadership staff, pertaining to QIC recommendations, subcommittee recommendations, and/or other stakeholder recommendations
- Being actively involved in the MVP QI Program including activities such as recommending quality study methodology, formulating topics for quality studies as they relate to accreditation and regulatory requirements and state and federal law, promoting Participating Provider compliance with medical necessity criteria and clinical practice and preventive health guidelines, assisting in on-going patient care monitoring as it relates to PHM programs, pharmacy, diagnostic-specific case reviews, and other focused studies, and directing credentialing and recredentialing activities in accordance with MVP's policies and procedures
- Reporting the QI Program activities and outcomes to the Board of Directors at least annually

MVP Medical Directors work closely with operational Senior Leaders to develop, evaluate, and improve Quality and Health Management programs, under the direction of the Chief Medical Officer. Responsibilities include assessment of current performance and identification of opportunities and methods for improvement. They are available to Quality and Health Management staff to assist in operational implementation of quality, medical, and behavioral health management programs and to participate in Quality and Health Management operational meetings as directed.

The MVP Medical Directors participate in the MVP Credentialing program. They provide clinical review and oversight of the MVP appeal and grievance process and direct the clinical development, continuous improvement, and clinical management of the MVP Quality Management efforts in geographic and product line initiatives. The Medical Directors also provide clinical leadership in the implementation of QI activities and actions related to MVP members and providers, including NCQA surveys, annual HEDIS reporting, CMS, and state regulatory audits. The MVP Medical Director(s) also oversee the QI activities in Vermont, ensuring those activities are designed to meet the needs of Vermont health plan members and the requirements of Rule-H-2009-03 in Vermont.

The MVP Medical Directors are also responsible for rendering decisions on utilization requests, appeals, quality of care complaints, and cases referred for peer review, and for carrying out educational and corrective action processes with individual providers in accordance with the MVP policies, procedures, and programs. In addition, the MVP Medical Directors may be appointed to serve on the QIC and subcommittees. This role also includes oversight, development, and approval of clinical quality protocols and provides input into the development of Clinical Operations, QI, and Credentialing administrative policies and procedures.

The Behavioral Health Medical Director, or other appropriate BH provider (i.e., a medical doctor or a clinical PhD or PsyD who may be a medical director, clinical director, or a Participating Provider from the organization or BH care delegate), is the designated provider responsible for the BH aspects of the QI Program and is responsible for:

- Compliance with state, federal, and accreditation requirements and regulations related to BH
- Participating in the QIC and various subcommittees reporting to the QIC, as applicable to BH
- Monitoring and directing BH quality activities among personnel and among the various subcommittees reporting to the QIC
- Providing oversight of the BH aspects of care to ensure appropriateness of care delivery and improve quality of service
- Providing clinical leadership in the implementation of QI activities and actions related to MVP members and Participating Providers, including NCQA surveys, annual HEDIS reporting, CMS, and state regulatory audits

QUALITY PROGRAM STRUCTURE

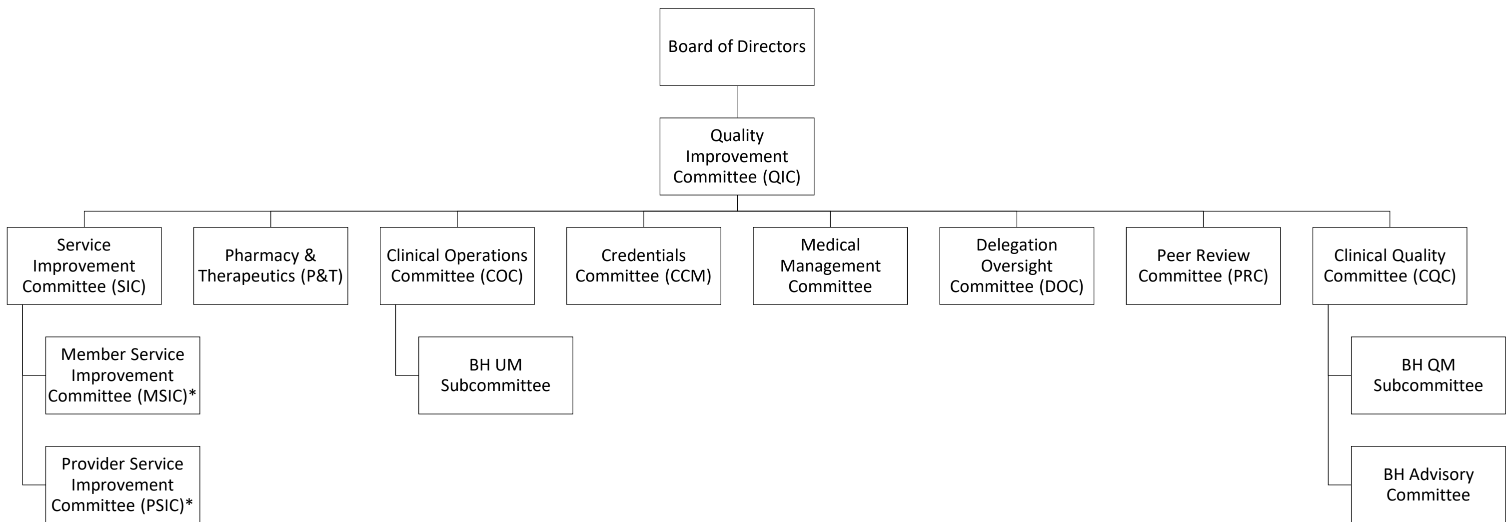
Quality is integrated throughout MVP and represents the strong commitment to quality of care and services provided to MVP members. The Board of Directors is the governing body designated for oversight of the QI Program and has delegated the authority and responsibility for the development and implementation of the QI Program to the QIC.

The QIC is a senior management led committee accountable directly to the Board of Directors and reports QI Program activities, findings, recommendations, actions, and results to the Board of Directors no less than quarterly. MVP ensures ongoing member, provider, and stakeholder input into the QI Program through a strong quality improvement committee and subcommittee structure focused on member and provider experience. The MVP QIC structure is designed to continually promote information, reports, and improvement activity results, driven by the QI Work Plan, throughout the organization and to providers, members, and stakeholders. The QIC serves as the umbrella committee through which all subcommittee activities are reported and approved. The QIC directs subcommittees to implement improvement activities based on performance trends, and member, provider, and system needs. Additional committees may also be included per MVP's need, including regional level committees as needed based on distribution of membership. These committees assist with monitoring and supporting the QI Program. The MVP QIC structure is outlined below:

MVP Quality Committee Structure

The MVP QI committees and subcommittees also serve as a communication pathway. Overlapping committee membership offers diverse expertise throughout the committee structure, however, chairpersons are responsible for ensuring that issues which require review by

members of other committees or subcommittees are communicated to the chairperson of that committee or subcommittee.



BH subcommittees address three populations: Adult, Children, and Health and Recovery Plans (HARP).

MVP Core Committee Charters

Quality Improvement Committee (QIC)	
Charter Statement	The QIC is the senior leadership committee, accountable to the Board of Directors, that reviews and monitors all MVP clinical quality and service functions and provides oversight of all subcommittees.
Purpose	The purpose of the QIC is to provide oversight and direction in assessing the appropriateness of care and service delivered, and to continuously enhance and improve the quality of care and services provided to members through a comprehensive, health plan-wide system of ongoing, objective, and systematic monitoring of activities and outcomes using the quality process.
Responsibilities	• Oversight of MVP's quality activities to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as NCQA • Annual recommendations and approval of the QI Program Description and Work Plan which includes applicable supporting department goals as indicated • Development of quality and performance improvement studies and activities, with report findings presented to the Board of Directors • Annual review and approval of Credentialing, Pharmacy, Utilization Management (UM), and PHM Program Descriptions and Work Plans as developed by the appointed subcommittees to facilitate alliance with the MVP strategic quality vision and goals

	• Evaluation of department quality activities which includes barrier analysis, trend identification, and recommended interventions required to improve the quality of care and/or service to members; this may include policy decisions and implementation of corrective action plans (CAPs) as appropriate • Prioritization of quality improvement efforts, facilitation of functional area collaboration, and assurance of appropriate resources to carry out quality activities • Review and establishment of benchmarks and performance goals for each quality improvement initiative and service indicator • Review and approval of due diligence information for any potential delegated entity and the annual oversight audit outcomes for delegated entities • Adoption of preventive health and clinical practice guidelines to promote appropriate and standardized quality of care • Monitoring of clinical quality indicators (such as HEDIS, adverse events, sentinel events, peer review outcomes, quality of care tracking, etc.) to identify deviation from standards of medical care, and supporting the formulation of corrective actions, as appropriate • Ongoing evaluation of the appropriateness and effectiveness of pay-for-performance (P4P) and value-based contracting initiatives and support in designing and modifying the program as warranted • Annual review and approval of all UM policies and procedures to ensure they comply with Medicare coverage standards and requirements (i.e., Non Coverage Determinations (NCD's), Local Coverage Determinations (LCD's)) • Review and removal of UM requirements that no longer warrant UM (i.e., analysis of UM decisions/outcomes, etc.) • Review the reason for its decisions regarding the development of policies and procedures'
Reports To	Board of Directors
Committee Chair	Chief Medical Officer, may delegate individual meetings to a Medical Director or Senior Quality Executive
Committee Composition	• Chief Medical Officer • At least two Medical Directors (a minimum of one medical and one BH specialty) Senior Leaders/Directors representing a range of business areas within MVP, i.e., Medical Affairs, Quality Improvement, Accreditation and Quality Regulatory Compliance, Population Health Management, Pharmacy, Customer Care and Experience, Provider Data Services, Network, and other MVP representatives as identified by subject matter expertise • Practicing Providers, at least four, representing the range of providers within the network and across the regions in which MVP operates, i.e., family practice, internal medicine, cardiology, OB/GYN, BH (i.e., physician or clinical PhD or PsyD), vision/dental care providers, and other high-volume specialists as appropriate • MVP Medicare Advantage Member

	• In addition, the committee may also have providers knowledgeable about members with disabilities, SUD, abuse of children, etc. • The provider representatives should have experience caring for MVP members, including a variety of ages and races/ethnicities, rural and urban populations, etc. • Committee member TBD with expertise in the care of the elderly or disabled
Frequency	Quarterly
Attendance Required	50% of scheduled meetings
Quorum	50% of the voting members plus one, based on the current voting membership at the time of the meeting.
Agenda	Agenda items for the next meeting are developed by the committee Chair in collaboration with Directors and Vice Presidents for Population Health Management, Pharmacy Management, Accreditation and Quality Regulatory Compliance, and Customer Care and Support Services. The committee receives regular reports from all subcommittees that are accountable to and/or advise the QIC.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed within three days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable. Materials included in meeting packet are based on needs for prior review and privacy/sensitivity of materials.
Decision Authority	The QIC is authorized by the Board of Directors to make all decisions related to the QI Program, with decisions made by consensus of the committee. Individuals are responsible to raise any issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information and/or situations when dissemination of information is to be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement annually.

Peer Review Committee (PRC)	
Charter Statement	The PRC is an ad-hoc committee of the QIC and is responsible for reviewing alleged inappropriate or aberrant services by a provider, including potential quality of care incidents, adverse events, and sentinel events where initial investigation indicates a significant potential or significant, severe adverse outcome has occurred or other cases as deemed appropriate by the Medical Director.
Purpose	The purpose of the PRC is to review clinical cases and apply clinical judgment in assessing the appropriateness of clinical care and recommending a CAP to best suit the individual situation. The PRC conducts peer review of quality issues that originate in regions in which there is no PRC structure.

Responsibilities	• To make determinations regarding appropriateness of care • To make recommendations regarding corrective actions relating to provider quality of care • To conduct the review by a provider of same or similar specialty as the provider and/or issue under review
Reports To	QIC
Committee Chair	Chief Medical Officer or Medical Director designee
Committee Composition	• Director, Accreditation and Quality Regulatory Compliance • Peer providers, at least three or more Participating Providers who are peers of the provider being reviewed and who represent a range of specialties, including at least one provider with the same or similar specialty as the case under review, but whose presence does not indicate a conflict of interest • *No Credentialing Committee members involved in the PRC's recommendation will be included in the Credentialing Committee meeting when the PRC's recommendation is discussed*
Frequency	Ad hoc, date and time to be determined based on need. Participating Providers serving on the committee may or may not be the same external providers serving on the PRC or Credentialing Committee. If the same providers are used, the PRC or Credentialing Committee meeting is adjourned and the PRC meeting is started as an independent meeting with an independent agenda and minutes.
Attendance Required	100% of scheduled meetings. Participating Providers are not standing members of the committee and their attendance may change based on type of case being reviewed.
Quorum	At least two Participating Providers and one Medical Director must be present for a quorum. All permanent committee members are voting members; the committee Chair is the determining vote in the case of a tie vote. All voting members who are present at the meeting constitute a quorum.
Agenda	Meetings are agenda driven. The committee Chair and/or Quality designee develop agenda items for the next meeting.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed within three days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials. All names and identifying information are redacted and information is distributed in a secure manner.
Decision Authority	The QIC authorizes the PRC to make decisions and recommendations regarding provider quality of care.
Evaluation	The committee reviews the charter annually.

Confidentiality	Peer review laws governing confidentiality of its proceedings protect each committee member. Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Credentials Committee (CCM)	
Charter Statement	The CCM is a standing subcommittee of the QIC that oversees and has operating authority of the Credentialing Program.
Purpose	The purpose of the CCM is to provide oversight of the development and annual review/approval of credentialing policies and participation criteria for Participating Providers and organizational providers. The CCM has final authority for credentialing and recredentialing licensed medical and BH providers, other licensed health care professionals, and organizational providers who have an independent relationship with MVP. The CCM oversees the credentialing process to ensure compliance with regulatory and accreditation requirements and ensure Participating Providers and organizational providers are qualified, properly credentialed, and available for access by MVP Members.
Responsibilities	• Provide guidance to organization staff on the overall direction of the Credentialing Program • Review and approve credentialing and recredentialing policies and procedures • Review, recommend, and approve credentialing and recredentialing criteria • Responsible for the credentialing and recredentialing decisions for physicians, non-physician providers, and organizational and ancillary providers at MVP • Provide clinical peer input to address standards of care for a particular type of provider • Review oversight audits of delegates Credentialing Program performance • Evaluate and report to management on the effectiveness of the Credentialing Program • Review potential quality of care and adverse events, including any CAPs from PRC, for recredentialing decisions
Reports To	QIC
Committee Chair	Senior Leader, Medical Director Team; as committee member leadership develops, a committee network provider may chair at the discretion of the CCM
Committee Composition	• Chief Medical Officer/Medical Director(s) • Senior Leader/Leader, Provider Data Services • Participating Providers from a range of specialties, i.e., family practice, internal medicine, OB/GYN, BH, high-volume specialists, ancillary providers, etc. • Other executive leadership or health plan staff as determined • The committee actively involves Participating Providers in credentialing review activities as available and to the extent that there is not a conflict of interest

Frequency	At least ten times per year to facilitate timely review of providers and to expedite network development; additional meetings scheduled as needed.
Attendance Required	50% of scheduled meetings
Quorum	A minimum of four voting members, including the Chair, must be present for a quorum. Three voting members must be appropriately licensed health care providers. Only health care providers are voting members; the Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven and follow a standard format. Agenda items for the next meeting are developed by the Corporate Credentialing Manager in collaboration with the committee Chair.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The Medical Director may approve clean files; the CCM has delegated responsibility for credentialing/recredentialing providers, facilities, and other organizational providers not meeting clean file criteria to the committee. The decision-making model is by consensus. Individuals are responsible and encouraged to raise any issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations of how dissemination of information is managed. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Medical Management Committee	
Charter Statement	The Medical Management Committee is a standing subcommittee of the QIC with oversight and operating authority of medical management activities.
Purpose	The purpose of the Medical Management Committee is to review and monitor the appropriateness of care provided to health plan members. The Medical Management Committee is responsible for the review, evaluation and approval of medical necessity criteria and management protocols, as well as UM policies and procedures. This includes procedures requiring prior authorization.
Responsibilities	• Review and maintain applicable policies/procedures and clinical practice guidelines annually • Annually review and approve the criteria for determination of medical appropriateness

