



**MVP Health Care®**

**2026 Quality Improvement Program Description**

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## 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.

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

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

The QI Department maintains strong inter/intradepartmental working relationships, with support integrated throughout MVP, to address the priorities and goals of the QI Program and assess its effectiveness. Collaborative activities include developing department objectives and plans, coordinating activities to achieve department goals, and participating in quality committees as

needed to support the QI Program. The QI Department collaborates across MVP with several functional areas including, but not limited to, Care Management, Provider Partnership Liaisons (PPL), Provider Relations, Population Health Management, Network/Contracting, Customer Care, Corporate Compliance, and Clinical Quality and Risk Management.

## **PURPOSE**

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

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

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

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

## **SCOPE**

The scope of the MVP 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 the benefit package. MVP incorporates all demographic groups, lines of business, benefit packages, care settings, and services in its quality management and improvement activities. Areas addressed by the QI Program include:

- Preventive health
- Emergency care
- Acute and chronic care
- Population health management (PHM)
- Health disparity reduction
- Behavioral health (BH)
- Episodic care

- Long-term services and support (LTSS)
- Ancillary services
- Continuity and coordination of care
- Patient safety
- Social determinants of health (SDOH)
- Administrative, member, and network services as applicable
- Dual eligible special needs plans (D-SNP)

The MVP QI Program includes the following activities:

- Identification of priorities and goals aligning with the MVP mission and health priorities defined by the Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), New York State Department of Health (NYSDOH), National Committee for Quality Assurance (NCQA), Vermont (VT) Department of Financial Regulation (DFR), NYS Department of Financial Services (DFS), National Institutes of Health (NIH), and other regulatory bodies
- Conducting quality activities, including peer review activities, in accordance with all applicable state and federal confidentiality laws and regulations and taking conflicts of interest into consideration when conducting peer review activities
- A focus on cultural competency and health equity, including the identification of interventions to improve health disparities based on age, race, ethnicity, preferred gender, primary language, etc. and by key population groups
- 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 capable of support the goals for quality management and value, including health information systems that provide data collection, integration, tracking, analysis, and reporting of data that reflects performance on standardized measures of health outcomes
- An ongoing documentation cycle that includes the QI Program Description, the QI Work Plan, and a QI Annual Report; these documents demonstrate a systematic process of quality assessment, identification of opportunities, action implementation as indicated, and ongoing evaluation
- Collecting and submitting all quality performance measurement data per state, federal, and accreditation requirements, including robust performance management tracking and reporting such as:
  - The annual Consumer Assessment of Health Care Providers and Systems (CAHPS®):

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

- Collaboration with Corporate Compliance and other applicable departments concerning oversight of delegated functions and services, including approval of the delegate’s programs, routine reporting of key performance metrics, and ongoing evaluation to determine whether the delegated activities are being carried out according to health plan and regulatory requirements, and accreditation standards

## PRIORITIES AND GOALS

The primary goal for MVP 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 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 priorities and goals support the MVP 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.***

<b><i>To improve health, provide peace of mind, and create healthier communities.</i></b>		
<b>Focus on Individuals</b>	<b>Whole Health</b>	<b>Active Local Involvement</b>
<b>Priorities</b>	<b>Priorities</b>	<b>Priorities</b>
<ul style="list-style-type: none"> <li>• Well-coordinated, timely, accessible care delivery</li> <li>• Member tools and resources to help make healthy decisions</li> <li>• Home and community connection</li> <li>• Right care, right place, right time</li> <li>• Member engagement</li> <li>• Provider engagement</li> <li>• High value care</li> <li>• Member satisfaction with provider and health plan</li> </ul>	<ul style="list-style-type: none"> <li>• Meaningful use of data</li> <li>• Prevent and manage top chronic illnesses</li> <li>• Manage co-morbid physical and behavioral health diagnoses</li> <li>• Manage episodic illnesses</li> <li>• Manage rare chronic conditions</li> <li>• Screen for unmet needs</li> <li>• Remove barriers to care; make it simple to get well/stay well/be well</li> <li>• Coordination of care across the health care continuum</li> <li>• BH integration</li> <li>• LTSS quality of life</li> </ul>	<ul style="list-style-type: none"> <li>• Local partnerships</li> <li>• Population health improvement</li> <li>• Preventive health and wellness</li> <li>• Maternal-child health care</li> <li>• Prevent and manage obesity</li> <li>• Tobacco cessation</li> <li>• Opioid misuse prevention and treatment</li> <li>• Address SDOH</li> <li>• Health equity/disparity reduction</li> <li>• Multi-cultural health</li> </ul>

## 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 the MVP bylaws and applicable federal and state statutes and regulations.

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

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

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

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

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

- Confidentiality policies and procedures comply with applicable state statutes that address protection of peer review documents and information
- Committee members and employees responsible for Quality, Health Management, Credentialing, and Pharmacy program activities are educated about maintaining the confidentiality of peer review documents
- The Confidentiality and Conflict of Interest Disclosure Agreement is distributed and required for all committee participants annually

- The Director, Accreditation and QI Regulatory Compliance designates Quality Department staff responsible for taking minutes and maintaining confidentiality
- For quality studies coordinated with, or provided to outside PRCs, references to members are coded by identification number rather than a protected health information (PHI) identifier such as medical record number or ID number, with references to individual providers by provider code number
- Records of review findings are maintained in secured files, which are made available only as required by law or specifically authorized in writing by the CEO, Chief Medical Officer, Chief Legal Officer and General Counsel; Vice President, Health Care Delivery; Vice President, Pharmacy Management; or the Board of Directors Chair

### **Conflict of Interest**

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

## **CULTURAL COMPETENCY AND HEALTH EQUITY**

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

## **Serving a Culturally and Linguistically Diverse Membership**

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

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

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

For 2026, these cultural and linguistic items will be tracked and monitored by the appropriate business area and reported up to the Service Improvement Committee (SIC), Clinical Quality Committee (CQC), and the QIC, as appropriate.

## AUTHORITY

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

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

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

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

- Compliance with state, federal, and accreditation requirements and regulations
- Chairing the QIC, or designating an appropriate alternate Chair, and participating as appropriate
- Monitoring and directing quality activities among personnel and among the various subcommittees reporting to the QIC

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

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

The MVP Medical Directors participate in the MVP Credentialing program. They provide clinical review and oversight of the MVP appeal and grievance process and direct clinical development, continuous improvement, and clinical management of the MVP Quality Management efforts in geographic and product line initiatives. The Medical Directors also provide clinical leadership in the implementation of QI activities and actions related to MVP members and providers, including NCQA surveys, annual HEDIS reporting, CMS, and state regulatory audits. The MVP Medical Director(s) also 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 also responsible for rendering decisions on utilization requests, appeals, quality of care complaints, and cases referred to peer review, and for carrying out educational and corrective action processes with individual providers in accordance with the MVP policies, procedures, and programs. In addition, the MVP Medical Directors may be appointed to serve on the QIC and subcommittees. This role also includes oversight, development, and approval of clinical quality protocols and provides input into the development of Clinical Operations, QI, and Credentialing administrative policies and procedures.

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

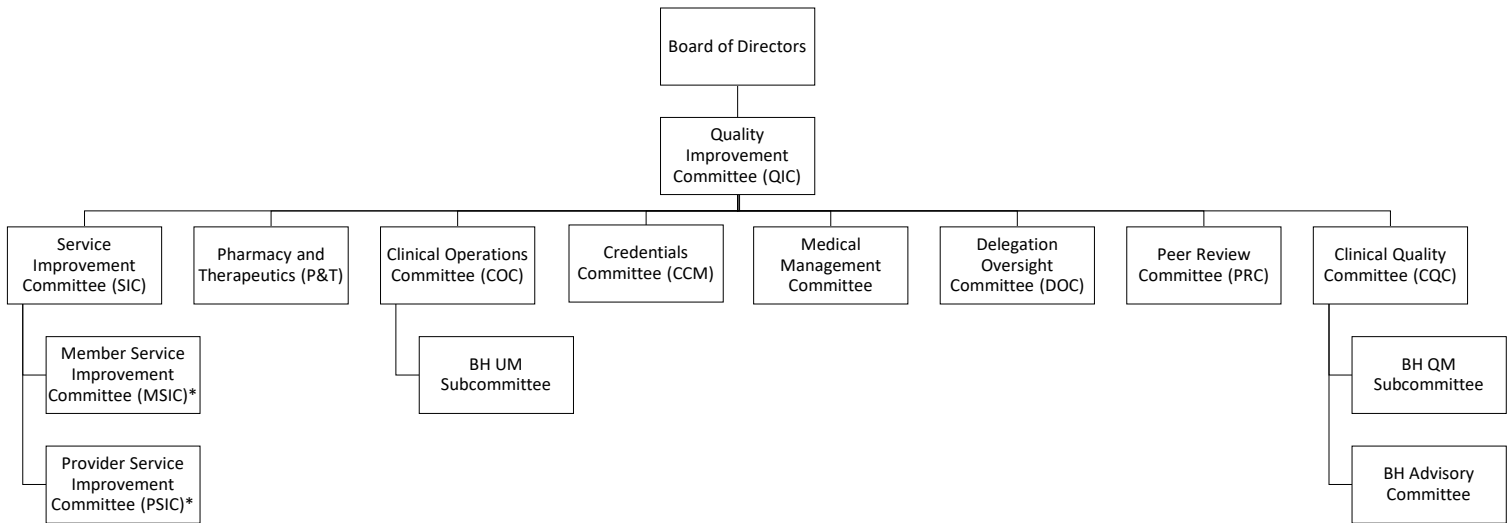
- Compliance with state, federal, and accreditation requirements and regulations related to BH
- Participating in the QIC and various subcommittees reporting to the QIC, as applicable to BH
- Monitoring and directing BH quality activities among personnel and among the various subcommittees reporting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

## **QUALITY PROGRAM STRUCTURE**

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

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

The MVP QIC structure is outlined below:



### MVP Quality Committee Structure

The MVP QI committees and subcommittees also serve as a communication pathway. Overlapping committee membership offers diverse expertise throughout the committee structure; however, chairpersons are responsible for ensuring that issues which require review by members of other committees or subcommittees are communicated to the chairperson of that committee or subcommittee.

Quality Improvement Committee (QIC)	
<b>Charter Statement</b>	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.
<b>Purpose</b>	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.
<b>Responsibilities</b>	<ul style="list-style-type: none"> <li>• Oversight of MVP quality activities to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as NCQA</li> <li>• Annual recommendations and approval of the QI Program Description and Work Plan which includes applicable supporting department goals as indicated</li> <li>• Development of quality and performance improvement studies and activities, with report findings presented to the Board of Directors</li> <li>• Annual review and approval of Credentialing, Pharmacy, Utilization Management (UM), and PHM Program Descriptions and Work Plans as</li> </ul>

<b>Quality Improvement Committee (QIC)</b>	
	<p>developed by the appointed subcommittees to facilitate alliance with the MVP strategic quality vision and goals</p> <ul style="list-style-type: none"> <li>• Evaluation of department quality activities which include barrier analysis, trend identification, and recommended interventions required to improve the quality of care and/or service to members; this may include policy decisions and implementation of corrective action plans (CAPs) as appropriate</li> <li>• Prioritization of quality improvement efforts, facilitation of functional area collaboration, and assurance of appropriate resources to carry out quality activities</li> <li>• Review and establishment of benchmarks and performance goals for each quality improvement initiative and service indicator</li> <li>• Review and approval of due diligence information for any potential delegated entity and the annual oversight audit outcomes for delegated entities</li> <li>• Adoption of preventive health and clinical practice guidelines to promote appropriate and standardized quality of care</li> <li>• Monitoring 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 support the formulation of corrective actions, as appropriate</li> <li>• Ongoing evaluation of the appropriateness and effectiveness of pay-for-performance (P4P) and value-based contracting initiatives and support in designing and modifying the program as warranted</li> <li>• Annual review and approval of all UM policies and procedures to ensure they comply with Medicare coverage standards and requirements (i.e., Non-Coverage Determinations [NCD's], Local Coverage Determinations [LCD's])</li> <li>• Review and removal of UM requirements that no longer warrant UM (i.e., analysis of UM decisions/outcomes, etc.)</li> <li>• Review the reason for its decisions regarding the development of policies and procedures</li> </ul>
<b>Reports To</b>	Board of Directors
<b>Committee Chair</b>	Chief Medical Officer, may delegate individual meetings to a Medical Director or Senior Quality Executive
<b>Committee Composition</b>	<ul style="list-style-type: none"> <li>• Chief Medical Officer</li> <li>• At least two Medical Directors (a minimum of one medical and one BH specialty) Senior Leaders/Directors representing a range of business areas within MVP, i.e., Medical Affairs, Quality Improvement, Accreditation and Quality Regulatory Compliance, Population Health Management, Pharmacy, Customer Care and Experience, Provider Data Services, Network, and other MVP representatives as identified by subject matter expertise</li> <li>• Practicing providers, at least four, representing the range of providers within the network and across the regions in which MVP operates, i.e., family practice, internal medicine, cardiology, OB/GYN, BH (i.e., physician or clinical PhD or</li> </ul>

<b>Quality Improvement Committee (QIC)</b>	
	<p>PsyD), vision/dental care providers, and other high-volume specialists as appropriate</p> <ul style="list-style-type: none"> <li>• MVP Medicare Advantage member</li> <li>• In addition, the committee may also have providers knowledgeable about members with disabilities, substance use disorder (SUD), abuse of children, etc.</li> <li>• The provider representatives should have experience caring for MVP members, including a variety of ages and races/ethnicities, rural and urban populations, etc.</li> <li>• Committee member to be determined (TBD) with expertise in the care of the elderly or disabled</li> </ul>
<b>Frequency</b>	Quarterly
<b>Attendance Required</b>	50% of scheduled meetings
<b>Quorum</b>	50% of the voting members plus one, based on the current voting membership at the time of the meeting.
<b>Agenda</b>	Agenda items for the next meeting are developed by the committee Chair in collaboration with Directors and Vice Presidents for Population Health Management, Pharmacy Management, Accreditation and Quality Regulatory Compliance, and Customer Care and Support Services. The committee receives regular reports from all subcommittees that are accountable to and/or advise the QIC.
<b>Recorder</b>	Delegated committee designee
<b>Minutes/Meeting Packets</b>	Draft minutes are completed within three days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable. Materials included in meeting packet are based on needs for prior review and privacy/sensitivity of materials.
<b>Decision Authority</b>	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 for raising any issues at committee meetings.
<b>Evaluation</b>	The committee reviews the charter annually.
<b>Confidentiality</b>	Each committee member is accountable to identify confidential information and/or situations when dissemination of information is to be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement annually.

