MVP Health Care®
2020 Quality Improvement Program

TABLE OF CONTENTS

PURPOSE

The Quality Improvement (QI) Program description provides the framework to improve the quality, safety, and efficiency of clinical care, enhance satisfaction, and improve the overall health of MVP Health Care's (MVP) membership 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.

GOALS AND OBJECTIVES

The goal of the QI Program is to continuously improve the quality and safety of clinical care, focused on integrating physical and behavioral health (BH) care, and the quality of services provided to MVP members/enrollees across health care organizations, settings, and levels of care. MVP strives to provide access to health care that is safe, timely, effective, efficient, equitable, and patient centered.

Specific QI Program goals and objectives are to:

1. Partner with MVP functional areas to make quality the focus in all processes and decisions.
2. Implement methods, tracking, monitoring, and oversight processes for all QI efforts, activities, and initiatives to measure their value and impact.
3. Establish collaborative partnerships to proactively engage clinicians, providers, and community hospitals and organizations to implement interventions that address the identified (medical and behavioral) health and service needs of our membership throughout the entire continuum of care and those that are likely to improve desired health outcomes.
4. Address health needs of all patients along the health care continuum, including those with complex health needs (advanced developmental, chronic physical and/or behavioral illness, or complicated clinical situation).
    a. Pharmacy Coordination
    b. Transition of Care Coordination
5. Maintain a systematic process to continuously identify, measure, assess, monitor, and improve the quality, safety, and efficiency of clinical care (medical and BH), and quality of service.
6. Establish Key Performance Indicators to measure progress toward targets.
    a. Maintain overall Medical Trend at or below target percent.
    b. Ensure all elements of the MVP QI Program operate at targeted levels in 2020 (maintaining at least four out of five quality score) by actively managing core target list of quality measures.
7. Assess the race, ethnicity, language, interpreters, cultural competency, gender identity, and sexual orientation needs of our diverse populations while considering such diversity in the analysis of data and implementation of interventions to reduce health care disparities, improve network adequacy, and improve cultural competency in materials and communications.

8. Develop and maintain a high-quality network of health care practitioners and providers meeting the needs and preferences of its membership by maintaining a systematic monitoring and evaluation process.
9. Operate a QI Program that is compliant with and responsive to federal, state, and local public health goals, and requirements of plan sponsors, regulators, and accrediting bodies.
10. Provide quality and cost data and promote evidence-based clinical practice so that providers and members may make informed decisions that allow members to maximize their health outcomes.
11. Provide insight based on Gaps in Care data to increase the knowledge base of the practitioners in the evaluation of their outcome measures.
12. Support the migration of BH program from delegation to internal functions.
13. Support QI principles throughout the organization acting as a resource in QI activities.

SCOPE

The scope of the QI Program is broad and includes a wide range of activities. Such activities incorporate assessment and improvement of key aspects of clinical care (medical and behavioral), patient safety, quality of products and services, satisfaction, and efficient use of resources. The program is comprehensive and dynamic and includes processes to identify, monitor, analyze, prioritize, and implement interventions and evaluate as necessary to promote accessible, efficient, quality health care for every member.

QI Program (medical and BH care) key aspects include:

- Care coordination
    - Local Care Coordinators (LCCs) for patients with multiple chronic or complex conditions
    - BH and Substance Use Disorder Care Coordinators (BHCCs) for those with BH and substance use disorder illness
    - Pharmacy coordination for patients on complex pharmaceutical regimens
    - Continuity and coordination of care (including care transitions)
    - Lifestyle management / disease management
    - Primary Care Physician (PCP) and specialist engagement
    - Appropriate use of services
    - Admissions
    - Readmissions
    - Emergency Room (ER) use
    - Ambulatory services
    - Pharmaceutical services
    - Establishment of standards of care and services
    - Efficiency of services
- Effectiveness of care
    - Chronic care maintenance
    - Preventive health maintenance
    - Population health maintenance
    - Health outcomes

- Member access / availability
- Safety initiatives
- Experience of care (satisfaction)
    - Member
    - Provider
- Utilization and resource use
- High quality network of physicians and providers
- Assessment of race, ethnic and linguistic, interpreter, and cultural competency needs and interventions to address barriers and limitations
- Community programs to improve access, quality, and safety and elimination of disparities

QUALITY IMPROVEMENT PROCESS

The QI Process utilizes the DMAIC Model:

1. *Define*: The Plan defines the quality projects in a systematic process by collecting data and information. The defining step includes identifying and prioritizing the opportunities, creating goals, and benchmarking.
2. *Measure*: The data and information are collected using statistically valid techniques using a variety of quality tools in the quality management process.
3. *Analyze*: The data and information undergo further evaluation by key interdivisional representatives, including qualitative and quantitative analysis.
4. *Improve*: Initiatives are designed using a targeted robust approach utilizing the Patient Centered Medical Home (PCMH) and Total Care and Cost Improvement (TCCI) framework. The targeted approach incorporates research and evidence-based best practice.
5. *Control*: Re-measure for improvement opportunities at established intervals.

QI PROGRAM ORGANIZATION AND STRUCTURE

To drive quality-focused collaboration between Health Management and Operations, the Quality team transitioned from Operations to Health Management on 1/1/2020. This transition aligns the Quality team with Health Management's goals and integrated care approach, allowing for a more direct impact to the health of our members.

MVP President - Chief Executive Officer

The MVP President and Chief Executive Officer (CEO) ensures that the goals and objectives of the QI Program are consistent with MVP's overall mission and business strategies. This individual is responsible for all aspects of MVP Health Plan and its various subsidiary companies. The CEO leads senior staff and the Board Strategic Planning Committee to develop and establish MVP's corporate core values, vision, and strategic plans. Responsibilities also include communicating MVP's values, vision, and mission to all staff and to the Board of Directors.

Executive Vice President – Chief Medical Officer or Interim Chief Medical officer
The Executive Vice President (EVP) and Chief Medical Officer (CMO) have overall responsibility for the QI Program and is responsible for overseeing and monitoring the progress and effectiveness of all quality improvement activities.

Senior Leader, Health Management Strategy
The Senior Leader, Health Management Strategy has overall responsibility for the programs and personnel who work in QI across all MVP regional offices. They oversee the development and execution of the Annual QI Report, Annual Program Description, and Annual QI Work Plan. The Senior Leader, Health Management Strategy oversees National Committee for Quality Assurance (NCQA) accreditation and certification preparations and associated continuous compliance efforts. The QI program is supported by staff in operational units. They collaborate with and support the Sr. Leader, Clinical Operations who oversees all clinical performance and service performance and service performance improvement efforts for all lines of business. The Senior Leader, Health Management Strategy, reports directly to the Sr. Leader, Health and Pharmacy Management.

Senior Leader, Finance and Network
The Senior Leader, Finance and Network assures that the QI Program and work plan activities approved by the QI Committee are implemented in accordance with the budget and that future programmatic interventions are included in rate projections.

Senior Leader, Quality Performance and Operations
The Senior Leader, Quality Performance and Operations manages the plan-wide, comprehensive QI programs and ensures compliance with accreditation and regulatory requirements. He/she oversees development and execution of the QI Program Description, Annual QI Report, and Annual QI Work Plan. This individual also ensures appropriate inclusion of QI efforts throughout the company, including Value Based Performance agreements. This individual assists in other regulatory reviews, such as Vermont Department of Financial Regulation (VTDFR), New York State Department of Health (NYSDOH), and New York State Department of Financial Services (NYSDFS). They collaborate and support the Senior Leader, Credentialing, Appeals, and Grievances for administrative expertise to the member, provider medical and inpatient hospital appeals processes, member complaint process, and regulatory complaint process. The Senior Leader, Quality Performance and Operations reports directly to the Senior Leader, Health Management Strategy.

Senior Leader, Medical Affairs
The Senior Leader, Medical Affairs and Medical Direction provides leadership for and management of the Regional Medical Directors, to ensure that individual cases are processed appropriately and in a timely fashion. This role is under the direction of the EVP, Medical Affairs CMO.

They direct the clinical development, continuous improvement and clinical management of the plan's Utilization Management (UM) program. They oversee the development and approval of protocols for preadmission certification, length of stay guidelines, and concurrent and retrospective review of hospital charges and ensures that MVP's denial and appeal processes adhere to state and federal regulatory agency standards. They provide clinical expertise in the evaluation of new technology and criteria development as well as analyzing and taking action to correct patterns of potential or actual

inappropriate under- or over-utilization. The individual is also the chairperson of the Medical Management Committee.

Regional Medical Directors / Medical Directors
The Regional Medical Directors and Medical Directors work closely with the Operational Senior Leaders to develop, evaluate, and improve the Quality and Medical 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 Medical Management staff to assist in operational implementation of quality and medical management programs and participates in Quality Management and Medical Management operational meetings as directed.

The MVP Regional Medical Directors participate in MVP's credentialing program. They provide clinical review and oversight of MVP's appeal and grievance process and directs the clinical development, continuous improvement, and clinical management of MVP's Quality Management efforts in geographic and product line initiatives. Regional Medical Directors also provide clinical leadership in the implementation of QI activities and actions related to MVP members and providers, including NCQA surveys, annual Healthcare Effectiveness Data and Information Set (HEDIS) reporting, CMS, and state regulatory audits. The assigned Regional Medical Director also oversees 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 responsible for rendering decisions on utilization requests, appeals, and cases referred for peer review, and for carrying out educational and corrective action processes with individual practitioners in accordance with MVP's policies, procedures, and programs. In addition, the MVP Medical Directors may be appointed to serve on the QI Committee and sub-committees. 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.

QUALITY IMPROVEMENT COMMITTEE STRUCTURE

The QI Staff coordinates inter-departmental QI activities and QI information throughout the Plan. Multidisciplinary committees and work groups monitor performance indicators, analyze data, implement interventions or process changes to improve performance, and report regularly to the Quality Improvement Committee (QIC).

The organizational flow charts describe the reporting relationships for key QI-related committees, including information about the role, structure, and function of QI-related committees. The charts also include information about the subcommittees that address three populations: Adult, HARP, and Children.

QUALITY IMPROVEMENT PROGRAM STRATEGY

MVP's QI Strategy has as its central focus the quality of care and services provided to MVP members. The QI Program employs a variety of methods for ongoing monitoring and assessment of the quality of care and service offered across all MVP business units and product lines. The principle of superior process and outcome is assured through significant coordination, analyses, collaboration with our Regional and Independent Practice Association (IPA) committees, and in partnership with our provider panel.

QI activities focus on achieving optimal health and well-being of MVP members and include:

- Analyses of inpatient and outpatient utilization, actuarial, and pharmacy data analysis
- Analyses of physician practice profiling data and hospital performance
- Identification of best practices using inpatient, outpatient, ancillary, and pharmacy data
- Investigation and tracking of member complaints, grievances, and appeals
- Individual problem identification and risk management
- Access and availability measurements
- Physician satisfaction surveys
- Quality indicator reporting
- Focused clinical studies and clinically focused member outcome surveys
- Member satisfaction surveys such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Ongoing monitoring of clinical and administrative data
- Employing predictive modeling to ensure MVP focuses on the current needs of its population
- Recommendations and data reported from QI Subcommittees and other corporate committees
- Population based data such as HEDIS and Quality Assurance Reporting Requirements (QARR)
- Reporting supplied by CMS, NYS, and VT
- Compliance with NCQA Health Plan Accreditation standards
- Supporting provider quality as demonstrated by MVP's NCQA Provider Quality certification
- Active participation in NYS Performance Improvement Programs
- Studies undertaken in support of QI actions and activities
- Investigation with appropriate follow-up of member complaints, quality of care, and service issues
- Medical record reviews to improve HEDIS results through the supplemental and hybrid data collection process
- Facilitating provider partnerships to assure delivery of high-quality treatment at the right level and right setting with improved outcomes for MVP members
- Using available and emerging technologies to make care and treatment more accessible and understandable to MVP members
- Providing education and training for MVP staff to empower each MVP employee to provide service which is meaningful and relevant for MVP members

The QIC is informed of the findings from all strategies to assure that appropriate and meaningful recommendations, actions, education and communications are developed.

QUALITY MANAGEMENT

The QIC is responsible for monitoring and evaluating the quality and appropriateness of clinical care and service and for determining standards, clinical guidelines, benchmarks, and goals that are reasonable and acceptable to practitioners, providers, and members.

The QIC evaluates the needs of MVP's population across all lines of business (Commercial, Medicare Advantage, Marketplace, HARP, Medicaid, and Safety Net programs) to prioritize the implementation of QI activities. Guidelines and programs are developed that are pertinent to the demographic mix, taking into consideration social determinants of health, the need to manage the care of members with high risk, acute, and chronic conditions, as well as the special needs of high risk populations, including members experiencing complex clinical and behavioral challenges along with overall health disparities.

Availability and Access
MVP is committed to continuously monitor the practitioner and provider network and expand, as needed, to assure adequate availability of practitioners and providers and access to care and services for MVP members.

Availability
The Service Improvement Committee (SIC) recommends standards for availability of practitioners and facility-based services and measures plan performance against these standards. The recommended standards are documented in the QI Policy "Standards for the Number and Geographic Distribution of Practitioners", which is in the Availability of Practitioners section of the QI Policy and Procedure manual.

Analysis of the provider network includes the availability of PCPs, as well as key specialty and ancillary practitioners and providers. MVP's network is assessed annually against standards that are based on geographic location, ratio of practitioners to membership, and the needs of the populations served in compliance with state and federal regulatory requirements and NCQA standards.

Results of analyses are reviewed by the SIC and opportunities for improvement are identified. This information is shared with MVP Network Development for recruitment of additional providers, if they are available.

Note: MVP's provider panel is open to all providers and practitioners who meet credentialing criteria. MVP imposes no limits based on specialty or region. The standards are listed below.

Availability of Practitioners Policy Standards Table

MVP Commercial Network (HMO/POS and EPO/PPO) Availability Standards

Primary Care	
PCP Adult (Internal Medicine, Family Practice, General Practice) PCP Pediatric (Pediatrics, Family Practice)	1:1500 members, 2 within 20 miles
Specialists, High Volume	
OB/GYN	1:1500 members, 2 within 20 miles
Ophthalmology/Optometry	1:2500 members, 2 within 20 miles
Cardiology	1:2500 members, 2 within 50 miles
Orthopedic Surgery	1:2500 members, 2 within 50 miles
Podiatry	1:2500 members, 2 within 50 miles
Specialist, High Impact	
Oncology	1:2500 members, 2 within 50 miles
Behavioral Health	
Psychiatry, Psychology, Social Work	1:2500 members, 2 within 20 miles

MVP Medicaid Managed Care (MMC) Network Availability Standards

Primary Care	
PCP Adult (Internal Medicine, Family Practice, General Practice) PCP Pediatric (Pediatrics, Family Practice)	1500 members, 3 within 20 miles
PCP (Provider + Extender) Ratio	1:2400 members
Specialists, High Volume	
OB/GYN	1:1500 members, 3 within 30 miles
Cardiology	1:2500 members, 3 within 30 miles
Ophthalmology/Optometry	1:2500 members, 3 within 30 miles
Orthopedic Surgery	1:2500 members, 3 within 30 miles
Podiatry	1:2500 members, 3 within 30 miles

Behavioral Health

Psychiatry, Psychology, Social Work	1:2500 members, 3 within 30 miles

MVP Medicare Advantage Network (HMO, PPO) Availability Standards

Primary Care

PCP Adult (Internal Medicine, Family Practice, General Practice)	1:1500 members, 2 within 20 miles

Specialists, High Volume

OB/GYN	1:1500 members, 2 within 20 miles
Ophthalmology/Optometry	1:2500 members, 2 within 20 miles
Cardiology	1:2500 members, 2 within 50 miles
Orthopedic Surgery	1:2500 members, 2 within 50 miles
Podiatry	1:2500 members, 2 within 50 miles

Behavioral Health

Psychiatry, Psychology, Social Work	1:2500 members, 2 within 20 miles

Access

The QIC approves standards for access to medical and BH care and telephone services. Access to clinical care is measured through a variety of methodologies including member surveys and member complaints, grievances, and appeals. Access to PCPs is also measured during QI site visits. MVP publishes Health Access Standards in the Provider Resource Manual, which is available at **mvphealthcare.com/PRM**. The Health Access Standards describe the timeframes within which MVP members can make appointments with contracted providers. The timeframes are determined by regulators and accrediting entities and are verified via office visits by Professional Relations (PR) Representatives and by "Secret Shopper" calls to the provider offices by MVP staff.

Access to Member Services is continuously monitored through automated reporting of calls and emails by the Customer Care Center (CCC), reported to the SIC, quarterly. Opportunities for improvement are addressed by the SIC and by Senior Management.

The CCC supports MVP members, providers, and brokers through telephonic, e-mail, and chat interactions.

The CCC is focused on providing the highest level of service to our members at what can be their greatest times of need, ensuring a truly member-focused experience that is easy for them to navigate and demonstrates our commitment to providing high-quality, low-effort service.

All contracted providers and practices are required to comply with the Americans With Disabilities Act regarding physical access to the office or facility. PR Representatives verify compliance when the PCP or practice contracts with MVP and, again, when they are reviewed for recredentialing. Additionally, all provider and practice offices attest to compliance with the Council for Affordable Quality Healthcare (CAQH), to which all contracted providers must provide credentialing data. MVP uses the CAQH information in the Credentialing and Recredentialing processes to verify provider or practitioner credentials and address information, in addition to confirming access attestation.

Call and E-mail Quality

The CCC has a robust call coaching program that involves the review of representative calls, assessing service, and providing feedback to each CCC representative. The goals are to ensure consistent information is available to callers, and to promote exceptional customer service. Call coaching evaluation scores are integrated into monthly reports of performance and statistical analysis for call quality. **In 2020, the target (goal) is that 95% of all calls coached through the quality program achieve a rating of satisfactory or better.**

Members may contact MVP via email for any inquiry. The most common topics the CCC receives through email are changes to PCP, checking claims/EOBs, change of address, premium billing questions, and requests for new ID cards. The email inquiries are managed by Member Services representatives, and turnaround timeframes and the quality of the response are monitored enterprise wide. Response times are calculated automatically through the phone system, as the speed to answer each message from the time received plus handle time to send a response. **MVP's Member Services target (goal) for 2020 is to respond within one business day.**

IVR Member Satisfaction Survey

The CCC offers an automated survey at the end of each call allowing the member to offer a rating on their experience. The questions gather feedback on inquiry resolution, professionalism, representative knowledgeability, and overall experience. Survey results are reviewed daily, any unsatisfactory results are verified, and representative education is completed. **In 2020, the target (goal) is to achieve a rating of 4.70 out of 5.**

2020 Initiatives

Phone System Upgrade

Throughout 2020 work is taking place to upgrade the phone platform used by the CCC. This initiative includes upgrades to the IVR phone system as well as the workforce management, quality, and reporting systems through a platform called Genesys PureCloud.

Genesys PureCloud will greatly enhance our ability to serve our members and providers. We utilize PureCloud for voice interactions, chat, email, and outgoing call campaigns. In the future, PureCloud can interface with social media, text chat, and our new Customer Relationship Management System, GIA.

KPI Name	KPI benchmark	Reason for benchmark	Action Plan
Quality of Telephone Responses	95% of calls evaluated for quality and accuracy are rated Satisfactory or better. Measured using scores of call coaching performed by Quality Analysts and Leaders.	Regulatory -NCQA The Care Center strives to provide members with accurate information and quality customer service. This data is used to identify opportunities for process improvements and determine if additional training is required to improve member satisfaction. This metric was chosen because it identifies how well the Care Center is responding to the needs of members and providing accurate information that is supportive of members and aligns with MVP goals.	Review calls for quality and accuracy. Representatives not meeting the benchmark are individually coached. Trends are addressed in team meetings and knowledge checks.
Email Response time	All Customer Care email inquiries are responded to within one business day. Measured using timeliness data from Avaya/Genesys.	Regulatory - NCQA The Care Center monitors this data to implement any necessary changes to number of representatives taking emails and/or priorities of email queues so that members are receiving timely responses. This supports member satisfaction and ensures they have access to information. This metric was chosen because it supports identification of any opportunities to improve timely responses to our members.	Ensure e-mail queues are staffed according to volumes allowing the CCC to meet member needs.
IVR Member Satisfaction Survey	Achieve an average rating of 4.70 out of 5. Measured using the IVR post-call satisfaction survey.	Internal goal Using the survey data, the Care Center is able to identify opportunities to improve the overall member experience. This metric was chosen because it uses direct feedback from our members and serves as an	Each IVR survey that receives a negative experience rating in multiple categories or overall is reviewed. If the rating is justified representative education is completed. Member follow up may be performed as needed

		immediate OSAT proxy for responsiveness to our members. Reviewing survey data allows us to quickly identify any issues with service and responsiveness and correct any issues.	(e.g., to correct misinformation). Trends are addressed through one on ones, in team meetings and knowledge checks.

QUALITY AND PATIENT SAFETY

Clinical Guidelines

The QIC adopts and makes available practice guidelines that are based on established evidence-based national guidelines or on recent scientific literature when nationally established guidelines are unavailable. MVP adopts preventive care guidelines for children and adults, perinatal care guidelines, as well as those related to BH and chronic medical conditions. The guidelines are reviewed by the physicians participating on the QIC and MMC. Input from specialty consultants including BH is sought when additional expertise is needed. Clinical guidelines are reinforced by educational programs whenever possible. Guidelines are updated at least every two years, or more frequently as relevant information becomes available.

To facilitate integration of guideline recommendations into everyday practice, MVP also distributes tools relevant to its guidelines. Tools include flow charts for documentation, member education materials and quick reference guides for practitioners. All items including the guidelines are available to practitioners on the MVP website and in printed format upon request.