	• Review and update documentation of trending data for procedures that have been approved for coverage based upon practice patterns to respond to pattern variance in future state • Liaison with the QIC for ongoing review of indicators of clinical quality
Reports To	QIC
Committee Chair	Vice President, Medical Affairs, may delegate individual meetings to a Medical Director
Committee Composition	• Medical Directors-Physical and Behavioral Health • Designated Medical Management staff • Other operational staff as requested, i.e., Networking/Contracting, Member/Provider Services, Compliance/Regulatory, Pharmacy, Utilization Management, Behavioral Health • Participating Providers representing the clinical breadth within the network and geographic service area may participate on the committee
Frequency	• Quarterly, with additional meetings scheduled per MVP's need • At least eight times per year
Attendance Required	50% of scheduled meetings.
Quorum	Minimum of 50% of committee members, including two MVP staff and two external providers (if included on the committee) must be present for a quorum. All permanent committee members are voting members; the committee Chair is the determining vote in the case of a tie vote. More than half of voting members.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting are developed by the committee Chair in collaboration with the VP, Medical Affairs, Medical Management.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The Medical Management Committee is authorized by the QIC to make all decisions related to the Medical Management Program, with decisions made by consensus of the committee. Individuals are responsible to raise issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when information is managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Pharmacy and Therapeutics Committee (P&T)	
Charter Statement	The P&T is a standing subcommittee of the QIC with oversight and operating authority of the Pharmacy Program.
Purpose	The P&T is responsible for development and annual review of Pharmacy policies and procedures, review of Pharmacy utilization data, decisions regarding inclusion of drugs on the Preferred Drug List (PDL), and recommendations for formulary management activities.
Responsibilities	• Develop and annually review the pharmacy policy and procedures • Conduct provider and member profiling for appropriate drug utilization (DUR) and recommendations for DUR activities such as targeted prescriber and/or member education initiatives • Evaluate and recommend drugs for inclusion in or removal from the PDL for appropriateness as a tool for providing high quality and cost-effective care • Evaluation of drug costs by therapeutic class for pharmaceutical containment and projection of pharmaceutical costs • Assure compliance with all contractual, regulatory, and accreditation pharmacy requirements • Review of complaints/grievances regarding pharmacy issues • Recommendations for formulary and medical drug management activities such as prior authorization, step therapy, age restrictions, quantity limitations, mandatory generics, and other activities that promote access and patient safety • Review of requests from providers for additions or changes to formulary
Reports To	QIC
Committee Chair	External Provider of appropriate specialty, may delegate individual meetings to an Associate Medical Director or Pharmacy Senior Leader
Committee Composition	• Vice President, Health and Pharmacy Management • Director, Pharmacy Management • Medical Director, Health Management • Medical Director, Behavioral Health • Participating Pharmacists and internal clinical pharmacists • Various external providers including specialties (i.e., Endocrinology, Cardiology, Oncology) • At least one physician and one pharmacist with specialized training in the elderly • A BH provider with expertise in caring for children
Frequency	• Monthly, with additional meetings scheduled per health plan need • At least eight times a year
Attendance Required	50% of scheduled meetings
Quorum	50% of membership, including the committee Chair or designee, must be present for a quorum. The committee Chair is the determining vote in the case of a tie

	vote. 50% of the voting members plus one, based on the current voting membership at the time of the meeting.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting are developed by the committee Chair in collaboration with the Senior Leaders of Pharmacy.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The committee is authorized by the QIC to make all decisions related to the pharmacy benefit. Decisions made by voting consensus. Individuals are responsible and encouraged to raise issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis, or when there are any changes.

Delegation Oversight Committee (DOC)	
Charter Statement	MVP is committed to ensuring that all vendors performing delegated functions are adhering to the performance standards required by contractual terms, meeting NCQA standards, and are compliant with all applicable state and federal laws and regulations. The empowerment of DOC is evident of MVP's commitment to ensuring its compliance, and the compliance and performance of its delegated entities, with all applicable laws and regulations. Further, effective delegation oversight provides a means to monitor the performance of any vendor facilitating plan functions and/or responsibilities.
Purpose	The purpose of the DOC is to serve as the consolidated corporate body with overarching authority for all vendors that are contracted to perform delegated health plan functions on behalf of MVP. Effective oversight through pre-delegation and ongoing auditing and monitoring ensures that delegated entities are compliant with all applicable state and federal laws and regulations, and MVP is compliant with regulatory guidelines as it relates to the delegation of core administrative and management functions.
Responsibilities	The DOC maintains authority for oversight of on-going monitoring of delegated functions by the operational areas. The operational areas that oversee delegated functions are responsible for the monitoring and oversight of those activities. Such oversight may include any of the following:

	• Oversee operations of the delegate to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies • Annual review of applicable delegate program descriptions, policies, and procedures by the operational area overseeing the relationship • Examine activity and performance reports to identify undesirable trends and/or patterns • Provide a feedback mechanism for communicating findings, recommendations, and a plan for implementing corrective action (when necessary) related to the scope of delegated functions • Monitor financial incentives to ensure quality of care/service is not compromised • Develop utilization and quality reporting, summary analysis of data, and specialized reports designed exclusively to describe the findings of delegate activities • Report recommended actions to address any identified opportunities for improvement or recommend termination of any delegation agreement, as necessary, to the QIC • Provide a forum for discussion and collaboration toward mutual goal attainment • Review findings of annual delegation audits with the DOC
Reports To	QIC
Committee Chair	Leader, Procurement and Delegation Oversight
Committee Composition	Committee members include subject matter experts from each appropriate operational area related to a delegated function. Requirements for committee membership include: • Seniority and comprehensive experience in the operational area overseeing the delegated relationship • A position to effectuate change in process and procedure • Demonstrated high integrity and good judgment • No conflict of interest with any delegated entity associated with MVP
Frequency	Meets at least four times per year; however, meetings are typically held monthly.
Attendance Required	50% of scheduled meetings.
Quorum	A minimum of half of the voting members, including the committee Chair, must be present for a quorum. The committee Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven. Agenda items for the next meeting are developed by the committee Chair in collaboration with the applicable department leads.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.

Decision Authority	The committee is authorized by the QIC to make all decisions related to delegated vendor oversight. Decisions made by consensus. Individuals are responsible and encouraged to raise issues at committee meetings.
Evaluation	The DOC will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Service Improvement Committee (SIC)	
Charter Statement	MVP SIC seeks to continually improve member and provider satisfaction and loyalty, as directed by the organization's QI workplan.
Purpose	The SIC is focused on continually improving the MVP member experience to drive improvement in member satisfaction and loyalty. This includes ensuring that MVP is compliant with regulatory and accreditation standards related to member and provider education and satisfaction. SIC goals are supported by a subcommittee structure that is focused on member and provider specific improvement activities, by the efforts for Commercial and Government Programs, and by major corporate initiatives. The SIC monitors member satisfaction including metrics such as: • Net Promoter Score (NPS) • Top 2 Box Score for Overall Satisfaction • Top 2 Box Score for Ease of Doing Business Research and/or root cause analysis will be initiated by the SIC into metrics where performance materially drops year over year.
Responsibilities	**SIC Committee:** • Review and evaluate key service performance indicators (NPS, Overall Satisfaction, Ease of Doing Business With MVP, etc.) • Review of key member feedback and satisfaction insights obtained through the following research: o Commercial, Medicare, and Medicaid CAHPS surveys o Semi-Annual Inform MVP Survey o MVP Medicare and Commercial New Member Surveys o General MVP Medicare, Commercial, and Medicaid Member Surveys o Annual Provider Satisfaction Survey • Review, provide feedback, and approve the annual service improvement plans developed by SIC subcommittees • Provide ongoing reports to the QIC, as appropriate, on the progress of SIC performance improvement initiatives • Support MVP's core value of *Being the Difference for the Customer*

	SIC Subcommittees: • Detailed review of member research (survey results) including quantitative results and qualitative feedback in the form of member commentary • Driven by member and provider feedback, identification, analysis, and selection of service improvement opportunities • Development of annual service improvement plans. This includes documenting targeted opportunities, associated performance metrics, and a high-level action plan • Presentation of the annual service improvement plan to SIC • Provide periodic updates on the status of the annual service improvement plans to SIC
Reports To	QIC
Committee Chair	VP, Customer Care and Support Services
Committee Composition	**Voting Membership** Chief Customer Experience Officer • VP, Member Insight and Analytics • Director, Accreditation and QI Regulatory Compliance • VP, Claims, Configuration, and Support Services • VP, Health and Pharmacy Management • VP, Controller • Director, Medicaid Services and Support • VP, Product Design and Strategy • Sr. Director, Managing Counsel • Director, Network Management Strategy • Managing Director, Growth • Managing Director, Growth – Medicare Portfolio and Partnerships **Non-Voting Membership:** • Leader, Internal Provider Relations • and Contracts • Professional, Market Research • Professional, Innovation Strategist
Frequency	At least four times a year/quarterly
Attendance Required	50% of scheduled meetings
Quorum	50% of voting members, based on the current voting membership at the time of the meeting.
Agenda	Agenda items for the next meeting are developed by the committee Chair in collaboration with other committee members.
Recorder	Committee Chair or delegate (committee Chair reviews and signs meeting minutes)
Minutes/Meeting Packets	Draft minutes are completed no later than 30 days after the meeting or as needed for regulatory reporting. Minutes are stored in a secure area and meeting packets are delivered to committee members in advance of the meeting.

Decision Authority	The QIC authorizes the SIC to make decisions and recommendations regarding service improvement opportunities and related plans. The decision-making model is by consensus. Individuals are responsible and encouraged to raise any issues at committee meetings.
Evaluation	The SIC reviews the committee charter annually.
Confidentiality	Each committee member is accountable to identify confidential information and/or situations when dissemination of information is to be managed in a specific member. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Provider Service Improvement Committee (PSIC)	
Charter Statement	The MVP PSIC seeks to improve provider service and experience, and the associated member experience, through consistent review of, and necessary action on, data collected from the MVP network of providers and internally collected data.
Purpose	The focus of the PSIC is to develop surveys to monitor provider satisfaction with MVP in comparison to competitors. The committee also reviews data collected from Directory Reviews and Access and Availability audits to ensure compliance with NCQA requirements and identify opportunities for improvement.
Responsibilities	The PSIC is responsible for the following functions: • Review results of annual Access and Availability studies and any associated service improvement plans • Review annual Network Analyses associated with NCQA requirements, as well as opportunities for improvement • Review Annual Provider Satisfaction Survey results, overall ratings, trends, and opportunities for improvement • Review metrics and provide root cause analysis when Access and Availability standards and/or NCQA compliance are not met, and development of corrective action
Reports To	SIC
Committee Chair	Leader, Internal Provider Relations and Contracts
Committee Composition	The PSIC includes a cross-departmental membership consisting of Leaders from Network and Contracting, Provider Data Services, Customer Care, Utilization Management, Market Research, Provider Engagement and Experience, Compliance, Marketing and Communications, Claims Operations, Behavioral Health, and Quality Improvement
Frequency	Monthly
Attendance Required	A member of each department or their designated representative is encouraged to attend each meeting.
Quorum	No quorum necessary due to a non-voting committee structure
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the committee Chair.

Recorder	Delegated committee designee
Minutes/Meeting Packets	Meeting minutes are distributed for review and approval no less than one week prior to the next monthly meeting.
Decision Authority	The committee makes decisions and recommendations that are subsequently reviewed by the SIC. Committee members are encouraged to raise any questions or concerns during the PSIC meetings. Decisions are made by consensus.
Evaluation	The committee will review the charter annually
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner.

Member Service Improvement Committee (MSIC)	
Charter Statement	The MVP MSIC is a subcommittee focused on supporting the enterprise-wide SIC in its mission to maintain or increase member satisfaction and loyalty.
Purpose	The subcommittee is focused on continually evaluating member feedback/satisfaction and uncovering potential member-specific improvement initiatives through various research channels. These channels include, but are not limited to, MVP's primary research activities and secondary research conducted on behalf of MVP.
Responsibilities	• Detailed review of in-house and secondary member research results, including quantitative and qualitative feedback in the form of member comments • Identify, analyze, and prioritize improvement opportunities based on available research • Develop annual service improvement plan; this includes documenting targeted opportunities, associated performance metrics, and interventions necessary to achieve goals • Present annual service improvement plan to SIC • Provide periodic annual service improvement plan updates to SIC
Reports To	SIC
Committee Chair	Professional, Market Research/Member and Customer Experience
Committee Composition	The MSIC is comprised of representation from the following areas. • Care Management • Claims • Customer Care • Member & Provider Communications • Customer Experience • Product Marketing • Medicaid Services & Support • Medical Management • Member Appeals & Grievances • Network Management • Pharmacy

	• Premium Billing Collections • Product Strategy & Design • Provider Data Management • Quality Operations • Quality Performance and Initiatives • Regulatory Compliance & Accreditation • Utilization Management Due to the fluid nature of the committee's work, representation may fluctuate throughout the year to accommodate workplan needs.
Frequency	At least six times per year
Attendance Required	50% of scheduled meetings
Quorum	No quorum necessary due to a non-voting committee structure
Agenda	Meetings are agenda driven and developed by the committee Chair.
Recorder	Committee Chair or designee
Minutes/Meeting Packets	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	Committee members have the authority to recommend which member issues and interventions are included in its annual improvement plan. Recommendations made by consensus.
Evaluation	The committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify and treat confidential information in accordance with MVP policies.

Clinical Operations Committee (COC)	
Charter Statement	The MVP COC is a standing subcommittee of the QIC and oversees and has operating authority for MVP's clinical operations. The COC reports up to the Board of Directors.
Purpose	The COC provides oversight of the development and implementation of clinical processes to collect, monitor, analyze, evaluate, and report trends, patterns and action items related to utilization data. Additionally, the COC reviews and analyzes data, interprets the variances, reviews outcomes, and develops interventions based on the findings. The COC focuses on prudently managing available resources to optimize the health and well-being of MVP members including Commercial, Medicare, Medicaid, medically fragile children, and HARP lines of business for both physical and behavioral health. COC also provides annual review of policies and procedures.

Responsibilities	In practice these responsibilities are carried out through the monitoring of the Clinical Operations work plan which includes the following functions:
	• Synopses from the current quarter’s adult and child BH UM subcommittees are reported out including Reporting <21-year-old medically fragile children separately including Pharmacy data
	• Monitoring, analyzing, and evaluating utilization including under- and over-utilization of services and cost data
	• Monitoring, analyzing, and evaluating Case Management (CM) activities including outreach, engagement, performance, and overall effectiveness
	• Monitoring, analyzing, and evaluating data, including but not limited to:
	  o Preventable admission rates
	  o Readmission rates
	  o Engagement rates
	  o Population health complexity, condition prevalence, and other health drivers
	  o Trends
	  o Average length of stay
	  o Emergency department (ED) utilization
	  o Prior authorization/denial and notices of action
	  o Annual review of authorization statistics to ensure access to services
	  o Annual review/report of additions and removals of prior authorizations
	  o UM and CM delegated entity performance
	  o Tracking and trending appeals
	• Staff Inter-Rater Reliability (IRR) and Quality Control (QC) monitoring and reporting
	• Parity reporting
	• Dual Eligible Special Needs Plan (D-SNP) product reporting
	• Vermont UM requirements review
	• Developing, implementing, and reviewing intervention strategies with measurable outcomes based on data findings
	• Ensuring timely reporting of UM and CM performance measurement data (Including Turn Around Time [TAT])
	• Implementing CAPs as appropriate
	• NCQA QI 3 Continuity and Coordination of Medical Care
	• Annual approval of the Utilization Management Program Description and Utilization Management Program Evaluation
	• Develop and revise a comprehensive documented process annually that describes the PHM strategy for meeting the care needs of member s, including goals, services, activities, etc.
	  o Stratify/segment the entire enrolled population into subsets for targeted intervention based on member health needs on an annual basis
	  o Present PHM Effectiveness Report for review and approval
	• Present Care Management satisfaction/experience survey results to committee

	• Present CM Physical Health and Behavioral Health Quality File Audit Review Results • Present Mental Health Review Agents Annual License Renewal Application • Conduct and present a summary of policies including updates and revisions as needed • Review and update Grievance System policy (or individual complaint/grievance/appeals policies) annually to ensure grievance and appeal processes are compliant with state/federal/accreditation requirements • Monitor member and provider grievances and appeals no less than annually
Reports To	QIC; Board of Directors
Committee Chair	• VP, Medical Affairs • Medical Director, Behavioral Health • VP, Health and Pharmacy Management
Committee Composition	• Chief Medical Officer / Medical Director, Clinical Collaboration and Performance Management • Medical Director Medicaid, and Medical Director Transactional Management • Director, Accreditation and QI Regulatory Compliance • Designee Senior Leader from each applicable functional area, i.e., Medical Management, Network Development and Contracting, Provider Relations/Services, Customer Care, Grievance and Appeals, Compliance and Regulatory Affairs, Pharmacy • BH Provider/Representative • Additional staff may participate as requested by the Chair
Frequency	Quarterly, ad hoc as necessary
Attendance Required	50% of scheduled meetings
Quorum	50% plus one of the voting members constitutes a quorum for the transaction of business. Less than a quorum will have the power to adjourn any meeting until such time a quorum is present.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the committee Chair.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The committee is authorized by the QIC to make decisions and recommendations regarding performance improvement processes. Decisions made by voting consensus. Individuals are responsible and encouraged to raise any concerns/issues at the committee meetings.
Evaluation	The COC will review the charter annually.

