



2021 Quality Program Description



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Introduction

UCare’s Quality Program Description provides the structure used to guide the formal processes for evaluating and improving the quality and appropriateness of health care services and the health status of the populations we serve. It describes the structure applicable to activities undertaken by UCare, including those activities undertaken for the benefit of UCare enrollees. The program allows UCare the flexibility to target activities that focus on trends and priorities identified at the state, regional and national levels. The Quality Program provides a structure for promoting and achieving excellence in all areas through continuous improvement and an emphasis of population health management and health and racial equity.

UCare maintains a company-wide commitment to quality and industry best practices and standards as set forth by state and federal regulations, as well as accrediting organizations. The Quality Program Description serves to resource, coordinate, integrate and oversee the Quality Program. This Program Description defines the program purpose, structure, policy and procedure for UCare in the framework of UCare’s Mission and Values.

UCare’s Quality Program Description applies to the following products:

UCare Products	
State Public Programs	Prepaid Medical Assistance Program (PMAP)
	Minnesota Senior Care Plus (MSC+)
	UCare Connect Special Needs Basic Care (Connect)
	MinnesotaCare (MnCare)
	UCare’s Minnesota Senior Health Options (MSHO)
Medicare	UCare Connect + Medicare
	UCare Medicare Plans
	EssentiaCare
	UCare Medicare with M Health Fairview and North Memorial Health
	Institutional Special Needs Plans (I-SNPs)
Marketplace	UCare Individual and Family Plans (IFP)
	UCare Individual & Family Plans with M Health Fairview

Mission Statement

UCare will improve the health of our members through innovative services and partnerships across communities.

Values (UCare’s Philosophy)

Integrity: UCare stands on its reputation. We are what we say we are; we do what we say we will do.

Community: UCare works with communities to support our members and to give back to the communities through UCare grants and volunteer efforts.

Quality: UCare strives to continually improve our products and operations to ensure the highest quality of care for our members.

Flexibility: UCare seeks to understand the needs of our members, providers and purchasers over time, and to develop programs and services to meet those needs.

Respect: UCare respects its members by providing quality care and services that recognize their unique needs. UCare respects its employees by providing a supportive work culture that encourages their development and embraces their diversity.

Quality Program

The Quality Program is a commitment to innovation, affordability, professional competence and continuous learning, teamwork and collaboration. The clinical aspects of the Quality Program are structured from evidence-based medicine. The Quality Program also ensures health services needs of members, including those with limited English proficiency and diverse cultural and ethnic backgrounds are met. The Quality Program supports efforts to

understand populations served, in terms of age groups, disease categories, social factors and special risk status through analysis, monitoring and evaluation of processes. In addition, the Quality Program designs interventions to target health care disparities and social risk factors to better support members in achieving optimum health. The quality of care and services are optimized and continuously improved while maintaining cost effective utilization of health care resources. This is accomplished by systematic monitoring and evaluation of provided services and by actively pursuing opportunities for improvement.

Goals

The goals of UCare's Quality Program are to focus on addressing the quadruple aim from a population health management standpoint, while addressing health and racial equity and health disparities.

Population Health Management:

- Continue to refine and develop a more robust population health management strategy to identify and address the needs of our members across the continuum of care to improve the overall health of the community.
- Foster partnerships among members, caregivers, providers and communities, which allows UCare to promote effective health management, health education and disease prevention, as well as encourage the optimal use of health care and services by members and providers.
- Implement aligned and evidence-based health promotion, disease management, care coordination and care management programs to support members in achieving their best health and well-being.
- Establish metrics to evaluate members' perception of their quality of life and develop goals for improvement.

Health and Racial Equity:

- Identify, implement and measure evidence-based strategies and metrics to address social factors that influence health, health care and racial disparities and inequities to improve overall health outcomes of our members.
- Ensure UCare's organizational initiatives are data-driven, equity-centered, community-informed and culturally appropriate and responsive to meet the needs of UCare members.
- Broaden and integrate perspective on the health and racial equity implications of business decisions at UCare.

Access:

- Ensure adequate access and availability to medical, specialty, dental, pharmacy, mental health and substance use disorder services to match member needs and preferences, including cultural, ethnic, racial and linguistic needs and preferences.
- Monitor telehealth trends and demonstrate that UCare's telehealth network is providing safe, equitable and coordinated care by credentialed providers.