Physician adherence to MVP's clinical guidelines is assessed through focused medical record review, analysis of claims data or HEDIS measures. A minimum of two important aspects of each of four guidelines are measured annually. Two of the guidelines address a BH issue, one of which addresses a BH issue specific to children. One of the BH guidelines may be a BH component of a medical clinical practice guideline.

Serving a Culturally and Linguistically Diverse Membership

MVP has developed a Cultural and Linguistic Competence Workgroup as a method of ensuring that the functions necessary to maintain compliance with section 15.10 of the NYS Medicaid Model Contract and NCQA 2020 Health Plan Accreditation standards QI 1, Element A, Factor 6 and NET 1, Element A, Factors 1 and 2 are carried out. The Workgroup meets twice a year to discuss the Medicaid Model Contract requirements and is co-led by the Medicaid Strategic Business Unit and Human Resources, and includes representation from Quality, Network, and Medical Management Configuration and Business Systems (Case Management (CM) Training). MVP made a business decision that the sub-workgroups meet twice per year or as needed. Subgroups meet to discuss requirements of the Medicaid Model Contract. CMS guidance does not speak to culture and language needs of Medicare Advantage members; however, MVP does offer multiple language interpreters as well as interpretation services for members with hearing difficulties.

MVP conducts a Cultural and Linguistic Competence Assessment annually to gather cultural and linguistic data representative of its service area. The following data elements have been identified for

each of the above counties, including race/ethnicity, languages spoken, level of educational attainment, gender, and age.

MVPs strategy to monitor cultural and linguistic needs of its membership includes:

a. MVP promotes and ensures the delivery of services in a culturally competent manner to all Enrollees, including but not limited to those with limited English proficiency, diverse cultural, and ethnic backgrounds, as well as Enrollees 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 Enrollees and their communities across all levels of the organization.
b. To comply with this section:
    i. MVPs 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 BH providers, individual BH practitioners, community-based providers, and peer-delivered services.
    ii. MVP's policies and procedures incorporate the importance of honoring Enrollees' beliefs, sensitivity to cultural diversity, fostering respect for Enrollees' culture and cultural identity, and eliminating cultural disparities.
    iii. QI maintains a cultural competence component of MVP's Internal Quality Assurance program referenced in Section 16.1 (d) of NYS Medicaid Model Contract
    iv. MVP's comprehensive cultural competence plan is based on Culturally and Linguistically Appropriate Services (CLAS) national standards of the US Department of Health and Human Services, Office of Minority Health, NCQA Health Plan Accreditation standards, QI 1, Element A, Factor 6, and NET 1, Element A, and managed through MVP's Internal Quality Assurance Program;
    v. Perform internal cultural competence activities including, but not limited to conducting:
        A. Organization-wide cultural competence self-assessment led by Human Resources (HR)
        B. Community needs assessments to identify threshold populations in each Service Area in which MVP operates (conducted by the Medicaid SBU)
        C. QI projects to improve cultural competence and reduce disparities, informed by such assessments and CLAS standards
    vi) HR facilitates annual training in cultural competence for all of MVP staff members. All elements of the curriculum are consistent with and/or reflects CLAS national standards. MVP's cultural competence training materials are subject to the review and approval by the State.
c. MVP's Network Management Department ensures the cultural competence of its provider network by requiring Participating Providers to certify, on an annual basis, completion of State-approved cultural competence training curriculum, including training on the use of interpreters, for all Participating Providers' staff who have regular and substantial contact with Enrollees. The State will provide cultural competence training materials to MVP and providers upon request.

Patient Safety

Facilitating the delivery of appropriate care in the right setting and at the right time, using Clinical Guidelines and MVP's Medical Policies, are key objectives of MVP's QI and Medical Management programs. As care grows increasingly more complex, provider and delivery system, medical and process errors may more commonly occur. To assure MVP members receive appropriate care, MVP processes and

programs are designed so that health care is simpler and easier to access, increasing the likelihood that members achieve an optimal health outcome. MVP's QI Program includes progressive elements aimed at maximizing appropriate care and reducing the potential for poor outcomes. Interventions address both ambulatory and inpatient opportunities for improvement.

When providers or members notify MVP of allegations of poor outcomes or episodes of care that do not meet minimum standards of medical practice, the issue is referred through the Quality Improvement Quality of Care (QOC) and Quality of Service (QOS) process. Once the issue is received, Quality staff members work to collect information that MVP Medical Directors use to substantiate or unsubstantiated the information. If the identified issue(s) is substantiated and involves a provider, the MVP Credentialing Department receives a referral to review and take appropriate action in accordance with their Performance Monitoring Policy (dated February 2020).

Serious Reportable Events

A Serious Reportable Event (SRE) is defined as an incident involving serious harm or death to a patient from a laps or error in a healthcare 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 our customers. If an SRE occurs within a facility, it is expected that the hospital will immediately report the event to the health plan 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 Long Term Services and Supports (LTSS). Critical Incidents are defined as episodes of abuse, neglect and exploitation and also 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 QOS process and are reported to NYSDOH on a quarterly basis.

PREVENTIVE HEALTH CARE

Preventive Health Guidelines

The QIC adopted preventive care guidelines for the following categories:

- Children: Birth to 21 years
- Adults: Ages 19 to 64
- Older Adults: Age 65 and older
- Perinatal Care

The guidelines are available on the MVP website to members and practitioners and in print format, upon request. The guidelines are updated at least every two years or more frequently as new information becomes available.

MVP encourages the use of preventive health services by notifying members, via interactive web-based tools, reminders and by making the guidelines available to all members on the website and in print

format, upon request. The MVP member newsletters regularly feature articles focused on health promotion and fitness.

MVP supports expectant members by covering and promoting perinatal classes and by encouraging members and practitioners to take advantage of the perinatal care programs available in their area.

Preventive information is targeted to members at risk for specific health issues, such as reminders for cervical cancer screening, chlamydia screening, flu immunizations, mammograms for women over 50, and retinal eye exams for members with diabetes.

Medical Records

The QIC recommends policies and standards for medical record confidentiality, documentation, content, accessibility, and continuity of care to comply with regulatory and accreditation requirements and to promote the delivery of high quality, safe care for MVP members.

The guidelines are available on the MVP website to practitioners and in print format, upon request. Areas for recommended improvement are communicated individually and on an aggregate basis to all physicians. Physicians are required to submit an action plan when their medical record practices do not meet established goals.

Regional Health Information Organizations (RHIOs)

Ensuring that member's medical information is easily accessible to treating physician at the point of care is essential to assure that the right care is delivered at the right time. MVP has been committed to the regional health information technology infrastructure development since 1999. In 2020, MVP continues to actively participate in the following RHIOs:

- HIXNY – Health Information Exchange of NY – New York Capital Region
- RRHIO – Rochester Regional Health Information Organization
- VITL – Vermont Information Technology Leaders

NYS, VT, AND CMS PERFORMANCE IMPROVEMENT PROJECTS

Quality Improvement Strategy (QIS)

Section 1311(c)(3) of the Affordable Care Act requires Marketplaces to display Qualified Health plans (QHPs) 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 NY and VT-based Marketplace products are required to report HEDIS clinical measures on an annual basis.

A QIS incentivizes improved care for our members by aligning payments to measures of performance when providers increase quality performance. MVP develops a QIS for its VT and NY 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 the Quality Steering Committee. The QIS is reported to the NYSDOH and VT DFR for review and approval.

For the 2020 plan year, providers treating Marketplace members in NY and VT are incentivized to demonstrate improved rates for two preventive care measures and two chronic care measures. The measures are:

Preventive Measures	Chronic Measures
Cervical Cancer Screening	Comprehensive Diabetes Care-Eye Exam
Colorectal Screening	Comprehensive Diabetes Care - Nephropathy

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. The QIS incentive payments to providers for measurement year 2019 will be distributed in June 2020. Measurement year 2020 QIC incentive payments will be distributed in June 2021.

Medicare Chronic Care Improvement Project (CCIP)

CMS requires health plans which offer Medicare Advantage (MA) products to conduct a Chronic Care Improvement Project (CCIP). These studies are conducted over a three-year period with the aim of improving health outcomes, coordination of care, and beneficiary satisfaction. They may be clinical or service-oriented, but they must be relevant to the health plan's Medicare HMO/POS, Medicare PPO, and Medicare Savings Account (MSA) member population.

In 2020, MVP is continuing its Diabetes CCIP efforts to promote effective management of diabetes. MVP is targeting members with poor diabetes control as exhibited by HbA1c levels greater than 9. MVP will outreach identified members to engage them in care management to help them develop goals and interventions, achieve quantifiable, and measurable outcomes. At a minimum, MVP will provide educational materials and a point of contact for ongoing support.

Medicare Monitoring of CMS Stars Performance Ratings

CMS has developed a method, referred to as Stars ratings, by which to assess the outcomes of several clinical, pharmacy, member satisfaction, and administrative metrics (information on appeals, complaints, members who leave the plan) related to the services administered by MA health plans. These services are provided by MVP and its provider network. MVP monitors the results of these Stars ratings to assess the effectiveness of care and services rendered to MA members. By monitoring these metrics, we may create and implement interventions to positively impact performance. Stars ratings, year over year performances and recommended interventions are presented and reviewed by the Medicare All-Star team, which is a multi-disciplinary workgroup that meets at least monthly. The All-Star team serves as a valuable component in brainstorming, problem solving, and developing initiatives to improve care provided to MVP MA members.

Medicare Member Surveys

CMS requires all health plans to contract with an approved Medicare CAHPS vendor to conduct the Medicare CAHPS satisfaction survey of Medicare enrollees and to report its performance to CMS annually. MVP's Member Service Improvement Committee (MSIC) monitors member satisfaction throughout the year by reviewing the detail data that we receive from our CAHPS survey vendor, information regarding member complaints, grievances, and appeals, and also the results of our self-administered member satisfaction surveys. MSIC makes recommendations to implement changes based on their review of this information. Due to COVID-19, the CAHPS survey that was sent in March 2020 will not be used for Stars scoring. It will only be used for informational reporting for the health plans.

In addition, CMS requires all health plans to contract with an approved Medicare vendor to annually administer the Health Outcomes Survey (HOS) of randomly sampled Medicare enrollees and report its performance to CMS. The goal of the HOS is to capture valid, reliable, and clinically meaningful data to use in QI activities, pay for performance, program oversight, public reporting, and to improve health. All managed care organizations with Medicare contracts must participate. Similar to the Medicare CAHPS, results of the HOS are reported to MVP's MSIC for review. Due to COVID-19, the HOS will be administered in August of 2020 rather than in April as normally scheduled.

Commercial and Medicaid CAHPS Surveys

The CAHPS survey is administered to a random sample of Commercial and Medicaid members on an annual basis. This survey is required for these populations by NCQA and the NYSDOH respectively and is administered by an approved CAHPS vendor. The survey covers topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services. For Medicaid members, adult and pediatric focused CAHPS surveys are distributed in alternating years.

When MVP receives results from these surveys, they are reviewed in the Commercial or Medicaid SIC. These groups will review the current results and compare them with prior years to identify trends and opportunities for improvement. These groups then work with different program areas to address areas that may be trending downward.

The administration of CAHPS surveys for Commercial and Medicaid members will not be delayed due to COVID-19 as per NCQA and NYSDOH. However, survey vendors need to modify survey processes, such as the frequency of telephone interactions, to reduce the potential for member abrasion.

Medicaid Annual Quality Incentive

The NYS Quality Incentive Program represents the outcome of health plan ratings across four components for all MMC plans:

- *Quality:* QARR measures of clinical and treatment-based measures
- *Satisfaction:* Self-reported member experience data from the CAHPS survey
- *Preventive Quality Indicators (PQI):* Measure of admissions that could have been avoided with appropriate outpatient care
- *Compliance:* Potential subtraction of up to 20 points based on secret shopper calls and health plans' ability to meet certain submission guidelines

Health plans' performance across these measures determines their eligibility to earn incentive funds and auto-enrollment of MMC members. MVP is pursuing several improvement activities around these components, including outreach call campaigns, member mailings, and clinical detailing with physician practices.

Medicaid Performance Opportunity Project

In 2018, NYSDOH, OMH, and OASAS committed to a new Medicaid Performance Opportunity Project (POP) that aims to improve outcomes for individuals who are high users of acute mental health services at risk for hospital readmission. The project activities target MMC enrollees who have high rates of mental health emergency department (ED) and inpatient service utilization. To help these "High Users" transition from the hospital to community-based care, the POP leverages financial incentives to MMC Organizations (MCOs) to scale up two best practice interventions:

1. *Intensive Care Transition Services:* When POP High Users are hospitalized, MCOs mobilize a provider to initiate a nine-month episode of Intensive Care Transition Services to help the member transition to the community.
2. *Clozapine Utilization*: MCOs are also incentivized to facilitate clinician psychopharmacology review to identify 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 Users in NYS.

On March 24, 2020, NYS released guidance that adjusts the POP program to allow for telephonic contact instead of face-to-face visits as a result of COVID-19. MVP has modified the program accordingly and will continue to measure milestones as follows:

Transition of Care Milestones

- *Milestone 1:* One visit within 10 days prior to discharge from any hospitalization (total of 1 visit)
- *Milestone 2:* One visit within 72-hours of discharge from any hospitalization (total of 1 visit)
- *Milestone 3a:* Six visits in the first month following discharge from any hospitalization (total of 3 visits)
- *Milestone 3b:* Six visits in first month following discharge from any hospitalization (total of 6 visits)
- *Milestone 4:* Four visits per month in second and third months (total of 8 visits)
- *Milestone 5:* Three visits per month in fourth, fifth, and six months (total of 9 visits)
- *Milestone* 6: Two visits per month in seventh, eighth, and ninth months (total of 6 visits)

Clozapine Milestones

- *Milestone 1:* New clozapine starts: POP-eligible High Users with at least one Medicaid claim indicating that a clozapine prescription was filled during the measurement month.
    - Eligible Population: Members flagged as POP High Users as October 1, 2018 with no clozapine prescription claims in the six months prior to the measurement month.
- *Milestone 2:* Clozapine continuation between 0-3 months: New clozapine starts with a medication possession ration (MPR) of at least 80% during the 0-90-day clozapine milestone 2 eligibility period.
    - Eligible Populations: New Clozapine starts identified at least three months prior to the measurement month.

- *Milestone 3:* Clozapine continuation between 4-6 months: New clozapine starts with an MPR of at least 80 % during the 91-180 milestone 3 eligibility period.
    - Eligible Population: New clozapine starts identified at least 6 months prior to the measurement month.
- *Milestone 4:* Clozapine continuation between 7-9 months: New clozapine starts with an MPR of at least 80% during the 181-270-day milestone 4 eligibility period.
    - Eligible Population: New clozapine starts identified at least nine months prior to the measurement month.

NYSDOH Performance Improvement Project: KIDS Quality Agenda

The NYSDOH Office of Quality and Patient Safety Performance Improvement Project (PIP) for 2019-2020 aligns with the priority focus areas defined by NYSDOH as critical contributing factors of a child's development, blood lead levels, and the ability to hear. This PIP incorporates three focus areas: blood lead testing and follow-up; newborn hearing screening and follow-up; and developmental screening. The interventions were designed to improve member testing and provider reporting rates for each focus area, among MVP's MMC and Child Health Plus (CHP) members during their first 1,000 days of life, with the goal of initiating early intervention or treatment to mitigate the long-term impact on the child's development. A cross-functional workgroup was established within the organization to develop and implement interventions designed to increase rates associated with this project. The interventions are focused on educating providers on updated screening and coding guidelines, and both provider and member notifications of gaps in care. MVP will provide targeted outreach for the population considered at-risk. MVP has partnered with The Children's Medical Group (TCMG) on the developmental screening initiative. MVP provided them with the proper coding guidelines and recommendations for use of standardized global development screening tools. MVP reviews their claims to ensure proper coding at the correct intervals and reviews corresponding charts to ensure the appropriate developmental screening tools were used. Best practices learned from TCMG will be shared with PCPs network wide. The proposal was submitted to and accepted by NYSDOH; the signed attestation was sent on May 14, 2019. MVP submitted the interim report to IPRO on February 7, 2020 and will attend quarterly meetings with them through the remainder of 2020 to discuss progress. The final documentation of results is due in July 2021.

The below chart represents the KPIs assigned to all NYS health plans by NYSDOH for the KIDS Quality Agenda PIP. The KPI benchmark represents the rate which MVP expects to achieve by end of 2020 final measurement year.

KPI Name	KPI Benchmark	Reason for Benchmark	Action Plan
The percentage of Medicaid and CHP-enrolled children who received blood lead tests around one year	74%	To increase blood-lead testing rates at around one-year of age for members enrolled in Medicaid and CHP, for the goal of identifying elevated blood lead levels and treating conditions that have	• Continue provider education on updated screening guidelines via fax, provider newsletters, and live calls. • Continue to distribute Gap in Care (GIC) reports to providers, including a list of one-year-old members who

of age (one-year-old test).		occurred as a result, as early as possible to mitigate long-term impact on the child's development.	require a blood lead screening. • Mail a notification reminder to caregivers.
The percentage of Medicaid and CHP-enrolled children who received blood lead tests around two years of age (two-year-old test).	82%	To increase blood-lead testing rates at around two-years of age for members enrolled in Medicaid and CHP, for the goal of identifying elevated blood lead levels and treating adverse conditions that have occurred as a result, as early as possible to mitigate long-term impact on the child's development.	• Continue provider education on updated blood-lead screening via fax, provider newsletters, and live calls. • Continue to distribute Gaps in Care reports to providers, including a list of two-year-old members who require a blood lead screening. • Mail a notification reminder to caregivers.
The percentage of Medicaid and CHP-enrolled children who received blood lead tests around one year of age and around two years of age.	51%	To increase blood-lead testing rates around one-year of age and two-years of age for members enrolled in Medicaid and CHP, for the goal of identifying elevated blood lead levels and treating adverse conditions that have occurred as a result, as early as possible to mitigate long-term impact on the child's development.	• Continue provider education on updated blood-lead screening via fax, provider newsletters, and live calls. • Distribute Gaps in Care reports to providers, including a list of one-year-old and two-year-old members who require blood lead screening. • Mail a notification reminder to caregivers.
The percentage of Medicaid and CHP-enrolled children in the eligible population with a capillary BLL of ≥5 mcg/dL who had a confirmatory venous blood lead test within three months.	76%	To increase venous confirmatory testing rates within three months of a capillary result of >5mcg/dl for Medicaid and CHP members.	• Continue provider education on updated blood lead screening and follow-up guidelines via fax, provider newsletters, live calls, and Gaps in Care reports. • MVPs CM department will contact PCPs and caregivers of members with an elevated capillary blood lead level of ≥5 mcg/dL who require a confirmatory venous sample within three months.
The percentage of Medicaid and CHP-enrolled	65%	To increase follow-up venous testing rates within three months of a confirmed	• Continue provider education on updated blood lead screening and follow-up

children in the eligible population with a confirmed venous BLL of ≥5 mcg/dL who had a follow up venous blood test within three months.		venous result of ≥5mcg/dl for Medicaid and CHP members to mitigate long-term impact on the child's development.	guidelines via fax, provider newsletters, live calls, and Gaps in Care reports. • MVPs CM department will contact PCPs and caregivers of members with a confirmed venous blood lead level of ≥5 mcg/dL who require a follow-up venous test within three months.
The percentage of Medicaid and CHP-enrolled children in the eligible population with a confirmed venous BLL of ≥10 mcg/dL who had a follow up venous blood lead test within one month.	65%	To increase follow-up venous testing rates within one month of a confirmed venous result of ≥10 mcg/dl for Medicaid and CHP members to mitigate any long-term impacts on the child's development.	• Continue provider education on updated blood lead screening and follow-up guidelines via fax, provider newsletters, live calls, and Gaps in Care reports. • MVPs CM department will contact PCPs and caregivers of members with a confirmed venous lead level of ≥10 mcg/dL who require a follow-up venous test within one month.
The percentage of Medicaid and CHP infants who completed hearing screening by one month of age.	99%	To increase the rates of Medicaid and CHP members who complete a screening by one month of age with the goal to identify and treat any hearing impairments to mitigate long-term impact on the child's development.	• MVP will continue interventions focused on provider notification of members requiring hearing screening via live calls or GIC reports. • MVP will outreach to maternity hospitals and birthing facilities to remind them of their obligations under PHL to perform the initial newborn hearing screening and to record the results. and facility education.
The percentage of Medicaid and CHP infants who did not pass	75%	To increase the rates of Medicaid and CHP members who did not pass the initial hearing screening and had a	• MVP will telephonically outreach providers of members who failed the initial screening to advise a

hearing screening by one month of age who had a diagnostic audiological evaluation by three months of age.		diagnostic audiological evaluation within one month with the goal to identify and treat any hearing impairments to mitigate long-term impact on the child's development.	diagnostic audiological exam is required within three months.
The percentage of Medicaid and CHP infants who did not pass hearing screening by one month of age and were diagnosed with hearing loss by three months of age who were referred to Early Intervention (EI) services by six months of age.	100%	To maintain a rate of 100% for Medicaid and CHP members who were diagnosed with hearing loss by six months of age and referred to EI services with the goal to mitigate long-term impact on the child's development.	• MVP will outreach both caregivers and providers of children who were diagnosed with hearing loss and were not referred to EI services to ensure the member is referred to EI by six months of age.
The percentage of Medicaid and CHP infants who completed hearing screening at any time before three months of age.	95%	To increase the rates of Medicaid and CHP members who completed a hearing screening at any time before three months of age for the goal of identifying and treating hearing impairments as early as possible to mitigate long-term impact on the child's development.	• MVP will continue interventions focused on provider notification of members requiring hearing screening via live calls or Gaps in Care reports. • MVP will outreach maternity hospitals and birthing facilities to remind them of their obligations under PHL to perform the initial newborn hearing screening and to record the results.
The percentage of Medicaid and CHP infants who did not pass hearing screening who had a diagnostic	77%	To increase the rates of Medicaid and CHP members who failed the initial hearing screening who had a diagnostic audiological evaluation at any time before six months of age for the	• MVP will telephonically outreach providers of members who did not pass the initial hearing screening to advise a diagnostic audiological exam is required

audiological evaluation at any time before six months of age.		goal of identifying and treating hearing impairments as early as possible to mitigate long-term impact on the child's development.	before the member turns six months of age.
The percentage of Medicaid and CHP infants who had a diagnosis of hearing loss who were referred to EI services at any time before nine months of age.	100%	To maintain testing rates of Medicaid and CHP members who had a diagnosis of hearing loss and were referred to EI services before nine months of age to mitigate long-term impact on the child's development.	• MVP will outreach both caregivers and providers of children who were diagnosed with hearing loss and were not referred to EI services to ensure the member is referred to EI by nine months of age.
The percentage of Medicaid and CHP children who were screened for developmental, behavioral, and social delays with a standardized global development screening tool by one year of age.	15%	To increase testing rates for Medicaid and CHP members who were screened for developmental, behavioral, and social delays with a standardized global development screening tool by one year of age with for the goal of identifying and treating any developmental delays as early as possible to mitigate long-term impact on the child's development.	• MVP will provide Gaps in Care reports to providers, including a list of members who are due for developmental screening. • MVP will work closely with TCMG to learn best practices to share with the rest of the provider network. • MVP will review charts for members assigned to TCMG to ensure standardized global development screening tools were used. • MVP will continue to educate all providers on the developmental screening and coding guidelines.
The percentage of Medicaid and CHP children who were screened for developmental, behavioral, and social delays with a standardized	38%	To increase testing rates for Medicaid and CHP members who were screened for developmental, behavioral, and social delays with a standardized global development screening tool by two years of age with for the goal of identifying and treating any developmental	• MVP will provide Gaps in Care reports to providers, including a list of members who are due for developmental screening. • MVP will work closely with TCMG to learn best practices to share with the rest of the provider network.