Confidentiality	Each committee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

<table>
<tr><th colspan="2">Clinical Quality Committee (CQC)</th></tr>
<tr><td>Charter Statement</td><td>The MVP CQC meets at least quarterly and must meet four times per calendar year. The CQC reports to the QIC on a quarterly basis. Ad hoc reporting will occur, as necessary. The CQC reports to the Board of Directors.</td></tr>
<tr><td>Purpose</td><td>• Present synopses of current quarter’s Adult and Children’s Behavioral Health Advisory Committees
• Present synopses of current quarter’s Adult and Children’s Behavioral Health Quality Management subcommittees
• Provide oversight of Quality Management activities for behavioral health and physical health throughout MVP
• Monitor, analyze, and evaluate quality management data
• Eliminate barriers to integration of physical and behavioral health across the enterprise
• Review and analyze data, review outcomes, and develop interventions based on the findings
• Manage available resources to optimize the health and well-being of MVP members
• All lines of business represented for both physical and behavioral health</td></tr>
<tr><td>Responsibilities</td><td>• The CQC oversees and approves activities of the two following behavioral health subcommittees:
o Behavioral Health Advisory Committee
o Behavioral Health Quality Management
• All lines of business are reviewed during the CQC
• Standing agenda items include but are not limited to:
o Outcomes of the Annual Commercial Behavioral Health Member Experience survey
o Reporting on outreach to providers/facilities on quality measure performance
o Care Management Policy annual review
o Performance Improvement Strategy Project (QIP) and Marketplace Quality Improvement Strategy (QIS) annual review
o Regulatory updates including NCQA and Department of Health (DOH) requirements
▪ Overview of regulatory projects including the HARP and Children’s PIPs, all Quality Performance Matrices (QPMs), CCIP updates
o Quality Initiatives Overview:</td></tr>
</table>

	▪ Routine performance reporting of HEDIS/Quality Assurance Reporting Requirements (QARR) measures ▪ Performance of Medicare STARS Program
Reports To	QIC; Board of Directors
Committee Chair	• Director, Behavioral Health Clinical Operations Quality Management Behavioral Health Liaison
Committee Composition	Voting Members • Chief Medical Officer • Leader, Behavioral Health Case Management, HARP • Leader, Member Advocacy, Appeals and Grievances • Leader, Behavioral Health Case Management • Director, Pharmacy Management • Director, Behavioral Health • Leader, Quality Operations • Professional, Compliance Customer Engagement • Medical Director, Behavioral Health • Vice President, Health and Pharmacy Management • Medical Director, HARP Behavioral Health Adult Services • Director, Utilization Management • Vice President, Medical Affairs • Medical Director, Medicaid Product Performance Management • Director, Quality Measurement and Improvement • Director, Customer Engagement and Support Services • Sr. Director, Quality Improvement Leader, Commercial Appeals Operations • Medical Director, Pediatrics • Leader, Behavioral Health Utilization Management
Frequency	Quarterly
Attendance Required	50% of scheduled meetings
Quorum	At each meeting of the CQC the presence of 50% plus one of the voting members constitutes a quorum for the transaction of business. Less than a quorum will have the power to adjourn any meeting until such time a quorum is present.
Agenda	Agenda items for the next meeting are developed by the committee Chairs, the Senior Leader, Behavioral Health, and the Quality Management Behavioral Health Liaison. The committee receives regular reports from all subcommittees that are accountable to and/or advise the CQC.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.

Decision Authority	The committee is authorized by the QIC to make decisions and recommendations regarding performance improvement processes. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the committee meetings.
Evaluation	The committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

BEHAVIORAL HEALTH PROGRAM STRUCTURE

MVP Quality Staff

The MVP Quality Staff dedicated to the MVP Behavioral Health QI Program includes the following individuals whose responsibilities are detailed in the Corporate MVP QI Program:

- MVP Chief Executive Officer
- Chief Medical Officer
- Sr. Director, Quality Improvement Chief Financial Officer
- Vice President, Medical Affairs and Medical Management
- Vice President, Health and Pharmacy Management
- Medical Directors and Associate Medical Directors

Additional personnel dedicated to the MVP Behavioral Health Quality Management/Utilization Management (QM/UM) Program include:

Director, Behavioral Health, under the direction of the Vice President, Strategic Provider Engagement and Care Management, the Director of Behavioral Health is responsible for the strategic planning, development, implementation, and ongoing oversight of the MVP Behavioral Health CM and UM program components.

Leader, Behavioral Health Utilization Management, direct supervision of licensed clinicians who perform utilization management to member s who are receiving behavioral health services. This position provides oversight, leadership, and direction for the clinical interventions targeted to improve member and provider satisfaction, decrease cost waste, maximize quality, and improve clinical outcomes for the clinical care of the member's behavioral health services.

Leader, Behavioral Health Case Management, direct supervision of licensed clinicians, as well as non-licensed staff (BH Health Coaches) who provide care management to member s with behavioral health needs across all lines of business except for HARP and children eligible for Home and Community Based Services (HCBS). This leader is responsible for management of the Performance Opportunity Project (POP). This position provides oversight, leadership, and direction for the clinical interventions targeted to improve member and provider satisfaction, decrease cost waste, maximize quality, and improve clinical outcomes.

Leader, Behavioral Health Case Management (HARP), direct supervision of licensed clinicians who provide case management to HARP enrolled members ages 21 and older. HARP CM works with members, providers, and Health Home Care Management Agencies to ensure members are connected to appropriate behavioral health services based on person-centered goals in the member's plan of care. HARP CM ensures members are accurately assessed and connected to HCBS. Once a member has completed the intake/evaluation with a HCBS provider, a HCBS Authorization form is submitted to MVP. HARP CM evaluates the member's ongoing meeting of requirements for accessing HCBS and ensures that the New York State Medical Necessity Criteria are met. In addition, HARP CM also processes Community Oriented Recovery and Empowerment (CORE) service requests.

Leader, Behavioral Health Case Management Children's Services and Government Liaison, direct supervision of licensed clinicians who specialize in Behavioral Health children's services. This position is responsible for managing children with complex behavioral health needs (children on a Medicaid plan eligible for HCBS as well as representing MVP as the government liaison attending external meetings). This position provides oversight, leadership, and direction for the clinical interventions targeted to improve member and provider satisfaction, decrease cost waste, maximize quality, and improve clinical outcomes. In addition, this position is responsible for the management of the medically fragile and foster care populations.

Quality Management Behavioral Health Liaison, provides support for and monitoring of the progress of the Behavioral Health QM/UM Program as a chairperson for all behavioral health subcommittees. This role ensures that MVP is meeting stated goals and objectives and complies with regulatory requirements, including NCQA submissions. This role ensures that the QM/UM work plan reflects the progress of QM/UM activities. This role supports committees and subcommittees' findings to identify barriers to improvement, propose methods for addressing the barriers, and to facilitate program development, evaluation, and reporting. This role supports market research on Behavioral Health Satisfaction Surveys to improve member and provider satisfaction.

MVP Behavioral Health Subcommittees

In compliance with NYSDOH requirements MVP maintains QM and UM committees, subcommittees, and advisory groups, which are specific to behavioral health for children and adults, to ensure that MVP's policies, procedures, and interventions are effective and relevant.

Behavioral Health Quality Management (BH QM) (HARP/Medicaid/D-SNP Non-Integrated and D-SNP Integrated Benefits Plan [IBP]) Subcommittee	
Charter Statement	The Mainstream Medicaid Qualified Medicaid Plan (QMP/HARP) BH QM subcommittees and Children's BH QM subcommittees are standing meetings scheduled in succession with one another and report up to the CQC, QIC, and then ultimately to the Board of Directors.

Purpose	The purpose of the QMP/HARP BH QM subcommittee is to: • Assess the clinical and service needs of QMP adults, HARP, and D-SNP members with BH diagnoses • Develop and implement a process to collect, monitor, analyze, evaluate, and report utilization data consistent with the reporting requirements of existing QARR measures with the addition of HEDIS based on claims and encounters • Implement, evaluate, and report on the various interventions/programs that will optimize clinical quality, maximize safe clinical practices, and enhance services to QMP/HARP/D-SNP members • Carry out the planned activities of the BH QM program and be accountable to and report regularly to the governing board or its designee concerning BH QM activities • Ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis for all QMP/HARP/D-SNP members

Responsibilities	• Report out the synopsis from current QMP BH Advisory subcommittee
	• Separately tracks, trends, and reports BH complaints, grievances, appeals, and denials for members with BH diagnoses who are QMP, HARP, and D-SNP members
	• BH prior authorization/denial and notices of action
	• The subcommittee will report out how the quality assurance program addresses specific monitoring requirements related to the populations, benefits, and services covered
	• Follow up after discharge:
	    o Follow-up After Hospitalization for Mental Illness (FUH), Follow-up after High-Intensity Care for SUD (FUI); Follow-Up After ED Visit for Mental Illness (FUM); Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
	    o Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
	    o Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
	• Adverse incident reporting for QMP, HARP, and D-SNP populations
	• Describe the HARP plan for capturing and reporting Behavioral Health HCBS services and support monitoring of compliance with HCBS requirements
	• Statewide reporting of HARP enrolled members without HCBS assessments
	• Will track and report on compliance with:
	    o BH quality assurance performance measure/reporting of HCBS assurances/sub-assurances and recovery measures including employment, housing, criminal justice status, etc.
	    o Protocols for expedited and standard appeals regarding plan of care denials for HCBS

	• Reporting on all performance improvement plans and updates on special populations • Will conduct an annual consumer perception survey (supplementary to CAHPS)
Reports To	CQC; QIC; Board of Directors
Committee Chair	Quality Management Behavioral Health Liaison (Behavioral Health Quality Administrator) and Senior Leader of Behavioral Health (Behavioral Health Director)
Committee Composition	Standing Voting Membership: • Chairs: Director, Behavioral Health Clinical Operations and the Quality Management Behavioral Health Liaison • Chief Medical Officer • Director, Customer Engagement and Support Services • Director, Integrated Health Contract Manager • Director, Pharmacy Management • Director, Utilization Management • Leader, Behavioral Health Utilization Management • Leader, Behavioral Health Case Management • Leader, Behavioral Health Case Management, Children Services and Government Liaison • Leader, Behavioral Health Case Management, HARP • Leader, Customer Care and Provider Relations • Leader, Member Advocacy, Appeals and Grievances • Leader, Quality Operations • Medical Director, Behavioral Health • Medical Director, HARP Behavioral Health Adult Services • Medical Director, Medicaid Product Performance Management • Medical Director, Pediatrics • Vice President, Health and Pharmacy Management • Vice President, Medical Affairs
Frequency	At least quarterly
Attendance Required	50% of scheduled meetings
Quorum	50% plus one of the voting members at the time of the meeting constitutes a quorum for the transaction of business. Less than a quorum will have the power to adjourn any meeting until such time a quorum is present.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the subcommittee Chair. All agenda items are based on requirements set forth in the New York Request for Qualifications for Adult Behavioral Health Benefit Administration. Quarterly reports with the required agenda items are received from the appropriate report owners and reviewed by the subcommittee Chairs and Liaison prior to subcommittee.
Recorder	Delegated subcommittee designee
Minutes/Meeting Packets	Maintains records documenting attendance, findings, recommendations, and actions. Draft minutes are completed within 30 days of the meeting, or as needed

	for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to subcommittee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The subcommittee is authorized by the CQC to make decisions, which reports up to the Board of Directors, and recommendations regarding quality management. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the subcommittee meetings.
Evaluation	The subcommittee will review the charter annually.
Confidentiality	Each subcommittee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner. Each subcommittee member must agree to and sign a subcommittee confidentiality statement on an annual basis.

Children's Behavioral Health Quality Management (BH QM) Subcommittee	
Charter Statement	The Children's BH QM subcommittees and QMP/HARP BH QM subcommittees are standing meetings scheduled in succession with one another and report up to the CQC and then ultimately to the Board of Directors.
Purpose	• Assess the clinical and service needs of the Medicaid enrolled children including HCBS; this includes children with BH needs, children in foster care, and medically fragile children • Carry out the planned quality activities related to children who access BH benefits or HCBS • The BH QM subcommittee shall be accountable to and report regularly to the governing board or its designee concerning BH QM activities • Develop and implement a process to collect, monitor, analyze, evaluate, and report utilization data consistent with the reporting requirements of existing QARR measures with the addition of HEDIS based on claims and encounter data • Ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency for members under the age of 21

Responsibilities	• Report out synopsis from current Children's BH Advisory subcommittee
	• Report to the NYS OMH and OASAS any deficiencies in performance and corrective action taken with respect to OMH and OASAS licensed, certified, or designated providers
	• Separately tracks, trends, and reports children's BH complaints, grievances, appeals, and denials for members with BH diagnoses
	• Discusses BH utilization requests, denials, and notices of action
	• Track and report compliance with:
	    o HCBS assurance and sub-assurances
	    o Protocols for expedited and standard appeals regarding plan of care denials for HCBS

	• Report out how the quality assurance program addresses specific monitoring requirements related to the populations, benefits and services covered
	• Follow up after discharge:
	  o FUH, FUI
	  o IET
	  o Follow-up Care for Children Prescribed ADHD Medication (ADD)
	• Adverse incident reporting for children
	• Reporting on all performance improvement plans and updates on special populations

Reports To	CQC; QIC; Board of Directors
Committee Chair	• Quality Management Behavioral Health Liaison (BH Quality Administrator) • Senior Leader of Behavioral Health (BH Director)
Committee Composition	Standing Voting Membership: • Chairs: Director, Behavioral Health Clinical Operations and the Quality Management Behavioral Health Liaison • Chief Medical Officer • Director, Customer Engagement and Support Services • Director, Integrated Health Contract Manager • Director, Pharmacy Management • Director, Utilization Management • Leader Behavioral Health Utilization Management • Leader, Behavioral Health Case Management • Leader, Behavioral Health Case Management, Children Services and Government Liaison • Leader, Behavioral Health Case Management, HARP • Leader, Customer Care and Provider Relations • Leader, Member Advocacy, Appeals and Grievances • Leader, Quality Operations • Medical Director, Behavioral Health • Medical Director, HARP Behavioral Health Adult Services • Medical Director, Medicaid Product Performance Management • Medical Director, Pediatrics • Vice President, Health and Pharmacy Management • Vice President, Medical Affairs
Frequency	At least quarterly
Attendance Required	50% of scheduled meetings
Quorum	50% plus one of the voting members at the time of the meeting constitutes a quorum for the transaction of business. Less than a quorum will have the power to adjourn any meeting until such time a quorum is present.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the subcommittee Chair. All agenda items are based on requirements set forth in the New York State

	Children's Health and Behavioral Health Benefit Administration: Medicaid Managed Care Organization (MCO) Children's System Transformation Requirements and Standards. Quarterly reports with the required agenda items are received from the appropriate report owners and reviewed by the subcommittee Chairs and Liaison prior to committee.
Recorder	Delegated subcommittee designee
Minutes/Meeting Packets	Maintains records documenting attendance, findings, recommendations, and actions. Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to subcommittee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The subcommittee is authorized by the CQC to make decisions, which reports up to the Board of Directors, and recommendations regarding quality management. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the subcommittee meetings.
Evaluation	The committee will review the charter annually.
Confidentiality	Each subcommittee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner. Each subcommittee member must agree to and sign a subcommittee confidentiality statement on an annual basis.

Behavioral Health Advisory Committee (HARP/Medicaid)	
Charter Statement	The QMP/HARP Behavioral Health Advisory subcommittees are to be held at least quarterly. The QMP/HARP and Children's Behavioral Health Advisory subcommittees are held in succession with one another and report up to the BH QM subcommittee, CQC, and to the Board of Directors.
Purpose	Solicit feedback and recommendations that service the needs of members to improve quality of care and member outcomes. Key stakeholders include members, family members, MVP BH staff, BH providers, peers, Regional Planning Consortiums (RPC), Local Government Unit (LGU), and other agencies that service the needs of members to improve quality of care and member outcomes.