<b>Peer Review Committee (PRC)</b>	
<b>Charter Statement</b>	The PRC is an ad-hoc committee of QIC and is responsible for reviewing alleged inappropriate or aberrant services by a provider, including potential quality of care incidents, adverse events, and sentinel events where the initial investigation indicates a significant potential or significant, severe adverse outcome has

<b>Peer Review Committee (PRC)</b>	
	occurred or other cases as deemed appropriate by the Medical Director. This committee may also review unwarranted variations in care which could result in low value care and gaps in quality.
<b>Purpose</b>	The purpose of the PRC is to review clinical cases and apply clinical judgment in assessing the appropriateness of clinical care and recommending a CAP to best suit the individual situation.
<b>Responsibilities</b>	<ul style="list-style-type: none"> <li>• To make determinations regarding appropriateness of care</li> <li>• To make recommendations regarding corrective actions relating to provider quality of care</li> <li>• To conduct the review including a provider of same or similar specialty as the provider and/or issue under review</li> <li>• To make recommendations related to unwarranted variations in care</li> </ul>
<b>Reports To</b>	QIC
<b>Committee Chair</b>	MVP Vice President, Health Care Delivery or Medical Director designee
<b>Committee Composition</b>	<ul style="list-style-type: none"> <li>• MVP Director, Accreditation and Quality Regulatory Compliance</li> <li>• PRC Chairperson, MVP Vice President, Health Care Delivery or Medical Director Designee</li> <li>• MVP Medical Directors, two, one Physical Health, one BH, who review Quality of Care Complaints</li> <li>• 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 <ul style="list-style-type: none"> <li>○ The committee may request the participation of outside specialty consultants if an MVP peer reviewer of the same/similar specialty is not available or has a known conflict of interest</li> <li>○ Representation from the Special Investigations Unit (SIU) as an ad-hoc participant if the PRC is recommended because of SIU findings, or if the review is deemed to require SIU involvement</li> </ul> </li> <li>• <i>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</i></li> </ul>
<b>Frequency</b>	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.
<b>Attendance Required</b>	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.
<b>Quorum</b>	At least two Participating Providers and one Medical Director must be present for a quorum. All permanent committee members are voting members; the committee

<b>Peer Review Committee (PRC)</b>	
	Chair is the determining vote in the case of a tie vote. All voting members who are present at the meeting constitute a quorum.
<b>Agenda</b>	Meetings are agenda driven. The committee Chair and/or Quality designee develop agenda items for the next meeting.
<b>Recorder</b>	Delegated committee designee
<b>Minutes/Meeting Packets</b>	Draft minutes are completed within three days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials. All names and identifying information are redacted and information is distributed in a secure manner.
<b>Decision Authority</b>	The QIC authorizes the PRC to make decisions and recommendations regarding provider quality of care.
<b>Evaluation</b>	The committee reviews the charter annually.
<b>Confidentiality</b>	Peer review laws govern confidentiality of its proceedings and protects 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.

<b>Credentials Committee (CCM)</b>	
<b>Charter Statement</b>	The CCM is a standing subcommittee of the QIC that oversees and has operating authority of the Credentialing Program.
<b>Purpose</b>	The purpose of the CCM is to provide oversight of the development and annual review/approval of credentialing policies and participation criteria for Participating Providers and organizational providers. The CCM has final authority for credentialing and recredentialing licensed medical and BH providers, other licensed health care professionals, and organizational providers who have an independent relationship with MVP. The CCM oversees the credentialing process to ensure compliance with regulatory and accreditation requirements and ensure Participating Providers and organizational providers are qualified, properly credentialed, and available for access by MVP members.
<b>Responsibilities</b>	<ul style="list-style-type: none"> <li>• Provide guidance to organization staff on the overall direction of the Credentialing Program</li> <li>• Review and approve credentialing and recredentialing policies and procedures</li> <li>• Review, recommend, and approve credentialing and recredentialing criteria</li> <li>• Responsible for the credentialing and recredentialing decisions for physicians, non-physician providers, and organizational and ancillary providers at MVP</li> <li>• Provide clinical peer input to address standards of care for a particular type of provider</li> <li>• Review oversight audits of delegates Credentialing Program performance</li> </ul>

<b>Credentials Committee (CCM)</b>	
	<ul style="list-style-type: none"> <li>• Evaluate and report to management on the effectiveness of the Credentialing Program</li> <li>• Review potential quality of care and adverse events, including any CAPs from PRC, for recredentialing decisions</li> </ul>
<b>Reports To</b>	QIC
<b>Committee Chair</b>	Senior Leader, Medical Director Team; as committee member leadership develops, a committee network provider may chair at the discretion of the CCM
<b>Committee Composition</b>	<ul style="list-style-type: none"> <li>• Chief Medical Officer/Medical Director(s)</li> <li>• Senior Leader/Leader, Credentialing</li> <li>• Participating Providers from a range of specialties, i.e., family practice, internal medicine, OB/GYN, BH, high-volume specialists, ancillary providers, etc.</li> <li>• Other executive leadership or health plan staff as determined</li> <li>• The committee actively involves Participating Providers in credentialing review activities as available and to the extent that there is not a conflict of interest</li> </ul>
<b>Frequency</b>	At least 10 times per year to facilitate timely review of providers and to expedite network development; additional meetings scheduled as needed.
<b>Attendance Required</b>	50% of scheduled meetings
<b>Quorum</b>	A minimum of four, 50% plus one (currently six) 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.
<b>Agenda</b>	Meetings are agenda driven and follow a standard format. Agenda items for the next meeting are developed by the Credentialing Quality and Compliance Analyst in collaboration with the Credentialing Team Lead, Credentialing Compliance/Delegation Program Manager, Credentialing Leader, and as necessary the committee Chair and/or MVP Medical Directors responsible for the Credentialing program.
<b>Recorder</b>	MVP Professional staff (Credentialing Quality and Compliance Analyst)
<b>Minutes/Meeting Packets</b>	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
<b>Decision Authority</b>	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.
<b>Evaluation</b>	The committee reviews the charter annually.
<b>Confidentiality</b>	Each committee member is accountable to identify confidential information or situations of how dissemination of information is managed. Each committee

<b>Credentials Committee (CCM)</b>	
	member must agree to and sign a committee confidentiality statement on an annual basis.

<b>Medical Management Committee</b>	
<b>Charter Statement</b>	The Medical Management Committee is a standing subcommittee of the QIC with oversight of and operating authority over medical management activities.
<b>Purpose</b>	The purpose of the Medical Management Committee is to review and monitor the appropriateness of care provided to health plan members. The Medical Management Committee is responsible for the review, evaluation, and approval of medical necessity criteria and management protocols, as well as utilization management policies and procedures. This includes procedures requiring prior authorization.
<b>Responsibilities</b>	<ul style="list-style-type: none"> <li>• Review and maintain applicable policies/procedures and clinical practice guidelines annually</li> <li>• Annually review and approve the criteria for determination of medical appropriateness</li> <li>• Review and update documentation of trending data for procedures that have been approved for coverage based upon practice patterns to respond to pattern variance in future state</li> <li>• Liaison with the QIC for ongoing review of indicators of clinical quality</li> </ul>
<b>Reports To</b>	QIC
<b>Committee Chair</b>	Medical Director, Medical Policy, who may delegate individual meetings to another Medical Director or the Sr. Leader, Medical Affairs
<b>Committee Composition</b>	<ul style="list-style-type: none"> <li>• Committee Chair: Medical Director, Medical Policy, may delegate individual meetings to another Medical Director or the Sr. Leader, Medical Affairs</li> <li>• Sr. Leader, Medical Directors/Medical Directors – Physical and Behavioral Health</li> <li>• Designated Medical Management staff</li> <li>• Other operational staff as requested, i.e., Networking/Contracting, Member/Provider Services, Compliance/Regulatory, Pharmacy, Utilization Management, Behavioral Health</li> <li>• Participating Providers representing the clinical breadth within the network and geographic service area may participate on the committee</li> </ul>
<b>Frequency</b>	At least quarterly. Additional meetings scheduled as needed, for a minimum of 8 meetings per year.
<b>Attendance Required</b>	50% of scheduled meetings
<b>Quorum</b>	Minimum of 50% of voting committee members, including two MVP staff and two external providers, must be present for a quorum. All permanent committee members are voting members; the committee Chair determines the vote in the case of a tie vote.

<b>Medical Management Committee</b>	
<b>Agenda</b>	<p>The Medical Management Committee agenda is developed and set by the Chair. Medical Management Committee follows a standing agenda that includes, but is not limited to:</p> <ul style="list-style-type: none"> <li>• Chair reports on activities of other committees, such as QIC, that impact Medical Management Committee business</li> <li>• Update provided on all policies that have gone through the Medical Policy Task Force (MPTF) committee and 14-day review by partnering physician representatives</li> <li>• Discussion on guidelines that have gone through the same process with MPTF and 14-day review</li> <li>• Discussion of data trends for procedures that are currently being monitored, but not managed, to look for overuse or abuse</li> </ul>
<b>Recorder</b>	Delegated committee designee
<b>Minutes/Meeting Packets</b>	Draft minutes are completed no later than 30 days after the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. 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.
<b>Decision Authority</b>	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.
<b>Evaluation</b>	The committee reviews the charter annually.
<b>Confidentiality</b>	The Medical Management Committee is authorized by the QIC to make all decisions related to the Medical Management Program, with decisions made by consensus of the committee. Individuals are responsible for raising issues at committee meetings.

<b>Pharmacy and Therapeutics Committee (P&amp;T)</b>	
<b>Charter Statement</b>	The P&T is a standing subcommittee of the QIC with oversight and operating authority of the Pharmacy Program.
<b>Purpose</b>	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.
<b>Responsibilities</b>	<ul style="list-style-type: none"> <li>• Develop and annually review the pharmacy policy and procedures</li> <li>• Conduct provider and member profiling for appropriate drug utilization (DUR) and recommendations for DUR activities such as targeted prescriber and/or member education initiatives</li> </ul>

<b>Pharmacy and Therapeutics Committee (P&amp;T)</b>	
	<ul style="list-style-type: none"> <li>• 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</li> <li>• Evaluation of drug costs by therapeutic class for pharmaceutical containment and projection of pharmaceutical costs</li> <li>• Assure compliance with all contractual, regulatory, and accreditation pharmacy requirements</li> <li>• Review of complaints/grievances regarding pharmacy issues</li> <li>• Recommendations for formulary and medical drug management activities such as prior authorization, step therapy, age restrictions, quantity limitations, mandatory generics, and other activities that promote access and patient safety</li> <li>• Review of requests from providers for additions or changes to formulary</li> </ul>
<b>Reports To</b>	QIC
<b>Committee Chair</b>	External provider of appropriate specialty may delegate individual meetings to an Associate Medical Director or Pharmacy Management
<b>Committee Composition</b>	<ul style="list-style-type: none"> <li>• Vice President, Health and Pharmacy Management</li> <li>• Director, Pharmacy Management</li> <li>• Medical Director, Health Management</li> <li>• Medical Director, Behavioral Health</li> <li>• Participating Pharmacists and internal clinical pharmacists</li> <li>• Various external providers including specialties (i.e., Endocrinology, Cardiology, Oncology)</li> <li>• At least one physician and one pharmacist with specialized training in the elderly</li> <li>• A BH provider with expertise in caring for children</li> <li>• Layperson to offer insights into real patient experiences</li> </ul>
<b>Frequency</b>	<ul style="list-style-type: none"> <li>• Monthly, with additional meetings scheduled per health plan need</li> <li>• At least eight times a year</li> </ul>
<b>Attendance Required</b>	50% of scheduled meetings
<b>Quorum</b>	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.
<b>Agenda</b>	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting are developed by the committee Chair in collaboration with the Senior Leaders of Pharmacy.
<b>Recorder</b>	Delegated committee designee
<b>Minutes/Meeting Packets</b>	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.

<b>Pharmacy and Therapeutics Committee (P&amp;T)</b>	
<b>Decision Authority</b>	The committee is authorized by the QIC to make all decisions related to the pharmacy benefit. Decisions made by voting consensus. Individuals are responsible and encouraged to raise issues at committee meetings.
<b>Evaluation</b>	The committee reviews the charter annually.
<b>Confidentiality</b>	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis, or when there are any changes.

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

<b>Delegation Oversight Committee (DOC)</b>	
	<ul style="list-style-type: none"> <li>• Oversee operations of the delegate to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies</li> <li>• Annual review of applicable delegate program descriptions, policies, and procedures by the operational area overseeing the relationship</li> <li>• Examine activity and performance reports to identify undesirable trends and/or patterns</li> <li>• Provide a feedback mechanism for communicating findings, recommendations, and a plan for implementing corrective action (when necessary) related to the scope of delegated functions</li> <li>• Monitor financial incentives to ensure quality of care/service is not compromised</li> <li>• Report recommended actions to address any identified opportunities for improvement or recommend termination of any delegation agreement, as necessary, to the QIC</li> <li>• Provide a forum for discussion and collaboration toward mutual goal attainment</li> <li>• Review findings of annual delegation audits with the DOC</li> </ul>
<b>Reports To</b>	QIC
<b>Committee Chair</b>	Director, Vendor Management
<b>Committee Composition</b>	<p>Committee members include subject matter experts from each appropriate operational area related to a delegated function. Requirements for committee membership include:</p> <ul style="list-style-type: none"> <li>• Seniority and comprehensive experience in the operational area overseeing the delegated relationship</li> <li>• A position to effectuate change in process and procedure</li> <li>• Demonstrated high integrity and good judgment</li> <li>• No conflict of interest with any delegated entity associated with MVP</li> </ul>
<b>Frequency</b>	Meets at least four times per year; however, meetings are typically held monthly.
<b>Attendance Required</b>	50% of scheduled meetings for each voting member
<b>Quorum</b>	A minimum of half of the voting members, including the DOC Chair, must be present for a quorum. The DOC Chair is the determining vote in the case of a tie vote.
<b>Agenda</b>	Meetings are agenda driven. Agenda items for the next meeting are developed by the Delegation Oversight Specialist in collaboration with the applicable department leads.
<b>Recorder</b>	Delegation Oversight Specialist
<b>Minutes/Meeting Packets</b>	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to DOC members prior to the scheduled meeting date

<b>Delegation Oversight Committee (DOC)</b>	
	with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
<b>Decision Authority</b>	The DOC 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.
<b>Evaluation</b>	The DOC will review the charter annually.
<b>Confidentiality</b>	Each DOC member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner. Each DOC member must agree to and sign a DOC confidentiality statement on an annual basis.

