MVP HEALTH CARE

QUALITY IMPROVEMENT

PROGRAM

2019

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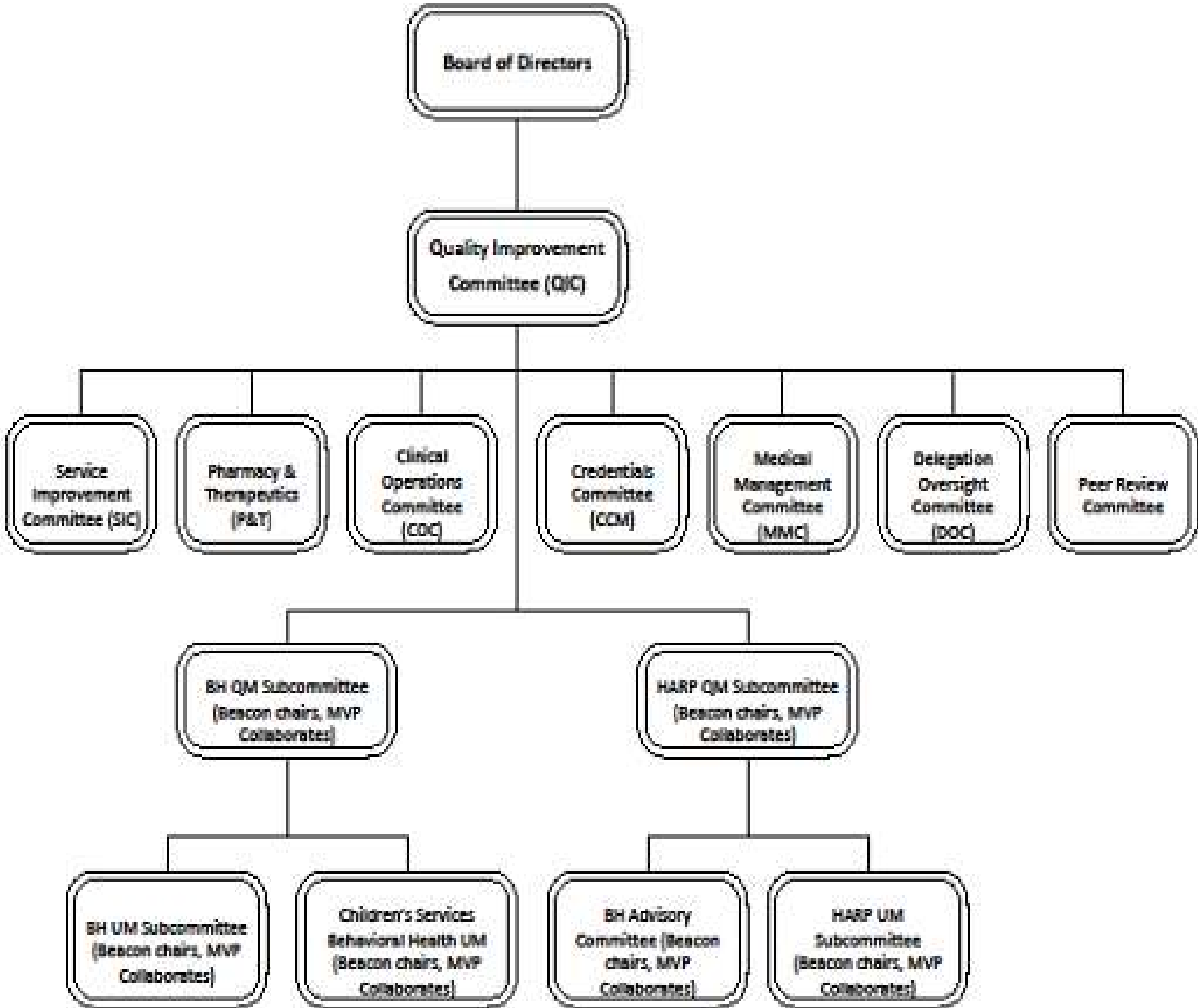
2019 MVP Health Care
Quality Committee Structure and Membership



2019 MVP Health Care
Quality Committee Structure and Membership

MVP HEALTH CARE

QUALITY IMPROVEMENT PROGRAM

I. PURPOSE

The purpose of the MVP Quality Improvement (QI) Program is to provide the structure, tools and information that will enable MVP staff, MVP providers and MVP members to provide and receive the highest quality of care. QI assesses MVP members' clinical and service needs and uses that information, in addition to evidence based clinical guidelines and continuous collaboration with MVP providers to develop, implement the tools and resources to support improved clinical quality, maximum clinical safety practices, and enhanced member experiences. The goal of the program is to ensure that MVP and its partners have the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis.

II. SCOPE

Components of the program include:

- Purpose, scope and objectives
- Program Structure
- Methodology
- Quality Management
- Performance Monitoring and Reporting
- Preventive Health Services
- Medical Records
- Utilization Management
- Behavioral Health
- Pharmacy
- Credentialing and Recredentialing
- Delegation
- Member Rights and Responsibilities
- Claims Operations
- Member Connections
- Resources
- Evaluation

III. OBJECTIVES

Provide a structured process, with adequate resources, to objectively and systematically monitor and improve the quality and appropriateness of care and services provided to MVP Health Care's members.

- Identify and pursue opportunities for improvement.
- Plan a schedule of activities and projects, tracked on the QI work plan, to achieve improvement over time, with ongoing evaluation and annual progress toward established goals reporting.
- Monitor the availability, accessibility, quality, continuity and coordination of patient care across the healthcare continuum.
- Provide information to providers, and training and tools to staff, to support culturally competent communication.
- Assess the appropriate use of resources and the provision of care.
- Develop preventive care guidelines and disseminate to physicians and members.
- Develop and support a structure to adopt, and make available to providers, clinical practice guidelines that are pertinent to the member populations served.
- Develop studies and measurements that are meaningful to track, evaluate and analyze for quality improvement.
- Offer health management programs that will improve the health status of members with chronic conditions and promote the use of those services to members and physicians.
- Work with community health care partners to ensure successful level-of-care transitions for members, especially those with complex health needs.
- Oversee programs designed to improve the quality of behavioral health care services.
- Work collaboratively with behavioral health delegates to improve the continuity of behavioral health care with medical care.
- Collect and utilize information to enhance the credentialing, peer review performance assessment and recredentialing processes.
- Promote a system of timely, thorough and appropriate resolution of member complaints, grievances and appeals including correction of problems identified.
- Monitor policies and procedures that protect members' privacy and the confidentiality of member information and records to ensure compliance with Health Insurance Portability and Accountability Act (HIPAA) and applicable state laws.
- Develop initiatives that will enhance patient safety in various care settings.
- Provide oversight of delegated activities as defined by National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS) and state regulators.

- Ensure MVP compliance with governmental agency regulatory requirements and NCQA accreditation standards.
- Monitor member and provider satisfaction with the health plan, identify opportunities for improvement and implement appropriate interventions to improve member and provider satisfaction.
- Implement effective pharmacy management procedures to promote appropriate access to care while assuring satisfaction and safety for MVP members.
- Encourage providers to participate in CMS and Health and Human Services' QI initiatives.

IV. PROGRAM STRUCTURE

MVP Board of Directors
The MVP Board of Directors has the final authority and overall responsibility for the quality of health care and services provided to members. 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 Operating Officer on a quarterly basis.

MVP Quality Staff

MVP President - Chief Operating Officer
The MVP President and Chief Operating Officer (COO) 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 COO leads senior staff and the Board Strategic Planning Committee in developing and establishing 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
The Executive Vice President (EVP) and Chief Medical Officer (CMO) has overall responsibility for the QI Program and is responsible for overseeing and monitoring the progress and effectiveness of all quality improvement activities.

Senior Leader, Operations and Government Programs
The Senior Leader, Operations and Government Programs has overall responsibility for the personnel who work in Medicaid and Medicare operational units across all MVP regional offices, as well as, the administration of claims, enrollment, configuration and enterprise systems for all MVP products. The QI program is supported by staff in these operational units, including the Senior Leader for Government Program Operations and Regulatory Affairs, the Senior Leader for Claims, Configuration and Support Services and the Senior Leader for Operational Transformation who report to the Senior Leader for Operations and

Government Programs. The Senior Leader for Operations and Government Programs reports directly to the President of MVP Health Care.

Senior Leader, Finance and Network
The EVP and Chief Financial Officer (CFO) assures that the QI Program and work plan activities approved by the Quality Improvement 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 of Quality Performance and Operations manages the plan-wide, comprehensive Quality Improvement 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. The individual also ensures appropriate inclusion of QI efforts throughout the company, including Value Based Performance agreements. The Senior Leader of Quality Performance and Operations oversees all clinical performance and service performance improvement efforts for all lines of business. He/she oversees NCQA accreditation/certification preparation and associated continuous compliance efforts. The 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). He/she directs and provides administrative expertise to the member, provider medical and inpatient hospital appeals processes, member complaint process and regulatory complaint process.

Senior Leader, Medical Affairs
Under the direction of the EVP, Medical Affairs/CMO, the Senior Leader of 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.

He/she directs the clinical development, continuous improvement and clinical management of the plan's Utilization Management (UM) program. He/she oversees 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. He/she provides 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/ Associate Medical Directors
Under the direction of the EVP – Chief Medical Officer, the Regional Medical Directors work closely with the Operational Senior Leaders to develop, evaluate and improve the Quality and Medical Management programs. Responsibilities include assessment of current performance and identification of opportunities

and methods for improvement. He/she is 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. A Medical Director participates in and is responsible for MVP's credentialing program. He/she provides 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.

These individuals also provide clinical leadership in the implementation of quality improvement 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 quality improvement 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 and Associate 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/Associate Medical Directors may be appointed to serve on the Quality Improvement 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 MVP Quality Improvement Committee structure ensures that all MVP functional areas have both accountability and input regarding quality improvement and the overall MVP member's experience. In addition to the MVP functional areas, all committees have representatives from across the MVP service area. Attendance via video or audio conferencing is acceptable for all groups.

Quality Improvement Committee

Role:
The Quality Improvement Committee (QIC) provides oversight and coordination for the MVP QI program. The committee receives and evaluates reports from the Medical Management Committee, Service Improvement Committee, Pharmacy & Therapeutics Committee, Delegation Oversight Committee, the Credentials Committee, the Clinical Operations Committee and the Peer Review Committee. The QI committee works collaboratively with MVP's representatives to provide

direction and assistance with meeting clinical quality and customer service goals. The QIC is also responsible for the execution of the activities outlined in the QI Program and oversight of the organization's QI Work Plan to ensure that the requirements of the regulatory and accrediting bodies are met. Specific functions of this committee include review and approval of policies, oversight of accreditation and survey findings and monitoring of corrective action plans, approval of proposed QI activities and review/analysis of their results, oversight of further actions taken as needed, and reassessment/follow-up to ensure that the cycle of improvement has been completed.

Reports to: Board of Directors

Meeting frequency: At least four times a year

Composition/Voting Members
Chairperson: CMO or designee

Voting membership consists of two participating physicians from Vermont, two participating physicians each from the Central and Mid-Hudson regions, three participating physicians from the East region; and five participating physicians from the West region.

MVP voting staff members include: Executive VP/Chief Medical Officer; Senior Leader of Quality Performance and Operations, Senior Leader of Medical Affairs, Senior Leader of Pharmacy Strategy and Management, MVP Regional Medical Directors and one layperson (an MVP member representing the MVP Medicare Advantage Membership). The chairperson votes in the event of a tie. Appointments to the QIC are made annually by the Chairman of the Board of Directors.

Quorum
A quorum requires 50% of the voting members plus one member present to vote. A quorum is based on current voting membership of the committee at the time of the meeting.

Service Improvement Committee
Role:
The purpose of the Service Improvement Committee (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.

Reports to: Quality Improvement Committee

Meeting frequency: At least four times per year

Composition/Voting Members
Chairperson: Director, Member Engagement

Voting membership includes representation from across MVP's Strategic Business Units and functional areas. The chairperson votes in the event of a tie.

