MVP Health Care®

2021 Quality Program Description

Table of Contents

INTRODUCTION

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

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

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

The MVP leadership team is committed to focusing clinical, network, and operational processes towards improving the health of members (including all demographic groups and those with special health care needs), enhancing each member's experience of care and service, lowering the per capita cost of their health care, and improving the work life of Participating Providers and their staff, as well as their experience and satisfaction. MVP's QI Program applies a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care systems and processes. Methods such as the DMAIC Model and other validated, data driven approaches to quality improvement, are used to monitor performance and measure effectiveness of quality improvement initiatives.

The QI Process utilizes the **DMAIC Model**:

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

This type of methodology supports MVP to develop targeted, measurable interventions and quickly evaluate the impact of an activity on improvement goals. In many instances, MVP deploys a rapid cycling improvement activity, designed to immediately impact process

improvements to improve member outcomes and member and provider satisfaction. These systematic approaches provide a continuous cycle for improving the quality of care and service for members.

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

PURPOSE

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

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

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

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

SCOPE

The scope of the QI Program is comprehensive and addresses both the quality and safety of clinical care and quality of services provided to MVP Members including medical, behavioral health, dental, and vision care as applicable to MVP's benefit package. MVP incorporates all demographic groups, lines of business, benefit packages, care settings, and services in its quality management and improvement activities. Areas addressed by the QI Program include preventive health; emergency care; acute and chronic care; population health management; health disparity reduction; behavioral health; episodic care; long-term services and supports; ancillary services;

continuity and coordination of care; patient safety; social determinants of health; and administrative, member, and network services as applicable. MVP's QI Program includes the following:

- Identification of priorities and goals aligning with MVP's mission and the health priorities defined by the Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), New York State Department of Health (NYSDOH), National Committee for Quality Assurance (NCQA), National Institutes of Health (NIH), and other regulatory bodies
- Conducting quality activities, including peer review activities, in accordance with all applicable state and federal confidentiality laws and regulations and taking conflicts of interest into consideration when conducting peer review activities
- A focus on cultural competency and health equity, including the identification of interventions to improve health disparities based on age, race, ethnicity, sex, primary language, etc. and by key population group
- Assessment and identification of interventions to address health disparities at a statewide and regional level, including identifying internal priorities for disparity reduction, quality measure improvement, and addressing inequalities
- A robust QIC structure, including subcommittees and additional ad hoc committees as applicable, to meet the needs of MVP, members, and providers
- Allocation of personnel and resources necessary to:
    - Support the QI Program, including data analysis and reporting
    - Meet the educational needs of members, providers, and staff relevant to quality improvement efforts
    - Meet all regulatory and accreditation requirements
- The technology infrastructure and data analytics capabilities to support goals for quality management and value include health information systems that provide data collection, integration, tracking, analysis, and reporting of data that reflects performance on standardized measures of health outcomes
- An ongoing documentation cycle that includes the QI Program Description, the QI Work Plan, and a QI Program Evaluation; these documents demonstrate a systematic process of quality assessment, identification of opportunities, action implementation as indicated, and ongoing evaluation
- Collecting and submitting all quality performance measurement data per state, federal, and accreditation requirements, including robust performance management tracking and reporting such as:
    - The annual Consumer Assessment of Health Care Providers and Systems (CAHPS®):
        - CAHPS is a Qualified Health Plan (QHP) Enrollee Experience survey for the Medicare, Medicaid, Commercial, and Marketplace lines of business
    - The annual Health Outcomes Survey (HOS):
        - HOS is a CMS-developed survey tool which assesses a health plan's ability to maintain or improve the physical and mental health of Medicare members over time
    - Healthcare Effectiveness Data and Information Set (HEDIS®) results for members:

        - HEDIS is an established set of performance measures developed and maintained by NCQA
    - Developing additional standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time
    - Administering an annual provider satisfaction survey and identifying improvement activities based on identified areas of provider need/dissatisfaction
- Monitoring, assessing, and promoting patient safety including efforts to prevent, detect, and remediate quality of care and critical incidents and a peer review process that addresses deviations in the provision of health care and action plans to improve services
- Ensuring member access to care in areas such as network adequacy, availability of services, timely appointment availability, transitions of coverage, coordination, and continuity of care, etc.
- Encouraging providers to participate in quality initiatives and giving support to providers, including a provider analytics system that delivers frequent, periodic quality improvement information to Participating Providers to support them in their efforts to provide high quality health care, and adoption and distribution of evidence-based practice guidelines
- Conducting and assessing quality improvement and performance improvement projects based on demonstration of need and relevance to the population served, with improvement initiatives aligned with identified health priorities, state/federal requirements, and applicable member population(s)
- Develop and implement a CCIP for Medicare, focused on improving care and health outcomes for members with chronic conditions
- Monitoring utilization patterns by performing assessment of utilization data to identify potential over- and under-utilization issues or practices using various data sources such as medical, behavioral health, pharmacy, dental, and vision claim/encounter data to identify patterns of potential or actual inappropriate utilization of services
- A Population Health Management (PHM) Strategy focused on four key areas of member health needs (keeping members healthy, managing members with emerging health risk, patient safety/outcomes across settings, and managing multiple chronic illnesses) that offers interventions to address member needs in all stages of health and across all health care settings
- Serving members with complex health needs, including members needing complex care management
- Achieving/maintaining NCQA accreditation and/or other applicable accreditations for appropriate products
- Monitoring for compliance with all regulatory and accreditation requirements
- Collaboration with Corporate Compliance and other applicable departments concerning oversight of delegated functions and services, including approval of the delegate's programs, routine reporting of key performance metrics, and ongoing evaluation to determine whether the delegated activities are being carried out according to health plan and regulatory requirements and accreditation standards

PRIORITIES AND GOALS

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

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

To improve health, provide peace of mind, and create healthier communities.		
Focus on Individuals	**Whole Health**	**Active Local Involvement**
Priorities	**Priorities**	**Priorities**
• Well-Coordinated, Timely, Accessible Care Delivery • Member Healthy Decisions • Home and Community Connection • Right Care, Right Place, Right Time • Member Engagement • Provider Engagement • High Value Care • Member Satisfaction with Provider and Health Plan	• Meaningful Use of Data • Prevent and Manage Top Chronic Illnesses • Manage Co-morbid Physical and Behavioral Health Diagnosis • Manage Episodic Illnesses • Manage Rare Chronic Conditions • Screen for Unmet Needs • Remove Barriers to Care; Make It Simple to Get Well/Stay Well/Be Well • Coordination of Care Across the Health Care Continuum • Behavioral Health Integration • Long-Term Services and Supports (LTSS) Quality of Life	• Local Partnerships • Population Health Improvement • Preventive Health and Wellness • Maternal-Child Health Care • Prevent and Manage Obesity • Tobacco Cessation • Opioid Misuse Prevention and Treatment • Address Social Determinants of Health • Health Equity/Disparity Reduction • Multi-Cultural Health

CONFIDENTIALITY

Confidential information is defined as any data or information that can directly or indirectly identify a member or provider. MVP and all Participating Providers and subcontractors comply with the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), and all applicable federal and state privacy laws. The QIC and its subcommittees have the responsibility to review quality of care and

resource utilization, as well as conduct peer review activities as appropriate. The QIC and related peer review committees conduct such proceedings in accordance with MVP's bylaws and applicable federal and state statutes and regulations.

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

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

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

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

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

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

CONFLICT OF INTEREST

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

CULTURAL COMPETENCY AND HEALTH EQUITY

MVP strives to meet the needs of all members with sensitivity to cultural needs and the impact of cultural differences on health services and outcomes. MVP is guided by requirements set by each respective state/federal contract and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) developed by the Office of Minority Health. Specifically, the QI Program identifies and addresses clinical areas of health disparities. MVP assures communications are culturally sensitive, appropriate, and meet federal and state requirements. Information provided to members promotes the delivery of services in a culturally competent manner to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, or disabilities and regardless of gender, sexual orientation, or gender identity. Population health management initiatives are reviewed to assure cultural issues and social determinants of health are identified, considered, and addressed. Additionally, MVP is committed to improving disparities in care as an approach to improving HEDIS measures, reducing utilization costs, and delivering locally tailored, culturally relevant care. As such, MVP has developed a health equity approach that identifies and highlights disparities, prioritizes projects, and collaborates across the community to reduce disparities by targeting member, provider, and community interventions. Disparity analysis includes analyzing HEDIS and utilization data by eligibility category, race, ethnicity, limited English proficiency, disability, age, gender, and geography to identify priority populations and interventions for targeting disparity reduction.

Serving a Culturally and Linguistically Diverse Membership

MVP developed a Cultural and Linguistic Competence Workgroup in 2020 as a method of ensuring that the functions necessary to maintain compliance with section 15.10 of the NYS Medicaid Model Contract and NCQA 2020 Health Plan Accreditation standards QI 1, Element A, Factor 6, and NET 1, Element A, Factors 1 and 2 are carried out efficiently and effectively. The Workgroup met twice and was co-led by the Medicaid Strategic Business Unit (SBU) and QI. It included representation from People & Talent, Informatics, Network, and Health Management Configuration and Business Systems (Case Management [CM] Training).

The following outlines MVP's strategy to monitor cultural and linguistic needs of its membership:

1. MVP promotes and ensures the delivery of services in a culturally competent manner to all members, including but not limited to those with limited English proficiency, diverse

cultural and ethnic backgrounds, as well as members with diverse sexual orientations, gender identities, and members of diverse faith communities. Cultural competence means having the capacity to function effectively within the context of the cultural beliefs, behaviors, and needs presented by members and their communities across all levels of the organization.

2. To comply with this section:
    a. MVP's Network Management Department maintains an inclusive culturally competent provider network. In accordance with Section 21 of the NYS Medicaid Model Contract, the Network also includes a culturally competent network of Behavioral Health (BH) providers, individual BH providers, community-based providers, and peer-delivered services.
    b. MVP's policies and procedures incorporate the importance of honoring members' beliefs, sensitivity to cultural diversity, fostering respect for members' culture and cultural identity, and eliminating cultural disparities.
    c. QI maintains a cultural competence component of MVP's Internal Quality Assurance program referenced in Section 16.1 (d) of NYS Medicaid Model Contract.
    d. MVP's comprehensive cultural competence plan is based on National CLAS Standards of the US Department of Health and Human Services, Office of Minority Health, NCQA Health Plan Accreditation standards, QI 1, Element A, Factor 6, and NET 1, Element A, and managed through MVP's Internal Quality Assurance Program.
    e. Perform internal cultural competence activities including, but not limited to conducting:
        i. Organization-wide cultural competence self-assessment led by Human Resources (HR)
        ii. Community needs assessments to identify threshold populations in each Service Area in which MVP operates (conducted by the Medicaid SBU)
        iii. Quality improvement projects to improve cultural competence and reduce disparities, informed by such assessments and National CLAS Standards
    f. HR facilitates annual training in cultural competence for all MVP staff members.
        i. All elements of the curriculum are consistent with and/or reflects National CLAS Standards.
        ii. MVP's cultural competence training materials are subject to the review and approval by the State.
    g. MVP's Network Management Department ensures the cultural competence of its provider network by requiring Participating Providers to attest, on an annual basis, to completion of a cultural competence training curriculum, including training on the use of interpreters, for all Participating Providers' staff who have regular and substantial contact with members. The State makes available cultural competence training materials for Article 31 and 32 Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS) facilities on their website(s).