<b>Service Improvement Committee (SIC)</b>	
<b>Charter Statement</b>	MVP SIC seeks to continually improve member and provider satisfaction and loyalty, as directed by the organization's QI workplan.
<b>Purpose</b>	<p>The SIC is focused on continually improving the MVP member experience to drive improvement in member and provider satisfaction and loyalty. This includes ensuring that MVP is compliant with regulatory and accreditation standards related to member and provider education and satisfaction.</p> <p>SIC goals are supported by a subcommittee structure that focuses on member- and provider-specific improvement activities, by the efforts for Commercial and Government Programs, and by major enterprise initiatives. The SIC monitors member satisfaction including metrics such as:</p> <ul style="list-style-type: none"> <li>• Net Promoter Score (NPS)</li> <li>• Top 2 Box Score for Overall Satisfaction</li> <li>• Top 2 Box Score for Ease of Doing Business</li> </ul> <p>Research and/or root cause analysis will be initiated by the SIC where performance materially drops year over year.</p>
<b>Responsibilities</b>	<p>SIC Committee:</p> <ul style="list-style-type: none"> <li>• Review and evaluate key service performance indicators (NPS, Overall Satisfaction, Ease of Doing Business with MVP, etc.)</li> <li>• Review of key member feedback and satisfaction insights obtained through the following research: <ul style="list-style-type: none"> <li>○ Commercial, Medicare, and Medicaid CAHPS surveys</li> <li>○ Periodic Inform MVP Survey</li> <li>○ MVP New Member Surveys for Medicare and Commercial</li> <li>○ General MVP Medicare, Commercial, and Medicaid Member Surveys</li> <li>○ Provider Satisfaction Surveys</li> </ul> </li> <li>• Review, provide feedback, and approve the annual service improvement plans developed by SIC subcommittees</li> <li>• Provide ongoing reports to the QIC, as appropriate, on the progress of SIC performance improvement initiatives</li> <li>• Support the MVP core value of <i>Being the Difference for the Customer</i></li> </ul>

<b>Service Improvement Committee (SIC)</b>	
	<p>SIC Subcommittees:</p> <ul style="list-style-type: none"> <li>• Detailed review of member and provider research (survey results) including quantitative results and qualitative feedback in the form of member and provider commentary</li> <li>• Driven by member and provider feedback, identification, analysis, and selection of service improvement opportunities</li> <li>• Development of annual service improvement plans. This includes documenting targeted opportunities, associated performance metrics, and a high-level action plan</li> <li>• Presentation of the annual service improvement plan to SIC</li> <li>• Provide periodic updates on the status of the annual service improvement plans to SIC</li> </ul>
<b>Reports To</b>	QIC
<b>Committee Chair</b>	Vice President, Customer Service and Claims
<b>Committee Composition</b>	<p>Voting Membership</p> <ul style="list-style-type: none"> <li>• Chief Customer Experience Officer</li> <li>• Sr. Director, Experience Design</li> <li>• Vice President, Network Operations</li> <li>• Director, Accreditation and Quality Regulatory Compliance</li> <li>• Vice President, Health and Pharmacy Management</li> <li>• Vice President, Controller</li> <li>• Vice President, Regulatory and Managing Counsel</li> <li>• Vice President, Digital Health &amp; Clinical Strategy</li> <li>• Sr. Director, Market Strategy</li> </ul> <p>Non-Voting Membership:</p> <ul style="list-style-type: none"> <li>• Leader, Service Design</li> <li>• Professionals, Sr. Service Designers – Insurance Products (two)</li> <li>• Leader, Internal Provider Relations and Contracts</li> </ul>
<b>Frequency</b>	At least four times a year/quarterly
<b>Attendance Required</b>	50% of scheduled meetings
<b>Quorum</b>	50% of voting members, based on the current voting membership at the time of the meeting.
<b>Agenda</b>	Agenda items for the next meeting are developed by the committee Chair in collaboration with other committee members.
<b>Recorder</b>	Committee Chair or delegate (committee Chair reviews and signs meeting minutes)
<b>Minutes/Meeting Packets</b>	Draft minutes are completed no later than 30 days after the meeting or as needed for regulatory reporting. Minutes are stored in a secure area and meeting packets are delivered to committee members in advance of the meeting.
<b>Decision Authority</b>	The QIC authorizes the SIC to make decisions and recommendations regarding service improvement opportunities and related plans. The decision-making model

<b>Service Improvement Committee (SIC)</b>	
	is by consensus. Individuals are responsible and encouraged to raise any issues at committee meetings.
<b>Evaluation</b>	The SIC reviews the committee charter annually.
<b>Confidentiality</b>	Each committee member is accountable to identify confidential information and/or situations when dissemination of information is to be managed in a specific member. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

<b>Provider Service Improvement Committee (PSIC)</b>	
<b>Charter Statement</b>	The MVP PSIC seeks to improve provider service and experience, and the associated member experience, through consistent review of, and necessary action on, data collected from the MVP network of providers and internally collected data.
<b>Purpose</b>	The focus of the PSIC is to review trends in data that impact a positive provider experience. The committee also reviews data collected from Directory Reviews and Access and Availability audits to ensure compliance with NCQA requirements and identify opportunities for improvement.
<b>Responsibilities</b>	The PSIC is responsible for the following functions: <ul style="list-style-type: none"> <li>• Review results of quarterly Access and Availability studies and any associated service improvement plans</li> <li>• Review annual Network Analyses associated with NCQA requirements, as well as opportunities for improvement</li> <li>• Review metrics and provide root cause analysis when Access and Availability standards and/or NCQA compliance are not met, and development of corrective action</li> </ul>
<b>Reports To</b>	SIC
<b>Committee Chair</b>	Director, Network Data and Regulatory Compliance
<b>Committee Composition</b>	The PSIC includes a cross-departmental membership consisting of Leaders from Network and Contracting, Provider Data Services, Customer Care, Utilization Management, Market Research, Provider Engagement and Experience, Compliance, Marketing and Communications, Claims Operations, Behavioral Health, and Quality Improvement
<b>Frequency</b>	Monthly
<b>Attendance Required</b>	A member of each department or their designated representative is encouraged to attend each meeting.
<b>Quorum</b>	No quorum necessary due to a non-voting committee structure
<b>Agenda</b>	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.
<b>Recorder</b>	Delegated committee designee
<b>Minutes/Meeting Packets</b>	Meeting minutes are distributed for review and approval no less than one week prior to the next monthly meeting.

<b>Provider Service Improvement Committee (PSIC)</b>	
<b>Decision Authority</b>	The committee makes decisions and recommendations that are subsequently reviewed by the SIC. Committee members are encouraged to raise any questions or concerns during the PSIC meetings. Decisions are made by consensus.
<b>Evaluation</b>	The committee will review the charter annually.
<b>Confidentiality</b>	Each committee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner.

<b>Member Service Improvement Committee (MSIC)</b>	
<b>Charter Statement</b>	The MVP MSIC is a subcommittee focused on supporting the enterprise wide SIC in its mission to maintain or increase member satisfaction and loyalty.
<b>Purpose</b>	The subcommittee is focused on continually evaluating member feedback/satisfaction and uncovering potential member-specific improvement initiatives through various research channels. These channels include, but are not limited to, MVP primary research activities and secondary research conducted on behalf of MVP.
<b>Responsibilities</b>	<ul style="list-style-type: none"> <li>• Detailed review of in-house and secondary member research results, including quantitative and qualitative feedback in the form of member comments</li> <li>• Identify, analyze, and prioritize improvement opportunities based on available research</li> <li>• Develop service improvement plans; this includes documenting targeted opportunities, associated performance metrics, and interventions necessary to achieve goals</li> <li>• Present service improvement plans to SIC</li> <li>• Provide periodic service improvement plan updates to SIC</li> </ul>
<b>Reports To</b>	SIC
<b>Committee Chair</b>	Leader, Service Design, Customer Experience
<b>Committee Composition</b>	<p>The MSIC is comprised of representation from the following areas.</p> <ul style="list-style-type: none"> <li>• Care Management</li> <li>• Claims</li> <li>• Customer Care</li> <li>• Marketing and Communications</li> <li>• Customer Experience</li> <li>• Product Marketing</li> <li>• Medicaid Services and Support</li> <li>• Medical Management</li> <li>• Member Appeals</li> <li>• Network Management</li> <li>• Pharmacy</li> <li>• Premium Billing Collections</li> <li>• Product Strategy and Design</li> </ul>

<b>Member Service Improvement Committee (MSIC)</b>	
	<ul style="list-style-type: none"> <li>• Provider Data Management</li> <li>• Quality Operations</li> <li>• Quality Performance and Initiatives</li> <li>• Regulatory Compliance and Accreditation</li> <li>• Utilization Management</li> </ul> <p>Due to the fluid nature of the committee's work, representation may fluctuate throughout the year to accommodate workplan needs.</p>
<b>Frequency</b>	At least quarterly but may be more often depending on the line of business issues to solution for.
<b>Attendance Required</b>	90% of scheduled meetings
<b>Quorum</b>	No quorum necessary due to a non-voting committee structure
<b>Agenda</b>	Meetings are agenda driven and developed by the committee Chair.
<b>Recorder</b>	Committee Chair or designee
<b>Minutes/Meeting Packets</b>	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
<b>Decision Authority</b>	Committee members have the authority to recommend which member issues and interventions are included in its annual improvement plan. Recommendations made by consensus.
<b>Evaluation</b>	The committee will review the charter annually.
<b>Confidentiality</b>	Each committee member is accountable for identifying and treating confidential information in accordance with MVP policies.

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

## Clinical Operations Committee (COC)

### Responsibilities

In practice these responsibilities are carried out through the monitoring of the Clinical Operations work plan which includes the following functions:

- Synopses from the current quarter's adult and child BH UM subcommittees are reported out, with <21-year-old medically fragile children reported out separately, including Pharmacy data
- Monitoring, analyzing, and evaluating utilization including under- and over-utilization of services and cost data
- Monitoring, analyzing, and evaluating Care Management (CM) activities including outreach, engagement, performance, and overall effectiveness
- Monitoring, analyzing, and evaluating data, including but not limited to:
  - Admission rates
  - Readmission rates
  - Engagement rates
  - Population health complexity, condition prevalence, and other health drivers
  - Trends
  - Average length of stay
  - Emergency department (ED) utilization
  - Prior authorization/denial and notices of action
  - Annual Review of authorization statistics to ensure access to services
  - Annual review/report of additions and removals of prior authorizations
  - UM and CM delegated entity performance
  - Tracking and trending appeals.
- Staff Inter-Rater Reliability (IRR) and Quality Control (QC) monitoring and reporting
- Parity reporting
- D-SNP product reporting
- LTSS program reporting
- Vermont UM requirements review
- Developing, implementing, and reviewing intervention strategies with measurable outcomes based on data findings
- Ensuring timely reporting of UM and CM performance measurement data (Including turnaround time [TAT])
- Implementing CAPs as appropriate
- NCQA QI 3
- NCQA Member Experience (ME) 7
- Annual approval of the Utilization Management Program Description and Utilization Management Program Evaluation
- Develop and revise a comprehensive documented process annually that describes the PHM strategy for meeting the care needs of customers, including goals, services, activities, etc.

<b>Clinical Operations Committee (COC)</b>	
	<ul style="list-style-type: none"> <li>• Stratify/segment the entire enrolled population into subsets for targeted intervention based on customer health needs on an annual basis.</li> <li>• Present PHM Effectiveness Report for review and approval</li> <li>• Present CM satisfaction/experience survey results to committee</li> <li>• Present CM PH and BH Quality File Audit Review Results</li> <li>• Present Mental Health Review Agents Annual License Renewal Application</li> <li>• Conduct and present a summary of policies including updates and revisions as needed</li> <li>• Review and update Grievance System policy (or individual complaint/grievance/appeals policies) annually to ensure grievance and appeal processes are compliant with state/federal/accreditation requirements</li> <li>• Monitor customer and provider grievances and appeals no less than annually</li> </ul>
<b>Reports To</b>	QIC; Board of Directors
<b>Committee Chair</b>	<ul style="list-style-type: none"> <li>• Vice President, Clinical Operations</li> <li>• Medical Director, Behavioral Health</li> <li>• Vice President, Health and Pharmacy Management</li> </ul>
<b>Committee Composition</b>	<ul style="list-style-type: none"> <li>• Chief Medical Officer / Delegate</li> <li>• Medical Director Transactional Management</li> <li>• Director, Accreditation and Quality Regulatory Compliance</li> <li>• Designee/Senior Leader from each applicable functional area, i.e., Medical Management, Network Development and Contracting, Provider Relations/Services, Customer Care, Grievance and Appeals, Compliance and Regulatory Affairs, Pharmacy</li> <li>• BH Provider/Representative</li> <li>• Additional staff may participate as requested by the Chair</li> </ul>
<b>Frequency</b>	Quarterly, ad hoc as necessary
<b>Attendance Required</b>	50% of scheduled meetings
<b>Quorum</b>	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.
<b>Agenda</b>	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.
<b>Recorder</b>	Delegated committee designee
<b>Minutes/Meeting Packets</b>	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.

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

<b>Clinical Quality Committee (CQC)</b>	
<b>Charter Statement</b>	The MVP CQC meets at least quarterly and must meet four times per calendar year. The CQC reports to the QIC on a quarterly basis. Ad hoc reporting will occur, as necessary. The CQC reports to the Board of Directors.
<b>Purpose</b>	<ul style="list-style-type: none"> <li>• Present synopses of current quarter's Adult and Children's Behavioral Health Advisory Committees</li> <li>• Present synopses of current quarter's Adult and Children's Behavioral Health Quality Management subcommittees</li> <li>• Provide oversight of Quality Management activities for behavioral health and physical health throughout MVP</li> <li>• Monitor, analyze, and evaluate quality management data</li> <li>• Eliminate barriers to integration of physical and behavioral health across the enterprise</li> <li>• Review and analyze data, review outcomes, and develop interventions based on the findings</li> <li>• Manage available resources to optimize the health and well-being of MVP members</li> <li>• All lines of business are represented for both physical and behavioral health</li> </ul>
<b>Responsibilities</b>	<ul style="list-style-type: none"> <li>• The CQC oversees and approves activities of the two following behavioral health subcommittees: <ul style="list-style-type: none"> <li>○ Behavioral Health Advisory Committee</li> <li>○ Behavioral Health Quality Management</li> </ul> </li> <li>• All lines of business are reviewed during the CQC</li> <li>• Standing agenda items include but are not limited to: <ul style="list-style-type: none"> <li>○ Outcomes of the Annual Commercial Behavioral Health Member Experience survey</li> <li>○ Reporting on outreach to providers/facilities on quality measure performance</li> <li>○ Care Management Policy annual review</li> <li>○ Performance Improvement Strategy Project (QIP) and Marketplace Quality Improvement Strategy (QIS) annual review</li> </ul> </li> </ul>

<b>Clinical Quality Committee (CQC)</b>	
	<ul style="list-style-type: none"> <li>○ Regulatory updates including NCQA and NYSDOH requirements</li> <li>○ Overview of regulatory projects including the HARP and Children’s PIPs, all Quality Performance Matrices (QPMs), and CCIP updates</li> <li>● Quality Initiatives Overview: <ul style="list-style-type: none"> <li>○ Routine performance reporting of HEDIS/Quality Assurance Reporting Requirements (QARR) measures</li> <li>○ Performance of Medicare STARS Program</li> <li>○ This committee also reports on the D-SNP and the Integrated Benefits Plan (IBP) (Dual Access Complete) programs.</li> </ul> </li> </ul>
<b>Reports To</b>	QIC; Board of Directors
<b>Committee Chair</b>	Sr. Director, Behavioral Health and Utilization Management Operations; Quality Management Behavioral Health Liaison
<b>Committee Composition</b>	<p>Voting Members</p> <ul style="list-style-type: none"> <li>● Chairs: Sr. Director, Behavioral Health and Utilization Management Operations and Quality Management Behavioral Health Liaison</li> <li>● Chief Medical Officer</li> <li>● Director, Accreditation &amp; Quality Regulatory Compliance</li> <li>● Director, Appeals and Grievances</li> <li>● Director, Pharmacy Management</li> <li>● Director, Utilization Management and Intake Operations Optimization</li> <li>● Leader, Behavioral Health Case Management</li> <li>● Leader, Behavioral Health Case Management, Children's Services and Government Liaison</li> <li>● Leader, Behavioral Health Case Management Performance and Initiatives</li> <li>● Medical Director, Behavioral Health</li> <li>● Medical Director, HARP Behavioral Health Adult Services</li> <li>● Medical Director, Pediatrics</li> <li>● Sr. Director, Care Management</li> <li>● Vice President Clinical Operations</li> <li>● Vice President, Health and Pharmacy Management</li> </ul>
<b>Frequency</b>	Quarterly
<b>Attendance Required</b>	50% of scheduled meetings
<b>Quorum</b>	At each meeting of the CQC the presence of 50% plus one of the voting members constitutes a quorum for the transaction of business. Less than a quorum will have the power to adjourn any meeting until such time a quorum is present.
<b>Agenda</b>	Agenda items for the next meeting are developed by the committee Chairs, the Senior Leader, Behavioral Health, and the Quality Management Behavioral Health Liaison. The committee receives regular reports from all subcommittees that are accountable to and/or advise the CQC.
<b>Recorder</b>	Delegated committee designee

<b>Clinical Quality Committee (CQC)</b>	
<b>Minutes/Meeting Packets</b>	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
<b>Decision Authority</b>	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.
<b>Evaluation</b>	The committee will review the charter annually.
<b>Confidentiality</b>	Each committee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

## **BEHAVIORAL HEALTH PROGRAM STRUCTURE**

### **MVP Quality Staff**

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

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

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

**Sr. Director, Behavioral Health and Utilization Management Operations**, under the direction of the Vice President, Clinical Operations, the Sr. Director, Behavioral Health and Utilization Management Operations is responsible for the strategic planning, development, implementation, and ongoing oversight of the MVP Behavioral Health CM and UM program components and the Credentialing and Intake Departments.