Ad Hoc members*:* EVP/Chief Medical Officer; Leader, QI Compliance and Accreditation

Quorum:
A quorum requires 50% of the voting members plus one member present to vote. A quorum is based on current voting membership of the committee at the time of the meeting.

Pharmacy and Therapeutics Committee
Role:
The Pharmacy and Therapeutics (P&T) Committee provides clinical and administrative evaluation and oversight of the pharmacy management programs in place at MVP. It implements and monitors the health plan's coverage policies and the Formulary process. The P&T Committee also evaluates new drugs, appropriate drug therapy within disease states, performs profiling and trend analysis, and evaluates drug use within clinical guidelines. The Committee also reviews the Drug Use Review (DUR) criteria used with reporting evaluation.

Reports to: Quality Improvement Committee

Meeting frequency: At least eight times a year

Composition/Voting Members:
Chairperson: A physician knowledgeable in drug therapy who has experience in a Managed Care Organization's P&T Committee.

Voting membership includes physicians that represent all major specialties that are actively involved in drug therapy. Specialties represented can include:

Internal Medicine	Family Practice
Pediatrics	Oncology
Gastroenterology	Dermatology
Rheumatology	Pulmonary Disease
OB/GYN	Infectious Disease
Ophthalmology	Endocrinology
Allergy/Immunology	Cardiology
Geriatrics	Pharmacy

Committee members are drawn from all of MVP's geographic service areas based upon availability and familiarity with MVP. Best efforts will be made to ensure all geographic regions will be represented. At least one physician and one pharmacist will be experts in the care of the elderly or disabled.

Voting members also include the VP of Medical Affairs, VP of Pharmacy, and the Pharmacy Director*.* Appointments to the Pharmacy and Therapeutics Committee, including the chair appointments, are made annually or as vacancies are noted by the QIC.

Quorum:
A quorum requires 50% of the voting members plus one member present to vote. A quorum is based on current membership of the committee at the time of the meeting.

Clinical Operations Committee (formerly known as the Utilization Management (UM) Committee)

Role: The Clinical Operations Committee will:

- 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 wellbeing of MVP members.

In practice these responsibilities are carried out by performing the following functions across all ages and lines of business (LOB):

- Monitoring, analyzing and evaluating utilization including under- and over-utilization of services and cost data.
- Monitoring, analyzing and evaluating data, including but not limited to:
- Preventable admission rates
- Readmission rates
- Trends
- Average length of stay
- Emergency department utilization.
- Prior authorization/denial and notices of action.
- Tracking and trending appeals.
- Developing, implementing and reviewing intervention strategies with measurable outcomes based on utilization data findings.
- Ensuring timely reporting of utilization and performance measurement data.
- Payment for all physical health services for medically fragile children will transition from Fee-For-Services Medicaid to MVP on October 1, 2019.

Reports to: Quality Improvement Committee

Meeting frequency: Quarterly. Conference calls and electronic meetings are permitted at the discretion of the Chair.

Composition/Voting Members:
Chairpersons: MVP Medical Director and Senior Leader, Clinical Operations

The MVP Clinical Operations Committee is comprised entirely of MVP employees. Providers, vendors and delegates will participate by invitation only when appropriate and determined by the UM Committee members. Only standing members of the committee will be eligible to vote. Each committee member may designate one alternate to attend as a Proxy, with the permission of the Chair.

Quorum: The presence of 50% plus one of the voting members constitutes a quorum for the transaction of business. Less than a quorum will have the power to adjourn any meeting until such time a quorum is present.

Credentials Committee
Role:
The Credentials Committee is responsible for the credentialing and recredentialing decisions for physicians, non-physician practitioners and organizational and ancillary providers at MVP. The committee is also responsible for establishing credentialing criteria, policies and procedures and quality standards by which new applicants and applicants for recredentialing are evaluated with recommendations made to the QIC for approval.

Reports to: Quality Improvement Committee

Meeting frequency: At least 10 times per year

Composition/Voting Members
Chairperson: Senior Leader, Clinical Transformation. He/she has overall responsibility for MVP's Credentialing process. The MVP Credentials Committee is composed of one physician from the East region and Vermont, two physicians from Central, three from the West, one voting member from Mid-Hudson and one voting member from MVP. The MVP voting member is the Senior Leaser of Clinical Transformation. One physician from each region and a representative from MVP is designated as an alternate. The alternate will vote only in the event of the absence of the designated voting member. Two ancillary providers also serve as voting members on an ad hoc basis. Ad hoc members will provide guidance to the committee on issues relating to the ancillary specialty they represent. The ancillary specialists represent the following disciplines: podiatry and optometry. The chairperson votes in the event of a tie. The ancillary providers will not be included in the quorum and may only vote on the providers from their same specialty that they represent. Appointments to the Credentials Committee are made annually by the QIC.

Quorum: A quorum requires 50% of the voting members plus one member present to vote. A quorum is based on current voting membership of the committee at the time of the meeting.

Medical Management Committee
Role:
The Medical Management Committee (MMC) provides corporate-wide clinical and administrative evaluation and oversight of the medical management

programs in place at MVP. The group monitors MVP's UM programs and activities to assure that the requirements set forth by regulatory and accrediting bodies are met. MMC also provides oversight to the Clinical Practice Guideline review process.

Reports to: Quality Improvement Committee

Meeting frequency: At least eight times a year

Composition/Voting Members
Chair: Senior Leader, Medical Affairs

Voting membership consists of 12 physicians including MVP employed physicians and at least six community physicians. The chairperson votes in the event of a tie. Appointments to the MMC are made annually by the QIC.

Quorum
A quorum requires 50% of the voting members plus one member present to vote. A quorum is based on current membership of the committee at the time of the meeting.

Regional Quality/Peer Review Committees*
Chairperson
Regional Medical Director

Role:
The Regional Peer Review Committees are comprised of participating physicians representing various specialties. The committees are responsible for the formal peer review process for measuring the outcomes and effectiveness of the care and services provided by individual physicians. Strategies to improve performance and remedial interventions taken pursuant to identified quality issues are addressed by the Peer Review Committees.

The Regional Peer Review Committees also serve as a resource to support the review of clinical and coverage guidelines and other clinically driven quality improvement initiatives as presented by the QIC to provide additional clinical input and expertise.

*MVMA IPA has a Peer Review Committee. This committee does not report to QIC; however, the MVMA Medical Director(s) are members of various MVP Quality Committees.

Composition/Voting Members

Specific to the clinical issue being reviewed.
Varies by region

Quorum
Any and all members present at the meeting.

Meeting Frequency
The regions convene meetings on an ad hoc basis or have the peer review function completed by the MVP Peer Review Committee.

Peer Review Committee
Role:
The Peer Review Committee conducts peer review of quality issues that originate in regions in which there is no peer review committee structure. Additionally, it reviews quality concerns involving non-physician providers and reviews cases in which there are differences in opinion between MVP Medical Directors and the MVP Regional Peer Review Committees for review and action.

Reports to: Quality Improvement Committee

Meeting frequency: ad hoc

Composition/Voting Members
Chairperson: Executive VP/Chief Medical Officer or physician designee
The Peer Review Committee will consist of all physician members who serve on the QIC and additional specialists in an ad hoc non-voting capacity with expertise as indicated by the issues under review. Medical Directors who were involved with a particular case will recuse themselves on the disposition of the case in review. The decisions of the QIC will be final.
Quorum
Any and all voting members who are present at the meeting constitute a quorum.

*MVMA IPA has a Peer Review Committee. This committee does not report to QIC; however, the MVMA Medical Director(s) are members of various MVP Quality Committees.

Delegation Oversight Committee
Role:
The Delegation Oversight Committee (DOC) ensures that MVP's delegates comply with MVP standards, federal and state regulatory requirements as well as NCQA accreditation standards. The committee also maintains MVP's delegation policies and procedures and ensures that all delegation agreements remain consistent with MVP policies.

Reports to: Quality Improvement Committee
Meeting frequency: At least four times a year

Composition/Voting Members

Chairperson: Leader, Quality Improvement Compliance and Accreditation

Voting membership includes physician representatives from MVP's service area and MVP staff from the functional areas charged with oversight of a delegated entity. There is at least one MVP Medical Director, the MVP Medicare Compliance Officer, Senior Leader of Corporate Provider Relations and Vendor Management, Utilization Management Compliance and one member from each

of the following areas: Quality Improvement, the Medicare Strategic Business Unit, Credentialing, Pharmacy and Claims.

Appointments to the DOC are made annually by the QIC. Other employees from MVP attend the meetings as needed in a non-voting capacity.

Quorum
Any and all voting members who are present at the meeting constitute a quorum.

Behavioral Health: HARP Behavioral Health QM/UM Program

PURPOSE

The HARP Behavioral Health QM/UM Program is the portion of MVP's Quality Improvement Program specifically designed to:

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

MVP implements this program in collaboration with its behavioral health delegate, Beacon Health Options.

GOALS

The HARP Behavioral Health QM/UM Program goals provide a framework within which MVP can objectively and systematically monitor and improve the quality and appropriateness of care and services provided to HARP members. It is MVP's goal to:

1. Identify and pursue opportunities for improvement;
2. Develop a BH QM/UM work plan, a schedule of activities designed to achieve improvement over time, with ongoing evaluation and annual reporting of progress toward established performance objectives;
3. Develop definitive strategies to promote Behavioral Health-Physical Health integration;
4. Monitor the availability, accessibility, quality, continuity, coordination and effectiveness of the integration of patient care across the continuum of behavioral health care and physical health care settings;
5. Assess the appropriate use of resources in the provision and integration of Physical Health (PH) care and Behavioral Health (BH) care;
6. Provide information to providers and training and tools to staff to support culturally competent communication with the diverse population that MVP serves;
7. Develop and support a structure to adopt, implement and disseminate to contracted primary care physicians, hospitals and outpatient clinics evidence-based clinical practice guidelines for behavioral health conditions that are commonly treated in primary care settings in order to facilitate the identification and appropriate referral of HARP members in these settings where such members are most likely to present;
8. Adopt, disseminate, and implement specifically for the HARP population the clinical practice guidelines listed below as well as nationally recognized clinical practice guidelines and other evidence-based and promising practices:
    i. Substance Abuse and Mental Health Services Administration's Assertive Community Treatment (SAMHSA's ACT)

ii. Illness Management and Recovery
iii. Integrated Dual Disorder Treatment for Co-occurring Disorders
iv. Supported Employment (Individual Placement and Support)
v. Family Psychoeducation
vi. Tobacco cessation
vii. Office of Mental Health (OMH) First Episode Psychosis practice guidelines
viii. Seeking Safety
ix. Motivational Enhancement Therapy
x. Twelve- Step Facilitation
xi. Community-Based Treatment for SUD (Substance Use Disorder)
xii. Medication-Assisted Treatment for SUD and other SUD Evidence-Based Practices as recognized by SAMHSA."

9. Develop studies and measurements that are meaningful to track, evaluate and analyze for quality improvement.
10. Offer physical health management programs that will improve the physical health status of HARP members with chronic conditions and promote the use of those services to HARP members and their physicians.
11. Work with community health care partners to ensure successful level of care transitions for HARP members with complex physical health needs.
12. Oversee programs designed to improve the quality of both behavioral health care services and physical health care services.
13. Work collaboratively with MVP's behavioral health delegate to achieve and maintain seamless coordination and continuity of behavioral health care and physical health care services.
14. Promote a system of timely, thorough and appropriate resolution of member complaints and appeals from HARP members.
15. Monitor policies and procedures that protect members' privacy and the confidentiality of member information and records to ensure compliance with Health Insurance Portability and Accountability Act (HIPAA) and applicable state laws.
16. Develop initiatives that will enhance patient safety in various care settings.
17. Provide oversight of delegated activities as defined by the Centers for Medicare and Medicaid Services (*CMS) and state regulators.*
18. Enable MVP to meet governmental agency regulatory standards.
19. Monitor member and provider satisfaction with the health plan, identify opportunities for improvement and implement appropriate interventions to improve member and provider satisfaction.
20. Implement effective pharmacy management procedures to promote appropriate access to care while assuring satisfaction and safety for HARP members.