For 2021, these cultural and linguistic items will be tracked and monitored by the appropriate business area and reported up to the Service Improvement Committee and Clinical Quality Committee, as appropriate.

AUTHORITY

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

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

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

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

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

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

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

The MVP Medical Directors are responsible for rendering decisions on utilization requests, appeals, quality of care complaints, and cases referred for peer review, and for carrying out educational and corrective action processes with individual providers in accordance with MVP's policies, procedures, and programs. In addition, the MVP Medical Directors may be appointed to serve on the QIC 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.

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

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

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

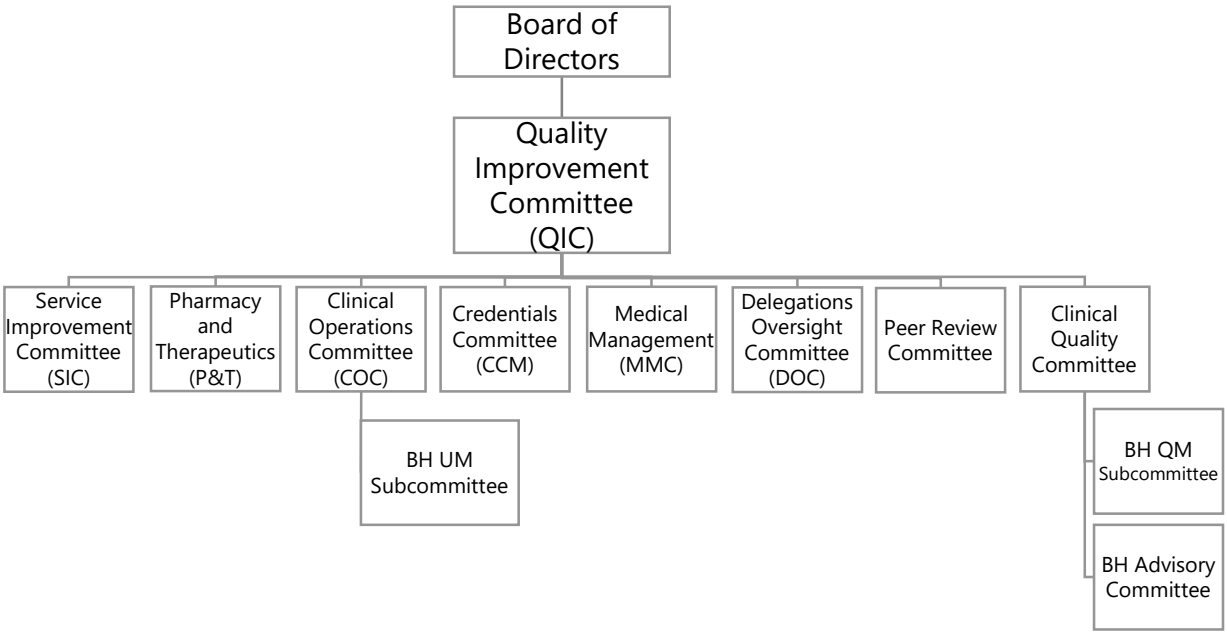
Quality Management Behavioral Health Liaison provides support for and monitors the progress of the BH Quality Management and Utilization Management Program to ensure it is meeting stated goals and objectives and complies with regulatory requirements. This manager will ensure that the Quality Management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

QUALITY PROGRAM STRUCTURE

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

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

MVP Quality Committee Structure



Subcommittees address 3 populations: Adult, HARP, and Children

MVP's Quality Improvement committees and subcommittees also serve as a communications pathway. Overlapping committee membership offers diverse expertise throughout the committee structure, however, Chairpersons are responsible for ensuring that issues which require review by members of the other committees or subcommittees are communicated to the Chairperson of that committee or subcommittee.

MVP Core Committee Charters

QIC	
Charter Statement	The QIC is the senior leadership committee, accountable to the Board of Directors that reviews and monitors all MVP clinical quality and service functions and provides oversight of all subcommittees.
Purpose	The purpose of the QIC is to provide oversight and direction in assessing the appropriateness of care and service delivered, and to continuously enhance and improve the quality of care and services provided to members through a comprehensive, health plan-wide system of ongoing, objective, and systematic monitoring of activities and outcomes using the quality process.

Responsibilities	• Oversight of MVP's quality activities to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as the NCQA • Annual development and approval of the QI Program Description and Work Plan incorporating applicable supporting department goals as indicated • Development of quality and performance improvement studies and activities, and reporting of findings to the Board of Directors • Annual review and approval or acceptance of the Credentialing, Pharmacy, Utilization Management, Care Management, and PHM Program Descriptions and Work Plans as developed by the appointed subcommittees to facilitate alliance with the strategic vision and goals • Evaluation of the effectiveness of each departments' activities to include analysis and recommendations of policy decisions based on identified trends, barrier analysis, and interventions required to improve the quality of care and/or service to members; implements corrective actions as appropriate, and acts as a communication channel to the Board of Directors • Prioritization of quality improvement efforts, facilitation of functional area collaboration, and assurance of appropriate resources to carry out quality activities • Review and establishment of benchmarks and performance goals for each quality improvement initiative and service indicator • Review and approval of due diligence information for any potential delegated entity and the annual oversight audit outcomes for delegated entities • Adoption of preventive health and clinical practice guidelines to promote appropriate and standardized quality of care • Monitoring of clinical quality indicators (such as HEDIS, adverse events, sentinel events, peer review outcomes, quality of care tracking, etc.) to identify deviation from standards of medical care, and supporting the formulation of corrective actions, as appropriate • Ongoing evaluation of the appropriateness and effectiveness of pay-for-performance and value-based contracting initiatives and support in designing and modifying the program as warranted
Reports To	Board of Directors
Committee Chair	Chief Medical Officer, may delegate individual meetings to a Medical Director or Senior Quality Executive
Committee Composition	• Chief Medical Officer • Behavioral Health Medical Director • Senior Leader, Medical Affairs • Senior Leader of Quality and Clinical Compliance • Senior Leader of Health and Pharmacy Management • Senior Leader, Engagement • Senior Leader, Provider Data Services • Leader, Delegation Oversight • Practicing Providers, at least four, representing the range of providers within the network and across the regions in which MVP operates, e.g. family practice,

	internal medicine, cardiology, OB/GYN, BH (i.e. physician or clinical PhD or PsyD), vision/dental care providers, and other high-volume specialists as appropriate • MVP Medicare Advantage Member • In addition, the committee may also have providers knowledgeable about members with disabilities, substance use disorders, abuse of children, etc. • The provider representatives should have experience caring for MVP Members, including a variety of ages and races/ethnicities, rural and urban populations, etc.
Frequency	Quarterly
Attendance Required	50% of scheduled meetings
Quorum	50% of the voting members plus one, based on the current voting membership at the time of the meeting.
Agenda	Agenda items for the next meeting are developed by the committee Chair in collaboration with the Senior Leader, Health and Pharmacy Management. The committee receives regular reports from all subcommittees that are accountable to and/or advise the QIC.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable. Materials included in meeting packet are based on needs for prior review and privacy/sensitivity of materials.
Decision Authority	The QIC is authorized by the Board of Directors to make all decisions related to the QI Program, with decisions made by consensus of the committee. Individuals are responsible to raise any issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information and/or situations when dissemination of information is to be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Peer Review Committee (PRC)	
Charter Statement	The PRC is an ad-hoc committee of the QIC and responsible for reviewing alleged inappropriate or aberrant services by a provider, including potential quality of care incidents, adverse events, and sentinel events where initial investigation indicates a significant potential or significant, severe adverse outcome has occurred or other cases as deemed appropriate by the Medical Director.
Purpose	The purpose of the PRC is to review clinical cases and apply clinical judgment in assessing the appropriateness of clinical care and recommending a corrective action plan to best suit the individual situation. The PRC conducts peer review of

	quality issues that originate in regions in which there is no peer review committee structure.
Responsibilities	• To make determinations regarding appropriateness of care • To make recommendations regarding corrective actions relating to provider quality of care • To conduct the review by a provider of same or similar specialty as the provider and/or issue under review
Reports To	QIC
Committee Chair	Chief Medical Officer
Committee Composition	• Chief Medical Officer/Medical Director • Senior Leader, Accreditation and QI Regulatory Compliance • Peer providers, at least three or more Participating Providers who are peers of the provider being reviewed and who represent a range of specialties, including at least one provider with the same or similar specialty as the case under review, but whose presence does not indicate a conflict of interest • No Credentialing Committee members involved in the PRC's recommendation will be included in the Credentialing Committee meeting when the PRC's recommendation is discussed
Frequency	Ad hoc, date and time to be determined based on need. Participating Providers serving on the committee may or may not be the same external providers serving on the PRC or Credentialing Committee. If the same providers are used, the PRC or Credentialing Committee meeting is adjourned and the PRC meeting is started as an independent meeting with an independent agenda and minutes.
Attendance Required	100% of scheduled meetings. Participating Providers are not standing members of the committee and their attendance may change based on type of case being reviewed.
Quorum	At least two Participating Providers and one Medical Director must be present for a quorum. All permanent committee members are voting members; the committee Chair is the determining vote in the case of a tie vote. All voting members who are present at the meeting constitute a quorum.
Agenda	Meetings are agenda driven. The committee Chair and/or Quality designee develop agenda items for the next meeting.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed within no later than 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials. All names and identifying information are redacted and information is distributed in a secure manner.
Decision Authority	The QIC authorizes the PRC to make decisions and recommendations regarding provider quality of care.
Evaluation	The committee reviews the charter annually.
Confidentiality	Peer review laws governing confidentiality of its proceedings protect each committee member. Each committee member is accountable to identify