global development screening tool by two years of age.		delays as early as possible to mitigate long-term impact on the child's development.	• MVP will review charts for members assigned to TCMG to ensure standardized global development screening tools were used. • MVP will continue to educate all providers on the developmental screening and coding guidelines.
The percentage of Medicaid and CHP children who were screened for developmental, behavioral, and social delays with a standardized global development screening tool by three years of age.	29%	To increase testing rates for Medicaid and CHP members who were screened for developmental, behavioral, and social delays with a standardized global development screening tool by three years of age with for the goal of identifying and treating any developmental delays as early as possible to mitigate long-term impact on the child's development.	• MVP will provide Gaps in Care reports to providers including a list of members who are due for developmental screening. • MVP will work closely with TCMG to learn best practices to share with the rest of the provider network. • MVP will review charts for members assigned to TCMG to ensure standardized global development screening tools were used. • MVP will continue to educate all providers on the developmental screening and coding guidelines.
The percentage of Medicaid and CHP children who were screened for developmental, behavioral, and social delays with a standardized global development screening tool according to AAP Well-Child Visit Guidelines.	25%	To increase testing rates for Medicaid and CHP members who were screened for developmental, behavioral, and social delays with a standardized global development screening tool at one year, two years and of age with for the goal of identifying and treating any developmental delays as early as possible to mitigate long-term impact on the child's development.	• MVP will provide Gaps in Care reports to providers, including a list of members who are due for developmental screening. • MVP will work closely with TCMG to learn best practices to share with the rest of the provider network. • MVP will review charts for members assigned to TCMG to ensure standardized global development screening tools were used. • MVP will continue to educate all providers on the developmental screening and coding guidelines.

The percentage of Medicaid and CHP children who were screened for autism with a standardized autism screening tool by 30 months of age. (1 test)	10%	To increase testing rates for Medicaid and CHP members who were screened for autism at least once by 30 months of age with a standardized autism development screening tool with for the goal of identifying and treating any developmental delays as early as possible to mitigate long-term impact on the child's development.	• MVP will provide Gaps in Care reports to providers, including a list of members who are due for an autism screening. • MVP will work closely with TCMG to learn best practices to share with the rest of the provider network. • MVP will review charts for members assigned to TCMG to ensure standardized global autism screening tools were used. • MVP will continue to educate all providers on the autism screening and coding guidelines.
The percentage of Medicaid and CHP children who were screened for autism with a standardized autism screening tool by 30 months of age. (2 tests)	10%	To increase testing rates for Medicaid and CHP members who were screened for autism twice by 30 months of age with a standardized global autism screening tool with for the goal of identifying and treating any developmental delays as early as possible to mitigate long-term impact on the child's development.	• MVP will provide Gaps in Care reports to providers, including a list of members who are due for an autism screening. • MVP will work closely with TCMG to learn best practices to share with the rest of the provider network. • MVP will review charts for members assigned to TCMG to ensure standardized global autism screening tools were used. • MVP will continue to educate all providers on the autism screening and coding guidelines.

NYSDOH HARP Performance Improvement Project 2019-2020

The NYSDOH of Quality and Patient Safety announced its HARP PIP for 2019-2020. This PIP's focus is on care transitions after ED and inpatient admissions. The aim of this project is to:

1. Identify and improve weaknesses in the discharge planning processes to achieve a comprehensive, patient centered discharge plan
2. Facilitate communication and coordination among providers, CM, and the member
3. Initiate and ensure medication adherence and provider information sharing.

The 2017-2018 HARP PIP Partners, St. Joseph's Medical Center, St. Vincent's Medical Center, Rochester Regional Health, Health Home of Upstate NY, Greater Rochester Health Home Network, Hudson River Health Care, and Hudson Valley Care Coalition, continued partnership for the 2019-2020 HARP PIP. MVP coordinated efforts with Beacon Health Options in 2019. As aligned with MVP's Integrated Health transition, all BH services and any activities associated with this PIP will be conducted and monitored solely by MVP and other PIP partners. Interventions that were focused on on-site CM shifted to post-discharge telephonic outreach beginning 1/1/2020 due to lack of MVPs CM staff. The proposal for this PIP was approved by NYS DOH on 4/5/19. The proposed interventions are in effect from Jan. 2019 – Dec. 2020 and implementations began in Jan. 2019. MVP submitted Interim results to IPRO on 2/7/2020 and will attend quarterly meetings with them for the remainder of 2020 to discuss progress. The final documentation and submission of results are due in July 2021.

The below chart represents the KPIs assigned to all NYS health plans by NYSDOH for the HARP PIP. The KPI Benchmark represents the rate in which MVP hopes to achieve.

KPI Name	KPI Benchmark	Reason for Benchmark	Action Plan
HARP member follow-Up appointment with provider after hospitalization for mental health within 7 calendar days. (FUH) **HEDIS 7–day**	65%	To improve rates for follow-up appointments within seven calendar days for HARP members who were admitted for mental illness and to reduce occurrence of re-admission.	• MVP CM team will continue post-discharge outreach to members to ensure an appointment is scheduled to occur within seven calendar days and to assist with coordination of care. We will also aim to increase Health Home enrollment via member mailings and an enhanced referral process. • Informatics is currently updating/optimizing the facility bill supplemental data process to capture rendering provider and their specialty on the facility claims to meet the specification changes. Informatics is using provider taxonomy codes to appropriately capture provider specialty information.
HARP member follow-Up appointment with provider after hospitalization for mental health within 30 calendar days. (FUH) **HEDIS 30–day**	84%	To improve rates for follow-up appointments within 30 calendar days for HARP members who were admitted for mental illness and to reduce occurrence of re-admission	• MVP CM team will continue post-discharge outreach to members to ensure an appointment is scheduled to occur within 30 calendar days and to assist with coordination of care. We will also aim to increase Health Home enrollment via member mailings and an enhanced referral process. • Informatics is currently updating/optimizing the facility bill supplemental data process to capture rendering provider and their specialty on

			the facility claims to meet the specification changes. Informatics is using provider taxonomy codes to appropriately capture provider specialty information.
HARP member follow-up appointment with provider after ED visit for alcohol and other drug abuse or dependence within seven calendar days (FUA) **HEDIS 7-day**	38%	To improve rates for follow-up appointments within seven calendar days for HARP members who were in the ED for alcohol and other drug abuse or dependence and to reduce occurrence of re-admission	• MVP CM team to continue post-ED telephonic outreach to members, utilizing the HIXNY data and the daily ED Census Log from St. Joseph's Medical Center, to ensure an appointment is scheduled to occur within seven calendar days and to assist with coordination of care. We will also aim to increase Health Home enrollment via member mailings and an enhance referral process. • MVP will continue to promote the use of telemedicine to meet the seven-calendar day- time frame. • MVP continues to explore electronic medical record and RHIO access to receive additional real-time ED notification.
HARP member follow-up appointment with provider after ED visit for alcohol and other drug abuse or other dependence within 30 calendar days. (FUA) **HEDIS 30-day**	45%	To improve rates for follow-up appointments within 30 calendar days for HARP members who were in the ED for alcohol and other drug abuse or dependence and to reduce occurrence of re-admission	• MVP CM team to continue post-ED telephonic outreach to members, utilizing the HIXNY data and the daily ED Census Log from St. Joseph's Medical Center, to ensure an appointment is scheduled to occur within 30 calendar days and to assist with coordination of care. We will also aim to increase Health Home enrollment via member mailings and an enhance referral process. • MVP will continue to promote the use of telemedicine to meet the 30-calendar day- time frame. • MVP continues to explore electronic medical record and RHIO access to receive additional real-time ED notification.
Member follow-up appointment with provider after ED Visit for Mental Illness within seven calendar days. (FUM) **HEDIS 7-day**	80%	To improve rates for follow-up appointments within seven calendar days for HARP members who were in the ED for mental illness, and to reduce	• MVP CM team to continue post-ED telephonic outreach to members, utilizing the HIXNY data and the daily ED Census Log from St. Joseph's Medical Center, to ensure an appointment is scheduled to occur within seven calendar days and to assist with coordination of care. We will also aim to increase Health Home

		occurrence of re-admission	enrollment via member mailings and an enhance referral process. • MVP will continue to promote the use of telemedicine to meet the seven-calendar day- time frame. • MVP continues to explore electronic medical record and RHIO access to receive additional real-time ED notification.
Member follow-up appointment with provider after ED visit for mental illness within 30 calendar days. (FUM) **HEDIS 30-day**	86%	To improve rates for follow-up appointments within 30 calendar days for HARP members who were in the ED for mental illness and to reduce occurrence of re-admission	• MVP CM team to continue post-ED telephonic outreach to members, utilizing the HIXNY data and the daily ED Census Log from St. Joseph's Medical Center, to ensure an appointment is scheduled to occur within 30 calendar days and to assist with coordination of care. We will also aim to increase Health Home enrollment via member mailings and an enhance referral process. • MVP will continue to promote the use of telemedicine to meet the 30-calendar day timeframe. • MVP continues to explore electronic medical record and RHIO access to receive additional real-time ED notification.
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) **HEDIS**	74%	To improve rates of medication adherence for individuals prescribed medication for Schizophrenia.	• The Quality and BH teams are reviewing staff and resources to determine whether we may contact HARP members prescribed medication for Schizophrenia to encourage adherence to their medication.
Initiation of Pharmacotherapy for HARP Members Upon New Episode of Opioid Dependence (POD) **NYS QARR**	37%	Increase the percentage of MVP HARP members who initiated pharmacotherapy with at least one prescription or visit for opioid treatment medication within 30 days following	• The HARP PIP workgroup is focusing on a Medication Assisted Treatment (MAT) intervention targeted at high-ED utilizers (five or more ED visits within 60 calendar days related to alcohol or other substance abuse) who are prescribed MAT. The CM team will outreach these members to determine the need for Intensive CM and to assist with coordination of care.

		an index visit with a diagnosis of opioid dependence	
Use of Pharmacotherapy for HARP Members for Alcohol Abuse or Dependence (POA) **NYS QARR**	17%	Increase the percentage of individuals with encounters associated with alcohol use or dependence with at least one prescription for appropriate pharmacotherapy	• The HARP PIP workgroup is focusing on a MAT intervention targeted at high-ED utilizers (five or more ED visits within 60 calendar days related alcohol or other substance abuse) who are prescribed MAT. The CM team will outreach these members to determine the need for Intensive CM and to assist with coordination of care.
HARP member follow-up appointment with provider after High Intensity Care for Substance Use Disorder within seven calendar days (FUI)	24% *state provided results	To improve rates for follow-up appointments within seven calendar days for HARP members who were in high intensity care facilities for substance use disorder.	• Continue interventions with MVP HARP PIP Facility partners surrounding the encouragement and tracking of provider information sharing and medication reconciliation. MVP CM to continue outreach calls to HARP members following an admission at a high intensity care facility for substance use disorder to ensure a follow-up appointment has been scheduled within seven calendar days.
HARP member follow-up appointment with provider after High Intensity Care for Substance Use Disorder within 30 calendar days (FUI)	57% *state provided results	To improve rates for follow-up appointments within 30 calendar days for HARP members who were in high intensity care facilities for substance use disorder.	• Continue interventions with MVP HARP PIP Facility partners surrounding the encouragement and tracking of provider information sharing and medication reconciliation. MVP CM to continue outreach calls to HARP members following an admission at a high intensity care facility-for substance use disorder to ensure a follow-up appointment has been scheduled within 30 calendar days.
30-day re-admission rate for HARP members admitted to Inpatient Psych	20%	Re-admission rate needs to be decreased.	• MVP CM to continue outreach to HARP members post-inpatient discharge or post-ED visit for mental illness to ensure a follow-up appointment is scheduled and to assist with coordination of care.

30-day readmission rate for HARP members admitted to Inpatient Detox	17%	Re-admission rate needs to be decreased.	• Outreach to facilities to request notification of inpatient admission within one-to-two days despite NYS Substance Use Disorder legislation prohibiting auth requirements for the first 14 days. • MAT focused intervention for high-ED utilizers prescribed MAT.
30-day readmission rate for HARP members admitted to Inpatient Rehab	11%	Re-admission rate needs to be decreased.	• Outreach to facilities to request notification of inpatient admission within one-to-two days despite NYS Substance Use Disorder legislation prohibiting auth requirements for the first 14 days. • MAT focused intervention for high-ED utilizers.

NYS QARR Action Plans

Each year MVP receives a Quality Performance Matrix (QPM) from the NYSDOH. The Matrix is aligned with performance goals from the NYS Prevention Agenda and/or Medicaid Redesign Team. In response to the matrix, MVP prepared and will implement four QARR action plans in 2020.

Each year, the NYSDOH provides managed care organizations with Quality Performance Matrices (QPMs) for MMC/CHP and HARP lines of business. The QPMs include 39 QARR measures for each line of business; each measure is calculated using a percentile ranking system based on individual and collective plan performance in the previous year. The matrix statistically compares current health plan rates to statewide averages and health plan performance for the last available measurement year for the categorization of each measure. The plan is asked to develop a root-cause analysis and action plan to address under-performance for up to two measures for each line of business that are below state benchmark.

Once NYSDOH assigns the QPMs, cross functional workgroups are convened to review the Medicaid and HARP QPM. The workgroups review past and current performance of the lowest performing measures per NYSDOH's direction. In addition to performance, the workgroup accounted for current activities that were in place or planned for the low performing measures, as well as, potential benefit to the member's health. Finally, the workgroups placed an emphasis on selecting BH measures to support MVP's BH and physical health integration efforts.

With these criteria in mind, the workgroups selected the measures below to address. NYSDOH assigned HBa1c poor control for the HARP population as a mandatory measure for MVP to review. The workgroup's next steps were to conduct a root cause analyses on each measure to determine barriers, to create action plans, and to implement interventions intended to improve measure performance. Documentation of this analysis and proposed action plans were submitted to NYSDOH for review on 2/19/2020. After receiving a preliminary round of comments from NYSDOH, MVP submitted revisions for final approval on 5/1/2020. In the meantime, planned interventions have been implemented and the workgroups meet monthly to monitor progress against the action plans. MVP expects final approval of

the QARR action plans by July 2020. The Quality team will continue to facilitate the work of the workgroups and report progress to the Quality Steering Committee.

Medicaid and CHP

- Follow-up for children prescribed ADHD medication initiation phase
- Follow-up for children prescribed ADHD medication continuation phase

HARP

- Follow-up after ED visit for mental illness and alcohol or other substance abuse within seven calendar days
- Poor HbA1c control

The cross functional QPM workgroups selected the following KPIs for QARR measures for the 2020 QPMs. The KPI Benchmarks in the table below represent the benchmark that the NYSDOH provided for the QPM measures.

HARP

KPI Name	KPI Benchmark	Reason for Benchmark	Action Plan
Poor HbA1c Control	36.8%	To decrease the rates of members with HbA1c levels over nine or have missing test results.	• Conduct provider and member outreach calls. • Establish data governance. • Enhance chart retrieval process

HARP- FUA/FUM 7-days

KPI Name	KPI Benchmark	Reason for Benchmark	Action Plan
Member follow-up appointment with provider after ED visit for a mental illness within seven calendar days	59%	To increase the rate of follow-up appointments within seven calendar days for HARP members seen in the ED for mental illness	• MVP CM to continue post-ED telephonic outreach to members using data from HIXNY and the daily ED Census Log from St. Joseph's Medical Center to ensure an appointment is scheduled to occur within seven calendar days and to assist with coordination of care. • We will aim to increase Health Home enrollment via member mailings and an enhanced referral process. • MVP will continue to promote the use of telemedicine to meet the seven-calendar-day timeframe.

Follow-Up appointment with provider after ED visit for alcohol and other drug dependence within seven calendar days	29%	To increase the rate of follow-up appointments within seven calendar days for HARP members seen in the ED for substance use	• MVP CM to continue post-ED telephonic outreach to members using data from HIXNY and the daily ED Census Log from St. Joseph's Medical Center to ensure an appointment is scheduled to occur within seven calendar days and to assist with coordination of care. • We will aim to increase Health Home enrollment via member mailings and an enhanced referral process. • MVP will continue to promote the use of telemedicine to meet the seven-day-calendar timeframe.

MMC / CHP

KPI Name	KPI Benchmark	Reason for Benchmark	Action Plan
Follow-up for children prescribed ADHD medication-initiation phase	59%	To increase the rate of a follow-up within 30 days of the first prescription fill for children prescribed ADHD medication	• Quality team to conduct provider and member outreach calls to ensure a follow-up appointment is scheduled. • Enhanced Gaps in Care reports will be sent to providers. • MVP is exploring promotion of E-consultation services.

MMC / CHP

KPI Name	KPI Benchmark	Reason for Benchmark	Action Plan
Follow-up for children prescribed ADHD medication-continuation phase	66%	To increase the rate of follow-up for children prescribed ADHD medication	• Quality team to conduct provider and member outreach calls to ensure a follow-up appointment is scheduled. • Enhanced Gaps in Care reports will be sent to providers. • MVP is exploring promotion of E-consultation services.

MVP's NYS Child/Teen Health Program
MVP participates in the NYS Child/Teen Health Program (NYSC/THP) for Medicaid-eligible children under 21 years of age, which promotes the provision of early and periodic screening services (well-care exams), with diagnosis and treatment of any physical, mental, or dental health problems identified during the conduct of well-care, to be consistent with nationally recognized standards.

MVP follows the recommendations of the American Academy of Pediatrics (AAP) for preventive care for children and adolescents and promotes the guidelines with plan providers who care for MVP children and adolescents, including the AAP periodicity schedule. MVP assesses provider adherence to guideline recommendations through HEDIS-NYS QARR reporting.

MVP also takes steps to identify members who do not access preventive care services, including well-care visits, immunizations, and blood lead testing. Through mailed reminders and telephonic outreach, MVP offers assistance setting appointments, coordinating transportation, addressing any barriers that exist to ensure medically necessary care is delivered to our members. Providers are given Gaps in Care reports that provide them with members who still need preventive services in accordance with current guidelines.

Vermont Department of Financial Regulation (VTDFR)
In accordance with Rule-H-2009-03, MVP incorporates feedback from VT providers and members into its annual QI work plan and program. Two participating physicians from Vermont are included in the QIC membership to ensure that Vermont-specific issues are considered and addressed in MVP's QI efforts.

Vermont members are surveyed to solicit their input and interest in existing and future benefit options. Members also have the option to provide feedback on the program directly to health plan staff as instructed through member newsletter correspondence.

PHYSICIAN PERFORMANCE IMPROVEMENT

The Physician Performance Improvement Program delivers information to physicians to facilitate the delivery of high quality, cost effective care.

Reports are produced for PCPs that are in a Comprehensive Primary Care Plus (CPC+), as well as Value Based Contracting (VBC) partners (e.g. IPA's, ACOs, etc.). Data is provided to them for the measures that are in their arrangement as well as additional measures that are important to MVP.

The following member-level detail reports are also available to assist practices in assuring that their members receive timely, comprehensive care: (all produced monthly)

- Gaps in Care Rate Report
- Member Attribution Reports
- Emergency Reports
- Inpatient Reports
- Care Management Reports
- Pharmacy Reports

- Patient Risk Reports

The success and impact of MVP's QI program is dependent upon physicians' engagement with and support of the program. MVP encourages the engagement and support by meeting with physicians and VBC partners, soliciting their feedback, and responding to their concerns. MVP has also been involved in multiple PCMH programs and is developing ACO and Shared Savings Reimbursement Arrangements across the plan, of which quality will be an important component as it will determine their ability to share in any potential savings achieved in the VBC partnerships. Physicians with large Medicaid and Medicare membership are eligible for additional reimbursement for high quality through our pay for performance program.