Quality of Care:

- Define, demonstrate and communicate the organization-wide commitment to improving the quality of care and patient safety.
- Coordinate quality improvement activities across all products to achieve efficiencies and reduce duplicative efforts.
- Continuously improve the quality, appropriateness, availability, accessibility, coordination and continuity of health care services to members across the continuum of care.
- Ensure a high-quality network through credentialing, peer review and contracting processes.
- Collaborate with providers to share best practices and promising practices and implement coordinated strategies to improve care coordination and quality.
- Improve and manage member outcomes, satisfaction and safety.

- Improve member and provider experience and enhance UCare’s understanding of key factors contributing to satisfaction.
- Continue to focus on maintaining and improving member health through Medicare and Individual and Family Plan (IFP) Star Ratings and Medicaid measures through innovative initiatives.

Regulatory:

- Maintain National Committee for Quality Assurance (NCQA) Health Plan Accreditation for all products.
- Explore NCQA Distinction in Multicultural Health Care.
- Exceed compliance with local, state and federal regulatory requirements, and accreditation standards.
- Provide oversight of delegated entities to ensure compliance with UCare standards as well as state and federal regulatory requirements and accreditation standards.

Patient Safety

The Quality Program includes an emphasis on patient safety. A number of activities are in place to monitor aspects of patient safety that include but are not limited to:

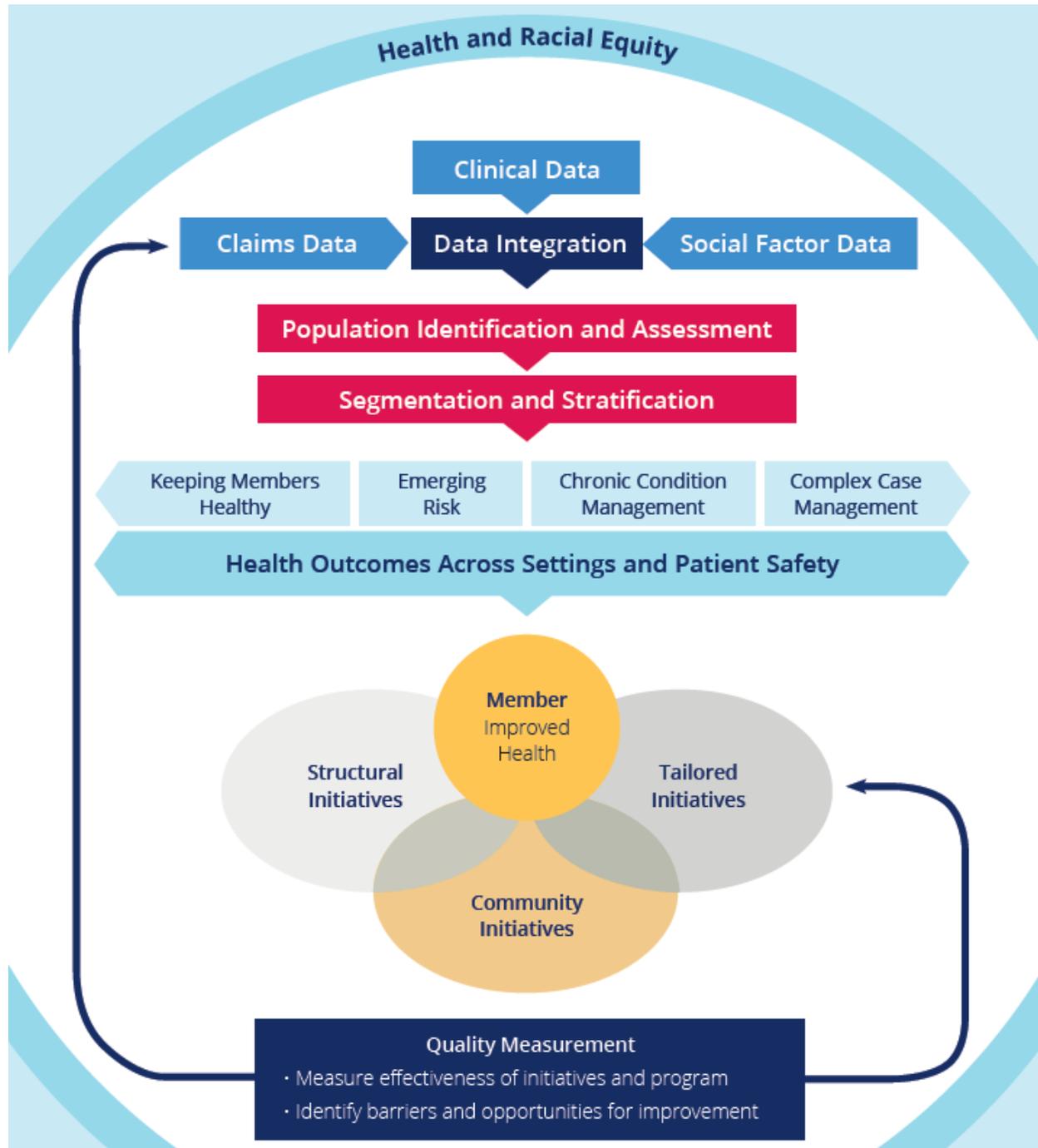
- Physician credentials are verified in accordance with NCQA, state and federal guidelines. Disciplinary actions against physicians are monitored on an ongoing basis.
- The Quality of Care Program monitors adverse events through both standard reports of inpatient claims and the identification of potential and/or actual adverse events referred from any part of the health care delivery system.
- The process of Utilization Management plays a vital role in the monitoring of patient safety through concurrent review, identification of potential quality of care issues and identification of potential trends in under and overutilization.
- Member complaints are monitored for adverse events. The Quality Management and Population Health Department, in consultation with clinical practitioners, investigates, tracks, analyzes and brings referred events to the appropriate committee, as needed.