**Director, BH Utilization and Case Management Operations Optimization**, oversees the development, implementation, ongoing operations, assessment and monitoring of MVP's Behavioral Health Program. This role is accountable for developing and implementing policies and procedures to support the functional infrastructure and ensuring compliance with Federal, State, NCQA, other regulatory agencies, and internal standards and requirements. This position provides oversight, leadership, and direction for the clinical interventions targeted to improve member and provider satisfaction, decrease cost waste, maximize quality, and improve clinical outcomes for the clinical care of the member's behavioral health needs and services.

### **Leader, Behavioral Health Case Management**

Provides direct supervision to licensed clinicians and non-licensed staff (Behavioral Health Coaches) who deliver case management services to members with behavioral health needs. This includes all lines of business except HARP and Medicaid-enrolled children eligible for Home and Community-Based Services (HCBS) or those in foster care placement.

This role oversees member engagement across commercial programs, employer groups with performance guarantees, and members with stop-loss concerns. It also involves coordination with internal stakeholders to ensure seamless care transitions and program alignment across all lines of business.

Key responsibilities include leading quality management initiatives tied to HEDIS and Medicare Stars, and managing member cohorts relevant to NCQA regulatory efforts. The position provides strategic oversight and clinical direction to drive interventions that enhance member and provider satisfaction, reduce cost inefficiencies, improve quality metrics, and support better clinical outcomes.

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

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

**Quality Management Behavioral Health Liaison** provides support for and monitoring of the progress of the BH QM/UM Program as a chairperson for all behavioral health subcommittees. This role ensures that MVP meets stated goals and objectives and complies with regulatory requirements, including being responsible for the completion and submission of the NCQA QI 4

Report, and creating, tracking and supporting interventions for all PIPs and QPMs. The liaison ensures that the QM/UM work plan reflects the progress of QM/UM activities and supports committees and subcommittees' findings to identify barriers to improvement, propose methods for addressing the barriers, and to facilitate program development, evaluation, and reporting. This role supports market research on Behavioral Health Satisfaction Surveys to improve member and provider satisfaction.

**MVP Behavioral Health Subcommittees**

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

<b>Behavioral Health Quality Management (BH QM) (HARP/Medicaid/D-SNP Non-Integrated and D-SNP IBP) Subcommittee</b>	
<b>Charter Statement</b>	The Mainstream Medicaid Qualified Medicaid Plan (QMP/HARP) BH QM subcommittees and Children’s BH QM subcommittees are standing meetings scheduled in succession with one another and report up to the CQC, QIC, and then ultimately to the Board of Directors.
<b>Purpose</b>	<p>The purpose of the HARP/Medicaid/D-SNP Non-Integrated and D-SNP IBP BH QM subcommittee is to:</p> <ul style="list-style-type: none"> <li>• Assess the clinical and service needs of QMP adults, HARP, and D-SNP members with BH diagnoses</li> <li>• 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</li> <li>• Implement, evaluate, and report on the various interventions/programs that will optimize clinical quality, maximize safe clinical practices, and enhance services to QMP/HARP/D-SNP members</li> <li>• 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</li> <li>• Ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis for all QMP/HARP/D-SNP members</li> </ul>
<b>Responsibilities</b>	<ul style="list-style-type: none"> <li>• Report out the synopsis from current QMP BH Advisory subcommittee</li> <li>• Separately tracks, trends, and reports BH complaints, grievances, appeals, and denials for members with BH diagnoses who are QMP, HARP, and D-SNP and IBP members</li> <li>• BH prior authorization/denial and notices of action for QMP, HARP, Child Health Plus (CHP), D-SNP, and IBP populations</li> <li>• The subcommittee will report how the quality assurance program addresses specific monitoring requirements related to the populations, benefits, and services covered</li> </ul>

<b>Behavioral Health Quality Management (BH QM) (HARP/Medicaid/D-SNP Non-Integrated and D-SNP IBP) Subcommittee</b>	
	<ul style="list-style-type: none"> <li>• Follow up after discharge: <ul style="list-style-type: none"> <li>○ Follow-up After Hospitalization for Mental Illness (FUH), Follow-up after High-Intensity Care for SUD (FUI); Follow-Up After ED Visit for Mental Illness (FUM); Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA)</li> <li>○ Initiation and Engagement of Substance Use Disorder Treatment (IET)</li> <li>○ Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)</li> </ul> </li> <li>• Adverse incident reporting for QMP, HARP, D-SNP, and DSNP-IBP populations</li> <li>• Describe the HARP plan for capturing and reporting BH HCBS services and support monitoring of compliance with HCBS requirements</li> <li>• Statewide reporting of HARP enrolled members without HCBS assessments</li> <li>• Will track and report on compliance for: <ul style="list-style-type: none"> <li>○ BH quality assurance performance measure/reporting of HCBS assurances/sub-assurances and recovery measures including employment, housing, criminal justice status, etc.</li> <li>○ Protocols for expedited and standard appeals regarding plan of care denials for HCBS</li> <li>○ All PIPs and QPMs and updates on special populations</li> <li>○ Behavioral Health Member Satisfaction Survey Results for HARP and Mainstream Medicaid populations</li> </ul> </li> <li>• Will conduct an annual consumer perception survey (supplementary to CAHPS)</li> </ul>
<b>Reports To</b>	CQC; QIC; Board of Directors
<b>Committee Chair</b>	Quality Management Behavioral Health Liaison (Behavioral Health Quality Administrator) and Senior Leader of Behavioral Health (Behavioral Health Director)
<b>Committee Composition</b>	<ul style="list-style-type: none"> <li>• Chairs: Sr. Director, Behavioral Health &amp; Utilization Management Operations and the Quality Management Behavioral Health Liaison</li> <li>• Chief Medical Officer</li> <li>• Director, Accreditation &amp; Quality Regulatory Compliance</li> <li>• Director, Appeals and Grievances</li> <li>• Director, Integrated Health Contract Manager</li> <li>• Director, Pharmacy Management</li> <li>• Director, Utilization Management and Intake Operations Optimization</li> <li>• Leader, Behavioral Health Case Management</li> <li>• Leader, Behavioral Health Case Management, Children Services &amp; Government Liaison</li> <li>• Leader, Behavioral Health Case Management Performance and Initiatives</li> </ul>

<b>Behavioral Health Quality Management (BH QM) (HARP/Medicaid/D-SNP Non-Integrated and D-SNP IBP) Subcommittee</b>	
	<ul style="list-style-type: none"> <li>• Leader, Care Center Staff</li> <li>• Medical Director, Behavioral Health</li> <li>• Medical Director, Behavioral Health Children's Services</li> <li>• Medical Director, HARP Behavioral Health Adult Services</li> <li>• Medical Director, Pediatrics</li> <li>• Vice President, Health and Pharmacy Management</li> <li>•</li> </ul>
<b>Frequency</b>	At least quarterly
<b>Attendance Required</b>	50% of scheduled meetings
<b>Quorum</b>	50% plus one of the voting members at the time of the meeting constitutes a quorum for the transaction of business. Less than a quorum will have the power to adjourn any meeting until such time a quorum is present.
<b>Agenda</b>	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the subcommittee Chair. All agenda items are based on requirements set forth in the New York Request for Qualifications for Adult Behavioral Health Benefit Administration. Quarterly reports with the required agenda items are received from the appropriate report owners and reviewed by the subcommittee Chairs and Liaison prior to subcommittee.
<b>Recorder</b>	Delegated subcommittee designee
<b>Minutes/Meeting Packets</b>	Maintains records documenting attendance, findings, recommendations, and actions. Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to subcommittee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
<b>Decision Authority</b>	The subcommittee is authorized by the CQC to make decisions, which report to the Board of Directors, and recommendations regarding quality management. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the subcommittee meetings.
<b>Evaluation</b>	The subcommittee will review the charter annually.
<b>Confidentiality</b>	Each subcommittee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner. Each subcommittee member must agree to and sign a subcommittee confidentiality statement on an annual basis.

<b>Children's Behavioral Health Quality Management (BH QM) Subcommittee</b>	
<b>Charter Statement</b>	The Children's BH QM subcommittees and QMP/HARP BH QM subcommittees are standing meetings scheduled in succession with one another and report up to the CQC and then ultimately to the Board of Directors.

<b>Children’s Behavioral Health Quality Management (BH QM) Subcommittee</b>	
<b>Purpose</b>	<ul style="list-style-type: none"> <li>• Assess the clinical and service needs of the Medicaid enrolled children including HCBS; this includes children with BH needs, children in foster care, and medically fragile children</li> <li>• Carry out the planned quality activities related to children who access BH benefits or HCBS</li> <li>• The BH QM subcommittee shall be accountable to and report regularly to the governing board or its designee concerning BH QM activities</li> <li>• 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</li> <li>• 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</li> <li>• As of January 1, 2025, this committee also includes CHP</li> </ul>
<b>Responsibilities</b>	<ul style="list-style-type: none"> <li>• Report out synopsis from current Children’s BH Advisory subcommittee</li> <li>• Report to the NYS OMH and OASAS any deficiencies in performance and corrective action taken with respect to OMH and OASAS licensed, certified, or designated providers</li> <li>• Separately tracks, trends, and reports children’s BH complaints, grievances, appeals, and denials for members with BH diagnoses</li> <li>• Discusses BH utilization requests, denials, and notices of action</li> <li>• Track and report compliance with: <ul style="list-style-type: none"> <li>○ HCBS assurance and sub-assurances</li> <li>○ Protocols for expedited and standard appeals regarding plan of care denials for HCBS</li> </ul> </li> <li>• Report out how the quality assurance program addresses specific monitoring requirements related to the populations, benefits and services covered</li> <li>• Follow up after discharge: <ul style="list-style-type: none"> <li>○ FUH, FUI, IET</li> <li>○ Follow-up Care for Children Prescribed ADHD Medication (ADD)</li> </ul> </li> <li>• Adverse incident reporting for children</li> <li>• Reporting on all performance improvement plans and updates on special populations</li> </ul>
<b>Reports To</b>	CQC; QIC; Board of Directors
<b>Committee Chair</b>	<ul style="list-style-type: none"> <li>• Quality Management Behavioral Health Liaison (BH Quality Administrator)</li> <li>• Senior Leader of Behavioral Health (BH Director)</li> </ul>
<b>Committee Composition</b>	<p>Standing Voting Membership:</p> <ul style="list-style-type: none"> <li>• Chairs: Sr. Director, Behavioral Health &amp; Utilization Management Operations and the Quality Management Behavioral Health Liaison</li> <li>• Chief Medical Officer</li> </ul>

<b>Children’s Behavioral Health Quality Management (BH QM) Subcommittee</b>	
	<ul style="list-style-type: none"> <li>• Director, Accreditation &amp; Quality Regulatory Compliance</li> <li>• Director, Appeals and Grievances</li> <li>• Director, Integrated Health Contract Manager</li> <li>• Director, Pharmacy Management</li> <li>• Director, Utilization Management and Intake Operations Optimization</li> <li>• Leader, Behavioral Health Case Management</li> <li>• Leader, Behavioral Health Case Management, Children Services &amp; Government Liaison</li> <li>• Leader, Behavioral Health Case Management Performance and Initiatives</li> <li>• Leader, Care Center Staff</li> <li>• Medical Director, Behavioral Health</li> <li>• Medical Director, Behavioral Health Children's Services</li> <li>• Medical Director, HARP Behavioral Health Adult Services</li> <li>• Medical Director, Pediatrics</li> <li>• Vice President, Health and Pharmacy Management</li> </ul>
<b>Frequency</b>	At least quarterly
<b>Attendance Required</b>	50% of scheduled meetings
<b>Quorum</b>	50% plus one of the voting members at the time of the meeting constitutes a quorum for the transaction of business. Less than a quorum will have the power to adjourn any meeting until such time a quorum is present.
<b>Agenda</b>	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the subcommittee Chair. All agenda items are based on requirements set forth in the NYS Children’s Health and Behavioral Health Benefit Administration: Medicaid Managed Care Organization (MCO) Children’s System Transformation Requirements and Standards. Quarterly reports with the required agenda items are received from the appropriate report owners and reviewed by the subcommittee Chairs and Liaison prior to committee.
<b>Recorder</b>	Delegated subcommittee designee
<b>Minutes/Meeting Packets</b>	Maintains records documenting attendance, findings, recommendations, and actions. Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to subcommittee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
<b>Decision Authority</b>	The subcommittee is authorized by the CQC to make decisions, which report to the Board of Directors, and recommendations regarding quality management. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the subcommittee meetings.

<b>Children’s Behavioral Health Quality Management (BH QM) Subcommittee</b>	
<b>Evaluation</b>	The committee will review the charter annually.
<b>Confidentiality</b>	Each subcommittee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner. Each subcommittee member must agree to and sign a subcommittee confidentiality statement on an annual basis.