Value-Based Care Unit
To maximize the impact of MVP's many QI activities and integrate them into effective collaborations with providers, MVP has created a value-based care contracting unit. This team supports exploratory analysis of provider quality and utilization, identifies opportunities for improvements, and engages providers in mutually beneficial value-based contracts. Through multi-department coordination and direct provider collaboration, MVP is able to best leverage collective interventions and resources, enabling improved outcomes for our members.

Marketplace (Health Exchanges)
MVP participates in the Marketplace within New York and Vermont. Quality is involved to ensure that MVP meets the QI requirements within the Accountable Care Act as well as any QI requirement specific to either state. MVP's Vermont Marketplace HMO product holds a full NCQA Health Plan Accreditation through 3/2/2023.

Patient-Centered Medical Home
MVP is engaged with 207 PCMH provider groups which were paid Medicaid pass-through dollars. Overall, nine out of 10 of our Medicaid Shared Savings / Shared Risk arrangements have PCMH involvement.

Each of these programs is focused on improving access, care coordination, quality, and patient satisfaction. Each of the programs features a per-member-per-month (PMPM) payment based on assigned or attributed members within a practice to support continued efforts in maintaining or achieving the current NCQA PCMH recognition levels. The PMPM payments range from $2-$9, depending on the line of business and arrangement terms.

CPC+ Program
The CPC+ Initiative is an advanced primary care medical home model which utilizes a public-private partnership with CMS and private payers. MVP is a payer-partner in the New York North Hudson-Capital Region. The goal of the CPC+ program is to improve quality, access, and efficiency through practice transformation focused in access and continuity; care management; comprehensive and coordinated care; patient and caregiver engagement; and planned care and population health. MVP supports the practices in the CPC+ program through incentives including care management fees and a performance-based incentive payment.

MVP is engaged in eight upside-risk only shared savings arrangements. These arrangements promote accountability for coordination of patient care and investment in infrastructure with an expectation for

QI and efficient utilization of services resulting in improved population health outcomes and savings across a designated population.

Our active shared savings arrangements are based on a total cost of care model that includes quality gates for shared savings distribution.

Shared Risk Programs
MVP is engaged in nine shared-risk arrangements. These arrangements promote accountability for coordination of patient care and investment in infrastructure with an expectation for QI and efficient utilization of services resulting in improved population health outcomes and savings across a designated population.

Our active shared risk arrangements are based on a total cost of care model that includes quality gates for shared savings distribution or applicable loss repayment.

Hospital and Facility Quality Incentive Programs
MVP currently engages in six Quality Incentive arrangements with hospitals and other facilities located across MVP's New York market.

These arrangements are designed with a focus on rewarding providers for comprehensive care management and increased quality of care for MVP members. The incentive is funded by allowing the facilities to keep a portion of their negotiated rate increase, tied to quality and performance measurement. We use a combination of nationally recognized/published data and self-reported measures from the facilities.

MVP's Provider Network, Provider Relations, Value Based Programs (VBP), and Quality teams collaborate to ensure provider arrangements are mutually beneficial while focused on MVP members. Some of the goals of the provider arrangement quality incentive programs address access to care, delivery of quality care, and social determinants of health. Together, the Quality, VBP, and Informatics teams created a Quality VBP Playbook whereby providing guidance for quality focus areas, measure selection methodology, scorecards, and line of business-specific measures, e.g., HEDIS, Clinical Advisory Group, Stars, and QARR. In addition to the Quality VBP Playbook, another playbook was developed to address reporting and data exchange. An additional VBP playbook will be created with legal, and others will be developed to address social determinants of health, revenue optimization, care and utilization management, and actuarial.

MVP's Quality Performance and Operations Team
While all MVP departments and programs have a role in Quality, the Quality team is responsible for assuring compliance with regulatory requirements, monitoring performance with measures, facilitating cross functional workgroups, maintaining alignment with accreditation standards, collecting data on member's health experiences, and designing/implementing interventions to improve the care members receive. The Quality team's role is to elicit input and expertise from the various departments by convening multi-specialty teams that analyze information from their specific perspectives, and use that information to identify gaps and opportunities and to design interventions intended to address the quality, performance, or compliance issues.

Ensuring compliance with NCQA, DOH, CMS, DFS, and VTDFR is foundational to MVP's quality program. In particular, compliance with NCQA's standards that govern health plan operations and quality, as well as, collection and submission of HEDIS data, is one of the common threads that links the Quality team's responsibilities together and is the basis for successful accreditation. Adherence to state and federal guidelines across the organization gives us a stable quality framework and allows MVP to avoid statements of deficiency for non-compliance.

On an annual basis, the Quality team selects measures that are integral to improving care for MVP's members as well as improving MVP's performance. Multiple MVP business areas utilize these measures to prioritize and to align their work and to design program-specific interventions around the priorities for their programs.

Priority measures are selected by considering many variables. First, an analysis of the prior year's priority measures is conducted, noting year over year performance and comparisons against benchmarks to determine measure improvement and measures that represent continued opportunities for improvement. Medicaid and HARP measures are compared against NYSDOH benchmarks, Commercial measures are compared against NCQA benchmarks, and Medicare measures use Stars measure cut points released by CMS. Lower performing measures are flagged to indicate the inherent value in rate improvement to our members. Then, points are assigned to measures based on their inclusion in regulatory incentive programs, value-based care arrangements, performance improvement plans, and other special focus projects. Higher point values are assigned to measures included in programs that earn revenue for MVP, as well as those that have increased weighting within the incentive program. Finally, points are totaled. Priority measures are identified when measures have high point values coupled with low performance, signaling significant opportunity for both members to improve their care through interventions and for MVP to earn dollars through incentive programs. Once priority measures are selected and communicated to MVP business partners, initiatives to close gaps may be developed and implemented as part of the overall Quality strategy. Measurement year (MY) indicates the calendar year that the services were provided that contributes to numerator and denominator of a HEDIS measures. MY and dates of service were used interchangeably but the industry is moving toward using measurement year.

See *Section 21* for the Priority Measures and Performance by Line of Business chart for MVP's 2020 priority measures and the data used to select them.

Quality Improvement Initiatives

The QI Initiatives team uses the Quality Analytics Solution (QAS) tool to review monthly HEDIS measure performance information. QAS allows the team to view our rate information by HEDIS year, line of business and specific measure. Our rates are compared to CMS, NCQA, and NYSDOH benchmarks, and calculates the number of additional passes that are needed to reach each percentile. QAS displays a year over year comparison of rates to allow us to view trending patterns. We can also drill down into provider specific performance and perform geo-mapping to identify the location of members in need of service, in comparison to provider location, and analyze performance data to identify areas on which MVP can focus its resources to improve results of industry standard measurements such as HEDIS, CMS Stars, NYS QARR, and CAHPS results.

When an area of focus has been identified, the team works with other departments to implement interventions or activities to support improvement. Some of the interventions which MVP implements are call campaigns, mass mailings, participation in health fairs, representation on community work groups, collaboration with MVP's Information Technology, Customer Care, and the CM teams, all with the goal of improving access for MVP's membership to services and activities which support improved overall health and wellness. The Initiatives team then analyzes the results of the efforts and makes changes to support more effective intervention processes.

The COVID-19 pandemic of 2020 caused the Initiatives team to review their normal member campaigns. Based on the recommendation of the AAP, and after consultation with many of our large pediatric practices, we have continued our call campaigns to Commercial and Medicaid members with children under the age of two, who were in need of preventive screening visits and immunizations. We have also continued to provide our partners in the BH CM team with the data that they need to outreach our members who are suffering with schizophrenia, to ensure they adhere to their medications and receive their needed screenings. Based on the guidance of CMS, NCQA, and NYSDOH, we have temporarily halted our outreach to members over the age of two for any preventive services.

In the interim, we are working with our Medical Directors and Informatics team to identify services that our members may still receive via telephone or telehealth and plan to implement these procedures by the end of the second quarter of 2020. To support this:

- We are creating Provider Tip Sheets that we will distribute to our practices to help the providers understand the services that may be performed, appropriate codes for claims submission, and recommended follow-up for patients that need additional services.
- We are offering practices their Gaps in Care reports to help them identify members in need of service.
- MVP can conduct member outreach to help the members schedule a telephone/telehealth visit.
    - Medicare members can receive their Annual Wellness Visit (AWV) via telemedicine, which will allow the member to earn 40 points toward their $100 Wellness Reward.
    - Commercial and Medicaid members two to 19 years of age can complete the requirements of the Children and Adolescents' Access to Primary Care Practitioners (CAP) measure via telemedicine. If the provider documents anticipatory guidance on diet, activity, and safety during this call, this could also help MVP with our compliance on the Weight Assessment and Counseling on Nutrition and Physical Activity for Children and Adolescents (WCC) measure.
    - Commercial and Medicaid members over 20 years of age can complete the Adults' Access to Preventive/Ambulatory Health Services (AAP) measure via telemedicine.

We will bundle the services for members who need their well visit (AWV and AAP) and their colorectal cancer screening, by offering the use of Cologuard colorectal cancer screening kits. This is a test that can be performed in the comfort of the member's home and could provide the member with early detection of colorectal cancer.

As states begin to reopen, and members are able to visit their providers for preventive screenings, we will reevaluate our member outreach and be prepared to resume our normal call campaigns and mailers to help our members receive the services that they need.

Measuring Performance

Performance is measured annually through the NCQA HEDIS, CMS Stars, NYS QARR, and CAHPS measurement process and through additional population-based studies. Results are analyzed by the line of business specific SICs and action plans are developed to address barriers and opportunities for improvement. Action plans are then presented to QIC for review and approval.

MVP's business objective is to monitor and measure performance, identify opportunities for improvement, collaborate with internal business partners to create synergies that improve the health of our members, build relationships with our providers, and ultimately improve MVP's quality performance.

QI HEDIS Operations

MVP collects medical records from providers to comply with NCQA and NYSDOH reporting and accreditation requirements for HEDIS and to promote delivery of high quality and safe care for MVP members.

Annually, MVP's HEDIS Operations team, within the Quality department, collects more than 22,000 charts to report on the following measures across all populations.

- Adult BMI Assessment (ABA)
- Adolescent Preventive Care (APC)
- Cervical Cancer Screening (CCS)
- Childhood Immunization Status (CIS) & Immunizations for Adolescents (IMA)
- Colorectal Cancer Screening (COL)
- Comprehensive Diabetes Care (CDC)
- Controlling High Blood Pressure (CBP)
- Lead Screening in Children (LSC)
- Prenatal & Postpartum Care (PPC)
- Transitions of Care (TRC) & Medication Reconciliation Post-Discharge (MRP)
- Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents (WCC) Adult

The HEDIS hybrid chart collection project began 2/1/2020 and ended 5/11/2020 as determined by NCQA. The HEDIS Operations team collects medical records from treating providers of the sampled members and abstracts the compliant information required to support the measures. These abstracted data will be entered in the NCQA certified HEDIS engine tool and extracted by the Informatics team to incorporate with other data sources such as claims and supplemental data to report the final rates for these measures. In order to ensure all review-nurses abstract the information from medical records accurately, HEDIS Operations team conducts interrater reliability (IRR) test and all nurses are required to attain 100% accuracy rate. Once the chart data collection is complete, the list of compliant members by medical record data gets submitted to the auditor for Medical Record Review Validation (MRRV). The auditor picks measures from each measure groups and exclusions, select 16 records from each group and informs the health plans. MVP provides medical record documentation for those 16. For HEDIS 2020, MRRV occurs between 5/1/20 and 5/29/20.

Key NCQA Deadlines for HEDIS 2020 (HEDIS 2019 Dates of Service)

- Roadmap submission 1/31/2020
- Roadmap audit 2/26/2020
- Supplemental data 3/2/2020
- Last administrative data refresh 4/21/2020
- Hybrid data due date 5/8/11 for IDSS, 5/11/2020 for MRRV
    - HEDIS auditor extended MVP's due date from 5/8/20 to 5/11/20 due to significant Inovalon HEDIS engine issues throughout the season
- Medical record review validation 5/29/2020
- Preliminary HEDIS results 6/1/2020
- Final HEDIS results 6/15/2020

The roadmap is a comprehensive document auditor used to review information about the organization's systems for collecting and processing data to produce measures results. The roadmap also includes information on operational and organizational structure of the teams that participate in HEDIS reporting. HEDIS Operations team writes the medical record and supplemental data section. The roadmap for HEDIS 2021 is due by January 2021. The auditor will review the roadmap and will plan an onsite visit with MVP. Onsite visit usually happens in the second week of February. During the onsite, various departments that participate in writing each of the roadmap sections will be invited to address any issues or questions the auditor might have upon reviewing the roadmap. HEDIS Operations team participate for the medical record and supplemental data section.

HEDIS Operations team closely work with Informatics Quality Measurement team to successfully submit final results to NCQA. Informatics team facilitates any interaction or communication with the NQCA certified auditor. Informatics creates the MRRV files based on the data collected by HEDIS Operations team and prepares the final measure results to submit to the auditor and to NCQA using the Interactive Data Submission System (IDSS). If there are any issues that the auditor identifies, HEDIS Operations team works with Informatics team to address.

For HEDIS 2021, MVP will create a project plan which will include a staffing model, reporting package, timeline, deadlines for tasks, and provider outreach plan. The project plan will be built using the accountable, responsible, consulted, and informed (ARCI) model to ensure smooth implementation.

In 2020, HEDIS operations team will participate in the year round HEDIS efforts. The activities planned in 2020 are:

- *HEDIS Reviewer Inter-Rater Reliability (IRR)* - In accordance with the 2021 HEDIS Chart Collection project plan that will be developed September 2020 for the HEDIS 2021 project, the HEDIS Operations team will require that staffing agencies perform IRR tests with a 95% rate threshold for all temporary staff before assignment on the HEDIS project. Additionally, the HEDIS Operations team will require that all staff, temporary and I MVP staff, will be required to complete IRR testing with a 100% threshold prior to beginning the HEDIS 2021 project.
- *Prenatal/Postpartum Care*: The HEDIS Operations team will create a project plan to collect medical records for the Prenatal and Postpartum care measure year-round. The intent of this effort is to improve our measure rate for all Medicaid, HARP, and Commercial members.

- *Robotic Annotation of Medical Records*: The HEDIS Operations team will collaborate with the Robotics Process Automation (RPA) team to develop natural language processing capability. This capability will enable chart annotation using the key words lists for each hybrid measure. This annotation will guide the nurse reviewer to the pages of medical records that include relevant information for the measures. This will be beneficial and time saving especially when the nurse is reviewing large volumes of charts.
- *Utilizing Medical Records Collected by Other Business Areas*: HEDIS operations will continue to collaborate with the Risk Adjustment Department and other MVP business areas to leverage medical records they collect for their business needs. For HEDIS 2020, Risk Adjustment team regularly accessed their inventory of records to provide any records that had already been collected for members in the sample for hybrid data collection.
- *Supplemental Data Collection*: In an effort to expand chart data collection, HEDIS operations will work with Informatics to expand supplemental data collection. The team will work with the HEDIS auditor to include more measures for which we collect supplemental data. The team will also work with the Network and VBP teams to establish additional data feeds and remote electronic medical record access from provider groups to close gaps. For the year-round HEDIS effort, collaboration with Informatics team will be critical. Any expansion of supplemental data will be reviewed by the Informatics team and be approved by the HEDIS auditor.
- *Quality Analytics Solution*: The Informatics team developed a quality dashboard named Quality Analytics Solution (QAS) that houses quality measure data at the measure, provider, and member levels and trending information for each HEDIS measure as well. The Informatics and Quality teams are collaborating to identify power users of the QAS system to empower quality staff and others with self-sufficient reporting capabilities. Stakeholders from various business areas are providing business requirements to support a QAS expansion of reporting capabilities to meet a broader span of business needs.
- *Leverage HIXNY data*: MVP's Quality, Network, and Informatics teams have been working to increase usage of and access to HIXNY's electronic medical record data to support Quality activities. Specifically, Network is working with providers to obtain consent agreements with HIXNY that allow MVP increased access to provider data present within the HIXNY portal. Informatics and Quality are collaborating to define the data elements that are critical to support HEDIS measures so that medical record data can be pulled directly out of the portal. Informatics and Quality will also collaborate to obtain approval from the HEDIS auditor for this type of data abstraction.

The HEDIS Operations' KPIs below are specific to HEDIS chart collection activities that were performed from 2/1/2020 to 5/8/2020. To maximize our hybrid measure rates in this period, maximal chart collection and review must occur. As a result, it is critically important to the success of this process to monitor chart collection and review activities, as well as individual productivity of our medical records reviewers and over readers. The KPIs represent these important metrics and are monitored at least daily during the chart collection period. The productivity outlined below is expected if the staffing model for the HEDIS 2021 project plan continues to utilize agency nurses (excluding Toney Nurse Consultants).

HEDIS Operations 2020 Hybrid Chart Collection Project Productivity KPIs

KPI Name	KPI Benchmark	Reason for Benchmark	Action Plan

Number of charts requested beginning from project start date	100%	Requesting all the charts needed is the first step to ensure complete data collection for hybrid measures	On a daily basis, monitor daily chart requests to ensure 100% of them are issued to providers within the first three weeks the project
Daily volume of data abstraction and Inovalon entry per reviewer	27 charts minimum reviewed daily	Threshold established from HEDIS 2019 & 2020 experience	Hire experienced HEDIS reviewers and monitor each reviewer's progress
Daily productivity of overreads for each overreader	35 charts minimum overread daily	Threshold established from HEDIS 2019 & 2020 experience	Hire experienced HEDIS overreaders and closely monitor each overreader's progress

Using the daily productivity data collected during the chart collection period referenced above, the HEDIS Operation team revised its daily productivity KPI for the 2021 Chart Collection period to 60 reviews and overreads per day, per reviewer. This revision is based the team's 2020 chart review experience and the volume of medical records that require review and overread in the short time period available. By September 2020, the HEDIS Operations team will build and implement a new HEDIS chart review project plan for 2021 which will include a communication and staffing plan that allows MVP to achieve the new thresholds indicated in the chart below. The HEDIS Operations team based these productivity expectations on Toney Nurse Consultants, who were utilized in the latter part of the HEDIS 2020 project. The staffing model will be created as an element of the HEDIS 2021 project plan, which is due 9/1/2020.

HEDIS Operations 2021 Hybrid Chart Collection Project Productivity KPIs

KPI Name	KPI Benchmark	Reason for Benchmark	Action Plan
Daily volume of data abstraction and Inovalon entry per reviewer	60 charts minimum reviewed daily	Threshold established from HEDIS 2019 & 2020 experience	Hire experienced HEDIS reviewers and monitor each reviewer's progress
Daily Productivity of overreads for each overreader	60 charts minimum overread daily	Threshold established from HEDIS 2019 & 2020 experience	Hire experienced HEDIS overreaders and closely monitor each overreaders progress

NCQA Reportable Events

MVP will notify NCQA, in writing, within 30 calendar days of any Reportable Events, including, but not limited to:

- Any issuance by a state or federal regulatory agency of any of the following:
  - Sanctions, including suspension of enrollment.
  - Fine equal to or exceeding $50,000 related to the organization's operations.
  - Request for corrective action where the substance of such corrective action relates to the organization's handling of UM decisions, network adequacy, benefit denials, complaints, grievances, appeals, or other important patient safety matters.
  - Changes in licensure or qualification status.

  - Violations of state or federal law that affect the scope of review under the standards and guidelines.
- Filing for bankruptcy under any state or federal bankruptcy law, or initiation of receivership, liquidation or state insurance supervision.

On an annual basis, MVP will also complete an attestation affirming that it has notified NCQA of all Reportable Events specified in NCQA's Policies and Procedures. The annual attestation will be submitted by 6/15/2020.

Quality Improvement Accreditation

MVP's QI Accreditation team manages three NCQA recognitions in various stages of survey. The Accreditation team works with all MVP departments to demonstrate and ensure compliance with NCQA standards. MVP's NCQA Accreditation team ensures compliance with all regulatory body requirements, such as NCQA, CMS, and NYS.

NCQA

MVP holds two NCQA Health Plan Accreditations (HPA) and one NCQA Provider Quality (PHQ) Certification. HPA is awarded to plans which "support care that keeps members at optimum levels of health while also controlling costs and meeting government and purchaser requirements." (NCQA Website). MVP submits documentation including policies, procedures, meeting minutes, and lists or universes of activity for key functions. Additionally, NCQA reviews case files selected from the universes to ensure that MVP adheres to its policies and procedures. By achieving accreditation, MVP demonstrates its commitment to quality.

Additionally, MVP holds an NCQA PHQ Certification. NCQA's Provider and Hospital Quality certification process offers the option of bringing forth a provider quality program, alone, or both provider and hospital quality programs. MVP opted to bring forth its Provider Excellence Program for certification. MVP may, in the future, add a hospital quality program to its NCQA certification.

Recognition	Product(s)	State(s)	Current Status	Next Survey Date
Health Plan Accreditation	Commercial HMO/POS	NY, VT	Fully Accredited Commendable	August 2020
Health Plan Accreditation	Marketplace HMO	VT	Fully Accredited*	January 2020
Provider Quality Certification	Commercial	NY	Interim Certified	March 2020

*Marketplace accreditations will not include HEDIS scores until 2020 dates of service are reported in 2021, therefore, the level of accreditation does not include the additional status of Excellent or Commendable.

HPA scores are a combination of compliance with standards, which is evaluated on a three-year cycle, and annual performance in the HEDIS measures. Each portion contributes a maximum of 50% of the plan's total accreditation score. The score for compliance with NCQA Standards remains static until the next survey for that product. MVP's Commercial HMO/POS standard score for 2018 was 49.9177 of 50 possible points for compliance with NCQA standards.