BEHAVIORAL HEALTH: HARP PROGRAM STRUCTURE

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 behavioral health care and services provided to HARP members. 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.

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

MVP President - Chief Operating Officer
Executive Vice President – Chief Medical Officer
Senior Leader, Operations and Government Programs
Senior Leader, Finance and Network
Senior Leader, Quality Performance and Operations
Senior Leader, Medical Affairs
Medical Directors and Associate Medical Directors

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

Senior Medical Director, Medicaid and Mid-Hudson
The MVP Senior Medical Director, Medicaid and Mid-Hudson is board-certified and licensed in New York State. This clinician provides medical direction and leadership for the clinical and quality management aspects of the HARP Behavioral Health QM/UM Program in collaboration with the Beacon Health Options Medical Director. This collaboration ensures that behavioral health and physical health care and services are rendered with a holistic approach that integrates and coordinates care across all the domains of health.

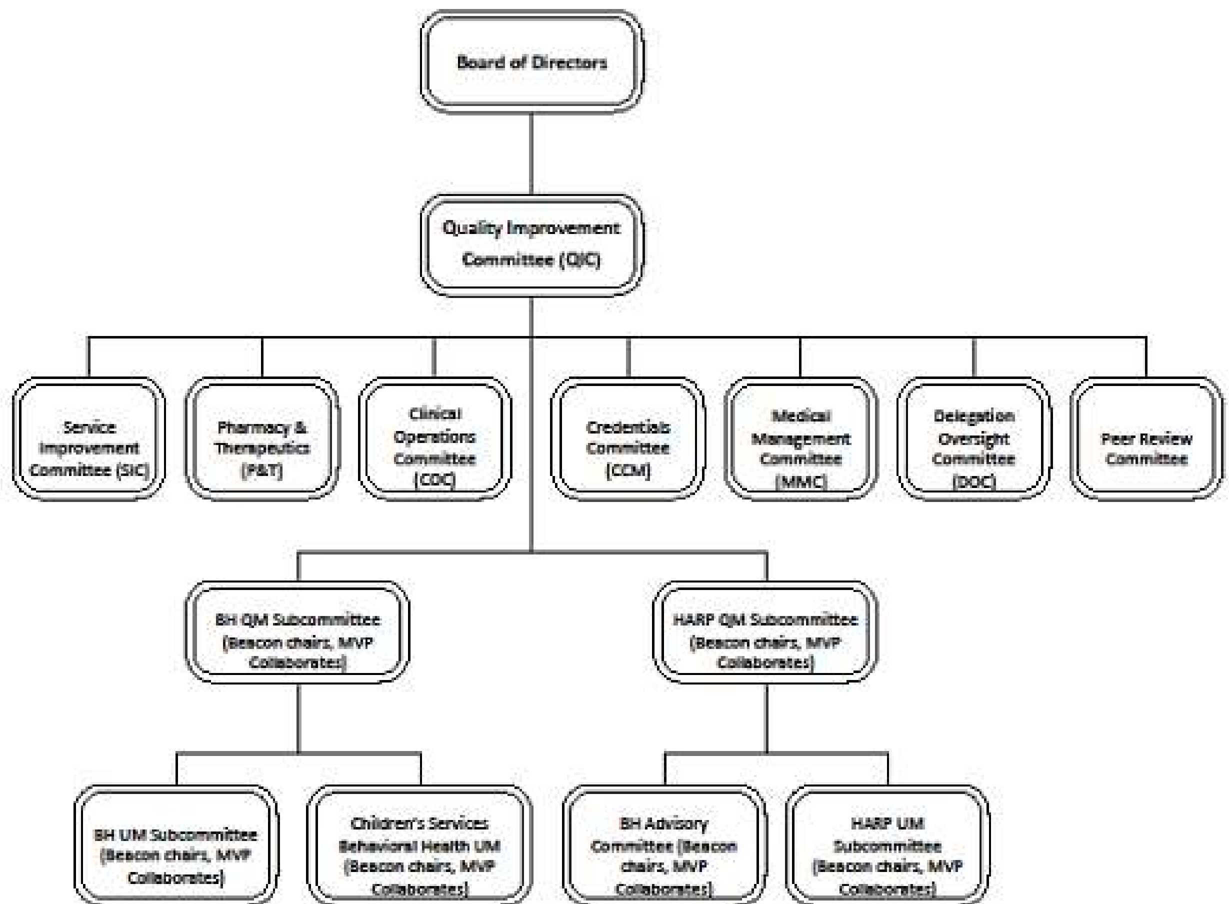
Behavioral Health Medical Director
Beacon Health Options, MVP's behavioral health vendor, has designated a Medical Director to provide medical direction and leadership for the integration of behavioral health and physical health care and services. This clinician will work collaboratively with MVP's Senior Medical Director, Medicaid & Mid-Hudson and Senior Leader, Behavioral Health Clinical Operations to support implementation of the HARP Behavioral Health QM/UM Program.

Senior Leader, Behavioral Health Clinical Operations
Under the direction of the Senior Leader, Behavioral Health, the Clinical Director, Behavioral Health is responsible for the strategic planning, development, implementation and ongoing oversight of the MVP Behavioral Health Case and Utilization Management program components. This leader, an MVP employee will oversee and support the responsibilities of the Behavioral Health Program Manager.

Behavioral Health Program Manager
The Behavioral Health Program Manager, an MVP employee, will provide support for and monitor the progress of the HARP Behavioral Health QM/UM Program to ensure it is meeting stated goals and objectives and complies with regulatory requirements. This manager will collaborate with MVP's behavioral

health vendor to ensure that the QM/UM work plan reflects the progress of QM/UM activities. This manager will also serve on the Medicaid BH QM Subcommittee, the Medicaid BH UM Subcommittee and the Medicaid BH Advisory Committee as a resource to interpret findings, to identify barriers to improvement, to propose methods for addressing the barriers and to facilitate program development, evaluation and reporting.

Quality Improvement Committee Structure



The QI Committee structure dedicated to the MVP HARP Behavioral Health QM/UM Program includes the following committees:

1. Quality Improvement Committee
2. Service Improvement Committee
3. Pharmacy and Therapeutics Committee
4. Utilization Management Subcommittee
5. Credentials Committee
6. Medical Management Committee
7. Delegation Oversight Committee
8. Peer Review Committee

MVP's corporate QI Program Description details the roles and responsibilities of the committees listed above.

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

HARP QM Subcommittee

1. Is responsible for carrying out the HARP BH QM program.
2. Is chaired by the BH QM administrator.
3. Has membership that includes peer specialists, providers, plans subcontractors, Regional Planning Consortia participants and other member-serving agencies as appropriate.
4. Membership also includes:
   MVP Senior Medical Director, Medicaid and Mid-Hudson, MVP Senior Leader Behavioral Health Clinical Operations and other MVP staff as determined by MVP.
5. MVP Behavioral Health Program Manager.
6. Beacon Medical Director and/or other Beacon staff as designated by Beacon.
7. Uses surveys, focus groups and other mechanisms as appropriate to obtain input on QIAs from stakeholders, including members, family members, peer specialists, providers, plans subcontractors, Regional Planning Consortia participants and other member-serving agencies.
8. Meets at least quarterly.
9. Reports regularly to the MVP Quality Improvement Committee.
10. Separately tracks, trends, and reports HARP complaints, grievances, appeals, and denials.
11. Will report to the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) any deficiencies in performance and corrective action taken with respect to OMH and OASAS licensed, certified or designated providers.
12. Will report on recovery measures employment, housing, criminal justice status etc.
13. Maintains records documenting attendance, findings, recommendations, and actions
14. Will track and report on compliance with:
15. Home and Community-based Services (HCBS) assurances and sub-assurances.
16. Protocols for expedited and standard appeals regarding plan of care denials for HCBS.
17. Protocols for the identification and prompt referral of individuals with First Episode Psychosis (FEP) to programs and services.
18. Oversees the development and implementation of HARP BH-specific quality improvement initiatives (QIAs), performance improvement projects and focused studies.
19. Will conduct an annual consumer perception survey (supplementary to Consumer Assessment of Healthcare Providers and Systems [CAHPS])

HARP UM Subcommittee

1. Is chaired by the BH Medical Director identified by Beacon, MVP’s behavioral health vendor.

2. Has membership that includes internal MVP staff and behavioral health vendor staff, which includes but is not limited to:
3. MVP Senior Medical Director, Medicaid and Mid-Hudson
4. MVP, Senior Leader Behavioral Health Clinical Operations
5. MVP Behavioral Health Program Manager
6. Beacon Medical Director and other Beacon staff as designated by Beacon
7. Is responsible for reviewing/analyzing data, variances and outcomes and developing and/or approving interventions.
8. Ensures interventions have measurable outcomes and are included in meeting minutes.
9. Meets at least quarterly.
10. Reports regularly to the MVP Quality Improvement Committee through the HARP QM Subcommittee.
11. Maintains records documenting attendance, findings, recommendations, and actions.
12. Reviews:
13. Under-utilization and over-utilization
14. Avoidable admission and readmission rates and Average Length of Stay (ALOS) for medical inpatient facilities;
15. Outpatient civil commitments (Assisted Outpatient Treatment);
16. ED utilization and crisis services use;
17. Use of crisis diversion services;
18. Prior authorization/denial and notices of action;
19. Substance Use Disorder (SUD) initiation and engagement rates;
20. First Episode Psychosis (FEP) initiation and engagement rates;
21. Pharmacy utilization including physical health, psychotropic and addiction medications;
22. BH Home and Community-Based Services (HCBS) utilization;
23. All physical health measures required by the MCO Model Contract;
24. Health Home engagement rates for HARP populations.
25. For Mental Health and SUD inpatient and residential reviews:
26. Readmission rates and trends
27. ALOS
28. Post discharge follow-up

BH Advisory Committees

1. Are chaired by the BH Medical Director
2. Membership includes BH staff, BH providers, peer specialists, members, local government unit (LGU) representatives.
3. Membership also includes:
   MVP Senior Medical Director, Medicaid and Mid-Hudson, MVP Senior Leader, Behavioral Health Clinical Operations and other MVP staff as determined by MVP.
4. MVP Behavioral Health Program Manager.
5. Beacon Medical Director and/or other Beacon staff as designated by Beacon.
6. Meet at least quarterly.
7. Report regularly to the MVP Quality Improvement Committee via the HARP QM Subcommittee.

8. Will review and consider recommendations of the Regional Planning Consortia regarding improved integration of BH and PH.
9. Maintain records documenting attendance, findings, recommendations, and actions.

EVALUATION

The HARP BH QI Program activities will be managed and advanced by the HARP BH QM and BH UM committees. The activities will be tabulated and 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 HARP members. Outcomes will be summarized annually and presented to the Board of Directors via the QIC.

BEHAVIORAL HEALTH: MAINSTREAM MEDICAID BEHAVIORAL HEALTH QM/UM PROGRAM

PURPOSE

The mainstream Medicaid Behavioral Health QM/UM Program is the portion of MVP's Quality Improvement Program specifically designed to:

- Assess the clinical and service needs of mainstream Medicaid members who have a behavioral health diagnosis;
- Develop, implement, evaluate and report on the various interventions/programs that will optimize clinical quality, maximize safe clinical practices, and enhance service to mainstream Medicaid members who have a behavioral health diagnosis;
- Ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis for mainstream Medicaid members who have a behavioral health diagnosis.

MVP implements this program in collaboration with its behavioral health delegate, Beacon Health Options.

GOALS

The mainstream Medicaid Behavioral QM/UM Program goals provide a framework within which MVP can objectively and systematically monitor and improve the quality and appropriateness of care and services provided to mainstream Medicaid members with a behavioral health diagnosis. It is MVP's goal to:

1. Identify and pursue opportunities for improvement.
2. Develop a Behavioral Health QM/UM work plan, a schedule of activities designed to achieve improvement over time, with ongoing evaluation and annual reporting of progress toward established performance objectives.
3. Develop definitive strategies to promote Behavioral Health-Physical Health integration.