<b>Behavioral Health Advisory Committee (HARP/Medicaid)</b>	
<b>Charter Statement</b>	The QMP/HARP Behavioral Health Advisory subcommittees are to be held at least quarterly. The QMP/HARP and Children’s Behavioral Health Advisory subcommittees are held in succession with one another and report up to the BH QM subcommittee, CQC, and to the Board of Directors.
<b>Purpose</b>	<ul style="list-style-type: none"> <li>• Solicit feedback and recommendations that service the needs of MVP members to improve quality of care and member outcomes</li> <li>• Special accommodations are made to ensure member accessibility to the committee including but not limited to providing a toll-free number; access to Teletypewriters (TTY) for the hearing impaired, and use of interpreters through Language Line Solutions.</li> <li>• Key stakeholders include: <ul style="list-style-type: none"> <li>○ Members</li> <li>○ Caregivers/Guardians</li> <li>○ Family members</li> <li>○ MVP Staff</li> <li>○ Behavioral Health and Other Health Care Providers/Peers</li> <li>○ Local Government Unit (LGU)</li> </ul> </li> </ul>
<b>Responsibilities</b>	<ul style="list-style-type: none"> <li>• 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 QMP and HARP members: <ul style="list-style-type: none"> <li>○ This includes, but is not limited to, challenges, barriers, resources, and unmet needs of this population</li> <li>○ Solicit ideas and feedback to improve overall member and provider experience</li> </ul> </li> <li>• Identify proposed resolutions of issues related to the management of the HARP population and BH benefits</li> </ul>
<b>Reports To</b>	BH QM subcommittee; CQC; QIC; Board of Directors
<b>Committee Chair</b>	Tri-chair: Quality Management Behavioral Health Liaison, Sr. Director, Behavioral Health and Utilization Management Operations and the Quality Management Behavioral Health Liaison, and an external chairperson.
<b>Committee Composition</b>	Internal: <ul style="list-style-type: none"> <li>• Chairs: Sr. Director, Behavioral Health &amp; Utilization Management Operations; Quality Management Behavioral Health Liaison</li> <li>• Chief Medical Officer, or delegate</li> </ul>

<b>Behavioral Health Advisory Committee (HARP/Medicaid)</b>	
	<ul style="list-style-type: none"> <li>• Director, Accreditation &amp; Quality Regulatory Compliance</li> <li>• Director, Appeals and Grievances</li> <li>• Director, Pharmacy Management</li> <li>• Director, Utilization Management and Intake Operations Optimization</li> <li>• Health Promotion Program Manager</li> <li>• Leader, Behavioral Health Case Management</li> <li>• Leader, Behavioral Health Case Management, Children Services &amp; Government Liaison</li> <li>• Leader, Behavioral Health Case Management Performance and Initiatives</li> <li>• Leader, Care Center Staff</li> <li>• Leader, Commercial Appeals Operations</li> <li>• Medical Director, Behavioral Health</li> <li>• Medical Director, Behavioral Health Children’s Services</li> <li>• Medical Director, HARP Behavioral Health Adult Services</li> <li>• Medical Director, Pediatrics</li> <li>• Professional, Compliance Customer Engagement</li> <li>• Professional, Customer &amp; Provider Communications</li> <li>• Vice President, Health and Pharmacy Management</li> </ul> <p>External:</p> <ul style="list-style-type: none"> <li>• MVP customers</li> <li>• Senior Director of Clinics and Clinical Services, Villa of Hope</li> <li>• Medicaid Managed Care Liaison Coordinator, Berkshire Farm Center</li> <li>• Sr. Director of Revenue Management, Children Services &amp; Government Liaison, Julia Dyckman Andrus Memorial</li> <li>• Director of Health Home Care Management, ASCEND Mental Wellness</li> <li>• Executive Director, New Hope Manor</li> <li>• Chief Executive Officer, Human Development Services of Westchester, Inc.</li> </ul>
<b>Frequency</b>	At least quarterly
<b>Attendance Required</b>	50% of scheduled meetings
<b>Quorum</b>	The QMP/HARP Behavioral Health Advisory subcommittees will solicit feedback and advice; it is not a voting committee. Minutes will reflect discussion and attendance.
<b>Agenda</b>	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the committee Chair with input requested by members, providers, stakeholders, and all other participants on the committee.
<b>Recorder</b>	Delegated committee designee
<b>Minutes/Meeting Packets</b>	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled

<b>Behavioral Health Advisory Committee (HARP/Medicaid)</b>	
	meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
<b>Decision Authority</b>	The subcommittee is authorized by the CQC to make recommendations regarding performance improvement processes. Individuals are responsible and encouraged to raise any concerns/issues at the committee meetings.
<b>Evaluation</b>	The subcommittee will review the charter annually.
<b>Confidentiality</b>	Each committee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner. Each committee member must agree to and sign a subcommittee confidentiality statement on an annual basis.

<b>Children’s Behavioral Health Advisory Committee</b>	
<b>Charter Statement</b>	The Children’s BH Advisory subcommittees are to be held at least quarterly. The QMP/HARP and Children’s BH Advisory subcommittees are held in succession with one another and report up to the BH QM subcommittee, CQC, and to the Board of Directors.
<b>Purpose</b>	<ul style="list-style-type: none"> <li>• Solicit feedback and recommendations that service the needs of MVP members to improve quality of care and member outcomes.</li> <li>• Special accommodations are made to ensure member accessibility to the committee including but not limited to providing a toll-free number, access to TTY for the hearing impaired, and use of interpreters through Language Line Solutions.</li> <li>• Key stakeholders include: <ul style="list-style-type: none"> <li>○ Members</li> <li>○ Members’ caregivers</li> <li>○ Family members</li> <li>○ Peers</li> <li>○ Foster Care Agencies (including Voluntary Foster Care Agencies [VFCAs])</li> <li>○ Subcontracted Plans</li> <li>○ LGU</li> <li>○ Representatives and other child service agencies</li> </ul> </li> <li>• Advise and assist the plan in identifying and resolving issues related to the management of children’s health and behavioral health benefits</li> </ul>
<b>Responsibilities</b>	<ul style="list-style-type: none"> <li>• Issues related to children identified with specific diagnostic groups must be separate standing agenda items in committee meetings. As of the VFCA carve-in on July 1, 2021, the VFCA population is also included</li> <li>• Provide a forum for members that includes among its members, MVP behavioral health staff, behavioral health providers, peer specialists, members, LGU representatives and other key stakeholders to discuss the physical and behavioral health needs of MVP child members</li> </ul>

<b>Children’s Behavioral Health Advisory Committee</b>	
	<ul style="list-style-type: none"> <li>• This includes, but is not limited to, challenges, barriers, resources, and unmet needs of this population</li> <li>• Soliciting ideas and feedback to improve overall member and provider experience</li> <li>• Identify proposed resolutions of issues related to the management of the physical and behavioral health needs of the MVP child population</li> </ul>
<b>Reports To</b>	BH QM subcommittee; CQC; QIC; Board of Directors
<b>Committee Chair</b>	Tri-chair: Quality Management Behavioral Health Liaison, Sr. Director, Behavioral Health and Utilization Management Operations, and an external chairperson
<b>Committee Composition</b>	<p>Internal Membership:</p> <ul style="list-style-type: none"> <li>• Chairs: Sr. Director, Behavioral Health &amp; Utilization Management Operations; Quality Management Behavioral Health Liaison</li> <li>• Chief Medical Officer, or delegate</li> <li>• Director, Accreditation &amp; Quality Regulatory Compliance</li> <li>• Director, Appeals and Grievances</li> <li>• Director, Pharmacy Management</li> <li>• Director, Utilization Management and Intake Operations Optimization</li> <li>• Foster Care Liaison, Medicaid Services and Supports</li> <li>• Health Promotion Program Manager</li> <li>• Leader, Behavioral Health Case Management</li> <li>• Leader, Behavioral Health Case Management, Children Services &amp; Government Liaison</li> <li>• Leader, Behavioral Health Case Management Performance and Initiatives</li> <li>• Leader, Care Center Staff</li> <li>• Leader, Commercial Appeals Operations</li> <li>• Medical Director, Behavioral Health</li> <li>• Medical Director, Behavioral Health Children’s Services</li> <li>• Medical Director, HARP Behavioral Health Adult Services</li> <li>• Medical Director, Pediatrics</li> <li>• Professional, Compliance Customer Engagement</li> <li>• Professional, Customer &amp; Provider Communications</li> <li>• Vice President, Health and Pharmacy Management</li> </ul> <p>External Membership:</p> <ul style="list-style-type: none"> <li>• MVP Customers’ Caregivers</li> <li>• Director of Clinical Services, Collaborative for Children &amp; Families, Inc.</li> <li>• Director of Community Services, Villa of Hope</li> <li>• Director of Health Home Care Management, ASCEND Mental Wellness</li> <li>• Executive Director, New Hope Manor</li> <li>• Manager Quality Programs, Children’s Health Home of Upstate New York</li> <li>• Manager Quality Programs, Children’s Health Home of Upstate New York</li> <li>• Medicaid Managed Care Liaison Coordinator, Berkshire Farm Center</li> </ul>
<b>Frequency</b>	At least quarterly

<b>Children’s Behavioral Health Advisory Committee</b>	
<b>Attendance Required</b>	50% of scheduled meetings
<b>Quorum</b>	The Children's BH Advisory Committee will solicit feedback and advice but is not a voting committee, therefore a quorum is not required.
<b>Agenda</b>	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.
<b>Recorder</b>	Delegated committee designee
<b>Minutes/Meeting Packets</b>	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials. Minutes will reflect discussion and attendance.
<b>Decision Authority</b>	This is a non-voting committee. The BH Advisory Committee is authorized by the CQC, which reports up to the Board of Directors, to make recommendations related to issues raised by MVP members, committee members, providers, or stakeholders. Individuals are responsible for raising any issues at committee meetings.
<b>Evaluation</b>	The committee will review the charter annually.
<b>Confidentiality</b>	Each committee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

<b>Behavioral Health Utilization Management (BH UM) Subcommittee (HARP/Medicaid/D-SNP Non-Integrated and D-SNP IBP)</b>	
<b>Charter Statement</b>	The QMP/HARP BH UM subcommittees are to be held at least quarterly. The QMP/HARP BH UM and Children’s BH UM subcommittees are scheduled in succession with one another and reported up to the COC, then the QIC, and then ultimately to the Board of Directors.
<b>Purpose</b>	<ul style="list-style-type: none"> <li>• Assess the clinical and service needs for the Mainstream Medicaid, HARP, D-SNP and D-SNP-IBP members with behavioral health diagnoses</li> <li>• 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, D-SNP and D-SNP-IBP members with BH diagnoses</li> <li>• Ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis for the Mainstream Medicaid, HARP, D-SNP and D-SNP-IBP members with BH diagnoses</li> </ul>

**Behavioral Health Utilization Management (BH UM) Subcommittee (HARP/Medicaid/D-SNP Non-Integrated and D-SNP IBP)**

<p><b>Responsibilities</b></p>	<p>The Mainstream Medicaid, HARP, D-SNP and D-SNP-IBP BH UM subcommittee shall be responsible for reviewing/analyzing data, variances, and outcomes and developing and/or approving interventions. Ensures interventions have measurable outcomes and are included in meeting minutes. The subcommittee is also responsible for reporting:</p> <ul style="list-style-type: none"> <li>• Under and over utilization of behavioral health services including cost data</li> <li>• Avoidable hospital admissions and readmission rates, trends, and the average length of stay for all mental health, substance use disorder, residential levels of care, and medical inpatient facilities</li> <li>• Inpatient Utilization</li> <li>• Outpatient Utilization including Outpatient Specialty Behavioral Health Services (reporting on unique members, units, units/1000 and cost)</li> <li>• Inpatient civil commitments</li> <li>• Outpatient civil commitments including Assisted Outpatient Treatment (AOT)</li> <li>• Emergency Department utilization and crisis services             <ul style="list-style-type: none"> <li>○ Use of Crisis Diversion Services</li> </ul> </li> <li>• Pharmacy utilization including physical health, psychotropic and addiction medications</li> <li>• Protocols for the identification and prompt referral of individuals with First Episode Psychosis (FEP) to programs and services             <ul style="list-style-type: none"> <li>○ Rates of initiation and engagement of individuals with FEP in services</li> </ul> </li> <li>• Behavioral Health HCBS utilization and CORE             <ul style="list-style-type: none"> <li>○ Health Home engagement rates for HARP population</li> </ul> </li> <li>• The BH UM Subcommittee also reports on D-SNP and Integrated Benefits Plan (Dual Access Complete) lines of business and includes:             <ul style="list-style-type: none"> <li>○ Total quarterly membership numbers</li> <li>○ Number of Admissions per quarter</li> <li>○ Outpatient Utilization</li> <li>○ Outpatient Specialty BH Services Utilization</li> </ul> </li> <li>• All physical health measures required by the MCO Model Contract</li> </ul>
<p><b>Reports To</b></p>	<p>COC; QIC; Board of Directors</p>
<p><b>Committee Chair</b></p>	<p>Behavioral Health Medical Director</p>
<p><b>Committee Composition</b></p>	<p>Standing Voting Membership:</p> <ul style="list-style-type: none"> <li>• Chair: Medical Director, Behavioral Health</li> <li>• Chief Medical Officer</li> <li>• Director, Accreditation &amp; Quality Regulatory Compliance</li> <li>• Director, Integrated Health Contract Manager</li> <li>• Director, Appeals and Grievances</li> <li>• Director, Pharmacy Management</li> <li>• Director, Utilization Management and Intake Operations Optimization</li> <li>• Leader, Behavioral Health Case Management</li> </ul>

<b>Behavioral Health Utilization Management (BH UM) Subcommittee (HARP/Medicaid/D-SNP Non-Integrated and D-SNP IBP)</b>	
	<ul style="list-style-type: none"> <li>• Leader, Behavioral Health Case Management, Children Services &amp; Government Liaison</li> <li>• Leader, Behavioral Health Case Management Performance and Initiatives</li> <li>• Leader, Care Center Staff</li> <li>• Medical Director, Behavioral Health Children’s Services</li> <li>• Medical Director, HARP Behavioral Health Adult Services</li> <li>• Medical Director, Pediatrics</li> <li>• Quality Management Behavioral Health Liaison</li> <li>• Sr. Director, Behavioral Health &amp; Utilization Management Operations</li> <li>• Sr. Director, Physical Health and Utilization Management</li> <li>• Vice President, Clinical Operations</li> <li>• Vice President, Health and Pharmacy Management</li> </ul>
<b>Frequency</b>	Quarterly
<b>Attendance Required</b>	50% of scheduled meetings
<b>Quorum</b>	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.
<b>Agenda</b>	Agenda items for the next meeting are developed by the subcommittee Chair. All agenda items are based on requirements set forth in the New York for Request for Qualifications for Adult Behavioral Health Benefit Administration: Managed Care Organizations and HARP (RFQ, 2015). Quarterly reports with the required agenda items are received from the appropriate report owners and reviewed by the subcommittee Chair and Liaison prior to presentation.
<b>Recorder</b>	Delegated subcommittee designee
<b>Minutes/Meeting Packets</b>	Draft minutes are completed within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to subcommittee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
<b>Decision Authority</b>	The subcommittee is authorized by the COC which reports up to the Board of Directors, to make decisions and recommendations regarding performance improvement processes. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the subcommittee meetings.
<b>Evaluation</b>	The subcommittee will review the charter annually.
<b>Confidentiality</b>	Each subcommittee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner. Each subcommittee member must agree to and sign a subcommittee confidentiality statement on an annual basis.