Safety measures may be addressed through the collaboration with primary care providers by:

- Education of members regarding their role in receiving safe and effective services through member newsletters, our website, and direct mailings.
- Distribution of medical and behavioral health Clinical Practice Guidelines to practitioners.
- Education of providers regarding improved safety practices in their clinical practice through provider newsletters and our website.
- Evaluation for safe clinic and/or medical office environments during office site reviews.
- Education to members regarding safe practices through home health education and discharge planning.
- Intervention for identified safety issues as identified through care management, potential quality of care assessment, and the grievance and clinical case review process.
- Dissemination of information to providers and members regarding activities in the network related to safety and quality improvement.

Population Health Framework

UCare’s Population Health Framework guides the development and refinement of our Population Health Program and related quality improvement activities with a cross-departmental, intersectional, equity-centered approach that improves the health of UCare members. This framework highlights a continuous cycle of data integration from various sources, identifying characteristics, barriers and needs of populations, segmenting members by risk level, targeting various interventions based on member need and risk level, and evaluating effectiveness of UCare’s processes and interventions.

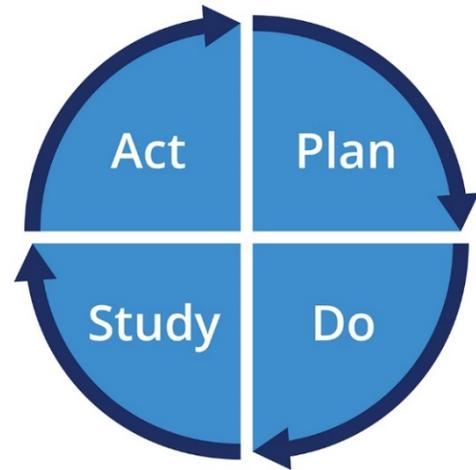


Quality Improvement Framework

UCare designs interventions to meet the Quadruple Aim by improving quality of care, and member and provider experience while reducing costs. The goal is to optimize health system performance for members. This process allows UCare to identify target populations, define aims and measures, develop interventions to improve population health, and evaluate and refine interventions based on project results. UCare’s improvement goals compare with local and national performance metrics and strive for statistically significant improvement year to year.

The Quality Improvement (QI) team uses a systematic and formal framework to design, evaluate and document QI initiatives – the Plan-Do-Study-Act (PDSA) cycle. The PDSA cycle is used as a guide to identify the following areas:

- **Plan:** Identify the objectives of the project and make predictions about what will happen. This step includes answering the following questions:
 - What are we trying to accomplish based on the data points and identified interventions?
 - How will we know a change led to improvement (i.e. quantitative measures)?
 - What change can we make that will result in improvement from this intervention?
- **Do:** Implement the intervention and analyze data.
- **Study:** Summarize what was learned based on the outcome data.
- **Act:** Identify needed changes that should be made to the intervention and repeat PDSA cycle.