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

Credentials Committee (CCM)	
Charter Statement	The CCM is a standing subcommittee of the QIC and oversees and has operating authority of the Credentialing Program.
Purpose	The purpose of the CCM is to provide oversight of the development and annual review/approval of credentialing policies. The CCM has final authority for credentialing and recredentialing licensed medical and behavioral health providers, other licensed health care professionals, and organizational providers who have an independent relationship with MVP. The CCM oversees the credentialing process to ensure compliance with regulatory and accreditation requirements and ensure Participating Providers and organizational providers are qualified, properly credentialed, and available for access by MVP Members.
Responsibilities	• Provide guidance to organization staff on the overall direction of the Credentialing Program • Review and approve credentialing and recredentialing policies and procedures • Review and recommend credentialing and recredentialing criteria • Responsible for the credentialing and recredentialing decisions for physicians, non-physician providers, and organizational and ancillary providers at MVP • Provide clinical peer input to address standards of care for a particular type of provider • Review oversight audits of delegates Credentialing Program performance • Evaluate and report to management on the effectiveness of the Credentialing Program • Review potential Quality of Care and adverse events, including any corrective action plans from PRC, for recredentialing decisions
Reports To	QIC
Committee Chair	Senior Leader, Medical Director Team; as committee member leadership develops, a committee network provider may chair at the discretion of the CCM
Committee Composition	• Chief Medical Officer/Medical Director(s) • Senior Leader/Leader, Provider Data Services • Participating Providers from a range of specialties, e.g. family practice, internal medicine, OB/GYN, BH, high-volume specialists, mid-level providers, etc. • Other executive leadership or health plan staff as determined • The committee actively involves Participating Providers in credentialing review activities as available and to the extent that there is not a conflict of interest
Frequency	At least ten times per year to facilitate timely review of providers and to expedite network development; additional meetings scheduled as needed.
Attendance Required	50% of scheduled meetings
Quorum	A minimum of four voting members, including the Chair, must be present for a quorum. Three voting members must be appropriately licensed health care

	providers. Only health care providers are voting members; the Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven and follow a standard format. Agenda items for the next meeting are developed by the Corporate Credentialing Manager in collaboration with the committee Chair.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed within no later than 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The Medical Director may approve clean files; the CCM has delegated responsibility for credentialing/recredentialing providers, facilities, and other organizational providers not meeting clean file criteria to the committee. The decision-making model is by consensus. Individuals are responsible and encouraged to raise any issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations of how dissemination of information is managed. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Medical Management Committee (MMC)	
Charter Statement	The MMC is a standing subcommittee of the QIC with oversight and operating authority of medical management activities.
Purpose	The purpose of the MMC is to review and monitor the appropriateness of care provided to health plan members. The MMC is responsible for the review and appropriate approval of medical necessity criteria and protocols, and utilization management policies and procedures, including a list of procedures requiring prior authorization.
Responsibilities	• Annually review and approve program descriptions, work plans and annual evaluations for PHM, Utilization Management, and Case Management • Review and maintain applicable policies/procedures and guidelines • Annually review and approve the criteria for determination of medical appropriateness • Review the utilization management process, including referrals, second opinions, prior authorization/pre-certification, concurrent and retrospective review, discharge planning, etc. • Review provider/facility/geographic area specific reports for trends/patterns in utilization • Formulate recommendations for specific providers for further study

	• Examine reports of the appropriateness of care for trends or patterns of under- or over- utilization and refer for performance improvement or corrective action if indicated • Examine results of annual surveys of members and providers regarding satisfaction with Utilization Management processes and Medical Management programs • Create and implement a feedback mechanism for communicating findings and recommendations, as well as a plan for implementing corrective actions • Liaison with the QIC for ongoing review of indicators of clinical quality
Reports To	QIC
Committee Chair	Medical Director, individual meetings may be chaired by an Associate Medical Director or Participating Provider at the discretion of the Medical Director.
Committee Composition	• Chief Medical Officer/Medical Directors • Designated Medical Management staff • Other operational staff as requested, e.g. Networking/Contracting, Member/Provider Services, Compliance/Regulatory, Pharmacy, Utilization Management, BH • Participating Providers representing the range within the network and across the service area may participate on the committee
Frequency	• Quarterly, with additional meetings scheduled per MVP's need • At least 8 times per year
Attendance Required	50% of scheduled meetings.
Quorum	Minimum of 50% of committee members, including two MVP staff and two external providers (if included on the committee) must be present for a quorum. All permanent committee members are voting members; the committee Chair is the determining vote in the case of a tie vote. More than half of voting members.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting are developed by the committee Chair in collaboration with the VP/Director of Medical Management.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed within no later than 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The MMC is authorized by the QIC to make all decisions related to the Medical Management Program, with decisions made by consensus of the committee. Individuals are responsible to raise issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when information is managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Pharmacy and Therapeutics Committee (P&T)	
Charter Statement	The P&T is a standing subcommittee of the QIC with oversight and operating authority of the Pharmacy Program.
Purpose	The P&T is responsible for development and annual review of Pharmacy policies and procedures, review of Pharmacy utilization data, decisions regarding inclusion of drugs on the Preferred Drug List (PDL), and recommendations for formulary management activities.
Responsibilities	• Develop and annually review the pharmacy policy and procedures • Conduct provider and member profiling for appropriate drug utilization (DUR) and recommendations for DUR activities such as targeted prescriber and/or member education initiatives • Evaluate and recommend drugs for inclusion in or removal from the PDL for appropriateness as a tool for providing high quality and cost-effective care • Evaluation of drug costs by therapeutic class for pharmaceutical containment and projection of pharmaceutical costs • Assure compliance with all contractual, regulatory, and accreditation pharmacy requirements • Review of complaints/grievances regarding pharmacy issues • Recommendations for formulary management activities such as prior authorization, step therapy, age restrictions, quantity limitations, mandatory generics, and other activities that promote access and patient safety • Review of requests from providers for additions or changes to formulary
Reports To	QIC
Committee Chair	Chief Medical Director, may delegate individual meetings to an Associate Medical Director or Senior Pharmacy Executive
Committee Composition	• Senior Leader, Health and Pharmacy Management • Senior Leader, Pharmacy • Medical Director, Health Management • Medical Director, Behavioral Health • Participating Pharmacists and internal clinical pharmacists • Various external providers including specialties (ex. Endocrinology, Cardiology, Oncology)
Frequency	• Quarterly, with additional meetings scheduled per health plan need • At least eight times a year
Attendance Required	50% of scheduled meetings
Quorum	50% of membership, including the committee Chair or designee, must be present for a quorum. The committee Chair is the determining vote in the case of a tie vote. 50% of the voting members plus one, based on the current voting membership at the time of the meeting.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting are developed by the committee Chair in collaboration with the VP/Director of Pharmacy.
Recorder	Delegated committee designee

Minutes/Meeting Packets	Draft minutes are completed within no later than 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The committee is authorized by the QIC to make all decisions related to the pharmacy benefit. Decisions made by consensus. Individuals are responsible and encouraged to raise issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Delegation Oversight Committee (DOC)	
Charter Statement	The DOC provides guidance to and oversight of operations affecting the scope of functions of delegated vendors, subcontractors, and MVP's specialty companies that provide services to MVP Members.
Purpose	The purpose of the DOC is to provide oversight and assess the appropriateness and quality of services provided on behalf of MVP to members. The DOC monitors delegate/vendor compliance with the delegation service agreement and regulatory requirements, identifies issues and opportunities for improvement, and develops mitigation plans as appropriate.
Responsibilities	• Oversee operations of the delegate/vendor to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies • Annually review the applicable delegate/vendor program descriptions, policies, and procedures • Examine activity and performance reports to identify undesirable trends and/or patterns • Provide a feedback mechanism for communicating findings, recommendations, and a plan for implementing corrective action (when necessary) related to the scope of delegated functions • Monitor financial incentives to ensure quality of care/service is not compromised • Develop utilization and quality reporting, summary analysis of data, and specialized reports designed exclusively to describe the findings of delegate/vendor activities • Report recommended actions to address any identified opportunities for improvement to the Performance Improvement Team • Provide a forum for discussion and collaboration for toward mutual goal attainment • Review findings of annual delegation audits with the DOC

	• Recommend continuation or termination of the delegation arrangement to the DOC
Reports To	QIC
Committee Chair	Leader, Delegation Oversight
Committee Composition	• Senior Leader, Medical Affairs • Medical Director, Behavioral Health Child • Medical Director, Behavioral Health Adult • Leader, Accreditation and QI Regulatory Compliance • Senior Leader, Pharmacy Management • Senior Leader, Clinical Compliance • Clinical Compliance Staff • Leader, Member Advocacy, Grievance and Appeals • Leader, Compliance, Medicare Compliance Officer • Senior Leader, Vendor Compliance Transaction Management • Senior Leader, Government Program Operations
Frequency	• Quarterly, with additional meetings scheduled per health plan need • At least four times a year
Attendance Required	50% of scheduled meetings.
Quorum	A minimum of four voting members, including the committee Chair, must be present for a quorum. All permanent committee members are voting members; the committee Chair is the determining vote in the case of a tie vote. All voting members who are present at the meeting.
Agenda	Meetings are agenda driven. Agenda items for the next meeting are developed by the committee Chair in collaboration with the applicable department leads.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed within no later than 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The committee is authorized by the QIC to make all decisions related to delegated vendor oversight. Decisions made by consensus. Individuals are responsible and encouraged to raise issues at committee meetings.
Evaluation	The committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Service Improvement Team (SIC)	
Charter Statement	MVP's SIC seeks to continually improve member and provider satisfaction and loyalty, as directed by the organization's QI workplan.

Purpose	The SIC is focused on continually improving the MVP Member and Participating Provider experience to ultimately drive improvement in customer satisfaction and loyalty. This includes ensuring 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, by the efforts of the SBUs for Commercial and Government Programs and by major corporate initiatives. The SIC monitors customer satisfaction including metrics such as: • Net Promoter Score • Top 2 Box Score for Overall Satisfaction • Top 2 Box Score for Ease of Doing Business Research and/or root cause analysis will be initiated by the SIC into metrics where performance materially drops year over year.
Responsibilities	**SIC Committee:** • Review and evaluate key service performance indicators (Net Promoter Score, Overall Satisfaction, Ease of Doing Business With MVP, etc.) • Review of customer feedback and satisfaction insights obtained through the following research: o Commercial, Medicare, and Medicaid CAHPS surveys o Semi-Annual Inform MVP Survey o MVP Medicare and Commercial New Member Surveys o General MVP Medicare, Commercial, and Medicaid Member Surveys o Annual Provider Satisfaction Survey • Review, provide feedback, and approve the annual service improvement plans developed by SIC sub-committees • Provide ongoing reports to the QIC, as appropriate, on the progress of SIC performance improvement initiatives • Support the development of a more customer centric culture **SIC Subcommittees:** • Detail review of customer research (survey results) including quantitative results and qualitative feedback in the form of customer commentary • Driven by member feedback, identification, analysis, and selection of service improvement opportunities • Development of annual service improvement plans; this includes documenting targeted opportunities, associated performance metrics and a high-level action plan. • Presentation of the annual service improvement plan to SIC • Provide periodic updates on the status of the annual service improvement plans to SIC
Reports To	QIC
Committee Chair	Chief of Customer Engagement and Senior Vice President

Committee Composition	**Voting Members:** • Chief of Customer Engagement and Senior Vice President • Senior Leader, Engagement • Senior Leader, Government Programs Operations and Regulatory Affairs • Senior Leader, Quality and Clinical Compliance • Senior Leader, Claims, Configuration, & Support Services • Senior Leader, Medicare Operations • Senior Leader, Corporate Professional Relations and Network Vendor Management • Senior Leader, Health and Pharmacy Management • Senior Leader, Financial Operations • Senior Leader, Clinical Operations Support UM Ops and Reporting • Senior Leader, Quality Performance and Operations (who is this?) • Medical Director, HARP BH Adult Services • Senior Leader, Accreditation and Quality Regulatory Compliance **Non-Voting Members** • Professional, Market Research • Professional, Exchange Business • Leader, QI Compliance and Accreditation • Leader, Corporate Professional Relations and Provider Operations • Senior Leader, Medicaid Services and Support
Frequency	At least four times a year
Attendance Required	50% of scheduled meetings
Quorum	50% of voting members, based on the current voting membership at the time of the meeting.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the committee Chair.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The committee is authorized by the QIC to make decisions and recommendations regarding service improvement initiatives. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the committee meetings.
Evaluation	The Committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner.