<b>Children’s Behavioral Health Utilization Management (BH UM) Subcommittee</b>	
<b>Charter Statement</b>	The Children’s BH UM subcommittee meetings are to be held at least quarterly. The Children’s BH UM and QMP/HARP BH UM are scheduled in succession with one another and reported up to the COC, then the QIC, and to the Board of Directors.
<b>Purpose</b>	<ul style="list-style-type: none"> <li>• Assess the clinical and service needs of Medicaid enrolled children including HCBS; this includes children in foster care and medically fragile children</li> <li>• Develop, implement, evaluate, and report utilization data and various interventions/programs that will optimize clinical quality, maximize safe clinical practices, and enhance services to the Medicaid enrolled children</li> <li>• Ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis for the child members</li> </ul>
<b>Responsibilities</b>	<ul style="list-style-type: none"> <li>• Review and analyze data, variances, and outcomes and develop and/or approve interventions</li> <li>• Ensure that interventions have measurable outcomes and are included in meeting minutes</li> <li>• Report out the following: <ul style="list-style-type: none"> <li>○ Under- and over-utilization of BH services and cost data</li> <li>○ Avoidable hospital admissions and readmission rates, trends, and the average length of stay for all inpatient classified levels of care <ul style="list-style-type: none"> <li>▪ Outpatient Utilization including Outpatient Specialty BH Services (reporting on unique members, units, units/1000, and cost); this includes: <ul style="list-style-type: none"> <li>• Children and Family Treatment and Support Services Utilization (CFTSS)</li> <li>• Applied Behavior Analysis (ABA)</li> </ul> </li> </ul> </li> <li>○ Inpatient civil commitments</li> <li>○ Outpatient civil commitments including AOT</li> <li>○ ED utilization and crisis services <ul style="list-style-type: none"> <li>▪ Use of Crisis Diversion Services</li> </ul> </li> <li>○ Pharmacy utilization including physical health, psychotropic, and addiction medications <ul style="list-style-type: none"> <li>▪ Separate analysis for children in foster care</li> <li>▪ Separate reporting &lt;21 medically fragile children</li> </ul> </li> <li>○ Number of physical and BH paid claims including spend amounts shown quarter over for both foster care and medically fragile children</li> <li>○ Behavioral Health prior authorization and notices of action</li> <li>○ Protocols for the identification and prompt referral of individuals with FEP to programs and services <ul style="list-style-type: none"> <li>▪ Rates of initiation and engagement of individuals with FEP in services</li> </ul> </li> </ul> </li> </ul>

<b>Children’s Behavioral Health Utilization Management (BH UM) Subcommittee</b>	
	<ul style="list-style-type: none"> <li>○ Discussion/analysis related to physical health services for medically fragile children/complex conditions</li> <li>○ Discussion/analysis related to BH and HCBS services for Medicaid enrolled children</li> <li>○ Children’s physical health services: Report on service utilization and outcomes for children including medically fragile children</li> <li>○ Transitional issues for youth ages 18 to 23 years, focusing on continuity of care and service utilization</li> <li>○ Behavioral Health HCBS <ul style="list-style-type: none"> <li>▪ 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: <ul style="list-style-type: none"> <li>● Use of crisis diversion and crisis intervention services</li> <li>● HCBS utilization</li> <li>● Enrollment in Health Home</li> </ul> </li> </ul> </li> </ul>
<b>Reports To</b>	COC; QIC; Board of Directors
<b>Committee Chair</b>	Behavioral Health Medical Director
<b>Committee Composition</b>	<p>Standing Voting Membership:</p> <ul style="list-style-type: none"> <li>● Chair: Medical Director, Behavioral Health</li> <li>● Chief Medical Officer</li> <li>● Director, Accreditation &amp; Quality Regulatory Compliance</li> <li>● Director, Integrated Health Contract Manager</li> <li>● Director, Appeals and Grievances</li> <li>● Director, Pharmacy Management</li> <li>● Director, Utilization Management and Intake Operations Optimization</li> <li>● Leader, Behavioral Health Case Management</li> <li>● Leader, Behavioral Health Case Management, Children Services &amp; Government Liaison</li> <li>● Leader, Care Center Staff</li> <li>● Medical Director, Behavioral Health Children’s Services</li> <li>● Medical Director, HARP Behavioral Health Adult Services</li> <li>● Medical Director, Pediatrics</li> <li>● Quality Management Behavioral Health Liaison</li> <li>● Sr. Director, Behavioral Health &amp; Utilization Management Operations</li> <li>● Sr. Director, Physical Health and Utilization Management</li> <li>● Vice President, Clinical Operations</li> <li>● Vice President, Health and Pharmacy Management</li> </ul>
<b>Frequency</b>	Quarterly
<b>Attendance Required</b>	50% of scheduled meetings

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

### **MVP QUALITY DEPARTMENT STAFFING**

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

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

<p><b>Quality Improvement - Implementation, Provider &amp; Ext Partnerships</b></p>	<p>performance across clinical and non-clinical measurement categories, as well as MVP performance in state and federal based financial quality incentive programs, including Medicare CMS STARS Program, and NYS Medicaid Incentive Programs. Maintains oversight of major functions of the MVP Quality Department including Quality Measurement, HEDIS Operations, Clinical Quality Initiatives, and Provider Strategies to include direct responsibility of the team that processes quality performance in support of business objectives, supports the regulatory submission of performance data to NCQA, CMS, NYS, and annual HEDIS audit.</p> <p>Additionally, this role is accountable for the management and oversight of all regulatory Quality Programs (QIS, QPM, PIP, CCIPs), ensuring that State and Federal Health Equity and SDOH requirements are fully integrated and complied with in quality program designs.</p>
<p><b>Director, Quality Ops Strategy Reporting</b></p>	<p>This role leads the production of monthly analytics and reports for major ratings systems, including Medicare STARS, Marketplace Quality Rating System, and Medicaid NCQA Health Plan Rating System, as well as quality-related pay-for-performance programs. The director ensures reports contain the most current HEDIS, CAHPS, and operational rates, along with historical data and benchmark comparisons, using data from MVP’s certified sources. Responsibilities include estimating roll-up ratings, tracking year-over-year performance trends, and providing actionable insights into health plans regarding benchmarks and improvement opportunities.</p> <p>Additionally, the role develops predictive analytical models using diverse datasets, such as demographics, disease prevalence, clinical gaps, and social risk factors, to identify barriers to care and opportunities for quality improvement. These analyses inform the design and evaluation of quality improvement projects and interventions across the organization.</p>
<p><b>Director, Quality Program Management</b></p>	<p>This role is accountable for leading the development, execution, and refinement of strategies to drive continuous improvement in quality performance across all lines of business, including Medicare Stars measures (HEDIS, CAHPS, Part D, Special Needs Plans [SNP]), Medicaid, Essential Plan, and HARP. The director oversees the implementation and outcome monitoring of the Quality strategy to achieve year-over-year improvement in clinical outcomes, working collaboratively across departments to establish objectives, policies, and strategies. Responsibilities include managing and monitoring quality performance, analyzing data trends, and supporting organization-wide change through education and improvement initiatives.</p> <p>The role assures that quality initiatives are focused on enhancing operational and program efficiencies, improving member outcomes, and developing systematic processes and structures that ensure sustained quality and strong commitment to enabling ongoing improvements.</p>
<p><b>Leader, HEDIS Data</b></p>	<p>Responsible for operations associated with the organization HEDIS project</p>

<b>Management and Strategic Operations</b>	and submission, including medical record collection, chart abstraction, and quality control, at the highest level of performance. Provides current and timely reports and maintains HEDIS activity targets. Responsible for coordinating documentation, effectively collecting, tracking, monitoring, and reporting of HEDIS data, to both NCQA and the State as required. Annual evaluation of effectiveness of the Quality Program.
<b>Leader, Provider Partnerships and Quality Program Implementation</b>	New leader that is liaison between quality and provider engagement teams, creates, implements, and manages provider incentive programs, manages the program implementation areas and program managers with their assigned items. This role requires strong collaboration, strategic thinking, and the ability to manage multiple priorities to ensure quality standards are met and exceeded. The individual will work closely with internal teams and external partners to drive initiatives that improve member outcomes and regulatory compliance.
<b>Professional, Clinical Quality</b>	MVP promotes maintenance of medical records in a current, detailed, and organized manner which permits effective and confidential patient care and quality review. The minimum standards for provider medical record keeping practices, which include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of member information, are outlined in the Provider Policies and Payment Policies. MVP may conduct medical record reviews for purposes including, but not limited to, utilization review, quality management, medical claim review, or member complaint/appeal investigation.
<b>Professional, HEDIS Project Manager</b>	Assists the Leader of HEDIS in project needs. This role requires strong collaboration, strategic thinking, and the ability to manage multiple priorities to ensure quality standards are met and exceeded. The individual will work closely with internal teams and external partners to drive initiatives that improve member outcomes and regulatory compliance.
<b>Professional, Medicare STARS Quality Program Manager</b>	Participates in the Quality Improvement Program organization's implementation. This professional is responsible for assisting in development, implementation, and outcome monitoring of the Quality strategy to improve performance on all Medicare Stars measures (including HEDIS, CAHPS, Part D, and SNP) to achieve year-over-year (YOY) improvement of clinical outcomes. Collaborate with other departments as needed to implement improvement initiatives as identified through the health plan and quality improvement activities.
<b>Professional, Program Manager Quality</b>	Support performance improvement initiatives by managing programs and interventions from initiation through delivery and monitors for continuous improvement. Collaborate with other departments as needed to implement improvement initiatives as identified through the health plan and quality improvement activities. This role requires strong collaboration, strategic thinking, and the ability to manage multiple priorities to ensure quality standards are met and exceeded. The individual will work closely with internal teams and external partners to drive initiatives that improve member

	outcomes and regulatory compliance.
<b>Professional, Quality Analyst</b>	Develop 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.
<b>Professional, Quality Liaison, Provider Engagement &amp; Outreach</b>	Support Health Home and Case Management Agency (CMA) guidance and training as it relates to quality measures and initiatives. Participate in work groups as a subject matter expert (SME). Supports provider engagement needs and assists with member and provider outreach. This role requires strong collaboration, strategic thinking, and the ability to manage multiple priorities to ensure quality standards are met and exceeded. The individual will work closely with internal teams and external partners to drive initiatives that improve member outcomes and regulatory compliance.
<b>Professional, Quality Performance Compliance Manager</b>	This role actively participates in the implementation of the Quality Improvement Program, supporting the planning, monitoring, and evaluation of both Quality and Regulatory Readiness initiatives through effective performance management. The individual is responsible for the development, implementation, monitoring, and reporting of all quality regulatory projects, and plays a key role in both planned and unplanned regulatory visits. By promoting collaborative practices across departments and services, this position helps drive improved quality outcomes, care processes, and regulatory compliance. Additionally, the role informs leadership on adherence requirements to State and Federal regulations and policies related to Quality Performance, Health Equity, and SDOH for NYS Government Programs and Medicare. Day-to-day responsibilities include supporting timely reporting, guiding and monitoring interventions to improve quality performance measures, and collaborating with other departments to implement improvement initiatives identified through the health plan's quality activities, as well as engaging in other compliance activities as they arise.
<b>Professional, Quality Performance Manager</b>	Responsible for improving performance outcomes for NYS Government programs, specifically Medicaid, Essential Plan, and HARP, in addition to Medicare STARS. Identifies trends and opportunities for performance improvement. This includes design, implementation, and evaluation of interventions. Performance is monitored and communicated with the appropriate stakeholders and committees. Collaborate with other departments as needed to implement improvement initiatives as identified through the health plan and quality improvement activities.
<b>Professional, Quality Strategy and Transformation</b>	New strategist around Quality Improvement and Transformation. The position focuses on opportunities to transform processes, deepen Quality integration across the enterprise, and develop strategies to guide the future direction of Quality strategy. This role focuses on enterprise collaboration, strategic

	<p>thinking, and the ability to manage multiple priorities to ensure quality standards are met and exceeded. The individual works closely with internal teams and external partners to drive, frame, design quality initiatives that improve member outcomes, regulatory compliance, and partner relationships.</p>
<p><b>Director, Accreditation and QI Regulatory Compliance</b></p>	<p>The Director, Accreditation and QI Regulatory Compliance, reports to the Vice President, Customer Care and Support Services and is responsible for directing the strategic management and planning of the NCQA HPA process. Additional responsibilities include:</p> <ul style="list-style-type: none"> <li>• Strategizing and leading organizational efforts to achieve and maintain NCQA accreditation</li> <li>• Development of accreditation work plans with timeframes and documentation required</li> <li>• Serves as a subject matter expert and liaison for NCQA standards interpretation, survey preparation, onsite file reviews, and follow-up activities</li> <li>• Development of training related to NCQA Standards based upon business owner needs</li> <li>• Provide oversight and direction to assure compliance with Quality activities associated with all regulatory agencies</li> <li>• Provide guidance and oversight of Quality Regulatory committees and subcommittees, Corporate Initiatives including new program development and initiation as it relates to regulatory compliance and QI Strategy Projects</li> <li>• Assumes ownership, including annual updates, of the QI Program Description, QI Annual Work Plan, and the QI Annual Report with presentation to the QIC for approval</li> <li>• Provides direction and oversight of all UM and CM file audits for NYS and VT DOH, CMS, DFR, DFS, and NCQA regulatory requirements</li> <li>• Provides direction and oversight of all internal compliance file audits for UM and CM related to external delegates and delegated vendor arrangements</li> <li>• Active preparation, facilitation, and participation in all regulatory audits as it relates to NCQA and regulatory compliance</li> </ul>
<p><b>Quality Improvement Project Manager</b></p>	<p>The QI Project Manager role assists the Director, Accreditation and QI Regulatory Compliance in strategic planning and management of the NCQA HPA process. This role works directly with leadership teams, key business owners or contributors across the organization, and key external stakeholders to support the design, implementation, and oversight of Quality Accreditation and Compliance strategic initiatives, along with the regulatory and operational responsibilities related to the Quality Committee Structure.</p> <p>This individual serves as a subject matter expert and liaison for NCQA Standards interpretation, survey preparation, and onsite/virtual survey file reviews and associated follow up activities based upon surveyor feedback.</p>

	<p>Develops and maintains accreditation work plans, timelines, and documentation. Assists business owners/leaders in ongoing NCQA Accreditation Standards training annually, develops and/or evaluates departmental policies and procedures for compliance with NCQA HPA Standards. In conjunction with the Director, Accreditation and Quality Regulatory Compliance, assumes ownership of the Quality trilogy documents, including the QI Program Description, QI Work Plan, and the QI Annual Report. Assures trilogy documents are updated annually, establishes timeframes for documentation revisions and review by key stakeholders, reviews for requirement accuracy and brand standards and is submitted timely to the QIC and the Board of Directors for final approval. Assists with the monthly Accreditation Workgroup meeting by developing and coordinating agenda topics, educational training slides, and presentation of content as required or by the request of business owners.</p>
<p><b>Quality Improvement Program Manager</b></p>	<p>The QI Program Manager assists the Director, Accreditation and QI Regulatory Compliance in strategic planning and management of the NCQA HPA process. This role works directly with leadership teams, key business owners or contributors across the organization, and key external stakeholders to support the design, implementation, and oversight of Quality Accreditation and Compliance strategic initiatives, along with the regulatory and operational responsibilities related to the Quality Committee Structure.</p> <p>This individual serves as a subject matter expert and liaison for NCQA Standards interpretation, survey preparation, and onsite/virtual survey file reviews and associated follow up activities based upon surveyor feedback. Develops and maintains accreditation work plans, timelines, and documentation. Assists business owners/leaders in ongoing NCQA Accreditation Standards training annually, develops and/or evaluates departmental policies and procedures for compliance with NCQA HPA Standards. In conjunction with the Director, Accreditation and Quality Regulatory Compliance, assumes ownership of the Quality trilogy documents, including the QI Program Description, QI Work Plan, and the QI Annual Report. Assures trilogy documents are updated annually, establishes timeframes for documentation revisions and review by key stakeholders, reviews for requirement accuracy and brand standards and is submitted timely to the QIC and the Board of Directors for final approval. Assists with the monthly Accreditation Workgroup meeting by developing and coordinating agenda topics, educational training slides, and presentation of content as required or by the request of business owners.</p>
<p><b>Sr. Director, Customer Care Center</b></p>	<p>Responsible for the appropriate processing of member grievances. The Sr. Director, Customer Care Center manages grievance data and reports. This position is required to represent Grievances at various health plan committee meetings and provides updates at these committees, as needed.</p>