MVP submits HEDIS data annually for Commercial, non-Marketplace, products, for which it receives a recalculated NCQA score. Points for the HEDIS measures are awarded based on the health plan's performance compared to national benchmarks (90th percentile of national results) and regional and national thresholds (the 75th, 50th, and 25th percentiles).

KPIs for QI, Accreditation are established to achieve NCQA HPA and NCQA PHQ.

KPI Name	KPI Benchmark	Reason for Benchmark	Action Plan
Attain Full NCQA PHQ Certification	PHQ Certification Timeframe: Attain PHQ certification by end of 3Q20	NYS AG requires that a plan be NCQA Certified in Provider Quality before offering products with tiered member responsibility	• MVP facilitates opening and closing conferences with NCQA surveyors • Train business owners about document submission requirements • Finalize and upload documents to NCQA Interactive Survey System (ISS) tool by 3/31/20 • PHQ certification results expected approximately 6/18/20; results expected within 30 calendar days of closing conference 5/20/2020
NCQA Marketplace Health Plan Accreditation - Vermont	Marketplace Accreditation Timeframe: Attain Marketplace HP accreditation by end of first quarter, 2020	Required by VTDFR to offer Marketplace products to Vermont residents	• MVP facilitates opening and closing conferences with NCQA surveyors • Document submission for this survey occurred on 12/3/19 • Develop and execute NCQA gap analysis based on NCQA findings • Generate case file universes: UM, CBH, CM, Pharmacy, Appeals, Credentialing • Complete practice file review sessions • Arrange and complete virtual onsite, held 1/27/20 • HP Accreditation results received and communicated to enterprise 2/14/20
NCQA Commercial HMO/POS Accreditation – New York and Vermont	NCQA Commercial HMO/POS Accreditation Timeframe: Attain HMO/POS HP accreditation by end of fourth quarter, 2020	Demonstrates MVPs commitment to quality across key departments and functions.	• MVP facilitates opening and closing conferences with NCQA surveyors • Develop and distribute NCQA project plan with Workstream Leads • Complete risk assessment against new standards • Develop and distribute communication plan

			• Training about standards with focus on new ones and document requirements • Generate case file universes: UM, CBH, CM, Pharmacy, Appeals, Credentialing • Complete practice file review sessions • Arrange and complete virtual onsite, scheduled to occur 10/12/2020 – 10/13/2020 • HP Accreditation results expected from NCQA and communicated to enterprise by mid-to-late November, within 30 calendar days of virtual onsite file review. • Date confirmation pending from NCQA on items listed above.
QOC and QOS Complaints	Acknowledge complaints in writing within five business days – all lines of business	Regulatory – CMS and NYSDOH Accreditation – NCQA Health Plan Accreditation standards	• Monitor dates received and ensure complaint acknowledgement letters are mailed within five business days of receipt of complaint
QOC and QOS Complaints	Mail case Closure notifications for Medicaid, CHP, Commercial, ASO, Essential Health Plan QOC/QOS cases within 45 calendar days of receipt of complaint	Regulatory – NYSDOH	• Monitor dates received and ensure complaint case closure letters are mailed within 45 calendar days of receipt of complaint
QOC and QOS Complaints	Mail case Closure notifications for Vermont QOC/QOS case within 15 calendar days of receipt of complaint	Regulatory – VTDFR	• Monitor dates received and ensure complaint case closure letters are mailed within 15 calendar days of receipt of complaint

The Leader of QI Accreditation will coordinate the 2020 QI Program Description to meet all CMS, NYSDOH, and NCQA HPA requirements. In addition, the Leader of QI Accreditation will coordinate the 2019 QI Annual Evaluation to meet all CMS, NYSDOH, and NCQA HPA requirements. Both documents, the 2020 QI Program Description and the 2019 QI Program Annual Evaluation will be written, reviewed by Sr. Leadership, and finalized in time for the second QIC meeting of 2020 or in time for an off-cycle

approval by the QIC voting members via email vote at the discretion of the Sr. Leader, Health Management Strategy.

QI, Accreditation coordinates the review and update of all QI policies and procedures within 24 months of the last review and/or update. The review and update schedule are required by CMS and by the NCQA HPA standards.

QI, Accreditation processes all QOC and QOS complaints filed by members. Each complaint must be acknowledged within the timeframes described in the KPI chart, above. The QIC Coordinator researches each complaint, including outreach to the office or facility named in the complaint. All complaints with a clinical component are reviewed by an MVP Medical Director. Complaint outcomes are either Substantiated or Unsubstantiated.

UTILIZATION MANAGEMENT

The QI program and process is integrated into all UM activities and functions.

MVP's UM Program has three objectives:

1. To provide equitable access to health care services in an appropriate and cost-efficient setting.
2. To provide a process and framework for the monitoring and evaluation of health care services rendered to MVP members.
3. To facilitate and encourage communication among providers, members, and the Health Plan to: support appropriate utilization of health care services; ensure continuity and coordination of care; and enhance member and provider satisfaction with the MVP Program.

The UM Program is evaluated and approved by the Clinical Operations Committee (COC) on an annual basis. Criteria used to make utilization review decisions are reviewed annually by the MMC and the QIC and an appropriate range of practicing physicians. MVP ensures that all medical necessity denials are made by physicians, PhD psychologists, or pharmacists (as applicable) and that all decisions are rendered on a timely basis. Written and oral verification of denials and approvals are sent to practitioners and members stating the reason for the denial, the availability of a Medical Director to discuss the case with the provider, and the process for appeal.

Pharmaceutical management policies and procedures promote clinically appropriate use of pharmaceuticals. CM policies and procedures enable the coordination of care and access to needed services for members living with complex conditions. The UM Department is developing a policy with Information Technology (IT) to outline the system controls which assure securities for date and time stamp, documentation, and decisions rendered. This includes, but is not limited to, all data entry, data feeds, rendered decisions, and issued notifications. To further align with NCQA standards, the policy will include an error reporting resolution process.

MVP, and all entities to which UM functions are delegated, assure the following on an annual basis:

1. UM decisions are based only on appropriateness of care and the benefit provisions of the subscriber's coverage.

2. Medical Directors, practitioners, providers, or staff, including those who supervise them, are not specifically rewarded for issuing denials of requested care.
3. Financial incentives such as annual salary reviews and/or incentive payments are not offered to encourage inappropriate utilization or decisions.

MVP provides both BH CM and UM for all lines of business. The goal of these programs is to allow for a more integrated approach to the management of BH services and medical services while adhering and aligning to all Parity regulations.

MVP's philosophy is to follow an approach to BH care that is patient centric and directly benefits members by attaining the highest degree of value from the available BH care delivery system. Basic elements include a highly accessible delivery system, a network of providers who meet credentialing requirements, and clinically sound, evidence-based decision-making tools to promote appropriate utilization and BH care resources in an efficient and effective manner.

Maintenance of Utilization Review (UR) Agent Licensing

MVP's service area includes geographic regions within the states of New York and Vermont. As such, MVP must maintain its UR Agent status as required by each state's government through renewal applications and reporting.

Prior to an UR Agent application submission to the appropriate state government agency, the completed application and report will be reviewed and approved by COC.

MVP will submit the Mental Health Review Agent annual renewal application by 9/15/2020, as required by VTDFR.

NYS requires biennial UR Agent submissions. MVP last submitted a Utilization Agent Report Application and Attestation to the NYS DFS in February 2019, with a modification in June 2019 to satisfy the requirements for the addition of BH and Substance Abuse UR processes in 2020. NYS DFS notified MVP that these were acceptable and valid through 5/16/2021. MVP will again submit a Utilization Agent Report Application and Attestation to NYS DFS by 5/1/2021.

UM Decisions Based on Appropriateness of Care and Available Benefit Coverage

It is the policy of MVP to facilitate the delivery of appropriate health care to our members and to monitor the impact of the UM Program to detect and correct potential under and over utilization of services.

MVP's UM Program does not provide financial incentives for issuing adverse determinations to employees, providers, or practitioners who make UM decisions.

Ensuring Appropriate Utilization

The QIC recognizes that both under- and over-utilization of services represent indicators of potential poor quality.

Under-utilization is monitored through member satisfaction surveys including CAHPS, member complaints, grievances, appeals, Physician Resource Management and Quality Profiles, and review of utilization data. Over-utilization is measured through utilization data, Physician Resource Management Reports, Pharmacy Profiles, HEDIS and QARR data, and other focused reviews. Data are compared to established benchmarks and thresholds for over/under utilization to identify opportunities for improvement.

Technology Assessment

MVP regularly reviews new medical technologies, new BH procedures, new applications of existing technologies and new drugs, orphan drugs, and FDA approved drugs which are used for conditions not addressed under FDA approval for possible coverage decisions. Research includes a review of information from regulatory bodies, medical literature search, and information from the contracted technology assessment vendors. The assessment process takes a multidisciplinary approach that involves the requestor, the Medical Policy Task Force, the MMC Workgroup, input from specialty consultants (including BH specialists when appropriate), and Product and Network Management.

Proposed technology policies are submitted to the regional Medical Directors and subsequently to the Pharmacy and Therapeutics and/or the MMC for review. This review includes practicing clinicians in appropriate specialties.

Proposed technology policies are then forwarded to the QIC for review and final approval.

A separate UM Program description is maintained for MVP which provides a comprehensive overview of the UM program.

Annual UM Evaluation

The following UM activities and initiatives were identified in the 2020 UM program evaluation.

The following monitoring tools are presented for evaluation by the QIC:

Ensuring Consistency in Applying Criteria

- UM Staff Annual Quality Control
- UM Staff Inter-Rater Reliability Testing
- Pharmacist Reviewer Annual Quality Control
- Annual Medical Director Quality Control
- Medical Director Inter-Rater Reliability Testing

<u>Monitoring Satisfaction with the UM Process</u>

Member Satisfaction

- Results of CAHPS Surveys
- Results of Monitoring Member Complaints

Practitioner Satisfaction

- Medical Director Inter-Rater Reliability Testing

- Results of Provider Satisfaction Surveys

Alignment with Population Health Management

- Emergency Room Utilization
- Reducing Readmission Rates

2020 UM KPI Status and Action Plan

The following UM KPIs are outlined to ensure alignment across all UM functions and processes. With the insourcing of BH operations, it was imperative to align the benchmarks internally in 2020. The following KPIs ensure compliance with New York, Vermont, and NCQA requirements. Based on the 2019 and previous year UM program evaluations, audit, and readiness review feedback it has been determined that maintenance of these KPIs and benchmarks ensure consistency and timeliness of UM decisions, as well as required documentation to support these decisions.

KPI	KPI Benchmark	Action Plan
Timeliness of decision making (physical health)	95%	Ongoing monitoring, work with claims operations to address retrospective review timeliness, identify process efficiency, incl. letter automation and staff balancing to meet pre-service urgent timeliness
Timeliness of decision making (BH)	95%	Ongoing monitoring, complete corrective action plan, work with intake team to ensure clinical team has adequate time to review
IRR (physical health UM staff)	80%	Annual testing, remediation as needed
IRR (BH UM staff)	80%	Annual testing, remediation as needed
IRR medical directors	90%	Annual testing, remediation as needed
IRR for HCBS services	85%	Annual testing, remediation as needed
Quality Check (QC) results for UM (physical health)	95%	Ongoing monitoring, retraining completed for individual staff that did not meet target, follow up quality review as needed
QC results for UM (BH)	95%	Ongoing monitoring, retraining to address corrective action plan

a. BEHAVIORAL HEALTH

Philosophy

MVP's philosophy is to follow an approach to BH care that is patient-centric and directly benefits members by attaining the highest degree of value from the available BH care delivery system. Basic elements include a highly accessible delivery system, a network of providers who meet credentialing requirements and clinically sound, evidence-based decision-making tools to promote utilization of appropriate BH care resources in an efficient and effective manner.

Organizational Structure
MVP's BH Unit is part of the Health Management team, which includes UM, CM, and Analytics, and provides Intensive CM and UM. The goal of this program is to enable a more integrated approach to the management of BH Services.

MVP members can speak with BH utilization managers (licensed registered nurses and social workers) after business hours through a toll-free telephone number, which is published both on the Member ID card and on the MVP website. BH related telephone calls can also be triaged by MVP's after-hours service, Citra Health.

Coordination of Behavioral and Medical Care
MVP ensures that there is ongoing collaboration between MVP's BH team and physical health team, along with staff from quality, pharmacy, medical management, professional relations, and case/disease management departments. The purpose of this collaboration is to manage the member's care in a manner that most effectively meets their needs. This includes CM to guide the member to the services and UM to ensure that the services requested are appropriate for the member's condition(s).

Additionally, in compliance with NYSDOH requirements for HARP, MMC, and CHP regulations, MVP maintains Quality Improvement/Management (QM) and UM committees, subcommittees, and advisory groups, which are specific to BH, to ensure that MVP's policies, procedures, and interventions are effective and relevant.

The committees, subcommittees, and advisory groups are described in Section 21 of this document.

The MVP Leadership staff who were involved with the Integrated Health QI Program included the following individuals whose responsibilities are detailed in the Corporate MVP QI Program:

- MVP Chief Executive Officer
- Chief Medical Officer
- Senior Leader, Operations and Government Programs
- Senior Leader, Finance and Network
- Senior Leader, Quality Performance and Operations
- Senior Leader, Medical Affairs
- Senior Leader, Health Management
- Medical Directors and Associate Medical Directors

Additional personnel dedicated to the MVP Behavioral Health QM/UM Program include:

Senior Leader, Behavioral Health Medical Director
MVP's BH Medical Director is a licensed psychiatrist. One of the primary aspects to this role is to provide medical direction and leadership for the integration of BH and physical health care and services. This clinician works collaboratively with MVP's Senior Medical Director, Medicaid & Mid-Hudson to support implementation of the MVP BH QM/UM Program.

Senior Leader, Behavioral Health Clinical Operations
The Clinical Director, BH, is responsible for the strategic planning, development, implementation, and ongoing oversight of the MVP BH Case and Utilization Management program components. This leader oversees and supports the responsibilities of the QM BH Liaison, under the direction of the Senior Leader, BH.

Quality Management Behavioral Health Liaison
The QM BH Liaison provides support for and monitors the progress of the BH QM and UM Program to ensure it is meeting stated goals and objectives and complies with regulatory requirements. This manager will ensure that the QM and UM work plan reflects the progress of QM and UM activities. This manager also serves on the committees and subcommittees as a resource to interpret findings, identify barriers to improvement, propose methods for addressing the barriers, and facilitate program development, evaluation, and reporting.

MVP Board of Directors
The MVP Board of Directors has the final authority and overall responsibility for the quality of physical health care and services and BH care and services provided to MVP members with BH diagnosis. The Board of Directors reviews and approves the QI Program, the QI Program Annual Evaluation, and the QI Work Plan on an annual basis. The Board reviews reports of progress by the Executive Vice President/Chief Medical Officer on a quarterly basis.

Evaluation
MVP's BH QM and UM Program activities will be managed by the BH QM and BH UM subcommittees. The activities will be tracked in a work plan. The QIC will assess progress toward annual goals and evaluate the effectiveness of the program. The QIC will recommend revisions as appropriate to further advance improved integration and coordination of BH and PH clinical care and services to mainstream Medicaid and HARP members as well as children engaged in Children's services. Outcomes will be summarized annually and presented to the Board of Directors.

MVP's BH WM and UM program is described in detail in the 2020 UM Program Description.

b. PHARMACY

Medicare Part D Medication Therapy Management Program
MVP's Pharmacy Department continues to enhance its' Medication Therapy Management (MTM) Program every year. Besides ensuring full compliance with CMS regulations, the MVP Pharmacy team routinely evaluates new ways to make this program more successful. Data gathered from physician comments and member surveys will continue to be used to evaluate program changes in future years.

Pharmacy Drug Safety Program
MVP's Pharmacy team, through its Pharmacy Benefits Manager (PBM), utilizes a Concurrent Drug Utilization Review (CDUR) program, which is a series of edits that a member-specific pharmacy claim passes through prior to final adjudication. Examples of a CDUR edit include but are not limited to drug-drug interactions by the level of severity, therapy duplications, refill-too-soon, low dose (under minimum daily dose), underutilization, and maximum daily dose (MDD) edits. It is the dispensing

pharmacist's decision as to what action to take based on the severity of the edit.

In addition, MVP's Pharmacy team maintains a drug safety program to notify physicians and members about potentially harmful interactions and drug level one and level two recalls with the goal of reducing medical errors and promoting patient safety. This information is placed on the MVP website for provider and member notification. MVP also notifies through direct mail members who currently receive prescriptions for medications that have been recalled in order to inform the member of the recall and the next steps that should be taken to minimize potential harmful effects.

The Pharmacy team reports on drug recalls to the Pharmacy and Therapeutics (P&T) Committee and the QIC at regularly scheduled meetings.

Interdepartmental Support
MVP's Pharmacy team works closely with CM to refer members that qualify for additional services and monitoring. The team also supports QI, Customer Care, and other departments within Health Management, including Appeals, to help provide a seamless experience for members and providers. To further support members, the Pharmacy team continues to partner with the Special Investigation Unit (SIU) and other departments to ensure appropriate utilization.

Opioid Utilization Management

Formulary Management for Opioid Addiction Prevention and Treatment
Beginning in 2016, several initiatives were implemented in conjunction with state and federal regulations to deter opioid abuse and enhance treatment of opioid addiction.

Edits were implemented for NYS lines of business to limit initial opioid prescriptions for acute pain to no greater than a seven days' supply (Medicaid) and four prescriptions per 30 days (Medicaid and Commercial/Marketplace). In addition, an edit was implemented for Medicaid to block opioid prescription fills for members undergoing treatment with medications for opioid withdrawal and/or stabilization.

Cumulative Morphine Equivalent Dose (cMED) point of service edits were implemented in 2017 for Medicare members. During 2018, MVP implemented a retrospective utilization report to identify at-risk Medicare members for additional review and management through the Patient Safety Committee.

MVP has added additional medication management tools including prior authorization and quantity limits to the opiate medication class.

Medicare Opioid Overutilization Program and Opioid Monitoring System
MVP's Pharmacy team reviews opioid and benzodiazepine utilization trends of its Medicare members. The team may reach out to the prescribers to review utilization trends and identify whether members should be referred to the Government Program's Patient Safety Committee for drug-level restrictions.

Medicare STARS
MVP's Pharmacy team works with the Medicare Business Unit and the QI team to monitor and improve all current and potential, future Part D measures.

Medicaid Restricted Recipient Program
The Medicaid Patient Safety Committee meets regularly to review members with existing restrictions from the State as well as members identified by MVP for potential restrictions based upon utilization patterns. Members are identified through aberrant pharmacy or medical claims via standard reporting by MVP coworkers. This program encompasses Medicaid members across MVP's footprint.

Drug Utilization Review and Monitoring Program
In 2019, the Pharmacy team initiated a multifaceted program to ensure that medications, especially BH drugs, are appropriately utilized to optimize therapeutic outcomes and reduce the risk of adverse events through improved medication use. The Drug Monitoring program identifies and intervenes on medication related problems for Medicaid members through claims review, analytics, clinical review, and health informatics. The program focuses on polypharmacy (duplicate therapy and uncoordinated care), non-adherence, sub-optimal dosing, and appropriate use of BH medications. Providers are notified of medication-related problems and opportunities to optimize therapy.

Electronic Prior Authorization
The Pharmacy team has analyzed implementation of electronic prior authorization options for providers. MVP continues to offer real-time benefits through our PBM to provide coverage and copayment information at the time of prescribing.

Robotic Prior Authorization
The Pharmacy team has begun work on robotic processing of prior authorization and member-initiated requests in order to streamline workflow and establish a more rapid turnaround time.

KPI Benchmarks
The outlined Pharmacist KPIs and their benchmarks align with those identified for other UM functions. These KPIs have been selected as they ensure consistency and timeliness of UM decision making as well as meeting documentation standards. It has been determined through 2019 and previous year program evaluation as well as audit and readiness review feedback that these benchmarks remain consistent in helping MVP maintain pharmacy compliance for all lines of business.

KPI Name	KPI Benchmark	Reason for Benchmark	Action Plan
Pharmacist Reviewer Quality Control	90%	Internal Control	Monitor and educate as needed
Pharmacist Reviewer Inter-Rater Reliability Testing	80%	Internal Control	Monitor and educate as needed

c. APPEALS OF UM DECISIONS

UM Decision Appeals – All Lines of Business and Products, Except Medicare
The member appeal process consists of two internal levels of appeal*, in addition to the member's right to seek State external review options for medical necessity and experimental/investigational denials.

Appeals of clinical matters are decided by personnel qualified to review the appeal, including licensed, certified, or registered health care professionals who were not involved in the initial determination, at least one of whom is a clinical peer reviewer. A member or his/her representative, or a provider acting on behalf of a member, may file an appeal verbally or in writing. Member appeals may be pre-service, post-service, or concurrent.

A full investigation of each appeal, including any aspects of clinical care, is conducted and completed within 15 days of receipt of the appeal. (Exchange members: group policies-pre-service/pre-authorization 15 calendar days, individual policies 30 days but not later than 60 days, all other appeals group policies 30 business days, and individual policies 45 calendar days. Medicaid/HARP policies, pre-service 30 calendar days, post-service 60 calendar days.) In the event that an expedited appeal is warranted, such as when a delay in decision making might seriously jeopardize the life or health of a member, or the member has been denied continued or extended health care services or related treatment while undergoing a course of continued treatment, or the member's health care provider believes an immediate appeal is warranted, an expedited appeal process is available. MVP will make the expedited appeal determination and notify the member and practitioner(s) (if known) by telephone as expeditiously as the medical condition requires, but no later than 24 hours (Exchange group, individual, and Medicaid/HARP policies no later than 72 hours) after the request is received. Expedited review is also granted to all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.