Clinical Operations Committee (COC)	
Charter Statement	The COC is a standing subcommittee of the QIC and oversees and has operating authority for MVP's clinical operations. The COC ultimately reports up to the Board of Directors.
Purpose	The COC provides oversight of the development and implementation of clinical processes to collect, monitor, analyze, evaluate, and report trends, patterns and action items related to utilization data. Additionally, the COC reviews and analyzes data, interprets the variances, reviews outcomes, and develops interventions based on the findings. Prudently manage available resources to optimize the health and well-being of MVP Members.

Responsibilities	In practice these responsibilities are carried out through the monitoring of the Clinical Operations work plan which includes the following functions:
	• Synopses from the current quarter's adult and child BH Utilization Management subcommittees are reported out
	• Monitoring, analyzing, and evaluating utilization including under- and over-utilization of services and cost data
	• Monitoring, analyzing, and evaluating Case Management activities including outreach, engagement, performance, and overall effectiveness
	• Monitoring, analyzing, and evaluating data, including but not limited to:
	  ○ Preventable admission rates
	  ○ Readmission rates
	  ○ Engagement rates
	  ○ Population health complexity, condition prevalence, and other health drivers
	  ○ Trends
	  ○ Average length of stay
	  ○ Emergency department utilization
	  ○ Prior authorization/denial and notices of action
	  ○ Utilization Management and Case Management delegated entity performance
	• Tracking and trending appeals
	• Developing, implementing, and reviewing intervention strategies with measurable outcomes based on data findings
	• Ensuring timely reporting of utilization and case management performance measurement data
	• Implementing Corrective Action Plans (CAP) as appropriate

Reports To	QIC; Board of Directors
Committee Chair	• Senior Leader, Medical Affairs • Medical Director, Behavioral Health
Committee Composition	• Chief Medical Officer / Medical Director • Senior Leader, Accreditation and Quality Regulatory Compliance • Designee Senior Leader from each applicable functional area, i.e. Medical Management, Network Development and Contracting, Provider Relations/Services, Member Services, Grievance and Appeals, Compliance and Regulatory Affairs, Pharmacy

	• BH Provider/Representative • Additional staff may participate as requested by the Chair
Frequency	Quarterly, ad hoc as necessary
Attendance Required	50% of scheduled meetings
Quorum	50% plus one of the voting members constitutes a quorum for the transaction of business. Less than a quorum will have the power to adjourn any meeting until such time a quorum is present.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the committee Chair.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The committee is authorized by the QIC to make decisions and recommendations regarding performance improvement processes. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the committee meetings.
Evaluation	The COC will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner.

Clinical Quality Committee (CQC)	
Charter Statement	The CQC meets at least quarterly and must meet four times per calendar year. The CQC reports to the QIC on a quarterly basis. Ad hoc reporting will occur as necessary. The CQC report up to the Board of Directors.
Purpose	Provides oversight for and coordination of the QI Program.
Responsibilities	• Present synopses of current quarter's adult and child BH Advisory subcommittees • Present synopses of current quarter's adult and child BH Quality Management subcommittees • Provide oversight of Quality Management activities for BH and physical health (PH) throughout MVP • Monitor, analyze, and evaluate quality management data • Eliminate barriers to Integration of physical and behavioral health across the enterprise • Review and analyze data, review outcomes, and develop interventions based on the findings • Manage available resources to optimize the health and wellbeing of MVP Members

	• Apply consideration for all lines of business for both physical and behavioral health • Review and consider the advice of the BH Quality Management and the BH Advisory subcommittees • Consider other quality improvements in all aspects of our work
Reports To	QIC; Board of Directors
Committee Chair	• Senior Leader, Behavioral Health • Quality Management Behavioral Health Liaison
Committee Composition	• Chief Medical Officer / Medical Director • Senior Leader of Quality Performance and Operations. • Senior Leader of Behavioral Health • Designee (Senior Leader or Leader) from each applicable functional area, i.e. Health Management, Network and Contracting, Provider Relations/Services, Member Services, Grievance and Appeals, Compliance and Regulatory Affairs, Pharmacy • Additional staff may participate as requested by the Chair
Frequency	Quarterly
Attendance Required	50% of scheduled meetings
Quorum	50% of the voting members, plus one based on the current voting membership at the time of the meeting.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the committee Chairs.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The committee is authorized by the QIC to make decisions and recommendations regarding performance improvement processes. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the committee meetings.
Evaluation	The Committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner.

BEHAVIORAL HEALTH PROGRAM STRUCTURE

MVP Quality Staff

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

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

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

Behavioral Health Medical Director, MVP's Behavioral Health Medical Director is a licensed psychiatrist. One of the primary aspects to this role is to provide medical direction and leadership for the integration of behavioral health and physical health care and services. This clinician works collaboratively with MVP's Senior Leader, Medical Affairs to support implementation of the MVP 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 will oversee and support the responsibilities of the Quality Management Behavioral Health Liaison.

Quality Management Behavioral Health Liaison, the Quality Management Behavioral Health Liaison will provide support for and monitor the progress of the Behavioral Health QM/UM Program to ensure it is meeting stated goals and objectives and complies with regulatory requirements. This role will ensure that the QM/UM work plan reflects the progress of QM/UM activities. This role will also serve on the committees and subcommittees 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.

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 MVP Members with BH diagnosis. The Board of Directors reviews and approves the QI Program, the QI Program Annual Evaluation and the QI Work Plan on an annual basis. The Board reviews reports of progress by the Executive Vice President/Chief Medical Officer on a quarterly basis.

Coordination of Behavioral and Medical Care

Additionally, in compliance with NYSDOH requirements for HARP, Medicaid Managed Care (MMC), and Child Health Plus (CHP) regulations, MVP maintains Quality Management (QM) and Utilization Management (UM) committees, subcommittees, and advisory groups, which are specific to behavioral health for children and adults, to ensure that MVP's policies, procedures, and interventions are effective and relevant.

MVP Behavioral Health Subcommittees

BH QM (HARP/Medicaid) Subcommittee	
Charter Statement	The Mainstream Medicaid (QMP)/HARP Behavioral Health QM (BH QM) subcommittees and Children's BH QM subcommittees are standing meetings scheduled in succession with one another and report up to the CQC and then ultimately to the Board of Directors.
Purpose	The purpose of the Mainstream Medicaid (QMP)/HARP BH QM subcommittee is to: • Assess the clinical and service needs of Mainstream Medicaid adults and HARP Members with BH diagnoses • Develop and implement a process to collect, monitor, analyze, evaluate, and report utilization data consistent with the reporting requirements of existing Quality Assurance Reporting Requirements (QARR) measures with the addition of HEDIS, based on claims and encounters • Implement, evaluate, and report on the various interventions/programs that will optimize clinical quality, maximize safe clinical practices, and enhance services to Mainstream Medicaid/HARP members • Carry out the planned activities of the BH QM program and be accountable to and report regularly to the governing board or its designee concerning BH QM activities • Ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis for all Mainstream Medicaid/HARP Members

Responsibilities	• Report out the synopsis from current Mainstream Medicaid BH Advisory subcommittee
	• Tracks, trends, and reports out complaints, grievances, appeals, and denials for Mainstream Medicaid adults and HARP Members with a BH diagnosis
	• Review BH prior authorization/denial and notices of action data
	• Report out how the quality assurance program addresses specific monitoring requirements related to the populations, benefits, and services covered
	• Follow up after discharge:
	  o Follow-up After Hospitalization for Mental Illness (FUH)
	  o Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)
	  o Substance Use Disorder (SUD) Initiation of Treatment and Engagement of Treatment Rates (IET)

	• Report to OMH and OASAS any deficiencies in performance and corrective action taken with respect to OMH and OASAS licensed, certified, or designated providers • Report adverse incidents for both the Mainstream Medicaid and HARP populations • Describe the HARP plan for capturing and reporting BH Home and Community-based Services (HCBS) and support monitoring of compliance with HCBS requirements • Statewide reporting of HARP Members without HCBS assessments • Track and report on compliance with: o BH quality assurance performance measure/reporting of HCBS assurances and sub-assurances and recovery measures including employment, housing, criminal justice status etc. o Protocols for expedited and standard appeals regarding plan of care denials for HCBS • Report on all performance improvement plans and updates on special populations • Conduct an annual consumer perception survey (supplementary to CAHPS)
Reports To	CQC; QIC; Board of Directors
Committee Chair	Quality Management Behavioral Health Liaison (BH Quality Administrator) and Senior Leader of Behavioral Health (BH Director)
Committee Composition	• Chief Medical Officer/Medical Director • Senior Leader, Accreditation and Quality Regulatory Compliance • Designee (Senior Leader/Leader) from each applicable functional area, i.e. Health Management, Network and Contracting, Provider Relations/Services, Member Services, Grievance and Appeals, Compliance and Regulatory Affairs, Pharmacy • Behavioral Health Provider/Representative • Additional staff may participate as requested by the Chair
Frequency	At least quarterly
Attendance Required	50% of scheduled meetings
Quorum	50% plus one of the voting members at the time of the meeting constitutes a quorum for the transaction of business.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the subcommittee Chair.
Recorder	Delegated subcommittee designee
Minutes/Meeting Packets	Maintains records documenting attendance, findings, recommendations, and actions. Draft minutes are completed within no later than 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to subcommittee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.