<b>Associate, Senior Complaint</b>	Responsible for logging member grievances and completing a thorough investigation of those pertaining to potential Quality of Care (QOC) issues, including referral to an MVP Medical Director as appropriate, to ensure resolution. The Senior Complaint Coordinator evaluates complaints and grievances by type, location, and region to identify trends indicating potential areas in need of further analysis and intervention as well as tracks and resolves all administrative member grievances and provider complaints.
<b>Leader, CCC</b>	Serves as the subject matter expert for Commercial, Medicare and State Government Program complaints. Assist with compliance oversight of delegated entities. Assures regulatory and accreditation compliance in all aspects related to complaints, including updating policies and procedures. Assist with regulatory and accreditation audits.
<b>Director, Member Appeals</b>	Responsible for the appropriate processing of member appeals as well as requests for State Fair Hearings and external reviews. The Director, Member Appeals manages appeal data and reports. This position is required to represent Appeals at various health plan committee meetings and provides updates at these committees, as needed.
<b>Professional, Senior Specialist,</b>	Responsible for reviewing and processing appeals filed by regulatory agencies (i.e.: DOH, Attorney General, DFS). This role will also process CTM complaints, 2 <sup>nd</sup> Level Appeals, LTSS and CDPAS appeals. You will also work with our Legal department in reviewing and preparing appeals for Fair Hearing. You will be based at our HQ-Health Management location. The role demands a meticulous approach to understanding policies, regulations and specific circumstances surrounding each case.
<b>Leader, Commercial Appeals</b>	Serves as the subject matter expert for Commercial and State Government Program appeals. Assists with compliance oversight of delegated entities. Assures regulatory and accreditation compliance in all aspects related to appeals and complaints, including updating policies and procedures. Assists with regulatory and accreditation audits.
<b>Leader, Medicare Appeals</b>	Serves as the subject matter expert for Medicare appeals Assists with compliance oversight of delegated entities. Assures regulatory compliance in all aspects related to appeals, including updating policies and procedures. Assists with regulatory audits.
<b>Professional, Compliance Coordinator</b>	Responsible for executing and maintaining oversight of compliance related projects and programs. Provides direction, implementation support and oversight for new and current department processes. Monthly quality monitoring of appeals documents and provides education to the appeals team regarding new regulations and policy changes, assuring all changes are implemented and compliant.
<b>Professional, Clinical Appeals Specialist</b>	Responsible for reviewing appeals involving clinical denials, thoroughly evaluating the medical necessity of the appeal in a fair, unbiased

	manner based on the merits of the case and applicable guidelines. Your efforts are instrumental in upholding the integrity of the decision-making process, ensuring that each party's rights are respected and the resolutions are reached in a timely manner.
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### **Converged Analytics by Inovalon®**

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

### **Enterprise Data Model for Analytics (EDMA)**

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

### **Facets®**

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

### **ZeOmega® /Jiva**

In January 2025, MVP partnered with **ZeOmega**, a leading PHM organization, to support an enterprise-wide transformation of the MVP care management platform. MVP will implement ZeOmega's **Jiva Population Health Enterprise Management Platform** to unify systems and

deliver a more efficient, connected, patient-centric experience for customers across New York State and Vermont.

This solution will help MVP ensure members receive the right care at the right time by leveraging next-generation interoperability, automation, utilization management, and predictive analytics capabilities. Jiva enables seamless data exchange with provider networks and equips care teams with real-time member insights – improving care coordination, streamlining decision-making, and supporting better outcomes while reducing administrative burden.

This platform is expected to go live in January 2026.

### **Reporting and Analytics**

Quality Analytics produces monthly reports for ratings systems such as Medicare STARS, Marketplace Quality Rating System, and Medicaid NCQA Health Plan Rating System. In addition, reports are produced for any Quality-related P4P programs outlined in contracts between providers and health plans. Reports contain the most current HEDIS, CAHPS, and operational rates, where applicable, from the MVP 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. YOY graphs are provided to show trending performance across current and prior measurement year. Finally, most current available benchmarks are provided, and current numerator and denominator, where relevant, are provided at the measure level to show health plans the benchmark currently achieved and distance, in numerator hits, to all remaining benchmarks not met.

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

### **Clinical Decision Support**

The Clinical Decision Support application is a longitudinal, multi-episode based predictive modeling and Care Management analytics tool. This tool allows the Quality and Care Management teams to use clinical, risk, and administrative profile information (obtained from medical claims, behavioral health claims, pharmacy claims, lab data, direct provider submitted supplemental data, and (health information exchange) data) to identify members who may be at risk for high future utilization or at high risk of inpatient readmission. To perform these Quality and Care Management activities, MVP utilizes the Arcadia Analytics Platform. The Arcadia

Analytics Platform is a population health platform that utilizes several statistically valid, case-mixed methodologies that allows health care organizations to measure the medical need of populations and to describe, or predict, a population's past or future health care utilization by taking into consideration each member's morbidity burden. The Arcadia Analytics Platform provides multiple concurrent and predictive markers derived from a member's diagnosis code history from all encounters (medical, behavioral health, pharmacy, lab, etc.); as well as demographic data during an appropriate period. The application supports the Quality team in identifying target populations for focused improvement interventions based on risk scores and needs.

### **Customer Relationship Management (CRM) Platform**

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

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

## **DOCUMENTATION CYCLE**

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

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

### **QI Program Description**

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

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

No less than annually, ideally during the first quarter of each calendar year, the designated Quality Department staff prepares, reviews, and revises as needed the QI Program Description. The QI Program Description is reviewed and approved by the QIC and Board of Directors on an

annual basis. MVP submits any substantial changes to its QI Program Description to the QIC and appropriate state agencies for review and approval as required by state contract, if applicable.

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

### **QI Work Plan**

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

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

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

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

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

### **QI Annual Report**

The QI Annual Report includes an annual summary of all quality activities, the impact the program has had on member care, an analysis of the achievement of stated goals and objectives, and the need for program revisions and modifications. The Annual Report outlines the completed and ongoing activities of the previous year for all departments within MVP, including activities regarding Provider Services, Member Services, Utilization Management, Health Management, Complex Case Management, Population Health Condition Management, and safety of clinical care. Annual Report findings are incorporated in the development of the annual QI Program Description and QI Work Plan for the subsequent year. The Vice President, Customer Care and Support Services and Director, Accreditation and QI Regulatory Compliance

are responsible for coordinating the evaluation process and a written description of the annual report and work plan is provided to the QIC and Board of Directors for approval annually.

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

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

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

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

MVP provides general information about the QI Program to members and providers on the website or member/provider materials such as the Member Handbook or Provider Policies and Payment Policies. If required, communication includes how to request specific information about

QI Program goals, processes, and outcomes as they relate to member care and services and may include results of performance measurement and improvement projects. Information available to members and providers may include full copies of the QI Program Description, QI Annual Report, or summary documents.

## **PERFORMANCE MEASUREMENT**

MVP continuously monitors and analyzes performance data to measure results against established benchmarks and to identify and prioritize improvement opportunities. Performance measurement is integrated into MVP QI methodology, using the PDSA cycle to ensure specific interventions are developed and implemented to improve performance, and the effectiveness of each intervention is assessed at defined intervals, using consistent, standardized methods appropriate to each intervention.

MVP tracks performance over time, comparing results to prior years, industry benchmarks, and internal targets, and uses dashboards and scorecards to promote transparency. Benchmarks and stretch goals are established based on evidence-based guidelines, NCQA standards, and United States Preventive Services Task Force (USPSTF) recommendations for preventive care, including cancer screening. An annual evaluation of the QI Program's effectiveness is conducted to assess resource adequacy, practitioner participation, and barriers to achieving objectives. Performance measurement incorporates analysis of disparities and social determinants of health to support equity-focused improvement strategies. Providers and leadership are actively engaged in reviewing performance data and developing improvement plans, while short-, intermediate-, and long-term outcomes are evaluated to ensure sustained improvement and systemic impact. MVP is focused on monitoring efforts of priority performance measures that align with the mission, goals, and regulatory requirements, as well as additional measures identified through analysis and stakeholder input. MVP reports all required measures in a timely, complete, and accurate manner to meet federal and state reporting requirements. Performance measures include all HEDIS measures required for the NCQA Health Plan Ratings and the designated set of CMS Adult, D-SNP, and Child CORE measures. HEDIS includes measures across six domains of care including:

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

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

## **Member Experience**

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

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

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

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

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

## **Provider Experience**

Provider experience is 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 SIC, with operational process improvements and service performance improvement projects based on formal analysis of identified areas of provider need/dissatisfaction.

## **PROMOTING MEMBER SAFETY AND QUALITY OF CARE**

The QI Program is a multidisciplinary program that utilizes an integrated approach to monitor, assess, and promote member safety and quality of care. MVP has mechanisms to assess the

quality and appropriateness of care furnished to all members including those with special health care needs, as defined by NYSDOH, VTDOH, and other regulatory bodies. These activities are both clinical and non-clinical in nature and address physical health, behavioral health, and social health services.

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

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

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

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

A Serious Reportable Event (SRE) is defined as an incident involving serious harm or death to a member from a lapse or error in a health care facility. The MVP policy for SREs 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 the MVP policy will change over time as dictated by Federal and/or State mandate and the needs of MVP members. If an SRE occurs within a facility, it is expected that the hospital will immediately report the event to MVP

and waive costs directly related to the event. The current MVP service agreement template for inpatient facilities includes language addressing the expectations of MVP, should an SRE occur.

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

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

### **Medical Record Documentation Standards**

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

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

### **Qualified Entities (QEs)**

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

### **Value Based Contracting (VBC)**

MVP partners with several providers across its geographical footprint in VBC. A VBC is a written agreement between the provider and insurer where health care services are tied to mutually agreed upon and predetermined criteria that are based on topics such as patient outcomes, effective collaboration, data sharing, quality requests, set capitation, and shared savings.

In 2026, MVP developed a revised Primary Care Model (PCM) which includes outcomes-based measures in addition to risk adjustment. Initial rollout is targeted for the Capital Region and will be expanded to additional geographic regions over time.

## **MEMBER ACCESS TO CARE**

MVP ensures member access to care in areas such as network adequacy, availability of services, timely appointment availability, transitions of care, assurances of adequate capacity and services,

coordination and continuity of care, and coverage and authorization. MVP ensures the availability and delivery of services in a culturally and linguistically competent manner to all members, including those with limited English proficiency and literacy and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, gender identity, etc. MVP also ensures all Participating Providers deliver physical access, reasonable accommodation, and accessible equipment for members with physical or mental disabilities. Numerous methods and sources of data are utilized to assure appropriate member access to care, including provider access and availability analysis, member inquiries and complaints/grievances/appeals, and review of CAHPS survey findings related to member experience of availability and access to services. MVP also ensures members have access to accurate and easy to understand information about Participating Providers. The MVP Provider Directory is available online and as hard copy as needed and meets all regulatory and accreditation requirements. The directory is updated in a timely manner upon receipt of updated information from providers and assessment of the accuracy of the directory is completed on an ongoing basis.

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

### **Network Adequacy**

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

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

ensures compliance with contractual, regulatory, and accreditation requirements, including all reporting requirements, to maintain adequate provider availability for members.

### **Appointment Availability**

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

### **After-Hours Access**

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

### **Out-of-Network Services and Second Opinions**

If the MVP provider network is unable to provide adequate and timely services as required by established standards, MVP will allow timely services through a licensed, qualified out-of-network provider until a Participating Provider is available at in-network cost.

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

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

## **Telemedicine Services**

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

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

## **Transitions of Coverage**

MVP ensures compliance with all federal, state, and NCQA Health Plan Accreditation transition of care policy requirements, including:

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

## **Continuity and Coordination of Care**

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

Continuity and coordination of medical care, and between medical and behavioral health care, may be assessed via several different measures or activities. These include, but are not limited

to, HEDIS measures, CAHPS or other member experience survey results, provider satisfaction surveys, etc. As stated in the NCQA requirements, MVP collects data related to continuity and coordination of care, analyzes the data to identify opportunities for improvement, selects opportunities for improvement, and implements actions for improvement. The effectiveness of improvement actions is measured annually, and re-measurement results analyzed.

### **Preventive Health Reminder Programs**

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

MVP utilizes various methods to remind members, parents or guardians, and providers, about recommended preventive health services to improve understanding, engagement, and compliance with recommended preventive health guidelines. Examples of MVP preventive health reminder efforts include, but are not limited to:

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

## **POPULATION HEALTH MANAGEMENT**

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

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

The MVP PHM Strategy outlines the following:

- How member health needs are identified and stratified for intervention
- Details of the PHM programs and services are tailored to address those needs for all stages of health and across health care settings
- Explains how members are informed of the programs and services and their eligibility to utilize them

- Utilizes assessments of SDOH to identify and address unique member needs and develop an individualized plan of care
- Identifies cultural and linguist preferences and offers communication and services targeted to meet those unique member needs

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

### **Care Management**

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

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

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

## **PROVIDER SUPPORTS**

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

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

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

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

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

### **Provider Analytics**

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

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

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

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

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

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

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

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

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

MVP is committed to further investment in provider analytics capabilities to ensure that providers have the tools necessary to build integrated care processes and drive optimal member outcomes; in pursuit of this goal, MVP implemented an enterprise population health solution to increase transparency and empower providers to make data-driven decisions. The solution has the capability to aggregate claims, clinical, social determinants of health, and admission, discharge, and Automated Data Transfer (ADT) data to build a high quality, comprehensive, and continuously updated data asset for providers. This aggregated data is then enriched and transformed for quality measure calculations, risk calculations, and predictive analytics that help identify the most significant gaps, provide actionable insights, and guide the MVP Strategic Clinical Provider Engagement team, in co-developing improvement strategies with providers in alignment with a member-centric approach to quality and population health management. The goal for MVP is to provide "any time" access to providers and practices so that they can access trend data as soon as it is available. Data and insights can also be integrated into a provider's workflow in a variety of ways based on a provider's need such as interactive reports, a desktop application overlay, and/or direct integration into a provider's electronic health record. This empowers teams by providing insights at the point of care.

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

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

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

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

### **Practice Guidelines**

Preventive health and clinical practice guidelines assist providers, members, medical consenters, and caregivers in making decisions regarding health care in specific clinical situations. Nationally recognized guidelines are adopted/approved by the MVP QIC or applicable subcommittee, in consultation with Participating Providers and/or feedback from board-certified providers from appropriate specialties as needed. Guidelines are based on the health needs of members and opportunities for improvement identified as part of the QI Program, valid and reliable clinical evidence, or a consensus of health care professionals in a particular field. Clinical and preventive health guidelines are revised in response to significant new scientific evidence, changes in national standards, or at minimum every two years. Providers can access Clinical Guidelines and Supporting Resources through the MVP website. Printed copies are available to MVP members upon request.

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

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

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

### **Special Needs Plans (SNPs)**

MVP SNPs are designed to provide benefits and integrated interdisciplinary care coordination to improve the health of New Yorkers who meet all eligibility requirements and reside in the Capital District: Albany, Columbia, Greene, Rensselaer, Saratoga, and Schenectady counties; Hudson Valley: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester counties; and West: Monroe county.

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

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

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

### **Medicare D-SNP**

#### *Coordination Only*

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

### **Medicare/Medicaid Advantage Plans (MAP)**

#### *Fully Integrated Dual Eligible Product (FIDE)*

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

### **Long Term Services and Supports (LTSS) Department Program Description**

The LTSS Department is responsible for the oversight, coordination, and quality assurance of Medicaid-funded long-term care services provided to eligible individuals across New York State. LTSS encompasses a comprehensive array of person-centered services designed to support individuals with chronic illnesses, disabilities, or functional limitations in achieving optimal health and independence in the least restrictive setting.