Responsibilities	• Review and consider recommendations of the RPC regarding improved integration of behavioral and physical health
	• Provide a forum for members that includes among its members, MVP BH staff, BH providers, peer specialists, members, LGU representatives, and other key stakeholders to discuss the physical and BH needs of MVP's QMP and HARP members:
	    o This includes, but is not limited to, challenges, barriers, resources, and unmet needs of this population
	    o Solicit ideas and feedback to improve overall member and provider experience

	• Identify proposed resolutions of issues related to the management of the HARP population and BH benefits
Reports To	BH QM subcommittee; CQC; QIC; Board of Directors
Committee Chair	Tri-chair: Quality Management Behavioral Health Liaison, Director of Behavioral Health, and an external chairperson.
Committee Composition	Internal Membership: • Chairs: Director, Behavioral Health; Quality Management Behavioral Health Liaison • Chief Medical Officer • Director, Customer Engagement and Support Services • Director, Pharmacy Management • Director, Quality Measurement and Improvement • Director, Utilization Management • Leader, Behavioral Health Case Management • Leader, Behavioral Health Case Management, Children Services and Government Liaison • Leader, Behavioral Health Case Manager, HARP • Leader, Behavioral Health Utilization Management • Leader, Commercial Appeals Operations • Leader, Customer Care and Provider Relations • Leader, Member Advocacy, Appeals, and Grievances • Leader, Quality Operations • Medical Director, Behavioral Health • Medical Director, Behavioral Health Children's Services • Medical Director, HARP Behavioral Health Adult Services • Medical Director, Medicaid Product Performance Management • Medical Director, Pediatrics • Professional, Compliance Customer Engagement • Quality Improvement Initiatives Program Manager • Vice President, Customer Care and Support Services • Vice President, Health and Pharmacy Management • Vice President, Medical Affairs External Membership: • MVP members • Administrative Director, St. Vincent's Hospital of Westchester, Co-Chair • Director of Community Services, Villa of Hope • Internal Medicine Participating Provider • Medicaid Managed Care Liaison Coordinator, Berkshire Farm Center • Sr. Director of Revenue Management, Children Services and Government Liaison, Julia Dyckman Andrus Memorial • Sr. Director, Integrated Behavioral Health Services, Villa of Hope
Frequency	At least quarterly

Attendance Required	50% of scheduled meetings
Quorum	The QMP/HARP Behavioral Health Advisory subcommittees will solicit feedback and advice; it is not a voting committee. Minutes will reflect discussion and attendance.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the committee Chair with input requested by members, providers, stakeholders, and all other participants of the committee.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The subcommittee is authorized by the CQC to make recommendations regarding performance improvement processes. Individuals are responsible and encouraged to raise any concerns/issues at the committee meetings.
Evaluation	The subcommittee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner. Each committee member must agree to and sign a subcommittee confidentiality statement on an annual basis.

Children's Behavioral Health Advisory Committee	
Charter Statement	The Children's BH Advisory subcommittees are to be held at least quarterly. The QMP/HARP and Children's BH Advisory subcommittees are held in succession with one another and report up to the BH QM subcommittee, CQC, and to the Board of Directors.
Purpose	• Solicit feedback and recommendations that service the needs of members to improve quality of care and member outcomes; key stakeholders include members, family members, peers, foster care agencies, subcontracted plans, RPC, LGU, and representatives and other child service agencies • Advise and assist the plan in identifying and resolving issues related to the management of children's health and BH benefits
Responsibilities	• Review and consider recommendations of the RPC regarding improved integration of behavioral and physical health • Issues related to children identified with specific diagnostic groups must be separate standing agenda items in subcommittee meetings • Provide a forum for members that includes among its members, MVP BH staff, BH providers, peer specialists, members, LGU representatives, and other key stakeholders to discuss the physical and BH needs of child members:

	◦ This includes, but is not limited to, challenges, barriers, resources, and unmet needs of this population ◦ Soliciting ideas and feedback to improve overall member and provider experience • Identify proposed resolutions of issues related to the management of the physical and BH needs of MVP's child population
Reports To	BH QM subcommittee; CQC; QIC; Board of Directors
Committee Chair	Tri-chair: Quality Management Behavioral Health Liaison, Director of Behavioral Health, and an external chairperson
Committee Composition	Internal Membership: • Chairs: Director, Behavioral Health Clinical Operations; Quality Management Behavioral Health Liaison • Chief Medical Officer • Director, Customer Engagement and Support Services • Director, Pharmacy Management • Director, Quality Measurement and Improvement • Director, Utilization Management • Foster Care Liaison, Medicaid Services and Supports • Leader, Behavioral Health Case Management • Leader, Behavioral Health Case Management, Children Services and Government Liaison • Leader, Behavioral Health Case Manager, HARP • Leader, Behavioral Health Utilization Management • Leader, Commercial Appeals Operations • Leader, Customer Care and Provider Relations • Leader, Member Advocacy, Appeals, and Grievances • Leader, Quality Operations • Medical Director, Behavioral Health • Medical Director, Behavioral Health Children's Services • Medical Director, HARP Behavioral Health Adult Services • Medical Director, Medicaid Product Performance Management • Medical Director, Pediatrics • Professional, Compliance Customer Engagement • Quality Improvement Initiatives Program Manager • Vice President, Customer Care and Support Services • Vice President, Health and Pharmacy Management • Vice President, Medical Affairs External Membership: • MVP members' parents • Administrative Director, St. Vincent's Hospital of Westchester, Co-Chair • Care Manager, St. Christopher's Inc. • Director of Care Management and Early Intervention, People, Inc. • Director of Community Services, Villa of Hope • Executive Director, New Hope Manor

	• Internal Medicine Participating Provider • Manager Quality Programs, Children's Health Home of Upstate New York • Medicaid Managed Care Liaison Coordinator, Berkshire Farm Center • Sr. Director of Revenue Management, Children Services and Government Liaison, Julia Dyckman Andrus Memorial • Sr. Director, Integrated Behavioral Health Services, Villa of Hope
Frequency	At least quarterly
Attendance Required	50% of scheduled meetings
Quorum	The Children's BH Advisory Committee will solicit feedback and advice but is not a voting committee, therefore a quorum is not required.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the subcommittee Chair with input requested by members, providers, stakeholders, and all other participants of the committee.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials. Minutes will reflect discussion and attendance.
Decision Authority	This is a non-voting committee. The BH Advisory Committee is authorized by the CQC, which reports up to the Board of Directors**,** to make recommendations related to issues raised by MVP members, committee members, providers, or stakeholders. Individuals are responsible to raise any issues at committee meetings.
Evaluation	The committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Behavioral Health Utilization Management (BH UM) Subcommittee (HARP/Medicaid/D-SNP Non-Integrated and D-SNP IBP)	
Charter Statement	The QMP/HARP BH UM subcommittees are to be held at least quarterly. The QMP/HARP BH UM and Children's BH UM subcommittees are scheduled in succession with one another and reported up to the COC, then the QIC, and then ultimately to the Board of Directors.
Purpose	• Assess the clinical and service needs of QMP, HARP, and D-SNP members with BH diagnoses

	• Develop, implement, evaluate, and report on the various interventions/programs that will optimize clinical quality, maximize safe evidence-based clinical practices, and enhance services to QMP/HARP/D-SNP members with BH diagnoses • Ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis for the QMP, HARP, and D-SNP members with BH diagnoses

Responsibilities	The QMP/HARP BH UM subcommittee shall be responsible for reviewing/analyzing data, variances, and outcomes and developing and/or approving interventions. Ensures interventions have measurable outcomes and are included in meeting minutes. The subcommittee is also responsible for reporting:
	• Under- and over-utilization of BH services and cost data
	  ○ Avoidable hospital admissions and readmission rates, trends, and the average length of stay for all mental health, SUD, residential levels of care, and medical inpatient facilities
	• Inpatient utilization:
	  ○ Outpatient Utilization including Outpatient Specialty BH Services (reporting on unique members, units, units/1000, and cost)
	• Inpatient civil commitments:
	  ○ Outpatient Civil Commitments including Assisted Outpatient Treatment (AOT)
	• ED utilization and crisis services:
	  ○ Use of Crisis Diversion Services
	• Pharmacy utilization including physical health, psychotropic, and addiction medications
	• Protocols for the identification and prompt referral of individuals with First Episode Psychosis (FEP) to programs and services:
	  ○ Rates of initiation and engagement of individuals with FEP in services
	• Behavioral HCBS utilization:
	  ○ Health Home engagement rates for the HARP population
	• D-SNP UM including:
	  ○ Total quarterly membership numbers
	  ○ Number of admissions per quarter
	• All physical health measures required by the MCO Model Contract

Reports To	COC; QIC; Board of Directors
Committee Chair	Behavioral Health Medical Director
Committee Composition	Standing Voting Membership: • Chair: Medical Director, Behavioral Health • Chief Medical Officer • Director, Behavioral Health Clinical Operations • Director, Customer Engagement and Support Services • Director, Integrated Health Contract Manager • Director, Pharmacy Management

	• Director, Utilization Management • Leader, Behavioral Health Case Management • Leader, Behavioral Health Case Management, Children Services and Government Liaison • Leader, Behavioral Health Utilization Management • Leader, Care Center Staff and Operations • Leader, Member Advocacy, Appeals, and Grievances • Leader, Quality Operations • Medical Director, Behavioral Health Children's Services • Medical Director, HARP Behavioral Health Adult Services • Medical Director, Medicaid Product Performance Management • Medical Director, Pediatrics • Quality Management Behavioral Health Liaison • Vice President, Health and Pharmacy Management • Vice President, Medical Affairs
Frequency	Quarterly
Attendance Required	50% of scheduled meetings
Quorum	50% plus one of the voting members constitutes a quorum for the transaction of business. Less than a quorum will have the power to adjourn any meeting until such time a quorum is present.
Agenda	Agenda items for the next meeting are developed by the subcommittee Chair. All agenda items are based on requirements set forth in the New York for Request for Qualifications for Adult Behavioral Health Benefit Administration: Managed Care Organizations and HARP (RFQ, 2015). Quarterly reports with the required agenda items are received from the appropriate report owners and reviewed by the subcommittee Chair and Liaison prior to presentation.
Recorder	Delegated subcommittee designee
Minutes/Meeting Packets	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to subcommittee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The subcommittee is authorized by the COC which reports up to the Board of Directors**,** to make decisions and recommendations regarding performance improvement processes. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the subcommittee meetings.
Evaluation	The subcommittee will review the charter annually.
Confidentiality	Each subcommittee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner. Each subcommittee member must agree to and sign a subcommittee confidentiality statement on an annual basis.

<table>
<tr><th colspan="2">Behavioral Health Utilization Management (BH UM) Subcommittee (Children’s)</th></tr>
<tr><td>Charter Statement</td><td>The Children’s BH UM subcommittee meetings are to be held at least quarterly. The Children’s BH UM and QMP/HARP BH UM are scheduled in succession with one another and reported up to the COC, then the QIC, and to the Board of Directors.</td></tr>
<tr><td>Purpose</td><td>

Assess the clinical and service needs of Medicaid enrolled children including HCBS:

This includes children in foster care and medically fragile children
Develop, implement, evaluate, and report utilization data and various interventions/programs that will optimize clinical quality, maximize safe clinical practices, and enhance services to the Medicaid enrolled children in the children’s transition program

Ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis for the Medicaid enrolled children
</td></tr>
<tr><td>Responsibilities</td><td>

Review and analyze data, variances, and outcomes and develop and/or approve interventions
Ensure that interventions have measurable outcomes and are included in meeting minutes
Report out the following:

Under- and over-utilization of BH services and cost data
Avoidable hospital admissions and readmission rates, trends, and the average length of stay for all inpatient classified levels of care

Outpatient Utilization including Outpatient Specialty BH Services (reporting on unique members, units, units/1000, and cost); this includes Children and Family Treatment and Support Services Utilization (CFTSS)
As of January 1, 2023, Applied Behavioral Analysis (ABA) is scheduled to be a covered service for the Medicaid line of business

Inpatient civil commitments
Outpatient civil commitments including AOT
ED utilization and crisis services

Use of Crisis Diversion Services

Pharmacy utilization including physical health, psychotropic, and addiction medications

Separate analysis for children in foster care
Separate reporting <21 medically fragile children

Number of physical and BH paid claims including spend amounts shown quarter over for both foster care and medically fragile children
Behavioral Health prior authorization and notices of action
Protocols for the identification and prompt referral of individuals with FEP to programs and services

</td></tr>
</table>

<table>
<tr><td></td><td>▪ Rates of initiation and engagement of individuals with FEP in services
o Discussion/analysis related to physical health services for medically fragile children/complex conditions
o Discussion/analysis related to BH and HCBS services for Medicaid enrolled children
o Children’s physical health services: Report on service utilization and outcomes for children including medically fragile children
o Transitional issues for youth ages 18 to 23 years, focusing on continuity of care and service utilization
o Behavioral Health HCBS
▪ For children eligible for HCBS, the Children’s BH UM subcommittee shall separately report, monitor findings, and recommend appropriate action on the following additional metrics:
• Use of crisis diversion and crisis intervention services
• HCBS utilization
• Enrollment in Health Home</td></tr>
<tr><td>Reports To</td><td>COC; QIC; Board of Directors</td></tr>
<tr><td>Committee Chair</td><td>Behavioral Health Medical Director</td></tr>
<tr><td>Committee Composition</td><td>Standing Voting Membership:
• Chair: Medical Director, Behavioral Health
• Chief Medical Officer
• Director, Behavioral Health Clinical Operations
• Director, Customer Engagement and Support Services
• Director, Integrated Health Contract Manager
• Director, Pharmacy Management
• Director, Utilization Management
• Leader, Behavioral Health Case Management
• Leader, Behavioral Health Case Management, Children Services and Government Liaison
• Leader, Behavioral Health Utilization Management
• Leader, Care Center Staff and Operations
• Leader, Member Advocacy, Appeals, and Grievances
• Leader, Quality Operations
• Medical Director, Behavioral Health Children’s Services
• Medical Director, HARP Behavioral Health Adult Services
• Medical Director, Medicaid Product Performance Management
• Medical Director, Pediatrics
• Quality Management Behavioral Health Liaison
• Vice President, Health and Pharmacy Management
• Vice President, Medical Affairs</td></tr>
<tr><td>Frequency</td><td>Quarterly</td></tr>
</table>

Attendance Required	50% of scheduled meetings
Quorum	50% of the voting members, plus one based on the current voting membership at the time of the meeting. Less than a quorum will have the power to adjourn any meeting until such time a quorum is present.
Agenda	Agenda items for the next meeting are developed by the subcommittee Chair. All agenda items are based on requirements set forth in the New York State Children's Health and Behavioral Health Benefit Administration: Medicaid MCO Children's System Transformation Requirements and Standards (2017). Quarterly reports with the required agenda items are received from the appropriate report owners and reviewed by the subcommittee Chair and Liaison prior to presentation.
Recorder	Delegated subcommittee designee
Minutes/Meeting Packets	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to subcommittee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The subcommittee is authorized by the COC, which reports up to the Board of Directors, to make decisions and recommendations regarding performance improvement processes. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the subcommittee meetings.
Evaluation	The subcommittee will review the charter annually.
Confidentiality	Each subcommittee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner. Each subcommittee member must agree to and sign a subcommittee confidentiality statement on an annual basis.

MVP QUALITY DEPARTMENT STAFFING

The Quality Department staffing model is outlined below. Department staffing is determined by membership, products offered, and (when applicable) state and/or federal contract requirements, and includes the following positions:

Chief Medical Officer	MVP's Chief Medical Officer and supporting Medical Directors (including a Behavioral Health Medical Director) have an active unencumbered license in accordance with the state laws and regulations to serve as Medical Director to oversee and be responsible for the proper provision of core benefits and services to members, the QI Program, the Medical Management Programs, and the Appeals and Grievance process.
Vice President, Medical Affairs	The Vice President, Medical Affairs provides oversight of the Physical Health and Behavioral Health Medical Directors; oversight of physical health and behavioral health UM activities, medical policy, coding, and new technology evaluation; Product Performance Management; Clinical Vendor Oversight; Value Based Contracting support.