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

Children's BH QM Subcommittee	
Charter Statement	The Children's BH QM Subcommittees and Mainstream Medicaid (QMP)/HARP BH QM subcommittees are standing meetings scheduled in succession with one another and report up to the CQC and then ultimately to the Board of Directors.
Purpose	• Assess the clinical and service needs of the Medicaid enrolled children with BH diagnoses including HCBS; this includes children in foster care and medically fragile children • Carry out the planned activities of the BH QM program. related but not limited to children who access BH benefits/or HCBS. • Accountable to and report regularly to the governing board or its designee concerning BH QM activities • Develop and implement a process to collect, monitor, analyze, evaluate, and report utilization data consistent with the reporting requirements of existing QARR measures with the addition of HEDIS based on claims and encounters • Ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis for the Children Transitional Members.
Responsibilities	• Report out synopsis from current Children's BH Advisory subcommittee • Report to OMH and OASAS any deficiencies in performance and corrective action taken with respect to OMH and OASAS licensed, certified, or designated providers • Tracks, trends, and reports complaints, grievances, appeals, and denials for members with BH diagnosis that are children • Review prior authorization/denial and notices of action data • Track and report on compliance with: o HCBS assurances and sub-assurances o Protocols for expedited and standard appeals regarding plan of care denials for HCBS. • Report out how the quality assurance program addresses specific monitoring requirements related to the populations, benefits, and services covered • Follow up after discharge: o Follow-up After Hospitalization for Mental Illness (FUH) o Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) o Substance Use Disorder (SUD) Initiation of Treatment and Engagement of Treatment Rates (IET)

	• Report on adverse incidents for children • Report on all performance improvement plans and updates on special populations • Conduct an annual consumer perception survey (supplementary to CAHPS)
Reports To	CQC; QIC; Board of Directors
Committee Chair	• Quality Management Behavioral Health Liaison (BH Quality Administrator) • Senior Leader of Behavioral Health (BH Director)
Committee Composition	• Chief Medical Officer/Medical Director • Senior Leader, Accreditation and QI Regulatory Compliance • Designee (Senior Leader/Leader) from each applicable functional area, i.e. Medical Management, Network and Contracting, Provider Relations/Services, Member Services, Grievance and Appeals, Compliance and Regulatory Affairs, Pharmacy • Behavioral Health Provider/Representative • Additional staff may participate as requested by the Chair
Frequency	At least quarterly
Attendance Required	50% of scheduled meetings
Quorum	50% plus one of the voting members at the time of the meeting constitutes a quorum for the transaction of business
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the subcommittee Chair.
Recorder	Delegated subcommittee designee
Minutes/Meeting Packets	Maintains records documenting attendance, findings, recommendations, and actions. Draft minutes are completed no later than 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to subcommittee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The subcommittee is authorized by the QIC to make decisions and recommendations regarding performance improvement processes. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the subcommittee meetings.
Evaluation	The Committee will review the charter annually.
Confidentiality	Each subcommittee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner.

BH Advisory Subcommittee (HARP/Medicaid)	
Charter Statement	The Mainstream Medicaid (QMP)/HARP Behavioral Health Advisory subcommittees are to be held at least quarterly. The Mainstream Medicaid (QMP)/HARP and Children's Behavioral Health Advisory subcommittees are held in succession with

	one another and report up to the BH QM subcommittee, CQC, and ultimately to the Board of Directors
Purpose	Solicit feedback and recommendations from key stakeholders (members, family members, peers, subcontracted plans, Regional Planning Consortia (RPC), local government unit (LGU) representatives, and other agencies that service the needs of our members to improve quality of care and member outcomes.
Responsibilities	• Review and consider recommendations of the RPC regarding improved integration of behavioral and physical health • Provide a forum for members that includes among its members, MVP BH staff, BH providers, peer specialists, members, LGU representatives, and other key stakeholders to discuss the physical and behavioral health needs of MVP's Mainstream Medicaid and HARP Members: o This includes, but is not limited to, challenges, barriers, resources, and unmet needs of this population o Solicit ideas and feedback to improve overall member and provider experience • Identify proposed resolutions of issues related to the management of the HARP population and BH benefits
Reports To	BH QM Subcommittee; CQC; QIC; Board of Directors
Committee Chair	Tri-chair: Quality Management Behavioral Health Liaison, Senior Leader of Behavioral Health, MVP Participating BH Provider
Committee Composition	• Chief Medical Officer/Medical Director • Senior Leader, Accreditation and Quality Regulatory Compliance • Designee (Senior Leader/Leader) from each applicable functional area, i.e. Medical Management, Network and Contracting, Provider Relations/Services, Member Services, Grievance and Appeals, Compliance and Regulatory Affairs, Pharmacy • Behavioral Health Provider/Representative • Additional staff may participate as requested by the Chair
Frequency	At least quarterly
Attendance Required	50% of scheduled meetings
Quorum	The Mainstream Medicaid/HARP Behavioral Health Advisory subcommittees will solicit feedback and advice; it does not make decisions. Minutes will reflect discussion and attendance.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the subcommittee Chair with input requested by members, providers, stakeholders, and all other participants of the committee.
Recorder	Delegated subcommittee designee
Minutes/Meeting Packets	Draft minutes are completed no later than 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to subcommittee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.

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

Children's BH Advisory Subcommittee	
Charter Statement	The Children's BH Advisory subcommittees are to be held at least quarterly. The Mainstream Medicaid/HARP and Children's BH Advisory subcommittees are held in succession with one another and report up to the BH QM subcommittee, CQC, and ultimately to the Board of Directors.
Purpose	Solicit feedback and recommendations from key stakeholders (members, family members, peers, VFCA's, subcontracted plans, RPC, LGU representatives, and other child service agencies that serve the needs of our members to improve quality of care and member outcomes. Advise and assist the plan in identifying and resolving issues related to the management of children's physical and behavioral health benefits.

Responsibilities	• Review and consider recommendations of the Regional planning Consortia (RPC) regarding improved integration of behavioral and physical health
	• Issues related to children identified with specific diagnostic groups must be separate standing agenda items in subcommittee meetings
	• Provide a forum for members that includes among its members, MVP BH staff, BH providers, peer specialists, members, local government unit (LGU) representatives, and other key stakeholders to discuss the physical and behavioral health needs of our child members:
	  o This includes, but is not limited to, challenges, barriers, resources, and unmet needs of this population
	  o Soliciting ideas and feedback to improve overall member and provider experience
	• Identify proposed resolutions of issues related to the management of the physical and behavioral health needs of MVP's child population

Reports To	BH QM Subcommittee; CQC; QIC; Board of Directors
Committee Chair	Tri-chair: Quality Management Behavioral Health Liaison, Senior Leader of Behavioral Health, MVP Participating BH Provider
Committee Composition	• Chief Medical Officer/Medical Director • Senior Leader, Accreditation and QI Regulatory Compliance • Designee (Senior Leader/Leader) from each applicable functional area, i.e. Health Management, Network and Contracting, Provider Relations/Services, Member Services, Grievance and Appeals, Compliance and Regulatory Affairs, Pharmacy • Behavioral Health Provider/Representative

	• Additional staff may participate as requested by the Chair
Frequency	At least quarterly
Attendance Required	50% of scheduled meetings
Quorum	The Children's BH Advisory Subcommittee will solicit feedback and advice but does not make decisions. Minutes will reflect discussion and attendance.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the subcommittee Chair with input requested by members, providers, stakeholders, and all other participants of the committee.
Recorder	Delegated subcommittee designee
Minutes/Meeting Packets	Draft minutes are completed no later than 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to subcommittee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The subcommittee is authorized by the CQC to make decisions and recommendations regarding performance improvement processes. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the subcommittee meetings.
Evaluation	The Committee will review the charter annually.
Confidentiality	Each subcommittee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner.

BH UM Subcommittee (HARP/Medicaid)	
Charter Statement	The Mainstream Medicaid (QMP)/HARP BH UM subcommittees are to be held at least quarterly. The Mainstream Medicaid/HARP BH UM and Children's BH UM subcommittees are scheduled in succession with one another and reported up to the COC, then the QIC, and then ultimately to the Board of Directors.
Purpose	• Assess the clinical and service needs of mainstream adult and HARP Members with BH diagnoses • Develop, implement, evaluate, and report on the various interventions/programs that will optimize clinical quality, maximize safe evidence-based clinical practices, and enhance services to Mainstream Medicaid/HARP members with BH diagnoses • Ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis for the Mainstream Medicaid and HARP members with BH diagnoses

Responsibilities	• Review and analyze data, variances, and outcomes, and develop and/or approve interventions
	• Ensure interventions have measurable outcomes and are included in meeting minutes
	• Report out the following:
	  ○ Under- and over-utilization of BH services and cost data
	  ○ Avoidable admission and readmission rates, trends, and Average Length of Stay (ALOS) for all MH inpatient, SUD inpatient, residential and (for HARP) medical inpatient facilities levels of care facilities
	  ○ Inpatient utilization
	  ○ Outpatient utilization including specialty BH services
	  ○ Inpatient civil commitments
	  ○ Outpatient civil commitments (AOT)
	  ○ Emergency Department (ED) utilization and crisis services use
	  ▪ Use of Crisis Diversion Services
	  ○ Pharmacy utilization including physical health, psychotropic and addiction medications
	  ○ Protocols for the identification and prompt referral of individuals with First Episode Psychosis (FEP) to programs and services:
	  ▪ Rates of initiation and engagement of individuals with FEP in services
	  ○ BH HCBS utilization:
	  ▪ Health Home engagement rates for HARP population
	  ○ All physical health measures required by the MCO Model Contract

Reports To	COC; QIC; Board of Directors
Committee Chair	Behavioral Health Medical Director
Committee Composition	• Chief Medical Officer/Medical Director • Senior Leader, Accreditation and Quality Regulatory Compliance • Designee (Senior Leader/Leader) from each applicable functional area, i.e. Medical Management, Network and Contracting, Provider Relations/Services, Member Services, Grievance and Appeals, Compliance and Regulatory Affairs, Pharmacy • Behavioral Health Provider/Representative • Additional staff may participate as requested by the Chair
Frequency	Quarterly
Attendance Required	50% of scheduled meetings
Quorum	50% plus one of the voting members constitutes a quorum for the transaction of business.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the subcommittee Chair.
Recorder	Delegated subcommittee designee
Minutes/Meeting Packets	Draft minutes are completed no later than 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are

	distributed by secure means to subcommittee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The subcommittee is authorized by the COC to make decisions and recommendations regarding performance improvement processes. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the subcommittee meetings.
Evaluation	The subcommittee will review the charter annually.
Confidentiality	Each subcommittee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner.
BH UM Subcommittee (Children's)	
Charter Statement	The Children's BH UM subcommittee meetings are to be held at least quarterly. The Children's BH UM and Mainstream Medicaid (QMP)/HARP BH UM are scheduled in succession with one another and reported up to the COC, then the QIC, and ultimately to the Board of Directors.
Purpose	• Assess the clinical and service needs of Medicaid Members who are children with BH diagnoses including HCBS: ○ This includes children in foster care and medically fragile children • Develop, implement, evaluate, and report utilization data and various interventions/programs that will optimize clinical quality, maximize safe clinical practices, and enhance services to Medicaid Members who are children in the children's transition program • Ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis for the Children Transitional Members.