4. Monitor the availability, accessibility, quality, continuity, coordination and effectiveness of the integration of patient care across the continuum of behavioral health care and physical health care settings.
5. Assess the appropriate use of resources in the provision and integration of Physical Health (PH) care and Behavioral Health care.
6. Provide information to providers and training and tools to staff to support culturally competent communication with the diverse population that MVP serves.
7. Develop and support a structure to adopt, implement and disseminate to contracted primary care physicians, hospitals and outpatient clinics evidence-based clinical practice guidelines for behavioral health conditions that are commonly treated in primary care settings in order to facilitate the identification and appropriate referral of Medicaid members with behavioral health diagnoses in these settings where such members are most likely to present.
8. Develop studies and measurements that are meaningful to track, evaluate and analyze for quality improvement.
9. Offer physical health management programs that will improve the physical health status of members with behavioral health diagnoses and chronic conditions and promote the use of those services to mainstream Medicaid members and their physicians.
10. Work with community health care partners to ensure successful level of care transitions for members with behavioral health diagnoses who also have complex physical health needs.
11. Oversee programs designed to improve the quality of both behavioral health care services and physical health care services.
12. Work collaboratively with MVP's behavioral health delegate to achieve and maintain seamless coordination and continuity of behavioral health care and physical health care services.
13. Promote a system of timely, thorough and appropriate resolution of member complaints and appeals from mainstream Medicaid members with a behavioral health diagnosis.
14. Monitor policies and procedures that protect members' privacy and the confidentiality of member information and records to ensure compliance with Health Insurance Portability and Accountability Act (HIPAA) and applicable state laws.
15. Develop initiatives that will enhance patient safety in various care settings.
16. Provide oversight of delegated activities as defined by the Centers for Medicare and Medicaid Services (CMS) and state regulators.
17. Enable MVP to meet governmental agency regulatory standards.
18. Monitor member and provider satisfaction with the health plan, identify opportunities for improvement and implement appropriate interventions to improve member and provider satisfaction.
19. Implement effective pharmacy management procedures to promote appropriate access to care while assuring satisfaction and safety for mainstream Medicaid members with a behavioral health diagnosis.

PROGRAM STRUCTURE

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 behavioral health care and services provided to mainstream Medicaid members. 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 presented by the Executive Vice President/Chief Medical Officer on a quarterly basis.

MVP Quality Staff

The Quality staff dedicated to the mainstream Medicaid Behavioral Health Quality Improvement Program includes the following individuals whose responsibilities are detailed in the Corporate MVP Health Care QI Program:

- MVP President - Chief Operating Officer
- Executive Vice President – Chief Medical Officer
- Senior Leader, Operations and Government Programs
- Senior Leader, Finance and Network
- Senior Leader, Quality Performance and Operations
- Senior Leader, Medical Affairs
- Medical Directors and Associate Medical Directors

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

Senior Medical Director, Medicaid and Mid-Hudson

The MVP Senior Medical Director, Medicaid and Mid-Hudson is board-certified and licensed in New York State. This clinician provides medical direction and leadership for the clinical and quality management aspects of the mainstream Medicaid Behavioral Health QM/UM Program in collaboration with the Beacon Health Options Medical Director. This collaboration ensures that behavioral health and physical health care and services are rendered with a holistic approach that integrates and coordinates care across all the domains of health.

Senior Leader, Behavioral Health Clinical Operations

Under the direction of the Senior Leader, Behavioral Health, the Clinical Director, Behavioral Health is responsible for the strategic planning, development, implementation and ongoing oversight of the MVP Behavioral Health Case and Utilization Management program components. This leader, an MVP employee will oversee and support the responsibilities of the Behavioral Health Program Manager.

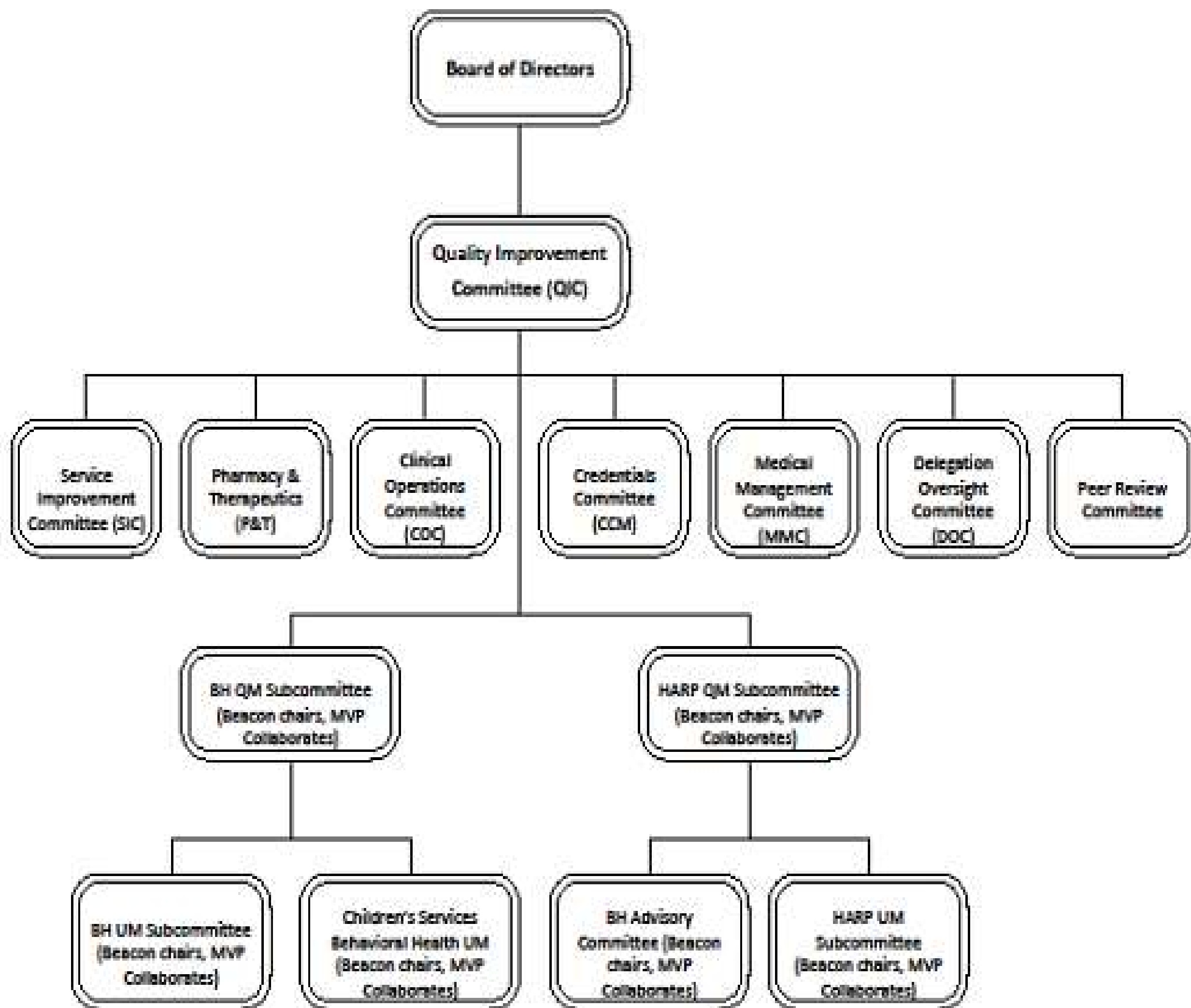
Behavioral Health Medical Director

Beacon Health Options, MVP's behavioral health vendor, has designated a Medical Director to provide medical direction and leadership for the integration of behavioral health and physical health care and services. This clinician will work collaboratively with MVP's Senior Medical Director, Medicaid and Mid-Hudson to

support implementation of the mainstream Medicaid Behavioral Health QM/UM Program.

Behavioral Health Program Manager
The Behavioral Health Program Manager, an MVP employee, will provide support for and monitor the progress of the mainstream Medicaid Behavioral Health QM/UM Program to ensure it is meeting stated goals and objectives and complies with regulatory requirements. This manager will collaborate with MVP's behavioral health vendor to ensure that the QM/UM work plan reflects the progress of QM/UM activities. This manager will also serve on the Medicaid BH QM Subcommittee and the Medicaid BH UM Subcommittee as a resource to interpret findings, to identify barriers to improvement, to propose methods for addressing the barriers and to facilitate program development, evaluation and reporting.

Quality Improvement Committee Structure



The QI Committee structure dedicated to the mainstream Medicaid Behavioral Health QM/UM Program includes the following committees:

- Quality Improvement Committee
- Service Improvement Committee
- Pharmacy and Therapeutics Committee
- Utilization Management Subcommittee
- Credentials Committee
- Medical Management Committee
- Delegation Oversight Committee
- Peer Review Committee

MVP's QI Program Description details the roles and responsibilities of each committee listed above.

Additional committees dedicated to the mainstream Medicaid Behavioral Health QM/UM Program include:

Medicaid BH QM Subcommittee

- Is responsible for carrying out the mainstream Medicaid BH QM program.
- Is led by the BH QM administrator.
- Meets at least quarterly.
- Reports regularly to the MVP Quality Improvement Committee.
- Maintains records documenting attendance, findings, recommendations, and actions.
- Separately tracks, trends, and reports BH complaints, grievances, appeals, and denials.
- Will report to the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) any deficiencies in performance and corrective action taken with respect to OMH and OASAS licensed, certified or designated providers.
- Oversees the development and implementation of mainstream Medicaid BH-specific quality improvement initiatives (QIAs), performance improvement projects and focused studies.
- Has membership that includes peer specialists, providers, plans subcontractors, Regional Planning Consortia participants, MVP Medicaid members and other member-serving agencies as appropriate.
- Membership also includes:
- MVP Senior Medical Director, Medicaid and Mid-Hudson, MVP Senior Leader, Behavioral Health Clinical Operations and other MVP staff as determined by MVP.
- MVP Behavioral Health Program Manager.
- Beacon Medical Director and/or other Beacon staff as designated by Beacon.
- Uses surveys, focus groups and other mechanisms as appropriate to obtain input from stakeholders, including members, family members, peer specialists, providers, plans subcontractors, Regional Planning Consortia participants and other member-serving agencies.

Medicaid BH UM Subcommittee

- Is chaired by the BH Medical Director identified by Beacon, MVP's behavioral health vendor.
- Has membership that includes internal MVP staff and behavioral health vendor staff, which includes but is not limited to:
- MVP Senior Medical Director, Medicaid and Mid-Hudson, MVP Senior Leader, Behavioral Health Clinical Operations and other MVP staff as determined by MVP.
- MVP Behavioral Health Program Manager
- Beacon Medical Director and/or other Beacon staff as designated by Beacon.
- Is responsible for reviewing/analyzing data, variances and outcomes and developing and/or approving interventions.
- Ensures interventions have measurable outcomes and are included in meeting minutes.
- Meets at least quarterly.
- Reports regularly to the MVP Quality Improvement Committee via the BH QM Subcommittee.
- Maintains records documenting attendance, findings, recommendations, and actions.
- Reviews:
- Under-utilization and over-utilization
- Outpatient civil commitments (Assisted Outpatient Treatment).
- ED utilization and crisis services use.
- Prior authorization/denial and notices of action.
- Substance Use Disorder (SUD) initiation and engagement rates.
- First Episode Psychosis (FEP) initiation and engagement rates.
- Pharmacy utilization including physical health, psychotropic and addiction medications;
- For Mental Health and SUD inpatient and residential reviews:
- Readmission rates and trends
- Average Length of Stay (ALOS)
- Post discharge follow-up

EVALUATION

The mainstream Medicaid BH QM/UM Program activities will be managed and advanced by the Medicaid BH QM and BH UM committees. The activities will be tabulated and 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 members. Outcomes will be summarized annually and presented to the Board of Directors via the QIC.