Senior Director, Quality Improvement, Performance and Initiatives	Responsible for development, implementation, and management of a data driven MVP Quality Strategy. This role is responsible for the following: • Oversight of major functions of the MVP Quality Department including Quality Measurement, HEDIS Operations, Clinical Quality Initiatives and Provider Strategies • Oversight of the team that processes quality performance in support of business objectives, supports the regulatory submission of performance data to NCQA, CMS, NYS, and annual HEDIS audit • MVP's enterprise-wide quality improvement model intended to produce better member care and reduce health disparities using available improvement levers • The holistic oversight and management of MVP's quality performance across clinical and non-clinical measurement categories, as well as MVP's performance in state and federal based financial quality incentive programs, including Medicare CMS STARS Program, and NYS Medicaid Incentive Programs
Director, Quality Performance Management – Regulatory Compliance and Health Equity	Responsible for oversight, implementation, performance monitoring and adherence to State and Federal regulations and policies related to Quality Performance and Health Equity for NYS Government programs, including Medicaid, Marketplace, Child Health Plus (CHP), Commercial, and Medicare. In addition, management and performance oversight of quality regulatory programs including PIP and CCIP.
Leader, Quality Performance Manager, Population Health (Medicaid)	Accountable to improve clinical outcomes and quality performance for NYS Government programs, specifically Medicaid, Essential Plan, and HARP.
Leader, Medicare STARS	Accountable for assisting in development, implementation, and outcome monitoring of the Quality strategy to improve performance on all Medicare Stars measures (including HEDIS, CAHPS, Part D and Special Needs Plan [SNP]) to achieve year over year improvement of clinical outcomes.
Leader, HEDIS Data Management and Strategic Operations	Manages operations associated with the organizations HEDIS project and submission, including medical record collection, chart abstraction, and quality control, at the highest level of performance. Responsible for effectively tracking and monitoring progress of HEDIS data, providing current and timely reports, and for maintaining HEDIS activity targets.
Quality Program Manager	Supports and facilitates program-level activities from the Quality Improvement strategy to ensure quality performance goals are achieved.
Clinical Quality Professional	Supports development of clinical quality initiatives and is responsible for the collection of HEDIS medical records, abstraction of the data, and quality control. In addition, will assist in monitoring of clinical provider performance

	and identify areas of opportunity for improvement.
Leader Quality Analytics	Provides oversight in strategic direction for quality performance initiatives, monitors overall performance, fosters relationships with internal and external quality performance stakeholders. Supervises team of informatics analysts dedicated to Quality reporting.
Informatics Analyst	Preparation of standard and as needed analyses in support of key corporate initiatives. Analyses are performed for all internal business areas including Quality Improvement.
Professional, Quality Liaison for Provider Engagement	Support MVP's Quality Provider strategies, including planning, implementation, execution, and performance monitoring of contracted, in-network Providers. Works directly with Providers, Network, and Community Based Organizations (CBOs) to improve measures and performance for Medicaid and Medicare.
Professional, Quality Performance Manager	Accountable to improve clinical outcomes and performance for NYS Government programs, specifically Medicaid, Essential Plan, and HARP, in addition to Medicare STARS. Identifies trends and opportunities for performance improvement. This includes design, implementation, and evaluation of interventions. Performance is monitored and communicated with the appropriate stakeholders and committees.
Professional, Quality Regulatory Compliance	Responsible for the implementation, performance monitoring, and adherence to State and Federal regulations and policies related to Quality Performance for all state and federal agencies. Accountable for the development, implementation, monitoring, and reporting of all quality regulatory projects. Project updates are shared with internal stakeholders, the Quality regulatory committee structure, and state and federal agencies.
Professional, Sr Business Analyst, Quality Improvement	Performs trend review and analysis to monitor overall performance, effectiveness of interventions, initiatives, and outreach efforts. They identify and project measures and metrics to inform the Quality strategy.
Director, Accreditation and QI Regulatory Compliance	The Director, Accreditation and QI Regulatory Compliance, reports to the Vice President, Customer Care and Support Services and is responsible for directing the strategic management and planning of the NCQA HPA process. Additional responsibilities include: • Strategizing and leading organizational efforts to achieve and maintain NCQA accreditation • Development of accreditation work plans with timeframes and documentation required • Serves as a subject matter expert and liaison for NCQA standards interpretation, survey preparation, onsite file reviews, and follow-up activities • Development of trainings related to NCQA Standards based upon business owner needs • Provide oversight and direction to assure compliance with Quality activities associated with all regulatory agencies

	• Provide guidance and oversight of Quality Regulatory committees and subcommittees, Corporate Initiatives including new program development and initiation as it relates to regulatory compliance and QI Strategy Projects Assumes ownership, including annual updates, of the QI Program Description, QI Annual Work Plan, and the QI Annual Report with presentation to the QIC for approval • Provides direction and oversight of all UM and CM file audits for NYS and VT DOH, CMS, DFR, DFS, and NCQA regulatory requirements • Provides direction and oversight of all internal compliance file audits for UM and CM related to external delegates and delegated vendor arrangements • Active preparation, facilitation, and participation in all regulatory audits as it relates to NCQA and regulatory compliance
Quality Improvement Program Manager	The QI Program Manager role assists the Director, Accreditation and QI Regulatory Compliance in strategic planning and management of the NCQA HPA process. This role works directly with leadership teams, key business owners or contributors across the organization, and key external stakeholders to support the design, implementation, and oversight of Quality Accreditation and Compliance strategic initiatives, along with the regulatory and operational responsibilities related to the Quality Committee Structure. This individual serves as a subject matter expert and liaison for NCQA Standards interpretation, survey preparation, and onsite/virtual survey file reviews and associated follow up activities based upon surveyor feedback. Develops and maintains accreditation work plans, timelines, and documentation. Assists business owners/leaders in ongoing NCQA Accreditation Standards training annually, develops and/or evaluates departmental policies and procedures for compliance with NCQA HPA Standards. In conjunction with the Director, Accreditation and Quality Regulatory Compliance, assumes ownership of the Quality trilogy documents, including the QI Program Description, QI Work Plan, and the QI Annual Report. Assures these trilogy documents are updated annually, establishes timeframes for documentation revisions and review by key stakeholders, reviews for requirement accuracy and brand standards and is submitted timely to the QIC and the Board of Directors for final approval. Assists with the monthly Accreditation Workgroup meeting by developing and coordinating agenda topics, educational training slides, and presentation of content as required or by the request of business owners.
Quality Improvement Project Manager	The QI Project Manager role assists the Director, Accreditation and QI Regulatory Compliance in strategic planning and management of the NCQA HPA process. This role works directly with leadership teams, key business owners or contributors across the organization, and key external stakeholders to support the design, implementation, and oversight of

	Quality Accreditation and Compliance strategic initiatives, along with the regulatory and operational responsibilities related to the Quality Committee Structure. This individual serves as a subject matter expert and liaison for NCQA Standards interpretation, survey preparation, and onsite/virtual survey file reviews and associated follow up activities based upon surveyor feedback. Develops and maintains accreditation work plans, timelines, and documentation. Assists business owners/leaders in ongoing NCQA Accreditation Standards training annually, develops and/or evaluates departmental policies and procedures for compliance with NCQA HPA Standards. In conjunction with the Director, Accreditation and Quality Regulatory Compliance, assumes ownership of the Quality trilogy documents, including the QI Program Description, QI Work Plan, and the QI Annual Report. Assures these trilogy documents are updated annually, establishes timeframes for documentation revisions and review by key stakeholders, reviews for requirement accuracy and brand standards and is submitted timely to the QIC and the Board of Directors for final approval. Assists with the monthly Accreditation Workgroup meeting by developing and coordinating agenda topics, educational training slides, and presentation of content as required or by the request of business owners.
Vice President, Customer Insight and Analytics	The Vice President, Customer Insight and Analytics is accountable for overseeing the MVP Voice of the Customer analytics function. This includes conducting member direct research through surveys and other research vehicles. In addition, this role is responsible for service improvement and transformation with a focus on improving the member experience. The VP, Member Insights and Analytics, reports into the Senior Vice President and Chief Customer Experience Officer.
Director, Member Advocacy, Appeals and Grievances	Responsible for the appropriate processing of member grievances and appeals as well as requests for State Fair Hearings and external reviews. The Director, Member Advocacy, Appeals, and Grievances manages grievance and appeal data and reports. This position is required to represent Appeals and Grievances at various health plan committee meetings and provides updates at these committees, as needed.
Associate, Senior Complaint/Fair Hearing Coordinator	Responsible for logging member grievances and completing a thorough investigation of those pertaining to potential Quality of Care (QOC) issues, including referral to an MVP Medical Director as appropriate, to ensure resolution. The Senior Complaint/Fair Hearing Coordinator evaluates complaints and grievances by type, location, and region to identify trends indicating potential areas in need of further analysis and intervention as well as tracks and resolves all administrative member grievances and provider complaints.

QI PROGRAM RESOURCES: INFRASTRUCTURE AND DATA ANALYTICS

MVP has the technology, infrastructure, and data analytics capabilities to support goals for quality management and value. The MVP health information systems collect, analyze, integrate, and report encounter data and other types of data to support utilization, complaints/grievances/appeals, care management/coordination, and all quality activities. The IT infrastructure integrates data for monitoring, analysis, evaluation, and improvement of the delivery, quality, and appropriateness of health care furnished to all members, including those with special health care needs. MVP IT systems and informatics tools support advanced assessment and improvement of both quality and value, including collection of all quality performance data, with the ability to stratify data at the regional level, across provider types, and across member populations. These systems capture, store, and analyze data from internal, subcontractor, and external sources and for effective use through a suite of data informatics and reporting solutions.

Converged Analytics by Inovalon®

Converged Analytics by Inovalon is a HEDIS Engine that is certified by NCQA and produces NCQA-certified HEDIS measures. Its primary use is to calculate HEDIS, and other state (NYS and VT) required performance measures. The tool also provides the ability to report to various regulatory bodies such as NCQA, CMS, NYS, and VT, at the individual member, provider, and population levels. The engine enables MVP to integrate claims and member, provider, and supplemental data into a single repository and automatically converts the raw data into statistically meaningful information by applying a series of certified clinical rules and algorithms. Claims, member, provider, and lab data along with extracts from other supplemental data sources (such as immunization registry data, CMS feeds, and chart data) are loaded into the engine to be processed at least monthly. The output is summarized for users with ability to drill down into the member/provider level details. The HEDIS engine output is also loaded into the Enterprise Data Model for Analytics warehouse to satisfy other partner/vendor reporting requirements and internal analytical and reporting needs.

Enterprise Data Model for Analytics (EDMA)

The foundation for MVP's Converged Analytics proprietary data integration and reporting strategy is EDMA. EDMA systematically receives, integrates, and transmits internal and external administrative and clinical data, including medical, behavioral, and pharmacy claims data, as well as lab test results. EDMA supplies the data needed for all Converged Analytics and reporting applications while orchestrating data interfaces among core applications. The output from the Converged Analytics HEDIS engine is stored in EDMA to enable downstream processing of measure data. Housing all information in the EDMA allows MVP to generate standard and ad-hoc quality reports from a single data repository.

Facets®

Facets provides claims processing with extensive capabilities for administration of multiple provider payment strategies. Facets receives appropriate health plan member and provider data systematically from Member Relations Manager and Provider Relations Manager systems; it also receives service authorization information in near real-time from CareRadius®, MVP's clinical documentation and authorization system, and is integrated with encounter production and submission software.

CareRadius
This member-centric health management platform is used for collaborative care management, care coordination, and behavioral health, condition, and utilization management. Integrated with EDMA for access to supporting clinical data, CareRadius allows Health Management and QI department staff to capture utilization, care, and PHM data; to proactively identify, stratify, and monitor high-risk members; to consistently determine appropriate levels of care through integration with InterQual® medical necessity criteria and clinical policies; and, to capture the impact of programs and interventions.

Reporting and Analytics
Quality Analytics produces monthly reports for ratings systems such as Medicare STARS, Marketplace Quality Rating System, and Medicaid NCQA Health Plan Rating System. In addition, reports are produced for any Quality-related P4P programs outlined in contracts between providers and health plans. Reports contain the most current HEDIS, CAHPS, and operational rates, where applicable, from MVP's source-of-truth HEDIS engine, certified CAHPS vendor, CMS Health Plan Management System (HPMS) and Complaint Tracker Module, and Acumen pharmacy data. Additional data points provided are source-of-truth rates from prior year final rates, prior year current month, and star or rating assignment (1-5) at the measure level. Domain- and overall-level roll-up ratings are estimated using calculations modeled from CMS or NCQA Technical Specifications. Roll-up overall STARS are estimated for current rates, and final overall STAR ratings from prior year are provided for comparison. Year-over-year graphs are provided to show trending performance across current and prior measurement year. Finally, most current available benchmarks are provided, and current numerator and denominator, where relevant, are provided at the measure level to show health plans the benchmark currently achieved and distance, in numerator hits, to all remaining benchmarks not met.

MVP develops predictive analytical models leveraging a variety of datasets including population demographics, disease prevalence and health care disparities, clinical gaps, and social risk factors to identify opportunities for improvement and trends that indicate potential barriers to care that can potentially affect the results of interventions and initiatives. These analyses are used to appropriately design QI projects and interventions and to evaluate the results of such initiatives.

Clinical Decision Support
The Clinical Decision Support application is a longitudinal, multi-episode based predictive modeling and Care Management analytics tool that allows the Quality and Care Management teams to use clinical, risk, and administrative profile information obtained from medical, behavioral health, and pharmacy claims and lab data to identify members who may be at risk for

high future utilization or at high risk of inpatient readmission. To perform these Quality and Care Management activities, the Johns Hopkins Adjusted Clinical Groups (ACG) System is utilized. The Johns Hopkins ACG System is a statistically valid, case-mix methodology that allows health care organizations to measure the medical need of populations and to describe or predict a population's past or future health care utilization by taking into consideration each member's morbidity burden. The ACG System provides multiple concurrent and predictive markers derived from a member's diagnosis code history from all encounters (medical, behavioral health, pharmacy, lab) as well as demographic data during a 12-month period. The application supports the Quality team in identifying target populations for focused improvement intervention based on risk score and need.

Customer Relationship Management (CRM) Platform
The CRM platform enables MVP to identify, engage, and serve members, providers, and federal/state partners in a holistic and coordinated fashion across wellness, clinical, administrative, and financial matters. The CRM platform captures, tracks, and allows MVP staff to manage complaints, grievances, and appeals for all required reporting.

MVP obtains data and analytical support through the Digital Transformation and Technology department and Operations Transformation, as necessary.

DOCUMENTATION CYCLE

The QI Program incorporates an ongoing documentation cycle that applies a systematic process of quality assessment, identification of opportunities, action implementation as indicated, and evaluation. Several key quality instruments demonstrate MVP's continuous quality improvement cycle using a predetermined documentation flow such as the:

- QI Program Description
- QI Work Plan
- QI Annual Report

QI Program Description
The QI Program Description is a written document that outlines MVP's structure and process to monitor and improve the quality and safety of clinical care and the quality of services provided to members. The QI Program Description includes the following at minimum:

- The scope and structure of the QI Program, including the behavioral health aspects of the program
- The specific role, structure, function, and responsibilities of the QIC and subcommittees/work groups, including meeting frequency and accountability to the MVP Board of Directors
- A description of dedicated QI Program staff and resources, including involvement of a designated provider and a BH care provider
- The BH aspects of the QI program, and how MVP serves a diverse membership

No less than annually, ideally during the first quarter of each calendar year, the designated Quality Department staff prepares, reviews, and revises as needed the QI Program Description. The QI Program Description is reviewed and approved by the QIC and Board of Directors on an annual basis. MVP submits any substantial changes to its QI Program Description to the QIC and appropriate state agencies for review and approval as required by state contract, if applicable.

At the discretion of MVP, the QI Program Description may include structure and process outlines for applicable functional areas within MVP, or departments may maintain their own program description. In either case, all program descriptions are formally approved or accepted by the QIC at least annually.

QI Work Plan

To implement the comprehensive scope of the QI Program, the QI Work Plan clearly defines the activities to be completed by each department and all supporting committees throughout the program year, based on the QI Annual Report of the previous year.

The Work Plan is developed annually after completing the QI Annual Report from the previous year and includes recommendations for improvement from the QI Annual Report. The Work Plan reflects the ongoing progress of all quality activities, including:

- Yearly planned quality activities and objectives for improving quality of clinical care, safety of clinical care, quality of services, and member experience
- Timeframe for each activity's completion
- Staff members responsible for each activity
- Monitoring of previously identified issues
- Evaluation of QI Program

MVP annually reviews the existing Work Plan and confirms compliance with MVP's current needs, accreditation requirements, and current state and/or federal requirements and deliverables related to the QI Program, as applicable. Work Plan status reports are reviewed by the QIC on a semiannual basis. The Work Plan is a fluid document; designated Quality Department staff make frequent updates to document progress of the QI Program throughout the year.

At the discretion of MVP, the QI Work Plan may include activities of all applicable departments (Customer Care, Utilization Management, Care Management, Provider Services, Credentialing, etc.) within MVP, or each department may maintain their own work plan independently. In either case, all work plans are formally approved or accepted by the QIC at least annually.

QI Annual Report

The QI Annual Report includes an annual summary of all quality activities, the impact the program has had on member care, an analysis of the achievement of stated goals and objectives, and the need for program revisions and modifications. The Annual Report outlines the completed and ongoing activities of the previous year for all departments within MVP, including activities regarding Provider Services, Member Services, Utilization Management, Care Management, Complex Case Management, Population Health Condition Management, and

safety of clinical care. Annual Report findings are incorporated in the development of the annual QI Program Description and QI Work Plan for the subsequent year. The Vice President, Customer Care and Support Services and Director, Accreditation and QI Regulatory Compliance are responsible for coordinating the evaluation process and a written description of the annual report and work plan is provided to the QIC and Board of Directors for approval annually.

The QI Annual Report identifies outcomes and includes evaluation of the following:

- Analysis and evaluation of the overall effectiveness of the QI Program, including progress toward influencing network-wide safe clinical practices, such as:
  - An evaluation of the adequacy of resources (i.e., staffing, analytic tools, etc.) and training related to the QI Program
  - The effectiveness of the Quality Committee Structure, including subcommittees and workgroups
  - Effectiveness of health plan leadership and external provider involvement in the QI Program
  - Conclusions regarding the need to restructure the QI Program for the following year
- A description of completed and ongoing quality activities that address quality and safety of clinical care and quality of service
- Trending of measures collected over time to assess performance in quality of clinical care and quality of service
- Interventions implemented to address the issues chosen for PIPs and focused studies
- Measurement of outcomes
- Measurement of the effectiveness of interventions
- An analysis of whether there have been demonstrated improvements in the quality of clinical care and/or quality of services
- Identification of limitations and barriers to achieving program goals
- Recommendations for the upcoming year's QI Work Plan
- An evaluation of the scope and content of the QI Program Description to ensure it covers all types of services in all settings and reflects demographic and health characteristics of the member population
- The communication of necessary information to other committees when problems or opportunities to improve member care involved more than one committee's intervention

At the end of the QI Program cycle each year (calendar year, unless otherwise specified by state contract), the Quality Department facilitates/prepares the QI Annual Report. The Annual Report assesses both progress in implementing the QI strategy and the extent to which the strategy is in fact promoting the development of an effective QI Program. Recommended changes in program strategy or administration and commitment of resources that have been forwarded and considered by the QIC should be included in the document.