Responsibilities	• Review and analyze data*, variances, and outcomes and develop and/or approve interventions
	• Ensure that interventions have measurable outcomes and are included in meeting minutes.
	• Report out the following:
	  ○ Under- and over-utilization of BH services and cost data
	  ○ Avoidable admission and readmission rates, trends, and ALOS for all MH inpatient, SUD inpatient, residential, and medical inpatient facilities levels of care facilities
	  ○ Outpatient utilization including OP specialty BH services
	  ○ Children and Family Treatment and Support Services (CFTSS) utilization
	  ○ Inpatient civil commitments
	  ○ Outpatient civil commitments (Assisted Outpatient Treatment)
	  ○ ED utilization and crisis services use
	  ▪ Use of Crisis Diversion Services
	  ○ Pharmacy utilization including physical health, psychotropic and addiction medications
	  ○ Separate analysis for children in foster care

	○ Protocols for the identification and prompt referral of individuals with First Episode Psychosis (FEP) to programs and services ○ Rates of initiation and engagement of individuals with FEP in services ○ Discussion/Analysis related to physical health services for medically fragile children/complex conditions ○ Discussion/Analysis related to BH and HCBS services for children enrolled in the Medicaid transitional program ○ Children's physical health services: ▪ Report on service utilization and outcomes for children including medically fragile children ▪ Transitional issues for youth ages 18 to 23 years, focusing on continuity of care and service utilization ○ BH HCBS: ▪ For children eligible for HCBS, the Children's BH UM subcommittee shall separately report, monitor findings and recommend appropriate action on the following additional metrics: • Use of crisis diversion and crisis intervention services • HCBS utilization • Health Home engagement rates for HARP population *Data specific to medically fragile children up to age 21 years is analyzed and reported separately.
Reports To	COC; QIC; Board of Directors
Committee Chair	Behavioral Health Medical Director
Committee Composition	• Chief Medical Officer/Medical Director • Senior Leader, Accreditation and Quality Regulatory Compliance • Designee (Senior Leader/Leader) from each applicable functional area, i.e. Medical Management, Network and Contracting, Provider Relations/Services, Member Services, Grievance and Appeals, Compliance and Regulatory Affairs, Pharmacy • Behavioral Health Provider/Representative • Additional staff may participate as requested by the Chair
Frequency	Quarterly
Attendance Required	50% of scheduled meetings
Quorum	50% of the voting members, plus one based on the current voting membership at the time of the meeting.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the subcommittee Chair.
Recorder	Delegated subcommittee designee
Minutes/Meeting Packets	Draft minutes are completed no later than 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to subcommittee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.

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

MVP QUALITY DEPARTMENT STAFFING

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

Quality Department Staffing

Chief Medical Officer	MVP's Chief Medical Officer and supporting Medical Directors (including a Behavioral Health Medical Director) have an active unencumbered license in accordance with the state laws and regulations to serve as Medical Director to oversee and be responsible for the proper provision of core benefits and services to members, the QI Program, the Medical Management Programs, and the Grievance System.
Senior Leader, Medical Affairs	The Senior Leader, Medical Affairs provides oversight of the Physical Health Medical Directors and their activities; Medical policy and new technology evaluation; Total Medical Expense; Trend Review; Clinical Vendor Oversight; Value Based Contracting support (West)
Senior Leader, Medical Director Team	The Senior Leader, Medical Director Team provides oversight of Behavioral Health Medical Directors, clinical innovation, product and sales support, Value Based Payment and network partnership overall, Value Based Payment support (East and Vermont). This clinician works collaboratively with MVP's Senior Leader, Medical Affairs to support the integration of physical and behavioral health care and services.

Senior Leader, Quality and Clinical Compliance	The Senior Leader, Quality and Clinical Compliance, reports to the Chief Medical Officer and is responsible for the oversight of the Quality and Clinical Compliance department. The key functions include Clinical Measures and Initiatives, HEDIS Operations, clinical regulatory compliance, and accreditation. Additionally, the Senior Leader, Quality and Clinical Compliance supports corporate initiatives through participation on committees and projects as requested, reviews statistical analysis of clinical, service, and utilization data, and recommends performance improvement initiatives while incorporating best practices as applicable.
Leader Quality Enablement	Leader, Quality Enablement reports to the Senior Leader, Quality and Clinical Compliance and is responsible for project management,

	administrative, and operational support for the department. The Leader, Quality Enablement works with all Quality and Clinical Compliance teams to implement solutions, improve processes, and develop and maintain documentation.
Senior Leader, Quality Integration and Collaborative Strategy	Senior Leader, Quality Integration and Collaborative Strategy reports to the Senior Leader, Quality and Clinical Compliance and is responsible for the end-to-end operations of HEDIS strategy, planning, data collection, quality control, analysis, and reporting. The Senior Leader, Quality Integration and Collaborative Strategy works to maintain and develop partnerships with providers to gain access to electronic health records and to promote the collection of year-round supplemental data. In addition, the Senior Leader, Quality Integration and Collaborative Strategy will work closely with the Quality Initiatives team and the Value Based Contracts team to improve HEDIS performance.
Quality Initiatives Program Manager	The Quality Initiatives Program Manager will support the development of Quality Improvement program initiatives and liaison with key clinical and operational teams across the organization to ensure strategic alignment on quality performance initiatives.
Quality Initiatives Program Lead	The Quality Initiatives Program Lead will support the development of QI Program initiatives, monitor the regulatory environment for impact to performance initiatives, and supports vendor relationships.
Leader, Quality Initiatives	The Leader, Quality Initiatives will oversee the team of Clinical Initiatives program managers who are focused on the development and tactical execution of member and provider initiatives. Additionally, the Leader, Quality Initiatives will foster relationships with internal and external quality performance stakeholders.

Senior Leader, Clinical Initiatives Strategy and Innovation	The Senior Leader, Clinical Initiative Strategy and Innovation provides oversight in strategic direction for quality performance initiatives and monitoring, including development of member and provider initiatives, coordinating meetings with internal business partners and strategic business units to ensure that quality is an enterprise-wide goal and continue to work with external vendors to identify opportunities for improved quality performance.
Leader, HEDIS Data Management and Strategic Operations	The Leader, HEDIS Data Management and Strategic Operations reports to the Senior Leader, Quality Integration and Collaborative Strategy and is responsible for daily operations associated with HEDIS medical record collection, chart abstraction, and quality control. The Leader, HEDIS Data Management and Strategic Operations will track and monitor the progress of the HEDIS data and will provide current and timely reports, while keeping all HEDIS activities on target with successful measurable outcomes. In addition, the Leader, HEDIS Data Management and Strategic Operations will maintain a tracking mechanism for the collection of supplemental data and will maintain strong relationships with internal Quality business partners.
HEDIS Program	The HEDIS Program Manager, Clinical Quality Coordinator, and Clinical

Manager, Clinical Quality Coordinator, and Clinical Quality Lead	Quality Lead reports to the Leader, HEDIS Data Management and Strategic Operations and are responsible for the collection of HEDIS medical records, abstraction of the data and quality control. In addition, the HEDIS Program Manager, Clinical Quality Coordinator, and Clinical Quality Lead will monitor providers' clinical performance and identify areas of opportunity for improvement.

Leader, Provider Quality Initiatives	Quality Initiative Leads will work with clinical, regulatory, and operational teams across the organization to designing and execute internal and external interventions aimed at closing clinical gaps in care. In addition, they are responsible for monitoring and communicating performance among key quality measures and metrics related to their respective focus areas.
Senior Leader, Accreditation and Quality Regulatory Compliance	The Senior Leader, Accreditation and Quality Regulatory Compliance, reports to the Senior Leader, Quality and Clinical Compliance, and is responsible for directing the strategic management and planning of the NCQA Health Plan Accreditation process. Additional responsibilities include: • Strategizing and leading organizational efforts to achieve and maintain accreditation • Development of accreditation work plans with timeliness and documentation needed • Serves as a subject matter expert and liaison for NCQA standards interpretation, survey preparation, onsite file reviews and follow-up activities • Development of trainings related to NCQA Standards based upon business owner needs • Provide oversight and direction to assure compliance with Quality activities associated with regulatory agencies such as NYSDOH, CMS and Department of Financial Services • Provide guidance and oversight of Quality subcommittees, Performance Improvement Projects, Continuous Chronic Improvement Projects, and QI Strategy Projects. • Assumes ownership of the QI Program Description, QI Annual Work Plan and the QI Annual Program Evaluation
Quality Management Behavioral Health Liaison	The Quality Management Behavioral Health Liaison will provide support for and monitor the progress of the Behavioral Health QM and UM Program to ensure it is meeting stated goals and objectives and complies with regulatory requirements. This role will ensure that the QM and UM Work Plan reflects the progress of QM and UM activities. This role will also serve on the committees and subcommittees 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.
QI Compliance Program Manager	The QI Compliance Program Manager reports to the Senior Leader, Accreditation and Quality Regulatory Compliance. The QI Compliance Program Manager is responsible for the development, implementation, oversight, and reporting to NYS DOH and other regulatory agencies on

	Performance Improvement Projects, Continuous Chronic Improvement Projects, and QI Strategy Projects. The QI Compliance Program Manager works collaboratively with other internal departments at MVP to drive performance and ensure the best possible outcomes for our members.
Leader, QI Compliance and Accreditation	The Leader of QI Compliance and Accreditation reports to the Senior Leader of Accreditation and Quality Regulatory Compliance. Responsibilities of the Leader, QI Compliance and Accreditation include the following: • Ensures compliance with NCQA accreditation requirements, conducting routine readiness assessments, evaluating policies and procedures, and reviewing processes and records • Implements and leads a process for ensuring that MVP achieves and maintains NCQA accreditation • Establishes and implements objectives, policies, and strategies to maintain a continual state of accreditation readiness and to achieve successful accreditation status for MVP • Serves as the Subject Matter Expert for NCQA Health Plan Accreditation
Quality Improvement Program Manager	The Quality Improvement Program Manager reports to and supports the Leader, Quality Improvement Compliance and Accreditation in the achievement of, as well as the ongoing maintenance of MVP's NCQA Accreditation and regulatory compliance requirements. The Quality Improvement Program Manager supports the document preparation and submission of documents for MVP NCQA accreditation survey. The Quality Improvement Program Manager supports and assists in the development of health plan performance improvement activities.
Quality Improvement Project Manager	The Quality Improvement Project Manager reports to and supports the Leader, Quality Improvement Compliance and Accreditation in the achievement of, as well as the ongoing maintenance of, MVP's NCQA Accreditation and regulatory compliance requirements. The Quality Improvement Project Manager supports the document preparation and submission of documents for MVP NCQA accreditation survey. The Quality Improvement Project Manager supports and assists in the development of health plan performance improvement activities.