Quality Improvement Steering Committee

Role:
The purpose of the Quality Improvement Steering Committee (QISC) is to oversee the quality improvement strategic direction at MVP Health Care. It is intended that the QISC leverage the experiences, expertise, and insight of key individuals at MVP committed to advancing the strategic goals in quality improvement.

Contributes to: Quality Improvement Committee

Meeting frequency: At least two times per year

Composition/Voting Members
Chairperson: Senior Leader, Quality Performance and Operations

Quorum:
A quorum is a majority of attendees at the time of the meeting.

V. QUALITY IMPROVEMENT PROGRAM METHODOLOGY

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, analysis, and cooperation with our Regional and IPA committees.

QI activities include:

- Analysis of inpatient and outpatient utilization, actuarial and pharmacy data analysis
- Analysis 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

- Recommendations and data reported from Quality Improvement Subcommittees and other corporate committees
- Population based data such as HEDIS and Quality Assurance Reporting Requirements (QARR)
- Reporting supplied by the Centers for Medicare and Medicaid Services, NYS and VT
- Studies undertaken in support of quality improvement actions and activities
- Investigation with appropriate follow-up of member complaints and other quality of care or service issues.
- Medical record reviews ad-hoc

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

VI. 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 quality improvement activities. Guidelines and programs are developed that are pertinent to the demographic mix, taking into consideration 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.

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

Availability
The SIC recommends standards for availability of practitioners and facility-based services and measures plan performance against these standards.

Analysis of the provider network includes the availability of primary care practitioners, 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.

Access

The QIC approves standards for access to medical and behavioral health 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 primary care physicians is also measured during quality improvement site visits. Telephone access for behavioral health triage and screening is measured and reported via phone system reports by MVP's Behavioral Health (BH) delegates.

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

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 behavioral health and chronic medical conditions. The guidelines are reviewed by the physicians participating on the QIC and MMC. Input from specialty consultants including behavioral health 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 behavioral health issue, one of which addresses a behavioral health issue specific to children. One of the behavioral health guidelines may be a behavioral health component of a medical clinical practice guideline.

Patient Safety

Facilitating the delivery of appropriate care in the best setting and at the right time is a key objective of MVP's QI and Medical Management programs. As care grows increasingly more complex, errors may be difficult to avoid. Support of processes and programs that minimize such errors will increase the likelihood

that members achieve an optimal health outcome. MVP's QI Program includes progressive elements aimed at maximizing appropriate care and reduction of medical errors. Interventions address both ambulatory and inpatient opportunities for improvement. Data on key quality indicators (safety and continuity of care) are used to provide meaningful measures to practitioners, employers and members in selecting acute care facilities for their health care.

Never Events/Serious Reportable Events
MVP's policy surrounding Never Events/Serious Reportable Events (SRE) is consistent with the policies defined by national healthcare quality organizations such as The Leapfrog Group and the National Quality Forum (NQF). The Never Events/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 a Never Event/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 a Never Event/SRE occur. MVP is also working to reduce hospital readmissions.

Reducing Hospital Readmission Rates and Inappropriate ER usage
Timely primary care follow-up after hospital discharge is known to reduce hospital readmission rates. MVP provides transition coaching to patients with eligible diagnoses upon their discharge from the hospital. MVP encourages members to talk with their doctors about the availability of urgent appointments at their offices. To reduce the over-use of emergency room visits for conditions that are not true emergencies, MVP works to educate members about its free nurse advice line, the availability of urgent care centers within the MVP network and "myVisitNow". The "myVisitNow" is a 24 hour a day, 7 day a week telemedicine program which will provide members with access to a video visit with a physician from their own location to address urgent care types of conditions. This program began on January 1st, 2017.

Regional Health Information Organizations (RHIOs)
MVP has supported the implementation of Health Information Technology and development of RHIOs since 1999. Assistance is provided in the form of logistical and technical expertise, Board of Director level leadership, data transfer, and financial assistance

MVP sees these organizations as much more than just exchanges for health information. Their real opportunity is in the community-wide partnership that the RHIO represents and the possibilities that it brings for health system improvements and continuity and coordination of care across large segments of our service area.

Patient Centered Medical Home (PCMH)
MVP is engaged in multiple Patient Centered Medical Home (PCMH) programs across all lines of business. MVP participates as a payer partner with CMS in the Comprehensive Primary Care Plus (CPC+) initiative, which includes practices across our East and Mid-Hudson NY regions. The CPC+ initiative is a project

working collaboratively with public and private payers to continue to support a national model for the purchase and delivery of comprehensive primary care that will improve health and reduce costs.

Each of these initiatives collects data to demonstrate the efficacy of the model in improving access to appropriate care, coordination of care, and quality and safety of care. The measures vary by initiative with collection methods including claims analysis, medical record review, self-reporting, and member and physician surveys. Each of the pilots features per member per month payment to practices based on the National Committee for Quality Assurance PCMH recognition level achieved.

MVP supports all of these projects through enhanced payments to practices that demonstrate adherence to PCMH principles and/or improved outcomes in specific care measures.

Shared Savings and Shared Risk Initiatives
MVP has entered into shared savings and shared risk programs with several Value Based Payment (VBP) contractors that promote accountability for a patient population, coordinates services under MVP plans, and encourages investment in infrastructure and redesigned care processes for high quality efficient services.

For each performance year, MVP develops a medical expense target (MET) which will represent the expected claims expense for a population. If the actual claims expense is less than the target, the VBP contractor will be eligible for a portion of the shared savings. However, exceeding the MET above the minimum loss rate, for the program, incurs shared losses for the VBP contractor and MVP.

Along with meeting financial targets, quality targets must be met to be eligible for a shared savings distribution. These quality targets also serve as a loss mitigation mechanism for high-quality providers that are not yet optimally efficient in a shared risk arrangement. The percentage of shared loss is reduced based on the performance year's quality scores. There is a menu of quality measures from which six or more measures will be selected based on a shared quality improvement opportunity for the provider and MVP upon which performance is measured. In addition, quality measures will also be selected that are aligned with the Delivery System Reform Incentive Payment (DSRIP) Program Clinical Advisory Group (CAG) measures. MVP will review prior performance to identify which measures have the greatest opportunity for improvement. If the program providers do not meet the quality threshold, then they will not be eligible for a shared savings payment, even if they meet the financial goals.

Quality Incentive Bonus Program
In the Quality Incentive Bonus program, a portion of a hospital's negotiated rate increase is tied to meeting certain quality performance requirements. The hospital is scored on select quality performance measures such as those included in the CMS Inpatient Quality Reporting Program. MVP and the individual hospital works together to choose measures for the hospital to be

scored on. The measurement period is based on the timeframe of the specific measures.

Care Management

MVP offers medical and behavioral health case management programs to members tailored to their needs. Drawing on the combined strengths of our registered nurses, social workers, respiratory therapists, behavioral health 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 case management 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 modelling 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 Catastrophic and Complex Care Management, Health Management, Transition Care, and Unplanned Care Programs. The 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. The Complex Care Program is 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. The Health Management Program is 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. The Transition Care Program is an intensive program for members recently discharged from the hospital to provide education to reduce their risk for readmission. The Unplanned Care Program is a program that identifies members who frequently utilize the Emergency Department 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, Utilization Management (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 the member 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.

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 the Care Management programs previously introduced, 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 team focuses on identifying members who need assistance or are at risk. In addition to the members' ability to 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. 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. 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.

Member Connections

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 case management 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 case management 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 Pharmacy Benefit Manager's (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
On January 1, 2017, MVP began to offer a new benefit called myVisitNow through American Well, covering 24/7 online doctor visits to eligible MVP members, upon renewal. Eligible MVP members are able to access doctors and other health care professionals including behavioral health specialists, dieticians, and lactation consultants from across the country, through a mobile device or computer with a web camera.

Clinical Improvement Activities
Annually, the QIC identifies opportunities to improve the quality of care provided to MVP members. This is accomplished by addressing clinical issues that impact the entire range of health services delivered throughout all population groups.

The conditions are chosen with consideration of member demographics and health risks of the population. The priorities of selecting the clinical issues to address, the populations affected as well as the outcome and level of improvement desired are proposed to the QIC for consideration and approval. Behavioral health issues are addressed through collaboration with MVP's BH delegates.

The results of these activities are analyzed to evaluate the success of the interventions, address barriers and identify opportunities to improve performance to achieve optimal outcomes.

Service Improvement Activities
Opportunities for improvement in customer service are identified through MVP's QI process. Topics are discussed by the Service Improvement Committee (SIC)

after analysis of customer service performance measures, member complaints, grievances and appeals, and the results of member and provider satisfaction surveys by the SIC subcommittees. The SIC subcommittees are aligned with MVP's Strategic Business Unit (SBU) structure for Commercial, Medicare and Medicaid member issues, along with a fourth subcommittee focused on improving providers' experience with the health plan.

Each subcommittee discusses member/provider satisfaction and plan performance data, and identifies and prioritizes improvement efforts. Progress is reported through the SIC and monitored by the QIC. Examples of SIC subcommittee topics include improving MVP's communications to members; tracking call center performance for all lines of business; measuring providers' satisfaction with MVP's processes and policy changes; and analyzing member complaints and appeals for potentially actionable trends.

MVP Health Care conducts member and provider surveys to measure satisfaction and identify opportunities for improvement. This includes periodic surveys of new members who enrolled in the current year. The objective of this research is to understand the decision making process during the enrollment period, and to determine how well new members understand their benefits. The objectives of the new member study measure the following:

- Sources of information used in enrollment process
- Was enrollment information sufficient
- Importance of health plan services offered in decision making
- Awareness of MVP's health coverage and prescription drug coverage
- Satisfaction with understanding MVP's benefits and ease of enrollment
- Likelihood to recommend MVP

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. QI is involved to ensure that MVP meets the quality improvement requirements within the Accountable Care Act as well as any quality improvement requirement specific to either state.

Quality Improvement Strategy (QIS)
In accordance with section 1311(g) of the Affordable Care Act entitled "Rewarding Quality Through Market-Based Incentives," an eligible issuer participating in a Marketplace for two or more consecutive years must implement, and report on, a quality improvement strategy (QIS). A QIS should incentivize quality by tying payments to performance measures when providers meet specific quality indicators. On January 1, 2017, MVP implemented a QIS for New York and Vermont.

Medicare Chronic Care Improvement Project (CCIP)
For health plans that participate in the Medicare Advantage (MA) program, CMS requires MVP 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.

Medicare Monitoring of CMS Stars Performance Ratings
CMS has developed a method to assess the outcomes of several clinical, pharmacy, satisfaction and administrative metrics related to the services administered by Medicare Advantage (MA) health plans. These services are provided by MVP and its provider network. MVP monitors the results of these metrics to assess the effectiveness of care and services rendered to MA members. The monitoring of metrics and implementation of interventions to positively impact performance is conducted throughout the year by a monitoring team of internal staff. MVP also utilizes other internal and external clinical and administrative data to identify opportunities to improve care and service to Medicare members. Input from members of the teams within the quality structure serves as a valuable component to improving care provided to MVP MA members.

Medicare Monitoring of Member Satisfaction
CMS requires all health plans to contract with an approved Medicare Consumer Assessment of Health Providers and Systems (CAHPS) vendor to conduct the Medicare CAHPS satisfaction survey of Medicare enrollees and to report its performance to CMS annually. Member satisfaction is also monitored throughout the year by reviewing MVP developed surveys, complaints, grievances and appeals information.

Medicaid Annual Quality Incentive
The New York State Quality Incentive Program represents the outcome of health plan ratings across four components for all Medicaid Managed Care 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 Medicaid Managed Care members. MVP Health Care is pursuing several improvement activities around these components, including member and provider Rewarding Quality Incentive (RQI) programs, outreach call campaigns and clinical detailing with physician practices.