In addition to providing information to the QIC, the annual QI Annual Report, or an executive summary as appropriate, can be used to provide information to a larger audience such as, accrediting agencies, regulators, stockholders, new employees, and the Board of Directors.

MVP provides general information about the QI Program to members and providers on the website or member/provider materials such as the Member Handbook or Provider Policies and Payment Policies. If required, communication includes how to request specific information about QI Program goals, processes, and outcomes as they relate to member care and services and may include results of performance measurement and improvement projects. Information available to members and providers may include full copies of the QI Program Description, QI Annual Report, or summary documents.

PERFORMANCE MEASUREMENT

MVP continuously monitors and analyzes data to measure performance against established benchmarks and to identify and prioritize improvement opportunities. Specific interventions are developed and implemented to improve performance and the effectiveness of each intervention is measured at specific intervals, applicable to the intervention.

MVP focuses monitoring efforts on the priority performance measures that align with the mission and goals outlined previously, as well as required additional measures. MVP reports all required measures in a timely, complete, and accurate manner as necessary to meet federal and state reporting requirements. Performance measures also include all HEDIS measures required for the NCQA Health Plan Ratings and the designated set of CMS Adult, D-SNP, and Child CORE measures. HEDIS includes measures across six domains of care including:

1. Effectiveness of Care
2. Access and Availability of Care
3. Experience of Care
4. Utilization and Risk Adjusted Utilization
5. Health Plan Descriptive Information
6. Measures Collected Using Electronic Clinical Data Systems

HEDIS is a collaborative process between MVP, the Quality Department, and several external vendors. MVP calculates and reports HEDIS rates utilizing an NCQA-certified software. HEDIS rates are audited by an NCQA-certified auditor and submitted to NCQA as required.

Member Experience

MVP supports continuous ongoing measurement of member experience by monitoring member inquiries, complaints/grievances, and appeals, member satisfaction surveys, member call center performance, and direct feedback from member focus groups and other applicable committees. The QI and Operations departments analyze findings related to member experience and presents results to the QIC and appropriate subcommittees.

CAHPS assesses patient experience in receiving care. CAHPS results are reviewed by the QIC and applicable subcommittees, with specific recommendations for performance improvement interventions or actions. In addition to any federal or state required CAHPS measures, MVP focuses on the following measures required for the NCQA Health Plan Ratings:

- Getting Care Quickly
- Getting Needed Care

- Coordination of Care
- Customer Service Rating of Health Plan
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Plan Administration
- Access to Information

HOS is a member-reported outcomes measure used in Medicare Star Ratings. The goal of HOS is to gather valid, reliable, and clinically meaningful health status data from Medicare members. HOS results are reviewed by the MSIC and applicable subcommittees, with specific recommendations for quality improvement activities, P4P, program oversight, public reporting, and to improve members' health. Five measures are incorporated into the HOS survey:

1. Improving and Maintaining Physical Health
2. Improving and Maintaining Mental Health
3. Falls Risk Management
4. Managing Urinary Incontinence
5. Physical Activity in Older Adults

Provider Experience

Provider satisfaction is assessed annually using valid survey methodology and a standardized comprehensive survey tool. The survey tool is designed to assess provider satisfaction with the network, claims, quality, utilization management, and other administrative services. The Provider Engagement and Network Development departments are responsible for coordinating the provider satisfaction survey, aggregating, and analyzing the findings, and reporting the results to appropriate committees. Survey results are reviewed by the SIC, with specific recommendations for performance improvement interventions or actions. Provider experience may also be assessed through monitoring of provider grievances and appeals as well as point-in-time provider surveys following call center and in-person interactions. Provider surveys, monitoring of provider grievances and appeals, and input from various quality committees and advisory workgroups provide ongoing data to the Performance Improvement Team and QIC, with operational process improvements and service performance improvement projects based on formal analysis of identified areas of provider need/dissatisfaction.

PROMOTING MEMBER SAFETY AND QUALITY OF CARE

The QI Program is a multidisciplinary program that utilizes an integrated approach to monitor, assess, and promote member safety and quality of care. MVP has mechanisms to assess the quality and appropriateness of care furnished to all members including those with special health care needs, as defined by NYS, VT, and other regulatory bodies. These activities are both clinical and non-clinical in nature and address physical health, behavioral health, and social health services.

Member safety is a key focus of the MVP QI Program. Monitoring and promoting member safety is integrated throughout many activities across MVP, including through identification of potential and/or actual quality of care events and critical incidents, as applicable. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of member care, is not compliant with evidence-based standard practices of care, or signals a potential sentinel event, up to and including death of a member. Internal staff from business areas including Health Management, Customer Care, Provider Services, and Quality Improvement, network providers, facilities or ancillary providers, members or member representatives, state partners, Medical Directors, or the Board of Directors may inform the Member Grievance and Appeals team of potential quality of care issues and/or critical incidents. Potential quality of care issues requires an investigation of the factors surrounding the event to determine the severity and need for corrective action, up to and including review by the PRC as indicated. This team tracks and monitors all issues and identifies any trends in occurrence, regardless of their outcome or severity level.

In addition, MVP monitors for quality of care and/or adverse events through claims-based reporting mechanisms. An adverse event is an event over which health care personnel could have exercised control, and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred. Although occurrence of an adverse event in and of itself is not necessarily a preventable quality of care issue, MVP monitors and tracks these occurrences for trends in type, location, etc., to monitor member safety and investigates further and/or requests a CAP any time a quality-of-care issue is definitively substantiated.

MVP's critical incident management processes comply with all health, safety, and welfare monitoring and reporting of critical incidents as required by state and federal regulations and meets all accreditation requirements. Management includes the establishment of protocols, procedures, and guidelines for consistent monitoring and trend analysis as defined by regulatory bodies.

Critical incidents, for example, may include events or occurrences that cause harm to a member or indicate risk to a member's health and welfare, such as abuse, neglect, and exploitation. Other events impacting a members' health and wellness, or potential risk, may be addressed through the quality-of-care process as noted above.

A Serious Reportable Event (SRE) is defined as an incident involving serious harm or death to a member from a lapse or error in a health care facility. MVP's policy regarding SRE is consistent with the policies defined by national health care quality organizations such as The Leapfrog Group and the National Quality Forum (NQF). The SREs covered under MVP's policy will change over time as dictated by Federal and/or State mandate and the needs of MVP's members. If an SRE occurs within a facility, it is expected that the hospital will immediately report the event to MVP and waive costs directly related to the event. MVP's current service agreement template for inpatient facilities includes language addressing MVP's expectations, should an SRE occur.

MVP's SRE policy includes a subset of events called Critical Incidents, which pertain only to members that receive LTSS. Critical Incidents are defined as episodes of abuse, neglect, and exploitation and includes episodes of care resulting in wrongful death and/or an injury from the use of restraints or evidence of a medication error. These events are investigated through the QOC and Quality of Service (QOS) process and are reported to NYSDOH on a quarterly basis.

MVP also ensures that the initial and recredentialing of all network providers complies with state and accreditation requirements, and performs ongoing monitoring of the provider network, including screening of providers against all applicable Exclusion Lists (i.e., System for Award Management [SAM], List of Excluded Individuals/Entities [LEIE], etc.).

Medical Record Documentation Standards
MVP promotes maintenance of medical records in a current, detailed, and organized manner which permits effective and confidential patient care and quality review. The minimum standards for provider medical record keeping practices, which include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of member information, are outlined in the Provider Policies and Payment Policies.

MVP may conduct medical record reviews for purposes including, but not limited to, utilization review, quality management, medical claim review, or member complaint/appeal investigation.

Qualified Entities (QEs)
MVP currently participates with Health Information Exchange of New York (HIXNY) to receive data for members from across the Statewide Health Information Network of New York (SHIN-NY) in accordance with policies. Data from the SHIN-NY includes the acquisition of records certified through the NCQA Data Aggregator Validation program for use in HEDIS performance measurement.

MEMBER ACCESS TO CARE

MVP ensures member access to care in areas such as network adequacy, availability of services, timely appointment availability, transitions of care, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization. MVP ensures the availability and delivery of services in a culturally and linguistically competent manner to all members, including those with limited English proficiency and literacy and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, gender identity, etc. MVP also ensures all Participating Providers deliver physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities. Numerous methods and sources of data are utilized to assure appropriate member access to care, including provider access and availability analysis, member inquiries and complaints/grievances/appeals, and review of CAHPS survey findings related to member experience of availability and access to services. MVP also ensures members have access to accurate and easy to understand information about Participating Providers. The MVP Provider Directory is available online and as a hard copy as needed and meets all regulatory and

accreditation requirements. The directory is updated in a timely manner upon receipt of updated information from providers and assessment of the accuracy of the directory is completed on an ongoing basis.

The Provider Network Department reports results to the SIC and the QIC for consideration of corrective action if opportunities are identified. Results are included in the annual QI Program Evaluation. MVP ensures compliance with contractual, regulatory, and accreditation requirements, including all reporting requirements, to maintain timely and appropriate access to care for all members.

Network Adequacy

MVP maintains and monitors the provider network to ensure members have adequate access to all covered services. MVP recognizes the necessity to have providers who are best able to meet the complete needs of members and eliminate barriers to access. Numerous factors beyond network adequacy analyses are considered, such as patterns of care, cultural and linguistic needs, and SDOH. Per applicable federal and state regulations, MVP contracts with all required and essential provider types, i.e., federally qualified health centers (FQHCs), rural health clinics (RHCs), etc. Additionally, MVP ensures adequate numbers and geographic distribution of primary care, specialists, behavioral health providers, and other health care providers while taking into consideration the special and cultural needs of members.

MVP uses a regionally focused data-driven approach to identify network adequacy issues and ensure implementation of locally driven mitigation strategies. Network adequacy is assessed on an ongoing basis to ensure adequacy standards are met and determine if modifications to the network need to occur. As a result of MVP's ongoing assessment of the Network, MVP has contracted with multiple provider groups offering virtual care and remote audio services in addition to traditional office-based care. Standards are set for the number and geographic distribution (i.e., time and distance standards), with consideration of clinical safety and appropriate standards for the applicable service area for designated practitioner/provider types. Results are reviewed and recommendations are made to the Performance Improvement Team and/or the QIC to address any deficiencies in the number and distribution of providers. MVP ensures compliance with contractual, regulatory, and accreditation requirements, including all reporting requirements, to maintain adequate provider availability for members.

Appointment Availability

MVP monitors provider appointment availability on an ongoing basis. At least annually, MVP uses a statistically valid sampling methodology to conduct appointment availability audits of Primary Care Providers (PCPs), high-volume specialists including OB/GYNs, BH, and high-impact specialists. CAHPS results are also analyzed to identify primary care, BH, and specialty appointment availability issues. MVP's partnership with providers offering virtual care, including video and audio visits, embraces current technology through the provision of care from the member's computer or mobile device. In addition, MVP analyzes appointment access, complaints, grievances, appeals and may solicit feedback from the member, provider and/or Community Advisory Committees related to appointment access trends.

After Hours Access
MVP annually conducts after hours call surveys to assess compliance with non-business hours telephone coverage standards. Member complaints/grievances to identify potential issues are also analyzed, and PCP offices surveyed after hours to verify availability of a live respondent or appropriate messaging about how to reach the covering provider.

Out-of-Network Services and Second Opinions
If the MVP provider network is unable to provide adequate and timely services as required by established standards, MVP will allow timely services through a licensed, qualified out-of-network provider until a Participating Provider is available at in-network cost. Network/Contracting staff will execute a single case agreement (SCA) to solidify payment terms, according to the authorization parameters and/or may attempt to recruit the provider and execute a full MVP contracted agreement. MVP coordinates with out-of-network providers for payment of services to ensure the cost to the member is not greater than it would be if the services were furnished within the network. At which time it may be appropriate that the member's treatment plan and care needs are considered prior to transition of care to an in-network provider. Unless otherwise mandated to be approved (Commercial lines of business only), second opinions with out-of-network providers are allowed for consult only under the same conditions. Requests for care provided by whom conducted the second opinion, will be considered upon review of the treatment plan, the member's immediate needs, and the availability of an in-network provider.

MVP educates members about accessing out-of-network benefits, and obtaining second opinions in the Member Handbook, Certificates of Coverage, on the member website, and in interactions with Customer Care staff, as applicable. If a member is obtaining services from an out-of-network provider, staff reach out to and educate the member about transitioning to a Participating Provider as soon as appropriate for their health and safety and assists the member with identifying Participating Providers that meet the member's needs.

Telemedicine Services
MVP is committed to transforming the health care experience for members by providing increased access to care through telemedicine services. Members are not required to receive services through telemedicine but rather it expands access for members to engage in care. Telemedicine services aim to enhance the member and provider experience, by bringing quality care closer in urban, rural, or underserved areas, providing timely access to specialty care, such as BH and SUD, urgent care providers, and nutrition and lactation support. Additionally, MVP has simplified access to virtual providers through Gia®. Gia connects members to a wide range of virtual care and includes content to direct members to quality care they need, when they need it.

Telemedicine services provide an opportunity for members to access care from a personalized service delivery model while complying with all state and federal laws, HIPAA, and record retention requirements. In situations where the MVP provider network is unable to provide adequate and timely services as required by established standards services, members have a choice between an out-of-network provider (as described above) and telemedicine.

Transitions of Coverage

MVP ensures compliance with all federal, state, and accreditation transition of care policy requirements, including:

- When an MVP member transitions to MVP from either Fee-for-Service (FFS) Medicaid or another health plan:
  - Members in an ongoing course of treatment or with an ongoing special condition where changing providers may disrupt care, the member may continue seeing their provider (even if they are out-of-network) for up to 90 days
  - New members who are pregnant and in their second or third trimester may continue seeing their provider(s) through their pregnancy and up to 60 days after delivery
- When a provider in good standing leaves the MVP network:
  - Members may continue seeing that provider for up to 90 days
  - Members who are pregnant and in their second or third trimester may continue seeing the provider through pregnancy and the postpartum period, i.e., up to 60 days after delivery

Continuity and Coordination of Care

MVP monitors and acts as needed to improve continuity and coordination of care across the MVP network. This includes continuity and coordination of medical care through collection of data on member movement between providers and data on member movement across settings. Continuity and coordination between medical and behavioral health care is also monitored with data collected in several areas to identify opportunities for collaboration. MVP collaborates with BH providers to complete analysis of the data collected in the areas noted above and identify opportunities for improvement.

Continuity and coordination of medical care, and between medical and behavioral health care, may be assessed via several different measures or activities. These include but are not limited to, HEDIS measures, CAHPS or other member experience survey results, provider satisfaction surveys, etc. As stated in the NCQA requirements, MVP collects data related to continuity and coordination of care, analyzes the data to identify opportunities for improvement, selects opportunities for improvement, and implements actions for improvement. The effectiveness of improvement actions is measured annually, and re-measurement results analyzed.

Preventive Health Reminder Programs

MVP is committed to helping members achieve and maintain their best health by promoting adherence to recommended preventive health services including examinations, immunizations, screenings, and tests to prevent disease before health effects occur, identify diseases in the earliest stages, and manage current health conditions to slow or stop disease progression.

MVP utilizes various methods to remind members, parents or guardians, and providers, about recommended preventive health services to improve understanding, engagement, and

compliance with recommended preventive health guidelines. Examples of MVP's preventive health reminder efforts include, but are not limited to:

- General and supportive member and provider education such as articles in newsletters, educational webinars, face-to-face interactions, and written educational materials
- Targeted telephonic and or written outreach to members, or members' parents or guardians to remind them of applicable preventive health services due or overdue and to help scheduling appointments and transportation to the appointments as needed
- Targeted written and or face-to-face communication to providers with assigned members who are due or overdue for preventive health services

POPULATION HEALTH MANAGEMENT

The MVP PHM Program includes a comprehensive strategy plan for managing the health of its enrolled population, improving health outcomes, and controlling health care costs and is coordinated with activities addressed in this program description. The PHM Strategy is closely aligned with the QI Program priorities and goals; PHM goals and objectives are focused on four key areas of member health needs:

1. Keeping members healthy
2. Managing members with emerging health risk
3. Member safety/outcomes across settings
4. Managing multiple chronic illnesses

The MVP PHM Strategy outlines the following:

- How member health needs are identified and stratified for intervention
- Details of the PHM programs and services offered aimed to address those needs for all stages of health and across health care settings
- Explains how members are informed of the programs and services and their eligibility to utilize them
- Utilizes assessments of SDOH to identify and address unique member needs and develop an individualized plan of care
- Identifies cultural and linguist preferences and offer communication and services targeted to meet those unique member's needs

PHM programs, activities, and outcomes are reported to the QIC for review, recommendations, and approval.