**Per Patient Protection and Affordable Care Act, members who are enrolled in individual policies have access to only one level of internal appeal. Medicaid and HARP members have access to only one level of internal appeal.*

UM Decision Appeals - Medicare Products

The member appeals process consists of one internal level. All Medicare members have the right to appeal any decision about payment or failure to provide what the member believes is a covered service. Appeals of clinical matters are decided by personnel qualified to review the appeal, including licensed, certified, or registered health care professionals who were not involved in the initial determination, at least one of whom is a clinical peer reviewer. A member or his/her representative may file an appeal verbally or in writing. Member appeals may be pre-service, post-service, or concurrent.

A full investigation of each appeal, including any aspects of clinical care, is conducted and completed within the Medicare processing timeframes. An expedited appeal is completed within 72 hours from receipt of the appeal. In the event that an expedited appeal is warranted, such as when a delay in decision making might seriously jeopardize the life or health of a member, or the member's health care provider believes an immediate appeal is warranted, an expedited appeal process will be granted. MVP will make the expedited appeal determination and notify the member and practitioner(s) (if known) by telephone and in writing. A standard Part C pre-service appeal is completed within 30 calendar days. A post-service appeal is completed in 60 calendar days. A 14-calendar day extension may be granted for Part C expedited and pre-service appeals if it is in the best interest of the member. A standard Part D appeal is completed within seven calendar days. A member appeal decision that is not favorable to the member is entitled to additional external appeal steps.

Appeals KPIs

The KPI's below were selected to comply with regulatory requirements for CMS, VTDFR, NYDOH, NYDFS, and NCQA.

KPI: Medicare Appeal Response Timeframe Part C

Appeal Type	KPI Benchmark	Benchmark Reason	Action Plan
Standard pre-service	30 calendar days of receipt	CMS NCQA	Appeal missed timeframes are addressed in real time with re-education
Standard post-service	60 calendar days of receipt		
Expedited pre-service	72 hours of receipt		

KPI: Medicare Appeal Response Timeframe Part D

Appeal Type	KPI Benchmark	Benchmark Reason	Action Plan
Standard	7 calendar days of receipt	CMS NCQA	Appeal missed timeframes are addressed in real time with re-education
Expedited	72 hours of receipt		

KPI: Commercial Appeal Response Timeframes VTDFR

Appeal Type	KPI Benchmark	Benchmark Reason	Action Plan
Standard	15 calendar days of receipt	VTDFR NCQA	Real time education was completed with the necessary MVP Staff to mitigate any further issues
Expedited	24 hours of receipt		

KPI: Commercial Appeal Response Timeframes NYDOH

Appeal Type	KPI Benchmark	Benchmark Reason	Action Plan
Standard	30 calendar days of receipt	NYDOH NCQA	Real time education was completed with the necessary MVP Staff to mitigate any further issues
Expedited	Earlier of 2BD of necessary info receipt or 72 hours of request		

KPI: Commercial Appeal Response Timeframes NYDFS Grandfathered Plans

Appeal Type	KPI Benchmarks	Benchmark Reason	Action Plan
Expedited Urgent	48 hours of receipt	NYDFS NCQA	Real time education was completed with the necessary MVP Staff to mitigate any further issues
Pre-service	15 calendar days of receipt		
Post-service	15 calendar days of receipt		
Unrelated to claim or service determinations	15 calendar days of necessary information receipt		
Voluntary Internal Second Level	15 calendar days of receipt		
Expedited/Urgent	Earlier of 2 business days of necessary information receipt or 72 hours of request		

Expedited/Urgent Second Level	48 hours of receipt		

KPI: Commercial Appeal Response Timeframes NYDFR Non-Grandfathered Plans

Appeal Type	KPI Benchmark	Benchmark Reason	Action Plan
Expedited/Urgent Appeal	Earlier of 2BD of necessary info receipt or 72 hours of request	NYDFR NCQA	Real time education was completed with the necessary MVP Staff to mitigate any further issues
Pre-service	15 calendar days of receipt		
Post-service	30 calendar days of receipt		
Appeals unrelated to claim or service determinations	30 business days of necessary information receipt		
Pre-service voluntary internal second level	15 calendar days of receipt		
Post-service voluntary internal second level	30 calendar days of receipt		
Unrelated to claim or service determinations	30 calendar days of receipt of necessary information		
Expedited/Urgent Second Level	Earlier of 2 business days of necessary information receipt or 72 hours of request		

CARE MANAGEMENT

MVP offers medical and BH CM programs to members tailored to their needs. Drawing on the combined strengths of our 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 nursing CM established by the American Nursing Association and the Case Management Society of America. Additionally, the medical team of clinicians is certified by the Commission for Case Management (CCMC), American Nurses Credentialing Center (ANCC) and/or well coaches for health coaching.

MVP's programs are designed to meet the various needs of the MVP membership. The programs are focused and time-sensitive and incorporate predictive modeling data to ensure that the most at-need members are triggered with an increased efficiency. Many of the programs are available to all members (adult and pediatric) for all lines of business.

The Care Management programs include the following programs:

- *Catastrophic Care Program* - focuses on providing an intensive, intricate, customized plan of care for members with complex injuries or diagnoses, often with critical health issues and co-morbidities.

- *Complex Care Program* - an intensive coaching and self-management support program designed to assist members with multiple chronic conditions or comorbidities to achieve a higher level of wellness and independent self-management of their conditions.
- *Health Management Program* - a coaching program designed to assist members who have been diagnosed with one chronic condition and provide them with the necessary tools to enhance their ability to self-manage.
- *Transition Care Program* - an intensive program for members recently discharged from the hospital to provide education to reduce their risk for readmission.
- *Unplanned Care Program* - a program that identifies members who frequently utilize the ED for routine care needs. This program is available for MVP Medicaid members.

MVP systematically reviews, identifies, and refers members who may benefit from the Care Management programs using claims data, hospital discharge data, lab data, Health Risk appraisal data, pharmacy data, UM data, and a variety of other sources. UM data collection includes information on pre-certification, pre-approval, concurrent review, hospital admissions, hospital days, and discharges.

The Health Management Programs are intended to identify and engage members with specific chronic diseases 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 physician interaction, and adherence to evidence-based care guidelines. The Health Management Programs offered by MVP include care for member living with:

- Asthma
- Low Back Pain (not available for all lines of business)
- Cardiac
- COPD
- Heart Failure
- Diabetes

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 one-on-one personal health coaching.

Through the analysis of MVPs clinical programs in 2019 it was identified that a stand-alone Care Management Program is required. MVP will be working to document this Care Management program content in a Care Management Program Description for 2021. This will ensure the UM, CM, and Population Health Management strategies and interventions are effectively documented, measured, and evaluated.

Care Advantage Program

The Care Advantage Program offers a proactive management approach to self-funded groups in support of an enhanced population health model. Offered in addition to Care Management programs, the Care Advantage program identifies members at various stages of health and wellness and works to engage a

larger percentage of the group's population with the overall goals of mitigating future cost and improving the overall health of the population.

The Care Advantage team focuses on identifying members who need assistance or are at risk. In addition to the members' ability to self-refer into the program, the Care Advantage team uses a variety of tools to identify members who may benefit from the program. These include, but are not limited to, claims data, hospital discharge data, Health Risk appraisal data, pharmacy data, nurse-line utilization data, biometric results, identified gaps in care, and predictive modeling.

Health Promotion

MVP's Health Promotion efforts are overseen by two teams:

1. Commercial Health Promotion works with employer groups to create worksite health promotion strategy. The team also offers a variety of well-being experiences in all dimensions of wellness in community setting available to all MVP members.
2. The Medicare Community Health Promotion team specializes in meeting the needs of MVP's Medicare Advantage population.

Both teams provide health and wellness education, information, and resources. Classes and programs are designed to help members stay active, follow healthy nutritional guidelines, and learn prevention techniques so that life-long wellness is always within their reach.

The Quality and Health Promotion teams will collaborate this year to better leverage MVP's Wellbeing Reward programs. Medicare Advantage and Commercial populations are eligible for Wellbeing Rewards whereby points are awarded to members who complete a combination of preventive screenings, living well classes and activities, doctor visits, activity attestations, or participate in select case management programs.

One specific Wellbeing Reward program example for the MVP Medicare Advantage program is SilverSneakers®, which is a partnership with Tivity Health to provide access to the SilverSneakers® fitness program. It is designed to offer members a combination of physical activity, healthy lifestyle, and socially oriented activities that promote greater control of their health.

2020 Care Management Key Performance Indicators

The following Care Management KPIs were selected to assist with monitoring and maintaining the engagement and satisfaction of our memberships utilization and outcomes related to the Care Management programs. Member satisfaction and SF 12 scores help us to trend our member's self-reported experience of MVP Care Management. The creation of the Care Management engagement rate KPI will allow MVP to monitor and manage the volume and percentage of members identified for and engaged in any component of Care Management. Lastly, the KPIs for staff quality results and timeliness of assessment completion ensure consistency among the CM staff to ensure alignment with policy and procedure, as well as regulatory and NCQA requirements. The most stringent regulatory requirement for any KPI is used across all lines of business unless otherwise noted.

Health Promotion KPIs

KPI Name	KPI Benchmark	Action Plan

Member Satisfaction Results	90%	Align BH and Care Management Programs to obtain target results. Monitor member complaints to address trends or systemic issues that could impact overall satisfaction.
SF 12 Results (Average Scores and positive trend between initial, six month and 12-month survey)	Average score at or above 50, Increase in average score between initial, 6 month and 12-month survey	Monitor program SF 12 completion rates across all programs and all LOBs to identify outliers. Evaluate and address opportunities to support increase in results over time.
Care Management Engagement Rates	Collect Baseline	Identify for the Care Management Program the number of members identified for Care Management intervention/ the number of members that engage in a CM assessment (survey)
Care Management QC results 2019	90%	Leaders will continue to assess Care Management cases on a monthly basis, immediately address any issues or concerns, and provide additional training as required.
Initial Assessment Initiation Timeframe	30-day completion 90% of the time	Leaders will continue to review monthly audit reports for compliance, immediately address any issues or concerns, and provide additional training as required.

Identified Opportunities and Goals for 2020

- Continue to collaborate with various entities and agencies to develop best practice programs for and management of our members.
- Improve online and digital communication strategies and resources for our members and partners.
- Increase documentation efficiencies and information sharing with implementation of VBC to include attribution information.
- Expand health information exchange data.
- Increase communication and collaboration with the Quality team and others within the company to ensure ongoing success with various quality and regulatory requirements.
- Continue evaluating best practices to identify areas of improvement for the program (review of assessments, workflows, face to face outreach process).
- Continue NCQA accreditation for HMO/POS LOBs in NY and Vermont, as well as for the Vermont Marketplace.
- Continue to develop the NCQA Population Health Management approach.
- Identify additional opportunities for more automation of current workflows and processes.
- Improve member satisfaction and experience to align with MVP Corporate goals.
- Monitor programs and identify opportunities specific to hospital readmissions and ED utilization.
- Improve coordination and support during transitions between care settings.
- Increase and maintain community tenure.
- Improve member experience through CM.

TRAINING

MVP Corporate Training

MVP complies with NYS and Federal (including CMS) requirements to provide mandatory training to its entire staff. Mandatory training topics include Annual Corporate Compliance, Health Insurance Privacy and Portability Act, 1996, Confidentiality and Privacy rules, HIV/AIDS Sensitivity, Unlawful Harassment Awareness and Prevention, Fraud, Waste and Abuse, and Diversity and Cultural Competence training. Mandatory training completion is verified either by an online training completion confirmation or by notification to a direct supervisor.

Staff Training

The UM, BH, and CM teams require clinical licensure, aligned with the minimum required license for each position. Monthly, at minimum, the staff list is reviewed for adequate licensure, in the states, in which the employee conducts activity on behalf of MVP. The following websites are utilized to validate that each employee maintains an active license, as needed per their job description.

- http://www.op.nysed.gov/opsearches.htm
- https://www.nursys.com/
- https://secure.professionals.vermont.gov/prweb/PRServletCustom/V9csDxL3sXkkjMC_FR2HrA%5B%5B*/!STANDARD?UserIdentifier=LicenseLookupGuestUser

In accordance with NYS training requirements for behavioral health[1], MVP delivers training on the following topics to internal staff across various departments:

Training Topic	Clinical Staff	Member Services	Provider Relations
NYS vision, mission, goals, operating principles for BH	R	R	R
New BH services and HCBS	R	R	R
HARP and HCBS eligibility requirements and protocols	R	R	R
Services for individuals with first episode psychosis	R	R	
Evidence-based practices	R		R
Recovery principles	R		R
BH/medical integration; co-occurring BH and medical disorders; integrated care management principles	R	R	R
Level of care guidelines for new BH services	R		
Access standards for new BH services	R	R	R
New information systems, data collection tools (when applicable)	R		R
Reporting and monitoring requirements (e.g., critical incident reporting, HCBS assurances)	R		
New authorization requirements for BH	R	R	R
Complaints, grievance, appeals	R	R	R
After hours and crisis triage protocols	R	R	R
Linkage requirements (i.e., with social services, Office for People with Developmental Disabilities, non-Medicaid BH services)	R	R	R

[1] (New York State 2015)

Network participation requirements (e.g., provider qualification validation)			R
Provider training and site visits			R
Provider profiling and performance management			R

When a delegate provides a function that has required training components, MVP provides the training content for completion to the delegate. The delegate is responsible for furnishing MVP's Vendor Management with proof of completion. Vendor Management coordinates with the delegate and the internal business area the delegate was contracted for to ensure satisfactory completion of required trainings.

NCQA Training

MVP engaged NCQA trainers to provide a three-day in-depth training, which will occur 2/4/2020 through 2/6/2020 and will focus on the 2020 NCQA HPA standards and preparation for the Commercial HMO/POS HPA survey. MVP staff from multiple departments will attend the training sessions. The training will cover each NCQA HPA standard which applies to MVP including, QI, UM, Population Health Management, Credentialing, Member Experience, Network Management, document preparation, using the Interactive Review Tool (IRT), and using NCQA's Policy Clarification System (PCS) to submit questions. This training will provide information in preparation for MVP's Commercial HPA survey that will begin with an offsite review, which consists of a documentation submission on 8/25/2020 and will continue with a virtual file review 10/12/2020 to 10/13/2020.

Provider Training and Resources

MVP also makes training and educational resources available to the provider network to ensure a successful partnership. Operational Resources guide providers through the functional aspects of how to do business with MVP and Clinical Education focuses on supporting the provision of care to membership.

Providers also may access MVP's Reference Library online for the following:

- Provider Resource Manual (PRM) and Payment Policies
- Provider Education Resources
    - Operational Resources
        - Provider Online Account
        - Provider Network and Demographics
        - Eligibility and Benefits
        - Authorizations
        - Claims and Electronic Remittance Advice
    - Clinical Education
        - Support for Children and Adults
        - Integrated Primary and Behavioral Health
        - HCBS
        - Diversity and Cultural Competency
        - Special Populations
        - Evidence-Based Practices Training
        - Substance Use Disorders
- EDI Information and Guides

- Coding, Medical Record Documentation, and Education
- HEDIS Reference Guides
- HEDIS Tip Sheets
- ICD-10 Updates and FAQs
- Opioid/Pain Management Resources
- Children and Family Treatment and Support Services
- Health Home
- Guides to MVP Benefits & Plans
- Understanding MVP's National Alliance with Cigna HealthCare
- Learn about MVP Policies
- Guides for Using Our Site
- Utilization Management

Additionally, MVP provides education to its physician practices through office visits by Professional Relations Representatives for each of MVPs service regions. The office visits include education regarding MVPs Provider Portal tools and reference guides, provider policies, and procedures for billing/claim submission, which are published in the PRM, and practitioner events such as "Ask the Carrier" in the Rochester region.

Member Resources
See Section 18, Member Experience

CREDENTIALING AND RECREDENTIALING

The MVP Credentialing program consists of a process to evaluate and monitor practitioners and contracted providers who provide care to MVP members. Practitioners credentialed and recredentialed include, but are not limited to, Physicians (MD/DO), Podiatrists (DPM), Oral surgeons (DMD/DDS), BH practitioners (licensure dependent on the state of practice), Optometrists (OD), independent nurse practitioners, and Ancillary providers (PT/OT/Audiologists, Chiropractors, Certified Nurse Midwives, Certified Diabetic Educators Nutritionists). Organizational providers credentialed and recredentialed include but are not limited to: Adult Day Care facilities, Hospitals, Skilled Nursing Facilities, Bariatric Surgery Centers, Free Standing Dialysis Centers, Federally Qualified Health Centers, Ambulatory Surgical Facilities, Home Health Care Agencies including personal care assistant programs, Ambulatory BH Treatment Facilities, Transplant Programs, Hospice Care, Portable X-ray suppliers, Free Standing Radiology Centers, and Urgent Care Centers.

The QIC reviews and approves credentialing policies. In accordance with NCQA, the Credentialing team will develop and QIC will review a policy that outlines the system controls which assure securities for date and time stamp, documentation, rendered decisions, and issued notifications. A summary evaluation of Credentialing activities is presented annually to the QIC as part of the QI Program Annual Report. The Senior Leader, Operations Enablement Operations Transformation and the Senior Leader, Medical Director Team oversee department operations with the Senior Leader, Medical Director Team having overall responsibility for the Credentialing program.

Practitioner Rights
MVP notifies practitioners of their rights during the Credentialing process. Practitioner rights include the following: the right to review the information obtained from any outside primary source that is presented to the Credentials Committee in support of their credentialing and/or recredentialing application; the right to correct erroneous information submitted by another party; and the right to be informed of the status of their credentialing or recredentialing application.

Ongoing and Performance Monitoring
Between recredentialing cycles, MVP performs ongoing monitoring of practitioner sanctions, adverse events such as, readmissions, unexpected death, accessibility issues, and complications of therapy, and member complaints that could impact the quality of care delivered to MVP members to determine if there is evidence suggesting that the practitioner no longer meets MVP's criteria and standards for participation.

MVP incorporates information from QI reports into its recredentialing decision making process as needed which may include information derived from member complaints and quality concerns. In addition, comprehensive provider reporting data for physicians is retained and available in the Standard Provider Reporting Package compiled by Informatics. There are no identified red flag criteria. This information is provided to all groups and is available for use by the Credentialing Department, as needed, for the evaluation of physicians who present with other issue or concerns. This data can be reviewed by line of business or in the aggregate.

Follow-up actions based on the committee's review include, but are not limited to, individual or group level corrective action plans, early recredentialing evaluation, focused physician visits, independent Medical Director intervention, and suspension or termination of participation.

Nondiscriminatory Credentialing and Recredentialing
MVP does not make credentialing or recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, or sexual orientation. MVP does not make credentialing or recredentialing decisions based solely on the types of procedures performed, or the type of patients the practitioner provides services to.

Council for Affordable Quality Healthcare
MVP participates in the CAQH, a not-for-profit alliance of the nation's leading health plans and networks. One of its purposes is to streamline the administrative credentialing and recredentialing processes. MVP requires practitioners to use CAQH's Universal Credentialing DataSource, a free online service that allows health care providers to fill out one application to meet the credentialing and recredentialing data needs of multiple health plans.

To ensure that MVP is meeting regulatory compliance, the credentialing application cycle time and recredentialing cycle compliance are closely monitored. These two indicators reflect MVP's ability to meet regulatory compliance of new providers joining the network and the processing of the recredentialing applications of participating providers.

KPI Name	KPI Benchmark	Reason for Benchmark	Action Plan
Credentialing Application Cycle Time	Credentialing applications processed within 60 days	Regulatory - NYSDOH	Review monthly application cycle time and review any file that takes more than 60 days to process to identify any roadblock to mitigate the roadblock going forward
Recredentialing Cycle Compliance	% of recredentialing applications processed within 36 months	NCQA, Medicare, NYSDOH, NYS Managed Care Medicaid Model Contract, and Vermont H-2009-03	Review the outstanding recredentialing report to identify any roadblock to mitigate the roadblock going forward
Delegation Oversight	Review all credentialing delegated vendors at least annually. Present report to DOC within 14 months of most recent previous report	NCQA HPA standard CR 8	Monitor credentialing delegated vendors and report review and CAP activity as required

DELEGATION

MVP does not delegate QI. MVP may delegate CM, Disease Management, Care Coordination, UM, Pharmacy Benefit Information, Credentialing, Networks, Member Connection, Population Health Management, and other activities as appropriate to other entities that meet MVP's requirements. MVP has written policies and procedures for the determination of functions to delegate, pre-delegation assessments, initial evaluation, and ongoing monitoring of delegates. The QI Team actively participates in delegation oversight and monitoring of all delegated functions and makes recommendations to the QIC (and/or appropriate subcommittee) regarding issues of overall compliance with MVP requirements.

When activities are delegated to another entity, the provision and oversight of these activities are completely and specifically documented in a mutually agreed upon document, that outlines the following:

- Responsibilities of MVP and delegated entity
- Specific delegated activities
- At least semi-annual reporting from each delegate to the appropriate MVP committee
- Process by which MVP evaluates the delegate's performance remedies, including revocation of the delegation if the delegated entity does not fulfill its obligations and annual evaluation of delegates activities to

determine compliance with MVP requirements, accreditation standards, and state and federal regulatory requirements.

If sub-delegation is agreed upon, it will be the responsibility of the delegate to oversee sub-delegation in accordance with the same requirements and periodicity established by MVP and the delegate, at a minimum. The delegate must confirm subdelegate's compliance with MVP, state, federal, and NCQA standards and include any subdelegate activity in all of its reporting to MVP. If the delegation arrangement includes the use of protected health information by the delegate, the Delegation Agreement and/or Business Associate Addendum (BAA) also includes the following provisions:

- A list of the allowed uses of protected health information
- A description of delegate safeguards to protect the information from inappropriate use or further disclosure
- A stipulation that the delegate ensures that subdelegates have similar safeguards
- A stipulation that the delegate provides individuals with access to their protected information
- A stipulation that the delegate informs MVP if inappropriate use of the information occurs
- A stipulation that the delegate ensures protected health information is returned, destroyed, or protected if the delegation agreement ends

In May 2020, QI transitioned leadership of the Delegation Oversight Committee to the Legal Department to be managed by the newly created position of Leader, Delegation Oversight. The Delegated Entities listing is maintained by the QI team Delegation Oversight team, which is part of the Legal Department, and is tracked in appropriate work plans.