New York State Department of Health Performance Improvement Project: Perinatal Care

The New York State Department of Health Office of Quality and Patient Safety Performance Improvement Project (PIP) for 2017-2018 concluded on December 31, 2018. This PIP included four priority focus areas, based on New York State Department of Health data, and in support of Medicaid benefit expansions, with the potential to affect birth outcomes: (1) Improving Access to 17-alphahydroxyprogesteronecaproate (17P) to reduce the risk of recurrent preterm birth, (2) Behavioral Health risk assessment and follow-up-depression, (3) Behavioral Health risk assessment and follow-up- tobacco use, and (4) Improving utilization of Long-Acting Reversible Contraception (LARC) to support birth spacing that is optimal for maternal-fetal outcomes and patient choice. MVP is using the existing Little Footprints program (LFP) and claims for data collection. The final report is due to New York State on July 3, 2019.

New York State Department of Health Performance Improvement Project for Health and Recovery Plans (HARP): Improving Inpatient Care Transitions for HARP Members

The New York State Department of Health Office of Quality and Patient Safety Performance Improvement Project for 2017-2018 to improve inpatient care transitions for HARP members also concludes December 31, 2018. MVP, in collaboration with their behavioral health delegate (Beacon Health Options), and select health home and facility partners, implemented a unique PIP focused on person-centered, integrated care. The PIP interventions were developed based on an analysis of barriers specific to MVP's HARP members and providers. There was a focus on collaborative care and member engagement to improve member compliance with follow-up care within 7 days post discharge for a mental health diagnosis. The Final report is due to New York State July 3.2019.

New York State Department of Health Performance Improvement Project Kids Quality Agenda

The New York State Department of Health Office of Quality and Patient Safety announced a PIP for 2019-2020. This PIP includes three focus areas that will be phased in with specific time frames: Phase 1: Blood Lead Testing and Follow-up (January 2019- December 2020), Phase 2: Newborn Hearing Screening and Follow-up (TBD 2019-December 2020) and Phase 3: Developmental Screening (TBD 2019-December 2020). This PIP is in the beginning phase, with the implementation of interventions expected to begin in April of 2019.

New York State Department of Health Performance Improvement Project HARP PIP

The New York State Department of Health Office of Quality and Patient Safety announced its HARP PIP for 2019-2020. This PIP's focus is on care transitions after Emergency Department 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, Case Management and the member, (3) Initiate and ensure medication adherence. The proposal for this PIP was due to New York State on January 18, 2019, with the implementation of interventions expected to begin in January 2019-December 2020.

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 New York State Prevention Agenda and/or Medicaid Redesign Team. In response to the matrix, MVP prepared and will implement four QARR action plans in 2019.

MVP's New York State Child/Teen Health Program

MVP participates in the New York State Child/Teen Health Program (NYSC/THP) for Medicaid-eligible children under age 21 years, 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 including the AAP periodicity schedule with plan providers who care for MVP children and adolescents. 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 with appointment setting, transportation coordination and works to address any barriers that exist to ensure medically necessary care is delivered with our members. Providers are given gaps in care reports that provide them with members who still need preventative 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 quality improvement efforts.

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

VII. PHYSICIAN PERFORMANCE IMPROVEMENT PROGRAM

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

Reports are produced for Primary Care providers that are in a Comprehensive Primary Care Plus (CPC +) and (Value Based Contracting) VBC care arrangement. 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

Population Health Management Specialists visit those providers that are in a CPC+ or VBC arrangement to discuss reports and to identify opportunities for improvement. Feedback is collected throughout the process regarding usefulness to practices on MVP's reports and focused physician visits.

The success and impact of MVP's quality improvement program is dependent upon physicians' engagement with and support of the program. MVP encourages the engagement and support by meeting with physicians, 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. Physicians with large Medicaid and Medicare membership are eligible for additional reimbursement for high quality through our pay for performance program.

VIII. PREVENTIVE HEALTH CARE

Preventive Health Guidelines
The Quality Improvement Committee (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.

Measuring performance
Performance is measured annually through the HEDIS and QARR measurement process and through additional population-based studies. Results are analyzed by the line-of-business specific Service Improvement Committees (SICs) and action plans are developed to address barriers and opportunities for improvement. Action plans are then presented to Quality Improvement Committee for review and approval.

IX. MEDICAL RECORDS

The Quality Improvement Committee 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.

X. UTILIZATION MANAGEMENT (UM)

The UM Program is evaluated and approved by the QIC on an annual basis. The QIC is responsible for an annual review of the UM Program. 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.

Policies and procedures for pharmaceutical management promote clinically appropriate use of pharmaceuticals. Case Management policies and procedures enable the coordination of care and access to needed services for members living with complex conditions.

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

1. That UM decisions are based only on appropriateness of care and the benefit provisions of the subscriber's coverage.
2. That Medical Directors, practitioners, providers or staff, including those who supervise them, are not specifically rewarded for issuing denials of requested care.
3. That financial incentives such as annual salary reviews and/or incentive payments are not offered to encourage inappropriate utilization or 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 behavioral health procedures (for Vermont only), 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 behavioral health 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.

Appealing UM Decisions (*All Product Lines with the Exclusion of 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 healthcare 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. (For 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 PPACA, 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.*

Appealing UM Decisions (*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 healthcare 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 7 calendar days. A member appeal decision that is not favorable to the member is entitled to additional external appeal steps.

A separate UM Program description is maintained for MVP which provides a comprehensive overview of the UM program. Behavioral Health UM functions are carried out via delegated relationships. BH practitioners from each BH delegate are involved in MVP's QI process by participating in ad hoc workgroups and Medical Director participation on the P&T committee. Oversight of the delegates is conducted according to MVP's delegation oversight policy.

XI. BEHAVIORAL HEALTH

Philosophy
MVP's philosophy is to follow an approach to behavioral healthcare that is patient-centric and directly benefits members by attaining the highest degree of value from the available behavioral healthcare 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 behavioral healthcare resources in an efficient and effective manner.

Organizational Structure
In 2018, MVP developed an internal Behavioral Health Unit to provide Intensive Case Management to most of our MVP membership and Utilization Management

to our Vermont members. The goal of this program is to allow for a more integrated approach to the management of Behavioral Health Services and alter the degree of relationships MVP currently has with delegated entities that manage these services.

Prior to the phasing in of this new unit, the day-to-day behavioral health responsibilities were carried out by MVP's delegated entities, Beacon Health Options and Primarilink, with a staff of licensed health care professionals who review, monitor and manage the behavioral healthcare services rendered to members. As of 2019, MVP no longer delegates Care Management or Utilization Management to Primarilink. MVP continues to delegate NYS Utilization Management to Beacon as well as Care Management for our NYS HARP LOB. MVP convenes regular meetings with Beacon to discuss performance in quality activities. Through these, as well as ad hoc meetings between quality leadership at both companies, opportunities for improvement are identified and appropriate actions taken to address them. Additionally, a Beacon Health Options' psychiatrist is a member of the MVP P&T Committee. Delegation oversight of QI-related behavioral health responsibilities (e.g. telephone statistics) are reported into the DOC regularly.

BH utilization managers (licensed registered nurses and social workers) from Beacon are available after business hours to members, providers and facilities through a toll-free telephone exchange system. BH related telephone calls are additionally handled by MVP CITRA after hours services

Coordination of Behavioral and Medical Care

MVP ensures that there is ongoing communication between Beacon Health Options and MVP. Representatives from the delegates participate in regular meetings along with staff from the quality, pharmacy, medical management, professional relations as well as the case/disease management department.

Annual Reporting

An annual evaluation of Beacon's performance is reported through the quality committee structure as outlined in MVP's delegation oversight policy. The Behavioral Health UM Program Description provides additional information regarding the UM components of Beacon's and MVP's Behavioral Health Program.

An integrated summary evaluation of the behavioral health aspects of MVP's QI program is conducted annually and is included as part of the QI Annual Report that is presented to the QIC. The report details behavioral health activities and initiatives for the preceding year.

Health and Recovery Plan (HARP) and Medicaid Behavioral Health

Please see the attached Quality Management/Utilization Management Program Documents for *Mainstream Medicaid Behavioral Health* and *Health and Recovery Plan (HARP)* for descriptions of these MVP-Beacon Health Options collaborative activities. Both of these programs became effective July 1, 2016.

The HARP Behavioral Health QM/UM Program is the portion of MVP's Quality Improvement Program specifically designed to:

- Assess the clinical and service needs of HARP members;
- Develop, implement, evaluate and report on the various interventions/programs that will optimize clinical quality, maximize safe clinical practices, and enhance service to HARP members**;**
- Ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis for HARP members.

The mainstream Medicaid Behavioral Health QM/UM Program is the portion of MVP's Quality Improvement Program specifically designed to:

- Assess the clinical and service needs of mainstream Medicaid members who have a behavioral health diagnosis;
- Develop, implement, evaluate and report on the various interventions/programs that will optimize clinical quality, maximize safe clinical practices, and enhance service to mainstream Medicaid members who have a behavioral health diagnosis;
- Ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis for mainstream Medicaid members who have a behavioral health diagnosis.

XII. 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 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 Pharmacy Department, through its 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), under-utilization, 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 Department 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 members through direct member mailings which are generated for those currently receiving 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 Department reports on drug recalls to the P&T Committee and the QIC at regularly scheduled meetings.

Electronic Prescribing

The Pharmacy Department continues to work with internal and external customers to promote electronic prescribing and medical records.

CVS/Caremark prescribers can electronically receive eligibility, prescription history and formulary information.

Population Health Management, Quality Improvement and Customer Care Center Support

MVP's Pharmacy department works closely with MVP's PHM department to ensure that a consistent message regarding the accepted protocols for medication management of asthma, diabetes and cardiac conditions is communicated to providers and members. The department also joins with QI and Customer Service teams to improve member and provider experience in their interactions with MVP.

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 New York State lines of business to limit initial opioid prescriptions for acute pain to no greater than a 7 days' supply (Medicaid) and 4 prescriptions per 30 days (Medicaid and Commercial/Marketplace). In addition, an edit was implemented for Medicaid that will 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.

Opioid Pilot Program
MVP's Pharmacy Department has implemented a pilot project to reduce opioid utilization in all lines of business. A multidisciplinary MVP and Beacon Health team worked with several large provider groups to mobilize the group's in house pharmacy resources to work with providers on member interventions. Member data was reviewed by the MVP pharmacy team and members with high opioid utilization were targeted for intervention. The pharmacy department met with the multidisciplinary team regularly to review progress and program enhancements.

Medicare Opioid Overutilization Program and Opioid Monitoring System
MVP's Pharmacy Department reviews opioid and acetaminophen 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 Department is working closely with the Medicare STARS and Clinical Reporting teams to provide information to providers prescribing high risk medications to Medicare members. The team is monitoring changes to the Acumen STARS reports and provider comments on the program. The Medicare Business Unit and the Quality Improvement Department work with the Pharmacy Department 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.

Psychotropic Drug Intervention Program (PDIP)
Beginning in 2017, MVP partnered with Beacon Health to initiate their state of the art quality management program that identifies and intervenes on medication-related problems. The program focuses on poly pharmacy, non-adherence and sub-optimal dosing. Poly pharmacy involves screening for both duplicate therapy and uncoordinated care. Providers are notified when these irregularities are discovered through data mining of claims. The program was initiated for the Medicaid line of business in 2017 and was expanded to include the Commercial products in 2018.

XIII. 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), Behavioral health 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 Behavioral Health 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. A summary evaluation of Credentialing activities is presented annually to the QIC as part of the QI Program Annual Report. The Senior Leader, Credentialing and Appeals and the Senior Leader, Clinical Transformation oversee department operations with the Senior Leader, Clinical Transformation 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, 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 Council for Affordable Quality Healthcare (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 healthcare providers to fill out one application to meet the credentialing and recredentialing data needs of multiple health plans.

XIV. DELEGATION

It is MVP policy to ensure that potential and current delegated entities have the capacity to perform activities that are normally performed by the plan. It is expected that all delegated activities will be performed at or above the minimally accepted levels as required by the plan and in accordance with the requirements set forth by federal and state regulatory agencies, NCQA, and MVP performance guarantees and standards.