Care Management

MVP offers both physical and behavioral health Care/Case Management programs to members that are individualized to their needs. Drawing on the combined strengths of MVP's registered nurses, social workers, respiratory therapists, BH professionals, wellness teams, physicians, pharmacists, and community providers, MVP provides a highly focused, integrated approach to management that promotes quality, cost-effective health care throughout the care continuum. MVP case managers utilize key principles within the framework of case management established by the American Nursing Association (ANA) and the Case Management Society of America

(CMSA). Additionally, the medical team of clinicians is certified by the Commission for Case Management (CCMC), American Nurses Credentialing Center (ANCC) and/or wellcoaches for health coaching.

MVP's Care Management programs are designed to meet the various needs of MVP members. The programs are focused, time-sensitive, and incorporate predictive modeling data to ensure that high risk members are triggered with increased efficiency. Many Care Management programs are available to both adult and pediatric members for all lines of business.

MVP systematically reviews, identifies, and refers members who may benefit from the Care Management programs using data from a variety of sources including claims, hospital discharge reports, lab reports, Health Risk Appraisal information, pharmacy medication reports, and utilization review reports. Utilization review reports include information on pre-certification, pre-approval, concurrent review, hospital admissions, and hospital discharges. Care Management referrals are received from members, providers, caregivers, and other team members to ensure that the members are receiving the support, interventions, and education that is needed in a timely manner.

Health Management

Health Management programs are intended to identify and engage members with specific chronic diseases (i.e., Asthma, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease) to positively influence a person's health status and outcomes. Member engagement focuses on early identification, planning, implementation, and evaluation using a variety of evidence-based interventions designed specifically for the target population. Interventions may include (but are not limited to) risk assessment, focused telephonic education, educational materials, guidance toward preventive services, connection with community resources, coaching members to enhance provider interaction, and adherence to evidence-based care guidelines. Once identified for engagement, contact is based on their degree of risk for complications, ongoing need, and progress toward goals. The amount of contact ranges from educational mailings to individualized personal health coaching.

PROVIDER SUPPORTS

MVP collaborates with Participating Providers to build useful, understandable, and relevant analyses, and reporting tools to improve care and compliance with practice guidelines. These analyses are delivered in a timely manner to support member outreach and engagement. This collaborative effort helps to establish the foundation for provider acceptance of results leading to continuous quality improvement activities that yield performance improvements.

Included is a multidimensional assessment of a PCP or other Providers' performance using clinical and administrative indicators of care that are accurate, measurable, and relevant to the target population. To support providers in their delivery of robust preventive and interventive

care, MVP provides quantitative and actionable analyses of the providers' member panel via analytic tools.

MVP offers a PHM tool designed to support providers in the delivery of timely, efficient, and evidence-based care to members. Claims data is used to create a detailed profile of each member with the ability to organize members by quality measures and disease conditions. This provider analytics tool includes:

- Disease registries
- Care gap reporting at member and population levels
- Claims-based patient histories
- Exportable patient data to support member outreach
- MVP Data Model for Analytics

Provider Analytics

MVP works closely with network provider organizations to establish processes and working relationships to maximize the efficiency and impact of both provider and payer. MVP deploys provider engagement resources to collaboratively define and assist providers in meeting quality, care coordination, and financial performance goals. In addition, MVP invests in and provides the tools and resources to be successful such as establishing bi-directional exchange of claims and clinical data to support high value health analytics and delivering analytical insights to inform and drive improved outcomes during execution.

MVP has a dedicated Strategic Clinical Provider Engagement team that works directly with MVP providers, meeting monthly or quarterly to define objectives, align resources, support efficiencies, collaboratively review data, tools and resources for care management, member activation, population health management, and other needs as identified. The strategic account leader and provider review practice patterns and overall practice optimization opportunities and collaborate closely to identify key priorities that will improve performance. Account leaders are also responsible for bringing feedback to assist in alignment of provider strategies throughout MVP's comprehensive network. In this way, MVP takes a disciplined, data-driven approach to increasing provider network relationships and enhancing the provider experience.

To promote bi-directional exchange of clinical information, MVP offers a range of options for providers to share data based on their capabilities. The preferred option is working with and incentivizing partners to contribute data to a local health information exchange (HIE); however, MVP may also incentivize providers to produce supplemental data files or grant electronic health record (EHR) access for e-chart acquisition. Data is used to improve quality and support risk adjustment. One way MVP incentivizes this type of exchange is defining data exchange as part of the framework for alternative payment models (APMs).

Beyond data exchange between the provider and the payer, MVP supports community health information exchange to improve population health and meaningful member engagement in the community. MVP also asks the providers to enter into a data agreement that allows MVP to securely gain access and utilize data from the exchange in appropriate ways as governed by state policy and regulation, such as quality improvement activities or to coordinate around

treatment needs. This reduces the need for providers to set up redundant clinical data feeds, improving efficiency, overhead, and maintenance for data exchange. MVP currently participates with HIXNY to receive Admission, Discharge, and Transfer alerts for NYS members and to access EHRs for members in accordance with SHIN-NY policy.

Lastly, MVP consistently makes investments in technology and is implementing an enterprise population health solution to increase transparency and empower providers to make data-driven decisions.

MVP had previously created a standard reporting package to share quality, cost, and utilization performance with providers monthly to identify provider performance opportunities and assist with population health management initiatives. This set of reports and data helps identify where to focus clinical efforts to improve outcomes and includes:

- Attribution summary and detail, including patient-level demographic information
- Member risk detail, which provides data on member risk, utilization metrics, and care coordination metrics allowing providers to identify high-risk members based on diagnosis and clinical activity
- Care management detail for all members engaged in an MVP care or health management program
- Emergency room and inpatient cost, utilization, and trending data
- Pharmacy comparisons of brand vs. generic
- Quality trend and gaps-in-care reports

Provider performance is tracked monthly, and outcomes are compared to mutually agreed upon targets. MVP also provides and reviews more advanced actuarial reporting and value-based contracting performance summaries with Participating Providers on at least a quarterly basis.

MVP is committed to further investment in provider analytics capabilities to ensure that providers have the tools necessary to build integrated care processes and drive optimal member outcomes; in pursuit of this goal, MVP is implementing an enterprise population health solution to increase transparency and empower providers to make data-driven decisions. The solution has the capability to aggregate claims, clinical, social determinants of health, and admission, discharge, and Automated Data Transfer (ADT) data to build a high quality, comprehensive, and continuously updated data asset for providers. This aggregated data is then enriched and transformed for quality measure calculations, risk calculations, and predictive analytics that help identify the most significant gaps, provide actionable insights, and guide the MVP Strategic Clinical Provider Engagement team, in co-developing improvement strategies with providers in alignment with a member-centric approach to quality and population health management.

MVP's goal is to provide "any time" access to providers and practices so that they can access trend data as soon as it is available. Data and insights can also be integrated into a provider's workflow in a variety of ways based on a provider's need such as interactive reports, a desktop application overlap, and/or direct integration into a provider's electronic health record. This empowers teams by providing insights at the point of care.

Reports and dashboards surface actionable insights to improve care and quality and may include:

- Quality gap closure opportunities
- Identified cohorts for care management
- Risk coding integrity
- Pharmacy spend and utilization
- Reports to support performance under value-based arrangements and APMs

These predictive analytic reports and scorecards will be tailored to each provider and distributed through secure and web-based reporting. With this investment, MVP and our providers will have an even greater ability to execute on improvement initiatives and measure the impact of our actions for our members.

In sharing performance, quality, and cost information, MVP aims to empower providers and members in their health care journey and collectively drive towards a health care delivery model that results in optimal outcomes, a better member experience where members feel like MVP and providers have made a difference, and overall healthier communities.

Practice Guidelines

Preventive health and clinical practice guidelines assist providers, members, medical consenters, and caregivers in making decisions regarding health care in specific clinical situations. Nationally recognized guidelines are adopted/approved by the MVP QIC or applicable subcommittee, in consultation with Participating Providers and/or feedback from board-certified providers from appropriate specialties as needed. Guidelines are based on the health needs of members and opportunities for improvement identified as part of the QI Program, valid and reliable clinical evidence, or a consensus of health care professionals in a particular field. Clinical and preventive health guidelines are updated upon significant new scientific evidence or change in national standards, or at least every two years. Guidelines are distributed to providers via the Provider Policies and Payment Policies, the MVP website, and/or provider newsletters and are available to all members or potential enrollees upon request.

Provider adherence to MVP's adopted preventive and clinical practice guidelines may be encouraged in the following ways:

- New provider orientations include reference to practice guidelines with discussion of health plan expectations
- Compliance measures are shared in provider newsletter articles available on the provider website
- Targeted mailings that include guidelines relevant to specific provider types underscore the importance of compliance
- Provider incentives

MVP uses applicable HEDIS measures to monitor provider compliance with adopted guidelines. If performance measurement rates fall below MVP/state/accreditation goals, MVP implements interventions for improvement as applicable.

Special Needs Plans (SNP)
The aim of MVP's SNP is to provide benefits and integrated interdisciplinary care coordination to improve the health of New Yorkers who meet all eligibility requirements and reside in the Capital District: Albany, Columbia, Greene, Rensselaer, Saratoga, and Schenectady counties; and Hudson Valley: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester counties.

MVP believes that by addressing each member's needs in a holistic manner, managing effective community care coordination and case management will assist in reducing and/or preventing the need for avoidable hospital admissions and ED visits, and will enhance engagement in improved health outcomes for:

- Individuals with new and existing chronic diseases such as diabetes, chronic heart failure, asthma, cardiovascular disorders, depression, etc.
- Individuals with mental illness and substance use disorders
- Individuals with limited history of preventive and well-care service

The MVP Model of Care (MOC) for SNP includes member telephonic, in-person, and in-home communications (as appropriate), including interpretation services, and is supported by an integrated interdisciplinary staff which focuses on the facilitation of psycho-social, medical, pharmacy, and behavioral health services. MVP is continuously identifying and expanding its use of digital communication including e-mail, SMS messaging, etc.

Dual Eligible Special Needs Plan (D-SNP)
MVP partnered with Belong Health to launch a joint venture that created the first D-SNP available in the Capital Region of NYS, which launched January 1, 2022. MVP offers D-SNP to individuals who are dually eligible for Medicare and Medicaid. This allows members to maximize their benefits in a more coordinated structure, including physical, behavioral, and social health needs.

Integrated Care Plan for Dual Eligible (IBP D-SNP)
Effective October 1, 2023, MVP launched a fully integrated plan for dual eligibles. This new plan enhances MVP's ability to manage concomitantly both an individual's Medicare and Medicaid benefit packages. Not only does this allow for greater care coordination but it provides the member the ability to maximize benefit offerings between two payment streams.

Medicaid Advantage Plans (MAP)
MAP is a special needs program offered by qualified Medicaid Managed organizations, such as MVP, to enrollees eligible according to the Medicaid Advantage contract in Appendix K-1. MVP abides by the Medicaid Advantage Model Contract-Section 16.1-in regard to quality management and performance improvement.

Long Term Services and Supports (LTSS)
LTSS includes services and supports utilized by Medicaid members. Program goals include providing education and internal referral information for members who request LTSS such as

Personal Care Aide (PCA) services, Consumer Directed Personal Assistance Program (CDPAP), Emergency Alert, and Adult Daycare.

Eligibility criteria includes completion of a Universal Assessment System (UAS) for members living in the community and have a nursing facility level score of five or greater, or members that require 120 days of nursing home services or more during the year.

Each member must have an assigned Care Manager who manages the Person Center Service Plan and is required for all members receiving LTSS.

MVP is committed to providing effective LTSS to members in the right place, at the right time, to live safely in the most integrated and least restrictive setting and promote an optimal level of health.

PERFORMANCE IMPROVEMENT ACTIVITIES

The QIC reviews and adopts an annual QI Program Description and QI Work Plan that aligns with MVP's strategic vision and goals and appropriate industry standards. The Quality Department implements and supports performance/quality improvement activities as required by state or federal regulatory contracts, including PIPs and CCIPs, in addition to NCQA accreditation requirements. Focus studies and health care initiatives also include behavioral health care issues and/or strategies.

MVP utilizes traditional quality/risk/utilization management approaches to identify activities relevant to MVP programs or a specific member population that describe an observable, measurable, and manageable issue. Initiatives are identified through analysis of key indicators of care and service based on reliable data which indicate the need for improvement in a particular clinical or non-clinical area. Baseline data may come from performance profiling of contracted providers, mid-level providers, ancillary providers, and organizational providers; provider office site evaluations; focus studies; utilization information (over-and under-utilization performance indicators); sentinel event monitoring; trends in member complaints, grievances, and/or appeals; issues identified during care coordination; and/or referrals from any source indicating potential problems, including those identified by affiliated hospitals and contracted providers. Other initiatives may be selected to test an innovative strategy or as required by state or federal contract. Projects and focus studies reflect the population served with consideration of SDOH, age groups, disease categories, and special risk status.

The QIC may assist in prioritizing initiatives focus with the greatest need or expected impact on health outcomes and member experience. PIPs, focused studies, and other quality initiatives are designed to achieve and sustain, through ongoing measurements and interventions, significant improvement over time in clinical and non-clinical care areas in accordance with principles of sound research design and appropriate statistical analysis. The QIC helps to define the study question and the quantifiable indicators, criteria, and goals to ensure the project is measurable and able to show sustained improvement. Evidence-based guidelines, industry standards, and contractual requirements are used as the foundation for developing performance indicators,

setting benchmarks and/or performance targets, and designing projects and programs that assist providers and members in managing the health of members. If data collection is conducted for a random sample of the population, baseline and follow-up sampling is conducted using the same methodology and statistical significance and a 90% or more confidence level is determined.

The QIC or subcommittee/work group may also assist in barrier analysis and development of interventions for improvement. Data is re-measured at defined intervals to monitor progress and make changes to interventions as indicated. Once a best practice is identified, control monitoring reports are implemented to monitor for opportunities in the process and need for additional intervention. Improvement maintained for one year is considered valid and may include, but is not limited to, the following:

- The achievement of a pre-defined goal and/or benchmark level of performance
- Successful reduction in at least 10% of members who did not achieve the outcome defined by the indicator (or the number of instances in which the desired outcome is not achieved)
- The improvement is reasonably attributable to interventions implemented by MVP through post measurement analysis.

NYS, VT, AND CMS PERFORMANCE IMPROVEMENT PROJECTS

Marketplace Quality Improvement Strategy (QIS)
Section 1311(c)(3) of the Affordable Care Act requires Marketplaces to display QHP quality ratings on Marketplace websites to assist in consumer selection of QHPs. Based on this authority, CMS established standards and requirements related to QHP issuer data collection and public reporting of quality rating information in every Marketplace. QHP issuers must submit quality rating information (specifically Quality Rating System clinical measure data and QHP Enrollee Response data) for its QHPs in accordance with CMS guidelines as a condition of certification and participation in the Marketplaces.

MVP offers QHPs in the states of New York and Vermont. These Marketplace plans are offered on the state-based exchanges. All NYS and VT-based Marketplace products are required to report HEDIS clinical measures on an annual basis.

A QIS incentivizes improved care for MVP members by aligning payments to measures of performance when providers increase quality performance. MVP develops a QIS for its VT and NYS Marketplace members by first identifying opportunities for care improvement through analysis of measure performance for this population. Once measures are identified, the plan is developed and approved by MVP Leadership. The QIS is reported to the NYSDOH and VT DFR for review and approval.

Once a measurement year concludes and claims run out occurs, MVP pulls final performance rates for the QIS measures. The rates are reviewed, and MVP's Informatics analysts calculate the incentive payments to be distributed to the Marketplace providers.

2022-2024 CCIP

MVP conducts a CCIP over a three-year period, with a focus on promoting effective management of chronic disease and improving care and health outcomes for members with chronic conditions, which meets all CMS requirements for Medicare, as applicable. Effective management of chronic disease includes slowing disease progression, preventing complications and development of comorbidities, reducing preventable ED utilization and inpatient stays, improving quality of life, and reducing costs for both MVP and MVP members. CCIP initiatives are developed through an analysis of a MVP target population and include activities such as care coordination, promotion of preventive screening, disease and lifestyle management programs, education and outreach to members and providers, etc. The chronic condition chosen for the 2022-2024 CCIP is Osteoporosis Management.

Performance Opportunity Project (POP)
MVP participates in the NYSDOH, OMH, and OASAS Medicaid POP. This project aims to improve outcomes for members who are high utilizers of acute mental health services and at risk for hospital readmission. The project targets Medicaid Managed Care members who have high rates of mental health emergency room and inpatient service utilization. To help POP identified members transition from the hospital to community-based care, the POP leverages two best practice interventions:

- Intensive Care Transition Services: When POP high utilizers are hospitalized, MVP mobilizes a provider to initiate a nine-month episode of Intensive Care Transition Services to help the member transition back into the community
- Clozapine Utilization: Where applicable, MVP reviews members who may be appropriate for clozapine initiation and continuation. Clozapine is the treatment of choice for refractory schizophrenia; however, clozapine is underutilized among high utilizers in NYS
- MVP is required to report POP Intensive Care Transition Services to OMH in Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) to receive 6 bonus points in New York State's Quality Incentive Program for reporting milestone achievement.