Senior Leader, Customer Care and Support Services	The Senior Leader, Customer Care and Support Services, is accountable for overseeing the Member Advocacy and Appeals staff, processes, and regulatory requirements. The Senior Leader, Customer Care and Support Services provides oversight of daily responsibilities managed by the Leader of Member Advocacy, Appeals and Grievances and the Senior Complaint and Fair Hearing Coordinator. The Senior Leader of Customer Care and Support Services reports to the Senior Vice President and Chief of Customer Engagement.
Leader, Member Advocacy, Appeals and	The Leader, Member Advocacy, Appeals and Grievances reports to the Senior Leader, Customer Care and Support Services and is responsible for

Grievances	the appropriate processing of member grievances and appeals as well as requests for State Fair Hearings and external reviews. The Leader, Member Advocacy, Appeals, and Grievances manages grievance and appeal data and reports. This position is required to represent Appeals and Grievances at various health plan committee meetings and provides updates at these committees, as needed.
Associate, Senior Complaint/Fair Hearing Coordinator	The Senior Complaint/Fair Hearing Coordinator logs member grievances and completes a thorough investigation of those pertaining to potential quality of care issues, including referral to Medical Director as appropriate, to ensure resolution. The Senior Complaint/Fair Hearing Coordinator evaluates complaints and grievances by type, location, and region to identify trends indicating potential areas in need of further analysis and intervention. The Senior Complaint/Fair Hearing Coordinator also tracks and resolves all administrative member grievances and provider complaints. The Senior Complaint/Fair Hearing Coordinator reports to the Leader, Commercial Appeals Operations, who reports to the Leader, Member Advocacy, Appeals, and Grievances.

QI PROGRAM RESOURCES: INFRASTRUCTURE AND DATA ANALYTICS

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

QSI-XL by Inovalon

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

Model for Analytics warehouse to satisfy other partner/vendor reporting requirements and internal analytical and reporting needs.

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

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

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

Reporting and Analytics
Quality Analytics produces monthly reports for ratings systems such as Medicare Stars, Marketplace Quality Rating System, and Medicaid NCQA Health Plan Rating System. In addition, reports are produced for any Quality-related Pay for Performance programs outlined in contracts between providers and health plans. Reports contain the most current HEDIS, CAHPS, and operational rates, where applicable, from MVP's source-of-truth HEDIS engine, certified CAHPS vendor, CMS Health Plan Management System (HPMS) and Complaint Tracker Module, and Acumen pharmacy data. Additional data points provided are source-of-truth rates from prior year final rates, prior year current month, and star or rating assignment (1-5) at the measure level. Domain- and overall-level roll-up ratings are estimated using calculations modeled from CMS or NCQA Technical Specifications. Roll-up overall Stars are estimated for current rates, and final overall Star ratings from prior year are provided for comparison. Year-over-year graphs are provided to show trending performance across current and prior measurement year. Finally, most current available benchmarks are provided, and current

numerator and denominator, where relevant, are provided at the measure level to show health plans the benchmark currently achieved and distance, in numerator hits, to all remaining benchmarks not met.

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

Clinical Decision Support
Predictive modeling software (ImpactPro) is used to identify members who may be at risk for high future utilization through risk score assignment. The Clinical Decision Support application is a multi-dimensional, episode-based predictive modeling and Care Management analytics tool that allows the Quality and Care Management teams to use clinical, risk, and administrative profile information obtained from medical, behavioral, and pharmacy claims data and lab value data to identify high risk members. The EDMA updates the Clinical Decision Support system bi-weekly with data, including eligibility, medical, behavioral and pharmacy claims data, demographic data, and lab test results to calculate and continuously update each member's risk score. The application supports the Quality team in identifying target populations for focused improvement intervention based on risk score and need.

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

MVP obtains data and analytical support through the Information Technology and Shared Services Department and Operations Transformation, as necessary.

DOCUMENTATION CYCLE

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

- QI Program Description
- QI Work Plan
- QI Program Evaluation

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

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

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

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

QI Work Plan

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

The Work Plan is developed annually after completing the QI Program Evaluation for the previous year and includes the recommendations for improvements from the annual Program Evaluation. The Work Plan reflects the ongoing progress of the quality activities, including:

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

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

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

QI Program Evaluation

The QI Program Evaluation includes an annual summary of all quality activities, the impact the program has had on member care, an analysis of the achievement of stated goals and objectives, and the need for program revisions and modifications. The Program Evaluation outlines the completed and ongoing activities of the previous year for all departments within MVP, including activities regarding Provider Services, Member Services, Utilization Management, Care Management, Complex Case Management, Condition Management, and safety of clinical care. Program Evaluation findings are incorporated in the development of the annual QI Program Description and QI Work Plan for the subsequent year. The Senior Leader, Quality and Clinical Compliance and Senior Leader, Accreditation and Quality Regulatory Compliance are responsible for coordinating the evaluation process and a written description of the evaluation and work plan is provided to the QIC and Board of Directors for approval annually.

The annual QI Program Evaluation identifies outcomes and includes evaluation of the following:

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

At the end of the QI Program cycle each year (calendar year, unless otherwise specified by state contract), the Quality Department facilitates/prepares the QI Program Evaluation. The evaluation assesses both progress in implementing the QI strategy and the extent to which the strategy is in fact promoting the development of an effective QI Program. Recommended changes in

program strategy or administration and commitment of resources that have been forwarded and considered by the QIC should be included in the document.

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

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

PERFORMANCE MEASUREMENT

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

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

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

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

Member Experience

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

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

- Getting Care Quickly
- Getting Needed Care
- Coordination of Care
- Customer Service
- Rating of Health Plan
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

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

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

Provider Experience

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

PROMOTING MEMBER SAFETY AND QUALITY OF CARE

The QI Program is a multidisciplinary program that utilizes an integrated approach to monitor, assess, and promote patient safety and quality of care. MVP has mechanisms to assess the quality and appropriateness of care furnished to all members including those with special health

care needs, as defined by New York State. These activities are both clinical and non-clinical in nature and address physical health, behavioral health, and social health services.

Member safety is a key focus of the MVP QI Program. Monitoring and promoting member safety is integrated throughout many activities across MVP, including through identification of potential and/or actual quality of care events and critical incidents, as applicable. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of member care, is not compliant with evidence-based standard practices of care, or signals a potential sentinel event, up to and including death of a member. Employees (including Health Management staff, Customer Care staff, Provider Services staff, Complaint Coordinators, etc.), panel providers, facilities or ancillary providers, members or member representatives, state partners, Medical Directors, or the Board of Directors may inform the Member Appeals team of potential quality of care issues and/or critical incidents. Potential quality of care issues requires an investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action, up to and including review by the PRC as indicated. Potential quality of care issues and critical incidents received in the Grievance and Appeals Department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

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

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

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

A Serious Reportable Event (SRE) is defined as an incident involving serious harm or death to a patient from a lapse or error in a health care facility. MVP's policy regarding SRE is consistent with the policies defined by national health care quality organizations such as The Leapfrog Group and the National Quality Forum (NQF). The SREs covered under MVP's policy will change over time as dictated by Federal and/or State mandate and the needs of our customers. If an

SRE occurs within a facility, it is expected that the hospital will immediately report the event to MVP and waive costs directly related to the event. MVP's current service agreement template for inpatient facilities includes language addressing MVP's expectations, should an SRE occur.

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

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

Medical Record Documentation Standards

MVP promotes maintenance of medical records in a current, detailed, and organized manner which permits effective and confidential patient care and quality review. The minimum standards for provider medical record keeping practices, which include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of member information, are outlined in the Provider Resources Manual. MVP may conduct medical record reviews for purposes including, but not limited to, utilization review, quality management, medical claim review, or member complaint/appeal investigation.

Regional Health Information Organizations (RHIOs)

MVP currently participates with HIXNY to receive admission, discharge, and transfer alerts for its NYS members and to access electronic health records for members when MVP has member consent or One-to-One Exchange established with providers, in accordance with the Statewide Health Information Network for New York ("SHIN-NY") policy.

MEMBER ACCESS TO CARE

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

Directory is available online and as a hard copy as needed and meets all regulatory and accreditation requirements. The directory is updated in a timely manner upon receipt of updated information from providers and assessment of the accuracy of the directory is completed on an ongoing basis.

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

Network Adequacy

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

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

Appointment Availability

MVP monitors provider appointment availability on an ongoing basis. At least annually, MVP uses a statistically valid sampling methodology to conduct appointment availability audits of Primary Care Providers (PCP), high-volume specialists including OB/GYNs, BH, and high-impact specialists. CAHPS results are also analyzed to identify primary care, BH, and specialty appointment availability issues. In addition, MVP analyzes appointment access, complaints, grievances, appeals and may solicit feedback from the Member, Provider and/or Community Advisory Committees related to appointment access trends.

After Hours Access

MVP annually conducts after hours call surveys to assess compliance with non-business hours telephone coverage standards. Member complaints/grievances to identify potential issues are

also analyzed, and PCP offices surveyed after hours to verify availability of a live respondent or appropriate messaging about how to reach the covering doctor.

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

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

Telemedicine Services
MVP is committed to transforming the health care experience for members and providing increased access to care through telemedicine services. Telemedicine services aim to enhance the member and provider experience, including member quality of life and engagement in their health care; bring quality care closer to members in urban, rural, or underserved areas while enhancing timely access to specialists such as but not limited to BH and SUD providers and facilitate and connect providers to educational resources such as webinars, trainings, and funding to provide telemedicine services. Telemedicine services provide an opportunity for member choice of multiple providers and specialists, thus can increase member choice for an alternative service delivery model for care, while complying with all state and federal laws, HIPAA, and record retention requirements. In situations where the MVP provider network is unable to provide adequate and timely services as required by established standards services, members have a choice between an out-of-network provider (as described above) and telemedicine. Members are not required to receive services through telemedicine.

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

- When an MVP Member transitions to MVP from either Fee-for-Service (FFS) Medicaid or another health plan:

    - Members in an ongoing course of treatment or with an ongoing special condition where changing providers may disrupt care, the member may continue seeing his/her provider (even if they are out-of-network) for up to 90 days
    - New members who are pregnant and in their 2nd or 3rd trimester may continue seeing their provider(s) through their pregnancy and up to 60 days after delivery
- When a provider in good standing leaves the MVP network:
    - Members may continue seeing that provider for up to 90 days
    - Members who are pregnant and in their 2nd or 3rd trimester may continue seeing the provider through pregnancy and the postpartum period, i.e. up to 60 days after delivery

Continuity and Coordination of Care

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

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

Preventive Health Reminder Programs

Population-based initiatives aim to improve adherence to recommended preventive health guidelines for examinations, screening tests, and immunizations promoting the prevention and early diagnosis of disease. These programs utilize various member and provider interventions and activities to improve access to these services and to increase member understanding and engagement. Examples of preventive health reminder programs include, but are not limited to:

- General and supportive member and provider education such as articles in member and provider newsletters, face-to-face interactions, and written educational materials provided to members at health fairs, diaper distribution events, etc.
- Targeted telephonic and/or written outreach to members/parents/guardians to remind them of applicable preventive health screenings and services due or overdue and assistance with scheduling appointments and transportation to the appointments as needed
- Targeted written and/or face-to-face education and communication to providers identifying assigned members due or overdue for preventive health screenings such as annual well visits, immunizations, lead testing, cervical cancer screening, breast cancer screening, etc.