Prior to the onset of delegation, a mutually agreed upon document will outline the terms of the arrangement. The document will outline each party's responsibilities, provisions for patient health information (PHI), the delegated activities, the frequency of reporting, the process for evaluation including the provision of member experience and clinical performance data when applicable, and the remedies available if the delegated entity does not fulfill its obligations.

The QIC is responsible for oversight of all delegation activities through its respective subcommittees. The DOC as assigned by the QIC, is responsible for the oversight of all delegated functions. The DOC reviews regular reports on the progress of all delegated processes and reports recommendations for corrective action to the QIC. MVP retains the right to rescind delegated functions should the delegated organization not execute the delegated responsibilities in

accordance with federal and state regulatory requirements, NCQA standards and MVP performance guarantees and standards.

Delegated Utilization Management
The QIC, as delegated by the Board of Directors is responsible for ensuring that UM and appeal functions carried out by a delegate are conducted in a manner that is consistent with MVP's own UM program, policies and expectations. The policies include the program description, requirement for frequency of reporting, process for evaluating performance and remedial action plans.

Delegated Credentialing
The QIC, as delegated by the MVP Board of Directors is responsible for ensuring that the same basic standards for participation are maintained throughout the network. The Board of Directors is accountable and retains the right to approve, suspend or terminate any practitioner, provider, or site of care from MVP participation.

Delegation of Member Connections, Member Services and Claims processing
The QIC, as delegated by the Board of Directors can approve the delegation of Member Connections, Member Services, Claims processing or other functions regulated by CMS to a qualified partner.

Delegation of Quality Improvement
The QIC, as delegated by the Board of Directors can approve the delegation of the QI functions such as member services access, complex case management, disease management and clinical guidelines to a qualified partner. The QIC is responsible for ensuring that the same basic standards for these functions are maintained across the network.

Delegation of Rights and Responsibilities
The QIC, as delegated by the Board of Directors approves the delegation of Rights and Responsibilities functions such as maintenance of the online provider and hospital directory to a qualified partner.

In addition to a formal process for oversight of the functions outlined above, MVP conducts formal oversight and reporting through its Quality Committee structure for specific functions as required by CMS. These functions include but are not limited to claims processing, Medicare Advantage sales agents, Risk Adjusting Processing and data encounter reporting and in home member health assessments.

V. MEMBER RIGHTS AND RESPONSIBILITIES

The QIC is responsible for the adoption and application of written policies regarding member rights and responsibilities and the application of the member complaint and appeal policies and procedures.

Complaints and Appeals
The complaint and appeal policies assure that members' written and oral concerns are registered, investigated and resolved in a timely fashion. Complaints and appeals are analyzed and trended on an aggregate basis and reported to the SIC and the QIC.

Issues that identify opportunities to improve the quality of care, access to care, or MVP administrative services are addressed.

Individual practitioner quality issues are brought to both the QI Department and Medical Director's attention. When remedial action is indicated with an individual practitioner, the Regional Peer Review Committee may become involved. Individual actions taken are reported to the QI Department.

After complete evaluation, review, analysis and recommendations, trended provider complaints are included in physician performance measures and taken into consideration at the time of recredentialing.

Member Communications
Representatives of the QI Department, Marketing Department, Member Services Department and others, as appropriate, review member communications. Communications reviewed include documents such as the subscriber contract, member handbook, and prospective marketing material to assure that the content is accurate and that the language is clear and understandable to the populations for which they are intended.

Specific member communications may require CMS (Medicare) and NYSDOH (Medicaid) review and approval prior to release to members in order to meet Federal and State communication requirements.

At the time of enrollment and annually thereafter, MVP notifies its members how to obtain language assistance including bilingual services, oral interpretation and written documentation in the members' preferred language.

Training in cultural diversity and sensitivity is provided to new UM and Customer Care Center employees during their onboarding time. The training materials are also made available annually to all MVP staff and to MVP's provider network for use within their own workplaces.

The MVP's quality assurance program includes a cultural competency function, with the goal of reducing disparities affecting cultural groups and increasing

access to health and behavioral health care. The program components includes, but shall not be limited to, the following:

i) Integrating cultural competence concerns into the MVP's quality improvement activities;
ii) Improving the quality of service delivery to members;
iii) Advising on educational and operational issues affecting various cultural groups;
iv) Implementing and maintaining community linkages; and
v) Comparing all metrics related to access, utilization and outcomes of cultural groups in the MVP's service area with the purpose of identifying and addressing disparities.

Confidentiality

The MVP HIPAA Steering Committee is responsible for adopting corporate confidentiality policies which protect member information and records in compliance with HIPAA and applicable state laws. The HIPAA Steering Committee, in cooperation with the HIPAA Compliance Officer and appropriate members of Senior Staff, develops and oversees the application of these policies and ensures that practitioner and member rights to confidentiality, as well as MVP proprietary interests, are protected and maintained.

XVI. RESOURCES

MVP's QI program structure requires the participation of its network of providers and MVP staff. On a regular basis, staff at all levels come together in a variety of committees and teams to take part in the execution and reporting of the action steps that are highlighted in the organizations' work plan. The QI Program Structure section of this document describes in detail participant roles, committee membership and frequency of committee meetings.

While more than 80 MVP employees are devoted to quality improvement efforts across the enterprise, striving for high quality care and customer service is every employee's responsibility. The QI process is an integral part of these employees' routine activities. Staff involved come from all levels and departments throughout the organization including, but not limited to, the Executive VP/Chief Medical Officer and all other Medical Directors, Credentialing, HEDIS/QARR coordinators, data analysts, UM, Appeals, Pharmacy, PHM, Case Management and QI. QI staff report to the Senior Leader, Quality and Advocacy. The Senior Medical Director for Medical and Quality Management is also a resource to the department's staff. This individual interacts directly with staff and attends staff level work groups and committees to provide clinical expertise.

MVP's work plan promotes collaboration among the departments listed above and others, including staff in the Customer Care Center, Enterprise Technology and Information Systems, Claims, and Communications Departments.

MVP utilizes MCSource, a clinical data warehouse to support the analysis done for its quality improvement activities. MCSource is updated on a monthly basis with data from multiple source systems within MVP. MCSource houses six years of data. It uses member demographic criteria to link the member enrollment records of unique individuals, regardless of multiple subscriber identification numbers, products, source systems, etc., and assigns a "consistent member ID" to each individual. MCSource has a custom reporting tool that allows users to build queries, filter data, and export results in text format or to Excel. Additionally, there are three diagnosis groupers available in MCSource for reporting: Medical-Severity Diagnosis Related Groups (MS-DRG), Episode Treatment Groups (ETG) and Diagnostic Cost Group (DCG).

Data from MCSource is also used to support both Optum Impact Pro for predictive modeling and MedMeasures for HEDIS reporting. MCSource, MedMeasures and the chart review component, MedCapture, are all part of the same suite of General Dynamics Information Technology (GDIT) products used to produce HEDIS rates.

MVP continuously evaluates the QI resource needs as part of ongoing monthly reports. Resources are also evaluated annually when the subsequent year's QI Work Plan is proposed and ultimately approved.

XVII. EVALUATION

The QI Program is evaluated on an annual basis.

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.

Approved 5/6/19 by QIC, Approved [date of BOD approval] by MVP Board of Directors

XVIII. Attachments to the 2019 Quality Improvement Program

2019 MVP Health Care
Quality Committee Structure and Membership

Quality Improvement Committee

***Reports to:** MVP Board of Directors*
***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 participating physicians from across MVP's service area and two Board of Directors appointees*.*

Voting Members	Candidates	Chair
Two participating physicians from Vermont	Dr. A. Kunin Dr. J. Schwartzberg	Dr. Cameron Senior Leader, Medical Affairs
Two participating physicians from Central	Dr. D. Aiello *(Vacant)	
Two participating physicians from Mid-Hudson	Dr. R. Basri (Vacant)	
Three participating physicians from East	Dr. R. Gullott Dr. D. Phelps Vacant	
Five participating physicians from West	Dr. N. Ambrosini Dr. E. Lewis *Dr. M. Schneider Dr. B. Steele Dr. J. Wood	
Board of Director	Dr. David Pratt	
Executive Vice President /CMO	Dr. Bruce Himelstein	
Senior Leader, Pharmacy	Jim Hopsicker	
Senior Leader, Credentialing and Appeals	Denise Stasik	
Senior Leader, Clinical Operations	Vacant	
Senior Leader, Medical Affairs and Direction	Dr. C. Cameron	
MVP Medical Directors	Dr. J. Merola Dr. K. Kilby	
Senior Leader, Quality Performance and Operations	Ruth Leslie	

Voting Members	Candidates	Chair
One Layperson (MVP Medicare member)	Vacant	

2019 MVP Health Care
Quality Committee Structure and Membership
Service Improvement Committee

Reports to: *Quality Improvement Committee*
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.*

Voting Members	Candidates	Chair
Senior Leader of Service & Experience	Laurie Metheny	**Kevin Husted,** Senior Leader of Engagement
Senior Leader of Medicaid Operations & Regulatory Affairs	Sue Montgomery	
Senior Leader, Credentialing and Appeals	Denise Stasik	
Senior Leader, Clinical Operations	Vacant	
Professional, Exchange Business	Meredith Rice	
Senior Leader of Claims Payment Strategies	Matt LoBoen	
Leader, Quality Improvement Compliance & Accreditation	Karen Fox	
Senior Leader of Medicare Operations	Nancy Reiss	
Senior Leader of Corporate Professional Relations and Network Vendor Management	Pat Deferio	
Senior Leader of Pharmacy	Wendy Colin	
Senior Leader of Financial Operations	Rich Odorizzi	

2019 MVP Health Care
Quality Committee Structure and Membership

Pharmacy & Therapeutics Committee

Reports to: *Quality Improvement Committee*
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.*

Voting Members	Candidates	Chair
Internal Medicine	Dr. Phelps	**Dr. Richard Gullott**
	Dr. Jagadish	
Pediatrics	Dr. Saperstone	
Family Practice	Dr. Sikule (VT)	
Rheumatology	Vacant	
Geriatrics	*Dr. Schabel	
	Dr. Buch	
Oncology	Dr. Willen	
Pulmonary Disease	Dr. Gullott (Chair)	
Infectious Disease	Dr. Tack	
Endocrinology	Dr. Aiello	
	Dr. DePapp	
Cardiology	Dr. Bisognano	
GI	Vacant	
Psychiatry	Dr. Jason Herrick	
	Dr. Sime (Beacon)	
	Dr. Germain	
Anesthesiology	Kevin Reilly, RPh	
Pharmacy	Dr. Cosler	
	Pravin Patel	
Voting members also include:		
VP of Pharmacy	Jim Hopsicker	
Pharmacy Director	Wendy Colin	
VP Medical Affairs and Medical Direction	Dr. Cameron	

2019 MVP Health Care
Quality Committee Structure and Membership

2019 Clinical Operations Committee

Reports to: *Quality Improvement Committee*
Meeting frequency: *Every other month*
Quorum: *50% of the voting members, plus one based on the current voting membership at the time of the meeting*

Voting Members	Candidates	Chairs
		Carl Cameron, MD Senior Leader, Medical Affairs **Vacant:** Senior Leader, Clinical Operations
Regional Medical Director, East	Kilby, Kim MD	
Regional Medical Director, West	Merola, Jason MD	
Senior Leader of Utilization Management	McCabe, Lisa	
Senior Leader of Care Management	Mannion, Cheryl	
Senior Leader, Clinical Operations Support	Dyroff, Lauren	
Senior Leader, Clinical Operations Compliance & Audit	Haesloop, Karen	
Senior Leader, Clinical Initiatives & Management	Vacant	
Senior Leader, Appeals	Strange, Jane	
Contracts Manager, Network Management	Nelson, Brenda	
Leader, Customer Care, Provider Services	LaBarge, DeAnna	
Senior Leader, Quality Performance and Operations	Leslie, Ruth	
Leader, Provider Engagement Business Development	Piche, Garrett	
Senior Leader, Pharmacy Senior Leader, Pharmacy *(Delegate)*	Hopsicker, Jim Colin, Wendy	
Senior Leader, Behavioral Health	Feld, Judith MD	
Senior Leader of Behavioral Health	Vidile, Angela	
Regional Medical Senior Leader of Mid-Hudson and Medicaid SBU	TBD	