MEMBER EXPERIENCE

MVP's web-based decision support and health information systems include access to health information and a Personal Health Assessment (PHA) tool. Utilization of the PHA and the features that accompany it enable early identification of members eligible for disease management and CM programs.

MVP displays health information in various formats including interactive quizzes, online courses, and tracking tools. These different formats allow members to tailor the health information they receive to suit their learning style. Other sources of health information available to MVP members include an online health library and access to a nurse advice line as well as telephonic and email coaching services. Similar to the PHA process, members utilizing the telephonic nurse advice line are assessed for eligibility to available disease and CM programs.

Easy access to information contributes to members' peace of mind that their health care needs will be met. MVP members can access claims information, including when claims are paid and the amount paid, via the website, mobile app, and the Customer Care Center. Pharmacy information is also readily available to members by phone and by accessing the PBM website. Responses to members' inquiries about financial decision making are supported by the Care Center staff's access to individualized benefit information and claims history, as well as information about referrals/authorizations, posted to the website.

myVisitNow® - Telemedicine Visits
MVP offers a web-based clinical consultation service, **myVisitNow**, through American Well, covering 24/7 online doctor visits to eligible MVP members, upon renewal. Eligible MVP members can access doctors and other health care professionals including BH specialists, dieticians, and lactation consultants from across the country, through a mobile device or computer with a web camera.

myERnow℠ – Virtual Emergency Room Visits
New in 2020, MVP began offering **myERnow** to support safe, effective, and timely access to clinical experts who can guide members to the most appropriate care. This service is offered at no cost to MVP members.

QI PROGRAM EVALUATION

The QI Program is evaluated on an annual basis. The analyses, including root cause(s) and action plans from the Annual Evaluation drive the QI Program Description Contents; the QI Program Description then drives the QI Workplan contents.

The QIC assesses progress toward the previous year's goals and evaluates the effectiveness of the program. The QIC revises the Program as appropriate to further advance improvement in clinical care and services to MVP members. In addition, the QIC reviews and adopts an annual QI Work Plan that includes goals and planned activities for the current year.

FACTORS AND CIRCUMSTANCES SPECIFIC TO 2020 WHICH IMPACT QUALITY ACROSS MVP

The SARS-COV-2 virus spread at a large scale within the United States resulting in the COVID-19 pandemic during the first quarter of 2020. To protect its employees and members, MVP shifted 95% of its workforce to a work-from-home model beginning March 2020. Many of MVP's partners in the communities that MVP serves also experienced sweeping changes in the way patient care is delivered.

To help promote a safe and healthy environment, many provider and facility locations closed or restricted their accessibility. In an effort to offset these changes, MVP encouraged increased usage of its existing online video chat-based telemedicine option, **myVisitNow**, to meet nonurgent needs and introduced **myERnow** to provide access to trained emergency medicine providers. Additionally, MVP has undertaken a Member Outreach Call Campaign designed to provide customized care to our vulnerable populations, including Medicare and HARP, those deemed medically fragile, and many more who rely on services that are more challenging to access or not available. MVP will continue collaboration with its partners to overcome challenges presented by the new "normal" and to ensure MVP members continue receiving quality care.

Many efforts are occurring across the organization to help our members during the pandemic and beyond. MVP is sending Care Packages to members who express a need for supplies to help keep them

safe. MVP identifies members in need via a member outreach call campaign and by inbound calls through customer care. The care package includes two disposable face masks, one package of tissues, one small bottle of hand sanitizer, and one "cheer" item such as a deck of cards, word search, or crossword puzzle book.

Each of MVP's regulatory oversight entities has issued guidance related to the COVID-19 pandemic. Their guidance ranges from relaxing some requirements and standards to allowing a wider array of practitioners to treat MVP members who are experiencing symptoms of COVID-19. All regulatory and accreditation audits and surveys have either been postponed or transitioned to a virtual format.

The COVID-19 pandemic will likely result in long-term changes in the way which we interact with our members and business partners. 2020 will be a year of transition and MVP will lead the communities it serves by putting members' and employees' safety at the forefront of planning and implementation activities. Enterprise-wide quality initiatives will have a critical role in the long-term health-minded approach to business, personal, and member interactions. Remaining current with federal state, local, and regulatory entity guidance, MVP will positively impact the delivery of safe and effective care to its members.

2020 QI PROGRAM ATTACHMENTS

Signature Page

The 2019 Annual QI Program Evaluation

The 2020 QI Program Description

The 2020 Annual QI Work Plan

Documents were reviewed and approved by:

Medical Director, Chairman, QIC	Date
Vice President/Chief Medical Officer, MVP	Date

Original Approval Date: August 7, 1995

QI Committee Structure and Membership

Quality Improvement Committee

Reports to: MVP Board of Directors
Meeting frequency: Quarterly
Quorum: 50% of the voting members plus one, based on the current voting membership at the time of the meeting.
Membership: includes participating physicians from across MVP's service area and two Board of Directors appointees*.
Purpose: The QI Program Description provides the framework to improve the quality, safety, and efficiency of clinical care, enhance satisfaction, and improve the health of MVP membership 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.

Internal to MVP Voting Members	Non-Voting Members
Carl Cameron, MD, Interim CMO, Chairperson or designee Judith Feld, MD, Sr. Leader, BH Medical Director Jim Hopsicker, Sr. Leader, Health and Pharmacy Management Kimberly Kilby, MD, Sr. Leader, Medical Director Team Andrew McNamara, MD, Sr. Leader, Health Management Clinical Strategy Jason Merola, MD, Senior Leader, Medical Affairs	Karla Austen, Sr. Leader, Finance and Network Nicole Becker, Professional, Credentialing Compliance Program Manager Wendy Colin, Sr. Leader, Pharmacy Management Kevin Husted, Sr. Leader, Engagement Ruth Leslie, Sr. Leader, Quality Performance and Operations Donna Milano, Associate, Network and Contracting Tina Nyland, Sr. Leader, Credentialing Janelle Piper, Professional, Pharmacy Program Management Nancy Reiss, Sr. Leader, Medicare Operations Charmain Smith, Sr. Leader, Health Management Strategy and Quality Jane Strange, Sr. Leader, Appeals Nicole Sunder, Sr. Leader, Health Management, Clinical Operations Debbie Zadrozny, Vendor, Provider Relations
External to MVP Members	
Domenic Aiello, MD, Voting Member Raymond Basri, MD, Voting Member John Bisognano, MD, Voting Member Kara Flaherty, MD, Voting Member (VT) Mark Foster, MD, Voting Member Richard Gullot, MD, Voting Member Adam Kunin, MD, Voting Member (VT) Ernest Levy, MD, Voting Member Edward Lewis, MD, Voting Member David Phelps, MD, Voting Member David Pratt, MD, Voting Member James Wood, MD, Voting Member Vacant, One Layperson, MVP Medicare Member, Voting Member	

Service Improvement Committee

Reports to: QIC
Meeting frequency: At least four times a year
Quorum: 50% of the voting members plus one, based on the current voting membership at the time of the meeting.
Membership: Includes representation from across MVP's Strategic Business Units and functional areas.
Purpose: The purpose of the SIC is to ensure continuous improvement in satisfaction and loyalty of MVP customers (members, employers, and practitioners), as directed by the organization's QI Work Plan. The SIC serves as an oversight body to ensure MVP's compliance 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, as well as by efforts within the Strategic Business Units for Commercial and Government Programs.

Voting Members	Non-Voting Members
Kevin Husted, Sr. Leader, Engagement, Chairperson Pat Deferio, Sr. Leader, Network Management Lauren Dyroff, Sr. Leader, Clinical Operations Support Ellen Grabowitz, MD, Medical Director, Behavioral Health Rosemarie Hogan, Sr. Leader, Claims and Enrollment Operations Jim Hopsicker, Sr. Leader, Health and Pharmacy Management Ruth Leslie, Sr. Leader, Quality Performance and Operations Andrew McNamara, MD, Sr. Leader, Health Management Clinical Laurie Metheny, Sr. Leader, Service and Experience Sue Montgomery, Sr. Leader, Government Programs Operations Rich Odorizzi, Sr. Leader, Controller Nancy Reiss, Sr. Leader, Medicare Operations Charmain Smith, Sr. Leader, Health Management Strategy and Quality Denise Stasik, Sr. Leader, Credentialing, Appeals, and Grievances	Angela Cacchione, Professional, Market Research Karen Fox, Leader, QI compliance and Accreditation Katie Moore, Leader, Corp PR and Provider Relations Meredith Rice, Professional, Exchange Business Paula Vernile, SR. Leader, Medicaid Services and Supports

Pharmacy & Therapeutics Committee

Reports to: QIC
Meeting frequency: At least eight times a year
Quorum: 50% of the voting members plus one, based on the current voting membership at the time of the meeting.
Membership: Includes at least one physician* and one pharmacist* who are experts in the care of the elderly or disabled.
Purpose: Provides oversight for and coordination of the QI Program.

Voting Members	External Members
Wendy Colin, Sr. Leader, Pharmacy Management Judith Feld, MD, Sr. Leader, BH Medical Director John Gassler, MD, Medical Director Jim Hopsicker, Sr. Leader, Health and Pharmacy Management, and Chairperson	Richard Gullot, MD, Internal Medicine, Chairperson Domenic Aiello, MD, Endocrinology, Voting Member John Bisognano, MD, Cardiology, Voting Member Deepak Buch, MD, Internal Medicine, Voting Member Leon Cosler, PhD, Voting Member Peter Deane, MD, Allergy, Immunology, Rheumatology, Voting Member Szolt Depapp, MD, Endocrinology, Voting Member Patrick Germain, MD, Anesthesiology, Voting Member Jason Herrick, MD, Child Psychology, Voting Member Grama Jagadish, MD, Internal Medicine, Voting Member Rachel Longo, PharmD, Voting Member Pravin Patel, R.Ph., Voting Member David Phelps, MD, Internal Medicine, Voting Member Kevin Reilly, R.Ph., Voting Member James Saperstone, MD, Pediatrics, Voting Member Scott Schabel, MD, Internal Medicine, Voting Member Kimberly Sikule, MD, Internal and Sports Medicine, Voting Member Marc Tack, MD, Infectious Disease, Voting Member Michael Tadros, MD, Gastroenterology, Voting Member David Wang, PharmD, Voting Member Michael Willen, MD, Oncology, Voting Member

Clinical Operations Committee

Reports to: QIC
Meeting frequency: Quarterly
Quorum: 50% of the voting members, plus one based on the current voting membership at the time of the meeting.
Purpose: Provide oversight of the development and implementation of the processes to collect, monitor, analyze, evaluate, and report utilization data. Review and analyze data, (reporting <21 medically fragile children separately), interpret the variances, review outcomes, and develop interventions based on the findings. Prudently manage available resources to optimize the health and well-being of MVP members.

Voting Members	Non-Voting Members
Carl Cameron, MD, Interim CMO, Co-Chair Judith Feld, MD, Sr. Leader, BH Medical Director, Co-Chair Nicole Sunder, Sr. Leader, Health Management Clinical Operations, Key Lead Michelle Clavecilla-Chan, SR. Leader, BH Clinical Operations Wendy Colin, Sr. Leader, Pharmacy Management Lauren Dyroff, Sr. Leader, Clinical Operations Support Ellen Grabowitz, Medical Director, Behavioral Health Jim Hopsicker, Sr. Leader, Health and Pharmacy Management Kimberly Kilby, MD, Sr. Leader, Medical Director Team DeAnna LaBarge, Leader, Customer Care and Provider Relations AnnBeth Litt, MD, Medical Director Ruth Leslie, Sr. Leader, Quality Performance and Operations Lisa McCabe, Sr. Leader, Utilization Management Cheryl Mannion, Sr. Leader, Care Management Jason Merola, MD, Senior Leader, Medical Affairs Brenda Nelson, Leader, Contract Management and Network Management Jennifer Singarayer, MD, Medical Director, Behavioral Health Julie Sheehy, Sr. Leader, Clinical Compliance Charmain Smith, Sr. leader, Health Management Strategy Jane Strange, Sr. Leader, Appeals Millicent Sutton, MD, Medical Director, Pediatrics Vacant, QM Behavioral Health Liaison	Janet Aery, Leader, Retro Review Michelle Bronson, Leader, IH Contract Manager Rosemarie Hogan, Sr. Leader, Claims and Enrollment Operations Lisa Horning, Professional, Clinical Compliance Tenley Klouse, Leader, Case Management Operations Barbara Lapinski, Leader, Prospective Review Operations Matt Lombardo, Sr. Leader, Actuarial Commercial and Medicaid LOB Tara Morris, Professional, Clinical Compliance Allison Morrison, Leader, Health Service Analytics Lisa Niro, Professional, Compliance Health Services Jasmine Ormsby, Professional, Compliance Health Services Gregg Rahn, Professional, Finance Carla Renders, Leader, Value Based Programs Deb Repice, Leader Case Management Operations Gale Zdunczyk, Leader, Concurrent Review Operations through May 1, 2020. Vacancy to be filled.

Clinical Quality Committee

Reports to: QIC
Meeting frequency: Quarterly
Quorum: 50% of the voting members, plus one based on the current voting membership at the time of the meeting.
Purpose: Provides oversight for and coordination of the QI Program.

Voting Members

Michelle Clavecilla-Chan, Sr. Leader, BH Clinical Operations, Co-Chair
Ruth Leslie, Sr. Leader, Quality Performance and Operations, Co-Chair
Carl Cameron, MD, Interim CMO
Wendy Colin, Sr. Leader, Pharmacy Management
Lisa Coppinger, Leader, Quality Initiatives
Lauren Dyroff, Sr. Leader, Clinical Operations Support
Judith Feld, MD, Sr. Leader, BH Medical Director
Ellen Grabowitz, Medical Director, Behavioral Health
Jim Hopsicker, Sr. Leader, Health and Pharmacy Management
Kimberly Kilby, MD, Sr. Leader, Medical Director Team
DeAnna LaBarge, Leader, Customer Care and Provider Relations
Cheryl Mannion, Sr. Leader, Care Management
Lisa McCabe, Sr. Leader, Utilization Management
Andrew McNamara, MD, Sr. Leader, Health Management Clinical Strategy
Jason Merola, MD, Senior Leader, Medical Affairs
Brenda Nelson, Leader, Contract Management and Network Management
Julie Sheehy, Sr. Leader, Clinical Compliance
Jennifer Singarayer, MD, Medical Director, Behavioral Health
Charmain Smith, Sr. Leader, Health Management Strategy and Quality
Jane Strange, Sr. Leader, Appeals
Nicole Sunder, Sr. Leader, Health Management, Clinical Operations
Millicent Sutton, MD, Medical Director, Pediatrics
Angela Vidile, Leader, BH Children's and HARP Services
Vacant, BH QM Behavioral Health Liaison

2020 Behavioral Health Utilization Management Subcommittee

Reports to: COC
Meeting frequency: At least Quarterly
Quorum: Meets concurrently with COC. COC quorum rules apply.
Purpose: MVP's BH QM and UM Program is the portion of MVP's QI Program specifically designed to:

1. Assess the clinical and service needs of mainstream adult, HARP members, and children with BH diagnosis.
2. Develop, implement, evaluate, and report on the various interventions/programs that will optimize clinical quality, maximize safe clinical practices, and enhance service to MVP members with BH diagnosis**.**
3. Ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis for all members with BH diagnosis.

Voting Members	**Non-Voting Members**
Carl Cameron, MD, Interim CMO, Co-Chair Judith Feld, MD, Sr. Leader, BH Medical Director, Co-Chair Nicole Sunder, Sr. Leader, Health Management Clinical Operations, Co-Chair Michelle Bronson, Leader, IH Contract Manger Michelle Clavecilla-Chan, Sr. Leader, BH Clinical Operations Wendy Colin, Sr. Leader, Pharmacy Management Patricia Deferio, Sr. Leader, Network Management Rhonda Drago, Professional, Ancillary Contract Negotiator Lauren Dyroff, Sr. Leader, Clinical Operations Support Ellen Grabowitz, Medical Director, Behavioral Health Jim Hopsicker, Sr. Leader, Health and Pharmacy Management DeAnna Moon, Leader, Care Center Staff and Operations Ruth Leslie, Sr. Leader, Quality Performance and Operations Cheryl Mannion, Sr. Leader, Care Management Lisa McCabe, Sr. Leader, Utilization Management Andrew McNamara, MD, Sr. Leader, Health Management Clinical Strategy Julie Sheehy, Sr. Leader, Clinical Compliance Jennifer Singarayer, MD, Medical Director, Behavioral Health Charmain Smith, Sr. Leader, Health Management Strategy and Quality Jane Strange, Sr. Leader, Appeals Millicent Sutton, MD, Medical Director, Pediatrics Angela Vidile, Leader, BH Children's and HARP Services Vacant, BH QM Behavioral Health Liaison	Kim Abramow, Professional, QI Compliance Program Manager Lisa Coppinger, Leader, Quality Initiatives Christina Cross, Program Manager, Network and Vendor Management Karen Fox Associate, Director, Quality Improvement, Compliance and Accreditation Neil O'Brien-Bosselman, Program Manager, Network and Vendor Management Sharron Tedesco, Professional, Quality Initiative Lead Ashely VanAlstine, Associate, QI Program Coordinator
External Members	
Kevin Dame, LMHC Supervisor of clinical Services Allee De Franza, LMSW Quality Specialist II Donna Hakala, RN, MS Regional Quality Director Joshua Maldonado, LMHC Clinical Director Children's Services Laurie Nadal, MD, Interim Medical Director Children Services Kelsey Osgood, Acct. Director	Deepa Patel, MA Quality Specialist Jamie Randorf, Acct. Executive Jennifer Rice, VP, Clinical Partnerships Raechel Schwartz, LCSW Director of Utilization Management Children's Services Rose Marie Sime, MD, Medical Director Melissa Wojewodzic, LMHC Regional Clinical Director

2020 Behavioral Health Quality Management Subcommittee

Reports to: CQC
Meeting frequency: At least Quarterly
Quorum: Meets concurrently with COC. COC Quorum rules apply.
Purpose: MVP's BH QM and UM Program is the portion of MVP's QI Program specifically designed to:

1. Assess the clinical and service needs of mainstream adult, HARP members, and children with BH diagnosis.
2. Develop, implement, evaluate, and report on the various interventions/programs that will optimize clinical quality, maximize safe clinical practices, and enhance service to MVP members with BH diagnosis**.**
3. Ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis for all members with BH diagnosis.

Voting Members	**Non-Voting Members**
Michelle Clavecilla-Chan, Sr. Leader, BH Clinical Operations, Co-Chair Ruth Leslie, Sr. Leader, Quality Performance and Operations, Co-Chair Carl Cameron, MD, Interim CMO Michelle Bronson, Leader, IH Contract Manger Wendy Colin, Sr. Leader, Pharmacy Management Patricia Deferio, Sr. Leader, Network Management Rhonda Drago, Professional, Ancillary Contract Negotiator Lauren Dyroff, Sr. Leader, Clinical Operations Support Judith Feld, MD, Sr. Leader, BH Medical Director Ellen Grabowitz, Medical Director, Behavioral Health Jim Hopsicker, Sr. Leader, Health and Pharmacy Management Kimberly Kilby, MD, Sr. Leader, Medical Director Team DeAnna Moon, Leader, Care Center Staff and Operations Cheryl Mannion, Sr. Leader, Care Management Lisa McCabe, Sr. Leader, Utilization Management Andrew McNamara, MD, Sr. Leader, Health Management Clinical Strategy Jason Merola, MD, Senior Leader, Medical Affairs Julie Sheehy, Sr. Leader, Clinical Compliance Jennifer Singarayer, MD, Medical Director, Behavioral Health Charmain Smith, Sr. Leader, Health Management Strategy and Quality Jane Strange, Sr. Leader, Appeals Nicole Sunder, Sr. Leader, Health Management, Clinical Operations Millicent Sutton, MD, Medical Director, Pediatrics Angela Vidile, Leader, BH Children's and HARP Services Vacant Senior, Leader, BH Quality Management	Kim Abramow, Professional, QI Compliance Program Manager Lisa Coppinger, Leader, Quality Initiatives Christina Cross, Program Manager, Network and Vendor Management Karen Fox Associate, Director, Quality Improvement, Compliance and Accreditation Neil O'Brien-Bosselman, Program Manager, Network and Vendor Management Sharron Tedesco, Professional, Quality Initiative Lead Ashely VanAlstine, Associate, QI Program Coordinator
External Members	
Kevin Dame, LMHC Supervisor of clinical Services Allee De Franza, LMSW Quality Specialist II Donna Hakala, RN, MS Regional Quality Director Joshua Maldonado, LMHC Clinical Director Children's Services Laurie Nadal, MD, Interim Medical Director Children Services Kelsey Osgood, Acct. Director	Deepa Patel, MA Quality Specialist Jamie Randorf, Acct. Executive Jennifer Rice, VP, Clinical Partnerships Raechel Schwartz, LCSW Director of Utilization Management Children's Services Rose Marie Sime, MD, Medical Director Melissa Wojewodzic, LMHC Regional Clinical Director

2020 Behavioral Health Advisory Committee

Reports to: CQC
Meeting frequency: At Least Quarterly
Quorum: Advisory Committee – will solicit feedback and advice but does not make decisions. Minutes will reflect discussion and attendance.
Purpose: The BH Advisory Committee will address three distinct populations within the framework of the meeting: adult, HARP, and children. Each population will be documented separately on the agendas and meeting minutes in accordance with NYS requirements.