## Program Objectives

- Promote access to high-quality, long-term care services
- Ensure services are delivered in accordance with NYSDOH regulations and Medicaid guidelines
- Support member choice, autonomy, and dignity through individualized care planning
- Monitor service delivery and outcomes to drive continuous quality improvement

## Core Service Areas

1. **Personal Care Services (PCS)** PCS are non-skilled services provided to assist individuals with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). PCS is authorized based on Physician Orders and a comprehensive assessment.
2. **Consumer Directed Personal Assistance Program (CDPAP)** CDPAP empowers Medicaid recipients to self-direct their care by selecting and supervising their own caregivers, including eligible family members. CDPAP is authorized based on Physician Orders and a comprehensive assessment.
3. **Private Duty Nursing (PDN)** PDN services provide continuous skilled nursing care in the home for medically fragile individuals. PDN is authorized based on medical necessity and supports individuals with complex health needs, including ventilator dependence and other life-sustaining interventions.
4. **Long Term Nursing Home Placement** For individuals whose needs cannot be safely met in the community, nursing home placement is available. Placement decisions are guided by comprehensive assessments and interdisciplinary care planning, with a focus on maintaining dignity and quality of life.
5. **Adult Day Health Care (ADHC)** ADHC programs offer medically supervised day services in a structured community setting. ADHC supports individuals who live at home but benefit from daytime clinical and social engagement.

## PERFORMANCE IMPROVEMENT ACTIVITIES

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

MVP utilizes traditional quality/risk/utilization management approaches to identify activities relevant to MVP programs or a specific member population that describe an observable, measurable, and manageable issue. Initiatives are identified through analysis of key indicators of care and service based on reliable data which indicate the need for improvement in a particular clinical or non-clinical area. Baseline data may come from performance profiling of contracted providers, mid-level providers, ancillary providers, and organizational providers; provider office site evaluations; focus studies; utilization information (over-and under-utilization performance indicators); sentinel event monitoring; trends in member complaints, grievances, and/or appeals; issues identified during care coordination; and/or referrals from any source indicating potential

problems, including those identified by affiliated hospitals and contracted providers. Other initiatives may be selected to test an innovative strategy or as required by state or federal contract. Projects and focus studies reflect the population served with consideration of SDOH, age groups, disease categories, and special risk status.

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

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

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

### **Marketplace Quality Improvement Strategy (QIS)**

Section 1311(c)(3) of the Affordable Care Act requires Marketplaces to display QHP quality ratings on Marketplace websites to assist in consumer selection of QHPs. Based on this authority, CMS established standards and requirements related to QHP issuer data collection and public reporting of quality rating information in every Marketplace. QHP issuers must submit quality rating information (specifically quality rating system [QRS] 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 NYS and VT. These Marketplace plans are offered on state-based exchanges. All NYS and VT-based Marketplace products are required to report HEDIS clinical measures on an annual basis.

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

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

### **Chronic Condition Improvement Program**

MVP conducts a continuous CCIP for each Medicare contract and D-SNP type/sub-type, that meets the requirements of the current CMS contracts.

MVP rotates condition(s) of focus for the CCIPs every three years. Each topic focuses on promoting effective management of chronic disease and improving care and health outcomes for members with chronic conditions, as it pertains to the specific population. CCIP chronic condition selections are made through careful analysis of each contract population's needs. CCIP initiatives include activities such as care coordination, promotion of preventive screenings, disease and lifestyle management programs, education and outreach to members and providers.

Effective management of chronic diseases include 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.

Beginning on January 1, 2025, the 2025-2027 CCIPs will focus on improving *Medication Adherence among Medicare members with chronic conditions including diabetes, high cholesterol, and hypertension*. Interventions for this program conclude December 31, 2027. The final Medication Adherence CCIPs report will be completed by December 2028.

### **2024-2025 Cancer Screening and Prevention Medicaid Managed Care PIP**

The NYSDOH Office of Quality and Patient Safety (OQPS), Office of Health Insurance Programs (OHIP), and Office of Public Health (OPH) have jointly proposed a two-year common-themed PIP for 2024-2025 to *improve cancer screening and prevention, specifically focusing on breast cancer screening (BCS-E), colorectal cancer screening (COL-E), cervical cancer screening (CCS and CCS-E), and human papillomavirus vaccination (IMA-HPV and IMA-HPV-E) among Medicaid Managed Care (MMC) and HIV SNP members*. As rationale for the PIP topic, NYSDOH presented the following facts about cancer, the need for preventive care and screenings, and related disparities to managed care plans:

In New York State, cancer is one of the most common chronic diseases and is the second leading cause of death:

- Breast cancer is the most diagnosed cancer and the second leading cause of cancer deaths among females in NYS
- Colorectal cancer is the second leading cause of cancer death among adults in NYS
- HPV is the most common sexually transmitted infection in the United States, and some high-risk strain types can cause cervical, vaginal, vulvar, oropharyngeal (throat), penile and anal cancers; HPV vaccination can prevent infections that cause these cancers
- Routine screening can prevent cervical cancer; the Papanicolaou test (also known as Pap smear) can detect precancerous cervical cell changes that could otherwise develop into cervical cancer without treatment

Health disparities exist in cancer outcomes and are largely attributed to exposure to risk factors, early detection, and access to preventive care and treatment. The final report for this PIP will be submitted to the NYSDOH in the summer of 2026.

### **2024-2026 Continuous Engagement in Care and Treatment HARP PIP**

HARP was designed to support individuals who have serious and persistent mental health and/or substance use treatment needs. Recognizing opportunities for improvement, and aligning several NYS priority areas, the NYSDOH Office of Health Services Quality and Analytics (OHSQA), OASAS, OMH, and NYS OHIP collaborated to select *continuous engagement in care and treatment* as the topic for the 2024-2025 common-themed PIP. During the calendar year 2025, this PIP was extended for another year and will now conclude at the end of 2026.

This PIP aims to improve *Engagement in Community-Based Mental Health Care after a Mental Health Hospitalization (EIC)*, and *Continued Engagement in Substance Use Disorder Treatment (CET)* by:

- Identifying barriers to continuous engagement in care and treatment through plan-specific barrier analysis
- Implementing quality interventions to address identified barriers to continuous engagement
- Identify and address health care disparities related to race or ethnicity in continuous engagement in care and treatment.

### **2026-2027 NEW Depression Screening and Follow-Up (DSF-E) Medicaid Managed Care PIP**

The NYSDOH OQPS, Office of Health Insurance Programs (OHIP), and Office of Public Health (OPH) have jointly proposed a two-year, common themed PIP for 2026–2027 focused on *improving depression screening and follow-up care among Medicaid Managed Care (MMC) and CHP*. The initiative centers on the DFS-E measure, with the goal of strengthening early identification of depression, promoting timely access to behavioral health services, and reducing disparities in mental health outcomes across NYS.

As rationale for selecting DSF-E as the PIP topic, NYSDOH presented the following facts about depression, the importance of routine screening, and the presence of disparities in behavioral health outcomes:

- **Depression is one of the most prevalent mental health conditions in the United States and a leading cause of disability:** It affects individuals of all ages and is

associated with significant impairment in daily functioning, increased risk of chronic disease, and higher health care utilization

- **Timely identification of depression improves outcomes:** Routine screening using validated tools (such as the PHQ 2 or PHQ 9) is an evidence-based strategy that supports early detection and facilitates connection to appropriate care
- **Depression is strongly associated with poorer health outcomes:** When left untreated, depression can worsen the trajectory of other chronic conditions—including diabetes, cardiovascular disease, and substance use disorders—and is associated with increased emergency room visits and hospitalizations
- **Follow-up after a positive screen is essential:** Evidence demonstrates that prompt follow-up (e.g., diagnostic evaluation, behavioral health referral, medication management, or brief intervention) improves symptom management, quality of life, and long-term recovery
- **Significant disparities in mental health care persist:** Differences in screening rates, access to behavioral health care, and timely follow-up contribute to inequitable outcomes among racial and ethnic minorities, individuals with lower socioeconomic status, and communities with limited access to mental health providers

The 2026–2027 DFS-E PIP requires Medicaid managed care plans to implement targeted quality improvement interventions aimed at increasing completion of annual depression screenings, improving the rate of timely follow-up for individuals with a positive screen, and reducing disparities in identification and treatment of depression across member populations.

## **QPMs and Quality Performance Satisfaction (QPS) Reports**

### **QPMs**

Each year, NYSDOH OHSQA provides MVP with two QPMs, one for the MVP Medicaid Managed Care (MMC) population and one for the MVP HARP population. Each QPM provides a framework for evaluating population-specific performance and helps MVP prioritize quality improvement planning efforts.

QPMs are developed using data from QARR submissions and are created by the intersection of three rows and three columns, resulting in nine cells. The rows (y-axis) represent trend over time, while the columns (x-axis) represent current performance relative to other plans. Each cell is assigned a letter to represent position across these two dimensions. Plan performance for each independent QARR measure is evaluated and assigned a letter grade (A-F) based on where within the matrix the measure lands. The comparisons are based on results from the QARR submission percentile rankings. The percentiles used are 0 to 49%, 50% to 89%, and 90%-100%. The resulting matrix layout is depicted in Figure 1.

Figure 1.

		<u>Percentile</u>		
		0 to 49%	50 to 89%	90 to 100%
<u>Trend</u>	↑	C	B	A
	No Change	D	C	B
	↓	F	D	C

Measures appearing in the "F" and "D" matrix cells are subject to a root cause analysis (RCA) and action plan report. Measures in the "F" cell are prioritized first. If fewer than two measures are in the "F" cell, measures chosen from D cells would make up the difference until two reports are created per product or until no additional measures remain in D cells, whichever occurs first. Plans are not required to submit RCAs nor action plan reports for measures in cells "A," "B," or "C."

After receiving the QPMs from NYSDOH OHSQA, the MVP Quality Program Manager distributes the QPMs to key stakeholders and organizes a workgroup series to identify which quality measures need to be addressed. The Quality Program Manager will collaborate with key stakeholders to complete the RCA process and create appropriate action plans, using the templates supplied by NYSDOH OHSQA. While MVP has measures in the "F," or "D" cells, MVP will develop two RCA and action plan reports from the Medicaid QPM, and two RCA and action plan reports from the HARP QPM, totaling up to four total RCA and action plan reports. The MVP Quality Program Manager will submit the RCA and action plan report documents via email to **QI@health.ny.gov**.

Once submitted, the NYSDOH OHSQA Plan Manager may arrange a conference call to review the responses and may request clarification or suggest edits to the action plan reports. When the RCAs and action plans are approved, the NYSDOH OHSQA Plan Manager will combine all four action plans into a singular QPM action plan. MVP will be asked to attest to commit to perform the interventions outlined in the final approved action plan. The MVP Quality Program Manager will obtain the required signatures from the MVP Chief Executive Officer and the MVP Chief Medical Officer and submit the attestation form with the approved QPM action plan via email to **QI@health.ny.gov**.

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

### **QPS Reports**

Also distributed with the QPMs are the QPS Reports. QPS reports detail plan performance on measures from the CAHPS survey, by product line. If one or more measures are significantly below the statewide average, then one measure must be selected to complete and submit an RCA and action plan report following the same submission and attestation process as the QPM. If there are no measures in the QPS Report that are significantly below the statewide average, there is no need to complete and submit an RCA and action plan report.

## **APPEAL SYSTEM**

MVP ensures that member appeals are addressed appropriately by investigating and resolving the appeals in a timely manner. Members may file a formal appeal of an adverse benefit determination, or upon exhaustion of the internal appeal process, request additional levels of appeal as applicable.

All member appeals are tracked. Data is analyzed and reported to QIC and applicable subcommittees quarterly and annually for identification of opportunities to improve or if a CAP is needed.

## **GRIEVANCE SYSTEM**

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

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

## **REGULATORY COMPLIANCE AND REPORTING**

MVP performs required quality of service, clinical performance, and utilization studies throughout the year based on contractual, state, federal, and other regulatory agency requirements. This also includes accrediting bodies such as NCQA. Functional areas utilize NCQA

Standards, clinical practice guidelines, state and federal rules and regulations, and guidance from nationally recognized medical societies and associations, such as NIH and CDC.

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

## **NCQA HEALTH PLAN ACCREDITATION**

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

MVP achieved NCQA HPA for its Commercial HMO/POS in NYS and VT, NYS Essential Health Plan, and NYS Marketplace Off-Exchange in September 2023. This certification is valid through October 2026.

The MVP HPA for the VT Marketplace product underwent NCQA survey during the first quarter of 2023. A re-survey for elements that received partial credit in Network and PHM standards began April 2024 and was successfully completed July 2024 with MVP receiving full accreditation through April 2026.

In 2026, MVP will undergo a full accreditation survey for all combined lines of business in NYS and VT beginning with document submission in February, followed by file review in April. A successful survey will result in accreditation for three years.

## **DELEGATED SERVICES**

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

- Responsibilities of MVP and the delegate
- Specific activities being delegated
- Frequency and type of reporting

- The process by which MVP evaluates the delegate's performance
- Statement of consequences and corrective action process should the delegate fail to meet the terms of the agreement, up to and including revocation of the delegation agreement

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

MVP is accountable for all functions and services delegated, and as such monitors the performance of the delegated entity through annual approval of the delegate's program's 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 assigned operational designees conduct an annual evaluation and documentation review that includes the delegate's program, applicable policies and procedures, applicable file reviews, and review of meeting minutes for compliance with health plan, state, and federal requirements and accreditation standards. The DOC regularly monitors the performance of delegated functions and may recommend de-delegation if the delegate is not performing adequately.

### **Optum Cancer Support Program**

MVP launched a partnership with Optum Health Solutions (OHS) in January of 2024, to provide a comprehensive oncology management program to members with complex cancer diagnoses. The program serves Medicare, Medicaid, CHP, Essential Health Plan, and Commercial members. The oncology management program includes prior authorization service for outpatient medical oncology treatments, Provider P4P Program, and a Cancer Support Program offered through CM.

Optum's Cancer Support Program (CSP) provides supportive services including:

- Educating on benefits, diagnosis, prognosis, treatment, and symptom management
- Identifying barriers to care, such as adherence and psychosocial and social determinants of health
- Providing Transition Care Management and ensuring a safe transition of patients from the acute care to home care setting
- Optimizing palliative and hospice care
- Facilitating Advance Care Planning
- Providing access to a digital site for patient education

The MVP CM role is to facilitate a connection to the CSP. In addition, MVP Care Managers offer guidance on benefits, education on symptom management, and advocacy for members that are not included in the CSP offered through OHS.

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

### **Optum Oncology UM Program**

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

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

### **Optum Oncology CM Program**

The partnership between MVP and OHS offers a comprehensive oncology CM program to members with certain diagnoses of cancer. The Optum CM program is dedicated to achieving the best possible outcomes for members, providing access to clinical and non-clinical support during a significant life event, and reducing the cost of care. The program is available to Medicare, Medicaid, CHP, Essential Health Plan, and Commercial members.

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

### **Optum Renal Program**

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

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

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

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

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

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

#### **ENDORSEMENT OF THE QUALITY IMPROVEMENT PROGRAM DESCRIPTION**

The Quality Improvement Program Description has been reviewed and endorsed by the Quality Senior Leadership effective this 16th day, month of February 2026.



June Stanley RN, MSN, FNP  
VP, Clinical Operations, Medical Management



Jason Merola, MD, MBA  
Chief Medical Officer, QIC Chairperson

#### **ENDORSEMENT OF THE QUALITY IMPROVEMENT PROGRAM DESCRIPTION**

The Quality Improvement Program Description has been reviewed and endorsed by the Board of Directors effective this 9<sup>th</sup> day, month of March, 2026.



Alan Goldberg  
Chair of the Board of Directors