Non-Voting Members	Candidates
Leaders of UM	Gale Zdunczyk Barbara Lapinski Janet Aery
Leaders of CM	Deb Repice Tenley Klouse
Leader, Health Services Analytics	Allison Morrison
Professional, Finance	Gregg Rahn **(docs only)**
Senior Leader, Actuarial Commercial & Medicaid LOB	Lombardo, Matt

Non-Voting Members	Candidates
Provider Relations/Network/Contracting	Renders, Carla Bronson, Michelle
Senior Leader, Claims & Enrollment Operations	Hogan, Rosemarie
Clinical Compliance	Morris, Tara Ormsby, Jasmine Everetts, Tom Niro, Lisa
EVP, Medicaid and MVP Operations OR Senior Leader, Operations Transformation Informatics	Clancy, Cathy or Flor, Ian
Vendors to which UM functions have been delegated (to participate periodically as appropriate) External personnel for input and feedback as needed	TBD on a meeting by meeting basis

Credentials Committee

Reports to: *Quality Improvement Committee*
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 votes only in the absence of the designated voting member for each region.*

Voting Members	Candidates	Chair
One East physician *(+ alternate)*	Dr. D. Phelps Dr. M. Singer *(alt.)*	**Dr. Mary Beth Robinson**
One Mid-Hudson physician *(+ alternate)*	Dr. D. Wu Dr. K. Murray *(alt)*	
Two Central physicians *(+ alternates)*	Dr. D. Buch Dr. D. Aiello *(alt.)* Dr. R. Saini Dr. C. Dator, Sr (*alt.*)	
One Vermont physician *(+ alternate)*	Dr. G. Mackenzie Dr. D. Miller *(alt.)*	
Three participating physicians from the West *(+ alternates)*	Dr. M. Robinson Dr. C. Hriesik Dr. M. Jamil Mroueh Dr. D. Tenhoopen *(alt)* Dr. J. Goldstein *(alt)* Vacant *(alt)*	
Two Ancillary Providers (ad hoc)	D. Chazan, D.P.M. W. Lapple, O.D.	
One voting member from MVP	Dr. K. Kilby Dr. J. Merola	

2019 MVP Health Care
Quality Committee Structure and Membership

Peer Review Committee

Reports to: *Quality Improvement Committee*
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 Quality Improvement Committee.*

Voting Members	Candidates	Chair
All physician members of the QIC Additional specialty expertise as deemed appropriate, specific to the clinical issue under review *Medical Senior Leaders involved in a particular case do not vote on that case's disposition.*	Physician QIC members	

2019 MVP Health Care
Quality Committee Structure and Membership
Delegation Oversight Committee

Reports to: *Quality Improvement Committee*
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.*

Voting Members	Candidates	Chair
MVP Medical Senior Leaders	Jason Merola, MD	**Karen Fox** Leader, QI Compliance and Accreditation
MVP Medicare Compliance Officer	Lisa John	
VP Clinical Operations	Vacant	
Senior Leader, Health Services Compliance **UM Compliance Coordinators** **CM Compliance Coordinator**	Karen Haesloop Jasmine Ormsby Tara Morris	
Appeals	April Snyder Jane Strange	
Credentialing Process Manager	Rita Logsdon Tina Nyland	
Senior Leader, Medicare Operations, Medicare SBU	Nancy Reiss	
Medicaid SBU	Susan Montgomery Nancy DiCioccio	
Senior Leader, Pharmacy	Wendy Colin	
Leader, Corporate PR, Network and Vendor Management	Vacant	
Program Managers - Corporate PR, Network and Vendor Management	Neil O'Brien-Bosselman Christina Cross	
Senior Leader, Operations	Michelle Shader	

MVP Physicians (External from service area)	David Phelps, MD *Vacant*	

2019 MVP Health Care
Quality Committee Structure and Membership

Medical Management Committee (MMC)

Reports to: *Quality Improvement Committee*
Meeting frequency: *At least 8 times per year*
Quorum: *Greater 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.*

Voting Members	Candidates	Chair
MVP Medical Senior Leaders	Jason Merola, MD Kimberly Kilby, MD David Simons, MD Paul Fine, MD Millicent Sutton, MD Judith Feld, MD (BH)	**Carl Cameron, MD** Senior Leader, Medical Affairs
MVMA Medical Senior Leaders	David Phelps, MD James Saperstone, MD	
MVP Physicians (External from service area)	Tauseef Ahmed, MD Lon Baratz, MD Sudershan Dang, MD Edward Tanner, MD	

Non-Voting Members	Candidates
MVMA Executive Senior Leader	Deborah Zadrozny
Utilization Management	Barbara Lapinski Lisa McCabe Gale Zdunczyk
Clinical Operations	Karen Haesloop Vacant
Clinical Transformation	Vacant
Medical Policy & Technology Assessment	Dan Flanagan
Administrative Assistant	Kate Stella

2019 MVP Health Care
Quality Committee Structure and Membership

Beacon- MVP Healthcare

Children's Service Behavioral Health Utilization Management (BHUM) Subcommittee 2018

<table>
<tr><th>LEADERSHIP</th><th>REPORTS TO</th></tr>
<tr><td>Chair: Behavioral Health Medical Senior Leader Co-Chair: Health Plan Medical Senior Leader

Administrator: Quality Lead</td><td>Behavioral Health Quality Management (BHQM) Subcommittee
Woburn Service Center Quality Committee</td></tr>
<tr><th rowspan="2">PURPOSE</th><th>MEMBERSHIP</th></tr>
<tr><th>Title</th></tr>
<tr><td>The purpose of the Children's Service Behavioral Health Utilization Management (BHUM) Subcommittee is to implement a process to collect, monitor, analyze, evaluate, and report Behavioral Health (BH) utilization data for all ages consistent with the Health and Recovery Plans (HARP) and Children's Service reporting requirements.</td><td>• Behavioral Health (BH) Medical Senior Leader (Beacon & Health Plan)
• Behavioral Health (BH) Clinical Senior Leaders (Beacon & Health Plan) Quality Leads (Beacon & Health Plan) Lead, Provider Relations (Beacon)
• Utilization Management Leads (Beacon & Health Plan)
• Behavioral Health Network Providers
• Members
• Family Members
• Peer Specialists
• Local Government Representatives
• Subcontracted Plans
• Regional Planning Consortium (RPC) and other member serving agencies.
• BH Medical Senior Leader for Children's Services (Beacon)</td></tr>
<tr><th colspan="2">AUTHORITY/ACCOUNTABILITY</th></tr>
<tr><td colspan="2">Delegated authority to carry out functions related to stated purpose, in addition to other utilization management tasks delegated by the Health Plan.</td></tr>
<tr><th colspan="2">RESPONSIBILITIES</th></tr>
<tr><td colspan="2">The MCO shall ensure intervention strategies have measurable outcomes and are recorded in the UM/clinical management committee meeting minutes. Analyses will be conducted separately for individuals under 21 years of age.

The BH UM Subcommittee shall develop and maintain mechanisms to:

1. Monitor service quality and develop quality improvement initiatives.
2. Solicit feedback and recommendations from key stakeholders to improve quality of care and member outcomes.
3. At a minimum, these mechanisms shall include consumer and other stakeholder advisory boards and key stakeholders. Key stakeholders shall include members, family members, subcontracted Plans, RPCs and other member serving agencies.</td></tr>
</table>

Management of these benefits should clearly articulate the purpose of the services and desired outcomes, plans to develop criteria for access and the frequency of UM activities.

The Behavioral Health Utilization Management (BHUM) sub-committee shall review and analyze data in the following areas, interpret the variances, review outcomes, and develop and/or approve interventions based on the findings.

1. Under and over utilization of Behavioral Health (BH) services and cost data
2. Admission, Readmission rates, trends, and the average length of stay for all Mental Health (MH) inpatient, Substance Use Disorder (SUD) inpatient and residential levels of care facilities
3. Tracking and trending denials of Behavioral Health (BH) services
4. Inpatient civil commitments
5. Outpatient civil commitments (AOT)
6. Follow up after discharge from MH inpatient, SUD inpatient and residential levels of care facilities;
7. Substance Use Disorder (SUD) initiation and engagement rates
8. Emergency Department (ED) utilization and crisis services use
9. BH prior authorization/denial and notices of action
10. Psychotropic medication utilization
11. Addiction medication utilization

Additional areas of focus for Utilization Management (UM) Subcommittee:

- The BH sub-committee shall review and analyze data in the following areas: Under- and over-utilization of BH services and cost data; admission and readmission rates/trends; ALOS; follow-up after discharge; inpatient and outpatient civil commitments; ED utilization and crisis services use; BH prior authorizations/denials/notices of action; SUD initiation and engagement rates; FEP initiation and engagement rates; psychotropic medication utilization (with separate analysis for children in foster care); addiction medication utilization; transitional issues for youth ages 18 to 23 years, focusing on the continuity of care and service utilization; and other metrics determined by the State
- For children eligible for HCBS, the UM BH subcommittee shall separately report, monitor and recommend appropriate action on: use of crisis diversion and crisis intervention services; prior authorizations/denials/notices of action; HCBS utilization; HCBS quality assurance performance measures as determined by the State and pending CMS requirements; and enrollment in Health Home.
- In collaboration with the Plan's UM Committee, the BH UM Committee will ensure intervention strategies have measurable outcomes and are recorded in the committee meeting minutes. Analyses shall be conducted separately for individuals under 21 years of age.
- The UM Committee looking at physical health services must include examination of service utilization and outcomes for children including medically fragile children.
- Avoidable hospital admissions and readmission rates and the average length of stay for all Mental Health (MH), Substance Use Disorder (SUD), residential levels of care, and medical inpatient facilities
- Use of crisis diversion services
- Follow up after discharge from inpatient care, and residential levels of care
- Prior authorization/denial and notices of action
- Pharmacy utilization including physical health, psychotropic and addiction medications
- 1915(i)-like HCBS service utilization

- Home and Community Based Services (HCBS) quality assurance performance measure reporting
- All physical health measures required by the MCO model contract
- Rates of initiation and engagement of individuals with First Episode Psychosis (FEP) in services; and
- Health Home engagement rates for HARP populations.

<table>
<tr><td colspan="3">SELECTION OF AGENDA ITEMS: agenda calendar</td></tr>
<tr><td colspan="3">Subcommittee reports; progress related to company's quality management program goals and associated Workplan.</td></tr>
<tr><td colspan="3">MEETING DOCUMENTATION (Who, when and how) – agenda, minutes, and materials</td></tr>
<tr><td colspan="3">Agenda, minutes and materials posted to committee members</td></tr>
<tr><td colspan="2">DATA AND REPORTS REVIEWED</td><td>FREQUENCY</td></tr>
<tr><td colspan="2">Data reports</td><td>Quarterly</td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="2">STRATEGIC COMMUNICATIONS</td><td>MEETING FREQUENCY</td></tr>
<tr><td>To</td><td>Via</td><td rowspan="4">Quarterly</td></tr>
<tr><td>• Behavioral Health Quality Management (BHQM) Subcommittee
• Woburn Service Center Quality Committee</td><td>Minutes, verbal and written reports</td></tr>
<tr><td>From</td><td>Via</td></tr>
<tr><td>Same as above</td><td>Same as above</td></tr>
<tr><td colspan="2">DATA AND REPORTS GENERATED</td><td>FREQUENCY</td></tr>
<tr><td colspan="2">Minutes and meeting materials</td><td>Quarterly</td></tr>
</table>