Voting Members	Non-Voting Members
Michelle Clavecilla-Chan, Sr. Leader, BH Clinical Operations, Co-Chair Ruth Leslie, Sr. Leader, Quality Performance and Operations, Co-Chair Carl Cameron, MD, Interim CMO Wendy Colin, Sr. Leader, Pharmacy Management Lauren Dyroff, Sr. Leader, Clinical Operations Support Judith Feld, MD, Sr. Leader, BH Medical Director Ellen Grabowitz, Medical Director, Behavioral Health Jim Hopsicker, Sr. Leader, Health and Pharmacy Management Kimberly Kilby, MD, Sr. Leader, Medical Director Team DeAnna LaBarge, Leader, Customer Care and Provider Relations Cheryl Mannion, Sr. Leader, Care Management Lisa McCabe, Sr. Leader, Utilization Management Andrew McNamara, MD, Sr. Leader, Health Management Clinical Strategy Jason Merola, MD, Regional Medical Director Brenda Nelson, Leader, Contract Management and Network Management Julie Sheehy, Sr. Leader, Clinical Compliance Jennifer Singarayer, MD, Medical Director, Behavioral Health Charmain Smith, Sr. Leader, Health Management Strategy and Quality Jane Strange, Sr. Leader, Appeals Nicole Sunder, Sr. Leader, Health Management, Clinical Operations Millicent Sutton, MD, Medical Director, Pediatrics Angela Vidile, Leader, BH Children's and HARP Services Vacant, BH QM Behavioral Health Liaison Vacant Senior, Leader, BH Quality Management	Kim Abramow, QI Program Manager Lisa Coppinger, Leader, Quality Initiatives and Clinical Reporting Christina Cross, Program Manager, Network and Vendor Management Karen Fox Associate, Director, Quality Improvement, Compliance and Accreditation Neil O'Brien-Bosselman, Program Manager, Network and Vendor Management Sharron Tedesco, Professional, Quality Initiative Lead
External Members	
Yolanda Burton, MMC Liaison Coordinator, Berkshire Farm Center, Voting Member Robert Corke, Executive Director, Yonkers Residential Center, Voting Member John Francis, St. Vincent's Hospital/Westchester, Voting Member Barrie Jacobsen, LCSW-R, Executive Director, New Hope Manor, Voting Member Camille Kurtz, Westchester Medical, Voting Member David Phelps, MD, Participating Provider, Voting Member Donna Reilly-Boccia, Westchester Medical Center, AVP BH CM Services, Co-Chair	Stephen B., MVP Member, Voting Member Glenn B., MVP Member, Voting Member Sheila D., MVP Member, Voting Member Linda B., MVP Member, Voting Member Elizabeth V., MVP Member Parent, Voting Member Susan G., MVP Member Parent, Voting Member Robin F., MVP Member Foster Parent, Voting Member

Credentials Committee

Reports to: QIC
Meeting frequency: At least ten times a year
Quorum: 50% of the voting members plus one, based on the current voting membership at the time.
Membership: Includes one alternate physician from each region and MVP. Each alternate vote only in the absence of the designated voting member for each region.
Purpose: Responsible for the credentialing and recredentialing decisions for physicians, non-physician practitioners, and organizational and ancillary providers at MVP.

Voting Members	Non-Voting Members
Judith Feld, MD, Sr. Leader, BH Medical Director Ellen Grabowitz, Medical Director, Behavioral Health Kimberly Kilby, MD, Sr. Leader, Medical Director Team Jason Merola, MD, Senior Leader, Medical Affairs Voting Member	Tina Nyland, Sr. Leader, Credentialing, Non-Voting Member

External Members

Mary Beth Robinson, MD, Chairperson
Dominic Aiello, MD, Central, Voting Member
Deepak Buch, MD, Central, Voting Member
David Chazan, DPM, Ancillary, Voting Member
Carlos Dator Jr., MD, Central, Voting Member
Jeffrey Goldstein, MD, West, Voting Member
Ellen Grabowitz, MD, Voting Member
Claudia Hriesik, MD, West, Voting Member
William Lapple, OD, Ancillary, Voting Member
Glen MacKenzie, MD, Vermont, Voting Member
Donna Miller, MD, Vermont, Voting Member
Jamil Mroueh, MD, West, Voting Member
Karen Murray, Mid-Hudson, MD, Voting Member
David Phelps, MD, East, Voting Member
Rajeev Saini, MD, Central, Voting Member
Mitchell Singer, MD, East, Voting Member
Derek Tenhoopen, MD, West, Voting Member
Daren Wu, MD, Mid-Hudson, Voting Member

Peer Review Committee

Reports to: QIC
Meeting frequency: Ad hoc
Quorum: Any and all voting members who are present at the meeting constitute a quorum.
Membership: Includes all physician members of the QIC.
Purpose: The Peer Review Committee conducts peer review of quality issues that originate in regions in which there is no peer review committee structure.

Voting Members	External Members
Carl Cameron, MD, Interim CMO, QIC Chairperson Judith Feld, MD, Sr. Leader, BH Medical Director Jim Hopsicker, Sr. Leader, Health and Pharmacy Management Kimberly Kilby, MD, Sr. Leader, Medical Director Team Andrew McNamara, MD, Sr. Leader, Health Management Clinical Strategy Jason Merola, MD, Senior Leader, Medical Affairs	Domenic Aiello, MD, Voting Member Raymond Basri, MD, Voting Member John Bisognano, MD, Voting Member Kara Flaherty, MD, Voting Member Mark Foster, MD, Voting Member Richard Gullot, MD, Voting Member Adam Kunin, MD, Voting Member Ernest Levy, MD, Voting Member Edward Lewis, MD, Voting Member David Phelps, MD, Voting Member David Pratt, MD, Voting Member James Wood, MD, Voting Member

Medical Management Committee (MMC)

Reports to: QIC
Meeting frequency: At least 8 times per year
Quorum: More than half of voting members
Membership: Includes MVP medical Senior Leaders, physician representatives from MVP's service area, and MVP staff from the functional areas.
Purpose: The MMC provides corporate-wide clinical and administrative evaluation and oversight of the medical management programs in place at MVP.

Voting Members	Non-Voting Members
Jason Merola, MD, Senior Leader, Medical Affairs, Chairperson Carl Cameron, MD, Interim CMO Claire Bolon, MD, Medical Director Judith Feld, MD, Sr. Leader, BH Medical Director Paul Fine, MD, Medical Director John Gassler, MD, Medical Director Ellen Grabowitz, Medical Director, Behavioral Health Kimberly Kilby, MD, Sr. Leader, Medical Director Team AnnBeth Litt, MD, Medical Director Jennifer Singarayer, MD, Medical Director, Behavioral Health Millicent Sutton, MD, Medical Director, Pediatrics	Michelle Clavecilla-Chan, Sr. Leader, BH Clinical Operations Dan Flanagan, Professional, Medical Policy and Technology Assessment Jim Hopsicker, Sr. Leader, Health and Pharmacy Management Barbara Lapinski, Leader, Prospective Review Operations Lisa McCabe, Sr. Leader, Utilization Management Kate Stella, Associate, Administrative Assistant Nicole Sunder, Sr. Leader, Health Management, Clinical Operations Debbie Zadrozny, Vendor, Provider Relations Gale Zdunczyk, Leader, Concurrent Review Operations through May 1, 2020. Vacancy to be filled.

External Members
Tauseef Ahmed, MD, Voting Member Lon Baratz, MD, Voting Member Sudershan Dang, MD, Voting Member David Phelps, MD, Voting Member James Saperstone, MD, Voting Member Edward Tanner, MD, Voting Member

Delegation Oversight Committee

Reports to: QIC
Meeting frequency: At least four times a year
Quorum: Any and all voting members who are present at the meeting
Membership: Includes physician representatives from MVP's service area and MVP staff from the functional areas charged with oversight of a delegated entity.
Purpose: Ensures that MVP's delegated vendors comply with MVP standards, federal and state regulatory requirements, and NCQA standards.

Voting Members	External Members
Karen Fox, Leader, QI compliance and Accreditation, Chair Wendy Colin, Sr. Leader, Pharmacy Management Christina Cross, Professional, Ancillary Contracts Nancy DiCioccio, Sr. Leader, Medicaid Operations Ellen Grabowitz, Medical Director, Behavioral Health Lisa Horning, Professional, Clinical Compliance Lisa John, Leader, Medicare Compliance Officer Rita Logsdon, Professional, Credentialing Delegation Project Manager Jason Merola, MD, Senior Leader, Medical Affairs Susan Montgomery, Sr. Leader, Government Programs Operations Tara Morris, Professional, Clinical Compliance Lisa Niro, Professional, Compliance Health Services Tina Nyland, Sr. Leader, Credentialing Neil O'Brien-Bosselman, Professional, Ancillary Contracts Jasmine Ormsby, Professional, Compliance Health Services Nancy Reiss, Sr. Leader, Medicare Operations Michelle Shader, Sr. Leader, Operations, Vendor Compliance Transaction Management Julie Sheehy, Sr. Leader, Clinical Compliance Jennifer Singarayer, MD, Medical Director, Behavioral Health Charmain Smith, Sr. Leader, Health Management Strategy and Quality April Snyder, Leader, Commercial Appeals Operations Jane Strange, Sr. Leader, Appeals Nicole Sunder, Sr. Leader, Health Management, Clinical Operations	David Phelps, MD, Voting Member

Priority Measures and Performance by Line of Business

The table below displays MVP's 2020 priority measures and the data used to select them. The column "2020 Target Benchmarks" provides the goal measure rate that MVP is striving to achieve by the end of 2020. Generally, the goal measure rate is equal to the next benchmark listed for the line of business.

Interventions that were underway or planned to begin in the first two quarters of 2020 were paused or delayed due to the impact of COVID-19 and the subsequent limited access to health care while stay-at-home orders are in place. As such, the Quality team is working on new approaches to address many of the priority measures through use of telemedicine and/or telephone interaction between providers and members. More information about other inventions can be found in the QI Initiatives section.

Medicaid Priority Measures and Performance

Measure Acronym	Full Measure Name	2019 MY	50th Percentile	75th Percentile	90th Percentile	2020 Target Benchmark
ADDC	Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	49.12	66.66	76.76	82.61	66.66
ADDI	Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	41.97	56.30	63.32	73.96	56.30
AMM-A	Antidepressant Medication Management - Effective Acute Phase Treatment	50.60	52.53	53.86	53.96	52.53
AMM-C	Antidepressant Medication Management - Effective Continuation Phase Treatment	34.69	37.51	38.76	39.33	37.51
CIS	Childhood Immunization Status - Combination 3	73.48	77.13	80.05	83.21	77.13
FUA-7	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up	26.20	20.44	25.38	31.36	31.36

FUA-30	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up	31.60	26.87	33.77	38.14	33.77
FUH-7	Follow-Up After Hospitalization for Mental Illness - 7-Day Follow-Up	12.47	63.18	68.38	76.52	63.18
FUH-30	Follow-Up After Hospitalization for Mental Illness - 30-Day Follow-Up	20.95	74.33	78.14	83.40	74.33
FUM-7	Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up	83.04	63.18	68.38	76.52	76.52
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up	88.30	74.33	78.14	83.40	83.40
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Total - Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	22.63	18.89	20.56	23.57	23.57
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Total - Initiation of Alcohol and Other Drug Abuse or Dependence Treatment	46.39	45.05	47.28	51.48	47.28
IMA	Immunizations for Adolescents - Combination 2	46.47	37.96	46.72	50.85	46.72
MMA	Medication Management for	30.18	36.60	41.40	43.03	36.60

	People with Asthma - Medication Compliance 75%					
POD	Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	N/A	N/A	N/A	N/A	N/A
PPC-pre	Prenatal and Postpartum Care - Prenatal Care	88.32	87.78	90.75	91.91	90.75
PPC-post	Prenatal and Postpartum Care - Postpartum Care	80.05	67.89	70.83	72.99	72.99
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	57.38	62.53	64.89	66.10	62.53
SPC-A	Statin Therapy for Patients with Cardiovascular Disease - Statin Adherence 80%	50.15	67.02	70.72	74.47	67.02
SPC-R	Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy	79.86	80.95	82.93	85.97	80.95
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	45.15	47.28	53.47	61.13	47.28
W15	Well Child Visits in the First 15 Months of Life - 5 or More Visits	87.94	83.25	87.37	87.54	87.54
ADV-MDC	Annual Dental Visit	67.68	61.93	65.29	68.87	68.87
AMR	Asthma Medication Ratio	89.51	63.62	65.90	67.03	67.03
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	38.00	43.12	47.20	50.91	43.12
ART	Disease Modifying Anti-Rheumatic Drug	78.47	81.78	84.36	85.83	81.78

	Therapy in Rheumatoid Arthritis					
AWC	Adolescent Well Care Visits	70.25	67.41	69.96	71.43	71.43
BCS	Breast Cancer Screening	66.58	68.66	70.83	74.86	68.66
CBP	Controlling High Blood Pressure	57.18	60.83	70.40	71.53	60.83
CCS	Cervical Cancer Screening	71.05	71.35	72.75	74.45	71.35
CDC-eye	Comprehensive Diabetes Care - Eye Exam	61.07	64.23	69.34	71.05	64.23
CDC-A1c	Comprehensive Diabetes Care - HbA1c Testing	92.70	91.73	93.67	95.13	93.67
CDC-Neph	Comprehensive Diabetes Care - Medical Attention for Nephropathy	89.29	91.24	92.88	92.32	91.24
CDC-BP	Comprehensive Diabetes Care BP	55.23	67.15		75.55	67.15
CHL	Chlamydia Screening in Women	70.88	74.05	79.46	81.51	74.05
COL	Colorectal Cancer Screening	56.69	55.96	61.31	66.67	61.31
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.76	80.84	82.67	85.45	82.67
W34	Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	86.45	84.68	86.28	87.18	87.18
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	78.59	87.83	91.48	94.16	87.83

HARP Priority Measure and Performance

Measure Acronym	Full Measure Name	2019 MY	50th Percentile	75th Percentile	90th Percentile	2020 Target Benchmark
AMM-A	Antidepressant Medication Management - Effective Acute Phase Treatment	52.69	52.53	53.86	53.96	53.86
AMM-C	Antidepressant Medication Management - Effective Continuation Phase Treatment	37.92	37.51	38.76	39.33	38.76
FUA-7	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up	39.78	20.44	25.38	31.36	31.36
FUA-30	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up	48.08	26.87	33.77	38.14	38.14
FUH-7	Follow-Up After Hospitalization for Mental Illness - 7-Day Follow-Up	6.45	63.18	68.38	76.52	63.18
FUH-30	Follow-Up After Hospitalization for Mental Illness - 30-Day Follow-Up	16.80	74.33	78.14	83.40	74.33
FUM-7	Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up	82.14	63.18	68.38	76.52	76.52
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up	88.86	74.33	78.14	83.40	83.40
IET	Initiation and Engagement of Alcohol and Other Drug Abuse	54.12	45.05	47.28	51.48	51.48

	or Dependence Treatment - Total - Initiation of Alcohol and Other Drug Abuse or Dependence Treatment					
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Total - Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	23.39	18.89	20.56	23.57	23.57
MMA	Medication Management for People with Asthma - Medication Compliance 75%	40.41	36.60	41.40	43.03	41.40
POD	Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	N/A	N/A	N/A	N/A	N/A
PPC-pre	Prenatal and Postpartum Care - Prenatal Care	79.12	46.97	N/A	92.46	92.46
PPC-post	Prenatal and Postpartum Care - Postpartum Care	57.14	46.97	71.29	73.28	71.29
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	65.17	62.53	64.89	66.10	66.10
SPC-A	Statin Therapy for Patients with Cardiovascular Disease - Statin Adherence 80%	44.93	67.02	70.72	74.47	67.02
SPC-R	Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy	80.23	80.95	82.93	85.97	80.95

SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	33.33	47.28	53.47	61.13	47.28
ART	Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	62.22	81.78	84.36	85.83	81.78
BCS	Breast Cancer Screening	58.33	68.66	70.83	74.86	68.66
CBP	Controlling High Blood Pressure	56.93	53.28	59.61	74.94	59.61
CCS	Cervical Cancer Screening	64.48	67.64	70.69	73.72	67.64
CDC-eye	Comprehensive Diabetes Care - Eye Exam	50.36	59.61	66.87	70.00	59.61
CDC-A1c	Comprehensive Diabetes Care - HbA1c Testing	91.48	87.67	93.67	93.19	93.67
CDC-Neph	Comprehensive Diabetes Care - Medical Attention for Nephropathy	93.67	90.27	92.88	92.70	92.70
CDC-BP	Comprehensive Diabetes Care BP	58.39	65.69	N/A	74.67	65.69
CHL	Chlamydia Screening in Women	79.00	74.05	79.46	81.51	79.46
COL	Colorectal Cancer Screening	56.45	54.50	70.69	73.72	70.69
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	84.71	80.84	82.67	85.45	85.45

Commercial Priority Measures and Performance

Measure Acronym	Full Measure Name	2019 MY	50th Percentile	75th Percentile	90th Percentile	2020 Target Benchmark
ADD-C	Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	55.07	47.86	53.00	60.00	60.00
ADD-I	Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	39.78	39.63	44.27	50.42	44.27
AMM-A	Antidepressant Medication Management - Effective Acute Phase Treatment	68.87	69.74	73.77	77.20	69.74
AMM-C	Antidepressant Medication Management - Effective Continuation Phase Treatment	54.18	53.20	57.36	62.24	57.36
CIS	Childhood Immunization Status - Combination 3	85.88	79.05	82.63	86.02	86.02
FUA-7	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up	18.96	9.61	12.97	16.67	16.67
FUA-30	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up	59.62	13.67	17.74	22.62	22.62
FUH-7	Follow-Up After Hospitalization for Mental Illness - 7-Day Follow-Up	37.04	44.30	50.63	58.73	44.30
FUH-30	Follow-Up After Hospitalization for	52.03	66.54	72.66	77.83	66.54

	Mental Illness - 30-Day Follow-Up					
FUM-7	Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up	36.56	44.14	52.24	61.49	44.14
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up	77.64	60.52	67.65	75.00	75.00
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Total - Initiation of Alcohol and Other Drug Abuse or Dependence Treatment	32.74	35.71	38.54	41.69	35.71
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Total - Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	14.08	13.07	15.62	18.12	15.62
IMA	Immunizations for Adolescents - Combination 2	30.41	26.03	29.44	36.01	36.01
MMA	Medication Management for People with Asthma - Medication Compliance 75%	53.09	53.07	57.32	60.81	57.32
PPC-pre	Prenatal and Postpartum Care - Prenatal Care	80.54	87.80	90.00	94.17	87.80
PPC-post	Prenatal and Postpartum Care - Postpartum Care	73.24	79.42	82.62	88.80	79.42
SPC-A	Statin Therapy for Patients with	56.44	N/A	N/A	N/A	N/A

	Cardiovascular Disease - Statin Adherence 80%					
SPC-R	Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy	80.16	N/A	N/A	N/A	N/A
SPR	Use of Spirometry Testing in the assessment and Diagnosis of COPD	39.28	39.95	44.12	49.70	39.95
W15	Well Child Visits in the First 15 Months of Life - 5 or More Visits	94.97	N/A	N/A	N/A	N/A
AMR	Asthma Medication Ratio	91.96	80.72	83.57	85.66	85.66
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	42.18	33.75	40.43	46.81	46.81
ART	Disease Modifying anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	86.08	87.90	90.57	92.31	87.90
AWC	Adolescent Well Care Visits	68.60	47.38	55.93	64.87	64.87
BCS	Breast Cancer Screening	73.51	71.75	75.74	79.34	75.74
CBP	Controlling High Blood Pressure	49.39	62.90	67.15	74.94	62.90
CCS	Cervical Cancer Screening	78.10	75.93	78.46	83.21	78.46
CDC-eye	Comprehensive Diabetes Care - Eye Exam	61.07	54.29	60.38	69.68	69.68
CDC-A1c	Comprehensive Diabetes Care - HbA1c Testing	89.29	91.48	92.94	94.71	91.48
CDC-Neph	Comprehensive Diabetes Care - Medical Attention for Nephropathy	86.62	90.27	91.24	93.43	90.27
CDC-BP	Comprehensive Diabetes Care BP	52.80	66.31	N/A	77.37	66.31

CHL	Chlamydia Screening in Women	59.71	47.13	55.05	65.20	65.20
COL	Colorectal Cancer Screening	73.48	64.45	68.11	76.52	76.52
W34	Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	89.87	78.82	83.99	88.87	88.87
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	75.91	76.01	80.83	90.00	76.01

Medicare Priority Measures and Performance

Measure Acronym	Full Measure Name	2019 MY	2019 3 Stars Cut point	2019 4 Stars Cut point	2019 5 Stars Cut point	2020 Target Benchmark
SPCA	Statin Therapy for Patients with Cardiovascular Disease - Adherent	62.62	76	81	85	76
SPCR	Statin Therapy for Patients with Cardiovascular Disease - Received	82.64	76	81	85	85
ART	Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	81.65	76	83	89	83
BCS	Breast Cancer Screening	82.16	68	76	82	82
CDC-eye	Comprehensive Diabetes Care EYE	80.05	64	73	80	80
CDC-A1c	Comprehensive Diabetes Care A1c Controlled	65.45	68	78	87	68
CDC-Neph	Comprehensive Diabetes Care Neph	94.89	87	95	97	95
OMW	Osteoporosis Management in Women Who Had a Fracture	37.5	45	57	78	45

CBP	Controlling high BP	61.8	62	75	82	62