MVP began participating in POP effective 2020. MVP assigned BH case managers who work with members on intensive care transitions. BH case managers collaborate across Health Management to better manage members' complex/co-morbid conditions. To ensure MVP POP members receive coordinated care in the community, BH case managers also collaborate with hospitals, community providers, and health homes. The BH leadership team will continue to train other departments on this initiative to ensure company awareness of POP. MVP works closely with Health Home partners to ensure post-discharge intensive care transitions are occurring with members. Data is collected in accordance with milestones identified by New York State.

2022-2024 Dental PIP
Aligning with NYS Medicaid Redesign Team (MRT) and the NYS Office of Health Insurance Programs (OHIP), the NYS Office of Quality Patient and Safety's 2022-2023 PIP for dental initiatives promotes the utilization of evidence-based preventive and restorative dentistry to improve rates of preventive dental care among mainstream Managed Medicaid and HIV SNP members, ages 21-64 years. MVP is working closely with Healthplex, MVP's delegated dental

health vendor, to deliver meaningful interventions that improve members dental health. MVP will analyze intervention progress and measure rate improvement for Annual Dental Visit (ADV) and Ambulatory Sensitive Non-Traumatic Dental ED Visits (NTDC-ED) from baseline measurement year 2021 to final measurement year 2023. The goals of this PIP are:

1. Increase the percentage of Medicaid adults that receive an ADV by ten percentage points from baseline for a rate of 26%.
2. Decrease the rate of ambulatory care sensitive ED visits for non-traumatic dental conditions in Medicaid adults from the baseline rate of 144 visits per 100,000 members months to 115 visits per 100,000 member months.
3. Increase the percentage of Medicaid adults in the Northeastern Region that receive an ADV by 8.7 percentage points from baseline for a rate of 19.5%.

Between the baseline period and the interim measurement period, only one of the three PIP indicator (Indicator 2) showed notable improvement and no indicators had yet met their intended final goal rates.

Indicator 1, ADV: Total declined from 17.94% to 15.79% between the baseline and interim measurement periods.

Indicator 2, NTDC-ED: Total rate improved between the baseline and interim measurement periods from 143.54 visits per 100,000 member months to 131.43 visits per 100,000 member months, respectively.

Indicator 3, Northeastern Regional Disparity for ADV: Rate declined very slightly from 10.79% to 10.62% between the baseline and interim measurement periods.

The final PIP report is due July 9, 2024.

2024-2026 Cancer Prevention PIP

The Office for Quality and Patient Safety (OQPS) announced that the 2024-2026 Managed Medicaid PIP topic will focus on Cancer Prevention.

2022-2024 HARP PIP

The NYS OQPS 2022-2024 HARP PIP focuses on improving cardiometabolic monitoring and outcomes for HARP members with Diabetes Mellitus. The PIP is aimed at improving four performance Indicators, HbA1c control, Poor Blood Pressure Control, Poor HbA1c control, and Tobacco Cessation Benefit Utilization. The goals of this PIP are:

1. Increase the rate of HARP members with HbA1c control <8% by five percentage points from baseline for a rate of 32.95%.
2. Increase the rate of HARP members with HbA1c control <8% in the Hudson Valley region by five percentage points from baseline for a rate of 80.74%.
3. Decrease the rate of HARP members with poor HbA1c control <9% by five percentage points from baseline for a rate of 63.92%.

4. Increase the rate of HARP members with Blood pressure Control <140/90 mmHg by five percentage points for a rate of 24.29%.
5. Increase the rate of at least one prescription for tobacco cessation pharmacotherapy by five percentage points for a rate of 22.14%.
6. Increase the rate of at least one outpatient visit for tobacco cessation counseling by five percentage points for a rate of 6.15%
7. Increase the rate of individuals with at least one prescription for tobacco cessation pharmacotherapy and one outpatient visit for tobacco cessation counseling by five percentage points for a rate of 5.49%

Interventions 2023

1. 2023 Q1 MVP sent mailers to HARP members identified as living with diabetes and as smokers regarding existing tobacco cessation programs, tobacco cessation education and information on how to schedule services for cessation counseling and or cessation pharmacotherapy (769 members).
2. 2023 Q2MVP sent an outreach mailer to HARP members with a diabetes diagnosis and an HbA1c testing gap (759 members) that promoted Scarlett's at home services.
3. 2023 Q3 MVP sent emails to providers in the Hudson Valley (identified disparity area) whose attributed HARP membership had primary care and diabetes test gaps. The outreach focused on supporting gap closure (109 providers)
4. 2023 Q3 MVP sent an educational member newsletter on diabetes care, diabetes self-management education, healthy living, tobacco cessation, and blood pressure and HbA1c control (1,631 HARP members)

The final PIP report is due July 9, 2024.

The OQPS announced that the 2024-2025 HARP PIP topic will focus on Continuing Engagement in Care and Treatment. At the time of this section's annual review, initial training for the 2024-2025 HARP PIP was not yet scheduled.

Quality Performance Matrices (QPM)

Each year the NYSDOH OQPS provides MVP with two QPMs which chart QARR measures based on the Medicaid and HARP product lines. The matrices provide plans with an overview of their own quality performance compared year over year and to the New York Statewide average. These comparisons further assist plans in identifying and prioritizing quality improvement interventions.

After receiving the QPMs, the MVP Quality Program Manager distributes the matrices to key stakeholders and organizes a brief workgroup series to identify which quality measure needs to be addressed, associated barriers, and potential quality interventions. MVP stakeholders will complete the Root Cause Analysis and Action Plan Template provided by NYSDOH OQPS for Medicaid and HARP and submit the documents via email to QI@health.ny.gov. Once submitted, the NYSDOH OQPS Quality Improvement Plan Manager may arrange a conference call to discuss the responses. When the root-cause analyses and action plans are finalized and

approved by the NYSDOH OQPS Quality Improvement Plan Manager, MVP will be asked to attest to commitment to the final approved proposals. The MVP Quality Program Manager will obtain signatures from the Chief Executive Officer and the Chief Medical Officer and resubmit the finalized proposals.

The Quality Program Manager is responsible for overseeing the interventions outlined in the final approved action plan and responsible for documenting progress on the interventions and measure performance. If interventions must be updated after approval and attestation, the MVP Quality Program Manager must notify the NYSDOH OQPS Quality Improvement Plan Manager as soon as possible. Interventions conclude at the end of the current measurement year.

Also enclosed with the QPMs are the Quality Performance Satisfaction Reports that details plan performance on measures from CAHPS, by product line. If one or more measure is significantly below the statewide average, then one measure must be selected to complete and submit a root-cause analysis and action plan report following the same submission and attestation process as the QPM. If there are no measures in the Quality Performance Satisfaction Report that are significantly below the statewide average, there is no need to complete and submit a root-cause analysis and action plan report.

GRIEVANCE AND APPEAL SYSTEM

MVP ensures that members' issues and concerns are addressed appropriately by investigating and resolving member appeals, complaints/grievances, and quality of care concerns in a timely manner. Members may file a complaint/grievance to express dissatisfaction with any issue that is not related to an adverse benefit determination (i.e., concerns regarding quality of care, behavior of a provider, or MVP employee) or file a formal appeal of an adverse benefit determination, or upon exhaustion of the internal appeal process, request additional levels of appeal as applicable.

All member appeals and grievances, including grievances associated with specific providers, related to quality of care and quality of service are tracked. Data is analyzed and reported to QIC and applicable subcommittees quarterly and annually for identification of opportunities to improve or if a CAP is needed. In addition, all substantiated member grievances associated with individual providers and related to quality of care and/or quality of service, are categorized according to severity level and reviewed by PRC when needed.

REGULATORY COMPLIANCE AND REPORTING

MVP performs required quality of service, clinical performance, and utilization studies throughout the year based on contractual, state, federal, and other regulatory agency requirements. This also includes accrediting bodies such as the NCQA. Functional areas utilize NCQA Standards, provider clinical practice guidelines, state and federal rules and regulations, and guidance from nationally recognized medical societies and associations, such as the NIH and the CDC.

The Accreditation and Quality Regulatory Compliance Department maintains an annual work plan of relevant quality reporting requirements for all applicable state and federal regulations and NCQA Accreditation requirements. Reports are submitted in accordance with these requirements. Additionally, the QI Program and all MVP internal business areas fully support every aspect of the federal privacy and security standards, Business Ethics and Code of Conduct, Compliance Plan, and Fraud, Waste and Abuse Plan.

NCQA HEALTH PLAN ACCREDITATION

MVP believes NCQA Accreditations and Certifications demonstrate a health plan's commitment to delivering high-quality care and service for members and thus strives for a continual state of accreditation readiness. The MVP Vice President, Customer Care and Support Services and Director, Accreditation and QI Regulatory Compliance facilitate the process with support from MVP's Accreditation team.

MVP achieved NCQA HPA for its Commercial HMO/POS in NYS and VT, NY Essential Health Plan (EHP), and NY Marketplace Off-Exchange in September 2023. This certificate is valid through August 2026.

The MVP HPA for the VT Marketplace product underwent NCQA survey during the first quarter of 2023. A resurvey for elements that received partial credit in Network and PHM standards is scheduled for April 2024. Upon successful completion of the VT Marketplace resurvey, MVP will receive full accreditation through 2026 and is planning to combine the two surveys into one for all accredited lines of business in 2026.

DELEGATED SERVICES

The DOC is committed to ensuring that all vendors performing delegated functions on behalf of MVP are adhering to performance standards required by their contracts and are compliant with all applicable laws, regulations, and accreditation guidelines. This is accomplished through oversight of the pre-delegation process for prospective delegates, and through ongoing auditing and monitoring of established delegates in accordance with the MVP DOC Charter. MVP evaluates each delegated entity's capacity to perform the proposed delegated activities prior to the execution of a delegation agreement. A mutually agreed upon delegation agreement, signed by both parties, may include, but is not limited to, the following elements:

- Responsibilities of MVP and the delegate
- Specific activities being delegated
- Frequency and type of reporting
- The process by which MVP evaluates the delegate's performance
- Statement of consequences and corrective action process should the delegate fail to meet the terms of the agreement, up to and including revocation of the delegation agreement

If the delegation arrangement includes the use of PHI, the delegation agreement also includes PHI provisions, typically accomplished in the form of a Business Associate Agreement signed by the delegated entity.

MVP is accountable for all functions and services delegated, and as such monitors the performance of the delegated entity through annual approval of the delegate's programs routine reporting of key performance metrics, and annual or more frequent evaluation to determine whether the delegated activities are being carried out according to health plan and regulatory requirements and accreditation standards.

MVP Medical Management, Quality, and/or Compliance designees conduct an annual evaluation and documentation review that includes the delegate's program, applicable policies and procedures, applicable file reviews, and review of meeting minutes for compliance with health plan, state, and federal requirements and accreditation standards. The DOC regularly monitors the performance of delegated functions and may recommend de-delegation if the delegate is not performing adequately.

University of Vermont (UVM) Health Advantage – Expert Care Guides Expansion
In 2022, MVP partnered with The University of Vermont Health Network (UVMHN) to co-create a unique doctor-influenced Medicare Advantage plan to meet the specific health care needs of older adults in Vermont and northern NYS.

UVMHA previously implemented a Care Guide program for their membership that was very successful in helping members get the right care and maximizing all their health care benefits. With the success of the Care Guide program in the UVM Health Advantage plans, MVP expanded the valuable and unique benefit of the Care Guide program to all new members of MVP Medicare Advantage plans, effective January 1, 2023.

Welcome calls help to remove transition of care issues, including:
- Prescriptions
- Prior authorizations
- Durable medical equipment
- Scheduled or upcoming provider appointments or visits
- Scheduled procedures and surgeries

During the welcome calls, the Care Guides will also review key member benefits and help answer questions about how to begin using their new plan. New members can trust that MVP Care Guides support and help ensure a smooth transition and work to ensure there is no disruption in their current care.

Ongoing Care Guide support is available for all Medicare members and includes:
- Reviewing benefits as they pertain to health care service needs
- Care Navigation via guidance and supporting Health Literacy to help members better understand their needs

- Support the identification of gaps in care
- Complex issue resolution including being the single point of contact for a member requiring expert support
- Care kit coordination for members receiving certain services such as joint replacements
- Targeted outbound contact to support access to care including notifications of changes in provider network status

Guides will triage to MVP clinical programs – such as Asthma Health Coaching, Care management for complex issues, and transfer meal delivery setup to Care Managers.

In support of open enrollment activities during the Annual Election Period, Medicare Care Guides actively participate in virtual and in-person information sessions, supporting Medicare Plan Guides and providing benefits information and a review of the Care Guide role for prospective members.

The Care Guide program is expanding to all lines of business in 2024, with the following services being added:

- Welcome call expansion to new members in other lines of business including Commercial plans
- Serving as the single point of contact for Optum Oncology, for plan transfers of members in oncology care management
- Contacting Medicare members who have not utilized dental benefits to provide support in finding in-network dental providers and understanding scope of covered services
- Support of quality campaigns for all likes of business where Care guide interventions are identifies

Optum Oncology Program

MVP has selected Optum Health Solutions to administer prior authorization services for outpatient medical oncology members beginning January 1, 2024. MVP's partnership with Optum Health Solutions offers a comprehensive oncology management program to members with certain cancer diagnoses. The Optum program is dedicated to achieving the best possible outcomes for members, providing access to clinical and non-clinical support during a significant life event, and reducing the cost of care. The program is available to Medicare, Medicaid, CHP, Essential Plan, and Commercial members.

Once a prior authorization request is received, Optum completes an assessment to determine if members are at high or low risk for complications and hospitalization. Members who are identified as high risk will be outreached by the Optum Cancer Support Program and provided comprehensive Care Management support. Members who are identified as low risk have access to the Optum Digital Care Management Experience and Care Management.

Supportive services provided by the program include:

- Education on benefits, diagnosis, prognosis, treatment, and symptom management
- Identifying and addressing barriers to care, such as adherence psychosocial and social determinants of health needs

- Providing Transitional Care Management and ensuring a safe transition for members from the acute care to home care setting
- Optimizing palliative and hospice care, if necessary
- Facilitating Advance Care Planning
- Providing access to a digital site for member education

MVP will monitor the total cost of care, readmission rates, and satisfaction survey results for oncology members during the year to measure effectiveness of interventions and opportunities to improve the program.

Optum Renal Program

MVP has selected Optum Health Solutions to administer a renal program designed around two core capabilities: disease management and value-based care arrangements for Medicare members with chronic kidney disease (CKD). Optum's team takes an integrated approach to assist members in managing their kidney disease; the program includes two major components that drive positive outcomes and medical cost savings, early identification, and targeted clinical interventions. The program is designed to improve clinical outcomes, improve quality of life, increase productivity, and reduce medical costs by early identification of individuals living with CKD through ongoing engagement with specialized renal nurses.

Renal nurses help empower members to make lifestyle changes and provide educational materials to help members manage their condition. In addition, renal nurses connect members with nephrologists, in-network dialysis centers, home therapy, preferred access placement, and kidney transplant services if needed.

Optum has a value-based care network with MVP's existing nephrology providers to align incentives with program goals of reducing total cost of care and improving kidney clinical outcomes. Optum's field-based nurses cultivate relationships with nephrology practices to facilitate better care coordination between the member and their providers.

Optum provides MVP with quarterly reporting which includes participation rates, access to Nephrology care and gaps in care closure.

MVP will monitor the total cost of care, readmission rates, and satisfaction survey results for oncology members during the year to measure effectiveness of interventions and opportunities to improve the program.

The MVP QIC has reviewed and adopted this document, including the QI Work Plan (Program Approval Signature on file within the Quality Department).

ENDORSEMENT OF THE QUALITY IMPROVEMENT PROGRAM DESCRIPTION
The Quality Improvement Program Description has been reviewed and endorsed by the Quality Senior Leadership effective this nineteenth day, month of February 2024.

Melissa Greenberg VP
Customer Care &
Support Services

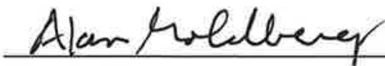
[illegible]

Melissa Greenberg
VP, Customer Care and Support Services

Digitally signed by Carl Cameron, MD
DN: cn=Carl Cameron, MD gn=Carl Cameron, MD c=US United States l=US United States o=MVP Health Care ou=Chief Meidcal Officer e=ccameron@mvphelathcare.com
Reason: I am approving this document
Location:
Date: 2024-04-02 14:08-04:00

Carl Cameron, MD, MBA
Chief Medical Officer, QIC Chairperson

ENDORSEMENT OF THE QUALITY IMPROVEMENT PROGRAM DESCRIPTION
The Quality Improvement Program Description has been reviewed and endorsed by the Board of Directors effective this nineteenth day, month of March 2024.



Alan Goldberg
Chair of the Board of Directors