POPULATION HEALTH MANAGEMENT

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

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

MVP's PHM Strategy outlines the following:

- How member health needs are identified and stratified for intervention
- Details of the PHM programs and services offered aimed to address those needs for all stages of health and across health care settings
- Explains how members are informed of the programs and services and their eligibility to utilize them
- Describes proven prevention interventions and tactics used to promote the transition to value-based care in MVP's network

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

Care Management

MVP offers both medical and behavioral health Care/Case Management programs to members that are individualized to their needs. Drawing on the combined strengths of our registered nurses, social workers, respiratory therapists, BH professionals, wellness teams, physicians, pharmacists, and community providers, MVP provides a highly focused, integrated approach to management that promotes quality, cost-effective health care throughout the care continuum. MVP case managers utilize key principles within the framework of case management nursing established by the American Nursing Association (ANA) and the Case Management Society of America (CMSA). Additionally, the medical team of clinicians is certified by the Commission for Case Management (CCMC), American Nurses Credentialing Center (ANCC) and/or Wellcoaches for health coaching.

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

MVP systematically reviews, identifies, and refers members who may benefit from the Care Management programs using data from a variety of sources including claims, hospital discharge reports, lab reports, Health Risk Appraisal information, pharmacy medication reports,

and utilization review reports. Utilization review reports include information on pre-certification, pre-approval, concurrent review, hospital admissions, and hospital discharges. Care Management referrals are received from members, providers, caregivers, and other team members to ensure that the members are receiving the support, interventions, and education that is needed in a timely manner.

Health Management

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

PROVIDER SUPPORTS

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

Included is a multidimensional assessment of a PCP or other provider's performance using clinical and administrative indicators of care that are accurate, measurable, and relevant to the target population. To support providers in their delivery of robust preventive and interventive care, MVP provides quantitative and actionable analyses of the providers' member panel via analytic tools.

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

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

Provider Analytics

MVP offers a quality, cost, and utilization tool designed to support providers who participate in a value-based program to identify provider performance opportunities and assist with population health management initiatives. Provider analytics prioritizes measures based on

providers' performance to help identify where to focus clinical efforts to optimize pay-for-performance (P4P) payouts, which may include:

- Key performance indicators
- Cost and utilization data
- Emergency room cost, utilization, and trending data
- Pharmacy comparisons of brand vs. generic
- Value-Based Contracting performance summaries

Through these supporting platforms, MVP works to keep providers engaged in the delivery of value-based care by promoting wellness and incentivizing the prudent maintenance of chronic conditions. This engagement helps providers identify performance insights as well as identify opportunities for improvement.

Interventions may be discussed with the provider to address providers' performance that is out of range from their peers, and such interventions may include, but are not limited to, provider education, sharing of best practices and/or documentation tools, assistance with barrier analysis, development of corrective action plans, ongoing medical record reviews, and potential termination of network status when recommended improvements are not implemented.

Practice Guidelines

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

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

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

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

PERFORMANCE IMPROVEMENT ACTIVITIES

MVP's QIC reviews and adopts an annual QI Program and QI Work Plan that aligns with MVP's strategic vision and goals and appropriate industry standards. The Quality Department implements and supports performance/quality improvement activities as required by state or federal contract, including quality improvement projects and/or chronic care improvement projects as required by state or federal regulators, and accreditation needs. Focus studies and health care initiatives also include behavioral health care issues and/or strategies.

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

The QIC may assist in prioritizing initiatives focusing on those with the greatest need or expected impact on health outcomes and member experience. Performance improvement projects, focused studies, and other quality initiatives are designed to achieve and sustain, through ongoing measurements and interventions, significant improvement over time in clinical and non-clinical care areas in accordance with principles of sound research design and appropriate statistical analysis. The QIC helps to define the study question and the quantifiable indicators, criteria, and goals to ensure the project is measurable and able to show sustained improvement. Evidence-based guidelines, industry standards, and contractual requirements are used as the foundation for developing performance indicators, setting benchmarks and/or performance targets, and designing projects and programs that assist providers and members in managing the health of members. If data collection is conducted for a random sample of the population, baseline and follow-up sampling is conducted using the same methodology and statistical significance and a 90% or more confidence level is determined.

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

- The achievement of a pre-defined goal and/or benchmark level of performance

- The achievement of a reduction of at least 10% in the number of members who do not achieve the outcome defined by the indicator (or the number of instances in which the desired outcome is not achieved)
- The improvement is reasonably attributable to interventions undertaken by MVP

NYS, VT, AND CMS PERFORMANCE IMPROVEMENT PROJECTS

Quality Improvement Strategy (QIS)

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

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

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

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

Chronic Care Improvement Program (CCIP)

MVP conducts a CCIP, with a focus on promoting effective management of chronic disease and improving care and health outcomes for members with chronic conditions, that meets all CMS requirements for Medicare, as applicable. Effective management of chronic disease includes slowing disease progression, preventing complications and development of comorbidities, reducing preventable emergency department utilization and inpatient stays, improving quality of life, and reducing costs for both MVP and MVP Members. CCIP interventions are developed through an analysis of a MVP target population and include activities such as care coordination, promotion of preventive screening, disease and lifestyle management programs, education and outreach to members and providers, etc.

GRIEVANCE AND APPEAL SYSTEM

MVP ensures members can address their problems quickly and with minimal burden and as such investigates and resolves member complaints/grievances and appeals and quality of care concerns in a timely manner. Members may file a complaint/grievance to express dissatisfaction

with any issue that is not related to an adverse benefit determination (e.g., concerns regarding quality of care or behavior of a provider or MVP employee) or file a formal appeal of an adverse benefit determination, or upon exhaustion of the internal appeal process, request further appeal as applicable. MVP reports on grievance and appeal processes and outcomes as required.

All member grievances and appeals are tracked and resolved, and data is analyzed and reported to the QIC and applicable subcommittees on an annual basis. Identified trends are used to recommend performance improvement activities as appropriate. In addition, member grievances associated with specific providers and related to quality of care and service are tracked, classified according to severity, and reviewed by the Medical Director if needed. Member grievances by associated provider are also analyzed and reported to the QIC and applicable subcommittees (including the CCM and PRC as appropriate) for identification of specific improvement activities or if corrective action is needed.

REGULATORY COMPLIANCE AND REPORTING

MVP performs required quality of service, clinical performance, and utilization studies throughout the year based on contractual requirements, requirements of other state and regulatory agencies, and those of applicable accrediting bodies such as NCQA. All functional areas utilize standards/guidelines from these sources and those promulgated by national and state medical societies or associations, the Centers for Disease Control and Prevention, the federal government, etc. The Quality Department maintains a schedule of relevant quality reporting requirements for all applicable state and federal regulations and accreditation requirements and submits reports in accordance with these requirements. Additionally, the QI Program and all MVP Departments fully support every aspect of the federal privacy and security standards, Business Ethics and Code of Conduct, Compliance Plan, and Waste, Fraud and Abuse Plan.

NCQA HEALTH PLAN ACCREDITATION

MVP adheres to the belief that NCQA Health Plan Accreditation demonstrates a health plan's commitment to delivering high-quality care and service for members and thus strives for a continual state of accreditation readiness. The MVP Chief Medical Officer; Senior Leader, Quality; and Leader, Quality Improvement, Compliance and Accreditation facilitate the accreditation process with support from MVP's QI Accreditation team.

MVP has achieved NCQA Health Plan Accreditation for its Commercial HMO/POS, and Essential Health Plan (EHP) products in New York and Vermont, as well as its Marketplace product in Vermont. In addition, MVP achieved a NCQA Physician Quality (PQ) Certification for selected specialties which serve its Commercial members in New York State. MVP will engage in a NCQA PQ Renewal Survey in 2021. MVP's Health Plan Accreditations are effective through 2022 (VT Marketplace) and 2023 (Commercial HMO/POS, EHP).

DELEGATED SERVICES

The Delegation Oversight Committee may authorize Participating Provider entities such as independent practice associations or hospitals, or other organizations to perform activities such

as utilization management, care management, or credentialing on MVP's behalf. MVP evaluates each delegated entity's capacity to perform the proposed delegated activities prior to the execution of a delegation agreement. A mutually agreed upon delegation agreement, signed by both parties, includes, but is not limited to, the following elements:

- Responsibilities of MVP and the delegate
- Specific activities being delegated
- Frequency and type of reporting (i.e. minimum of semiannual reporting)
- The process by which MVP evaluates the delegate's performance
- Explicit statement of consequences and corrective action process if the delegate fails to meet the terms of the agreement, up to and including revocation of the delegation agreement
- The process for providing member experience and clinical performance data to the delegate when requested

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

MVP retains accountability for all functions and services delegated, and as such monitors the performance of the delegated entity through annual approval of the delegate's programs (Credentialing, Utilization Management, Care Management, etc.), routine reporting of key performance metrics, and annual or more frequent evaluation to determine whether the delegated activities are being carried out according to health plan and regulatory requirements and accreditation standards. MVP Health Management, and/or Compliance designees, conduct an annual evaluation and documentation review that includes the delegate's program, applicable policies and procedures, applicable file reviews, and review of meetings minutes for compliance with health plan, state and federal requirements and accreditation standards. MVP retains the right to reclaim the responsibility for performance of delegated functions, at any time, if the delegate is not performing adequately.

MVP Health Care's Quality Improvement Committee has reviewed and adopted this document, including the Quality Improvement Work Plan (Program Approval Signature on file within the Quality Department).

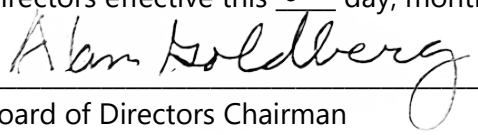
ENDORSEMENT OF THE Quality Improvement Program Description
The Quality Improvement Program Description has been reviewed and endorsed by the Quality Senior Leadership effective this 28th day, month of January, 2021.

Denise Stasik
_____
Senior Leader, Quality and Clinical Compliance

Carl Cameron
_____
Chief Medical Officer

ENDORSEMENT OF THE Quality Improvement Program Description

The Quality Improvement Program Description has been reviewed and endorsed by the Board of Directors effective this 9th day, month of March, 2021.



Board of Directors Chairman