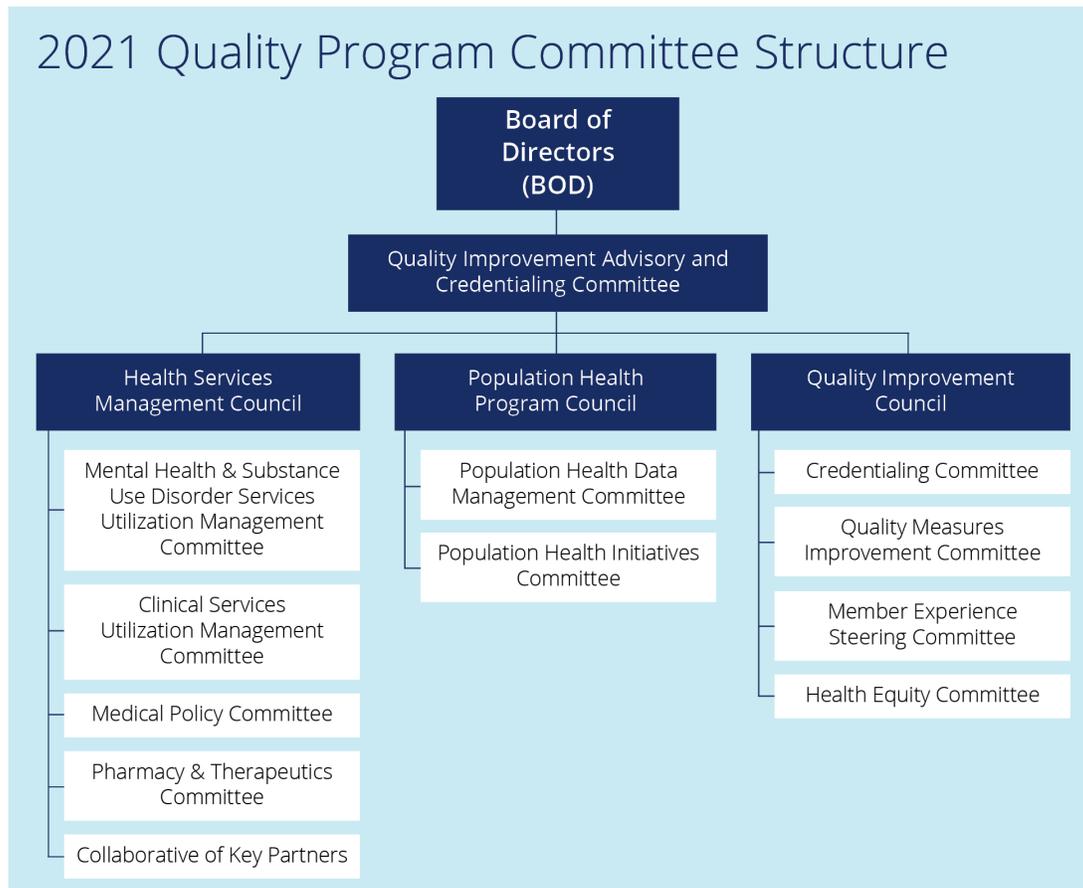
Throughout the PDSA cycle, the QI team will incorporate additional questions to ensure each initiative is designed and evaluated from a health and racial equity perspective. Questions include:

- Does it consider health and racial equity? If so, how?
- What does the current or historical data tell us about existing health and racial inequities?
- What other critical information cannot be captured in the data?
- How is the information shared with populations experiencing health inequities and/or disparities afterwards to improve their health and well-being?

In addition, UCare’s new Health Equity Officer has been added to all Quality Program Councils and many sub-committees to strengthen UCare’s health and racial equity efforts.

Organizational Structure

To promote quality throughout the UCare organization, specific relationships and linkages between the Board of Directors, program committees, operational departments and UCare employees are described on the following pages. UCare has created committees to provide oversight and implementation of all quality improvement activities.



Board of Directors

UCare's Board of Directors ("BOD") along with the Chief Executive Officer, executes the leadership function and are ultimately responsible for the Quality Program including systems and procedures designed to ensure the quality of care provided to our members. Results of pertinent quality improvement activities are reported at each meeting. Responsibilities include:

- The Chair of the Board of Directors appoints a Quality Improvement Advisory and Credentialing Committee (QIACC) committee chair, which is comprised of physicians and staff from clinics that are participating providers under contract with the corporation.
- The Chair of the Board appoints a committee chair from among the committee's members.
- Reviews, evaluates and approves the Quality Program Description, annual Quality Work Plan, and the annual Quality Program Evaluation.
- Review of programs and standards to promote the provision of optimal achievable patient care by the corporation's participating clinics and other providers.

Membership consists of:

Chairperson: Head of the Department of Family Medicine and Community Health at the University of Minnesota Medical School
 Finance Officer, Department of Family Medicine at the University of Minnesota Medical School
 Six elected UCare health plan members

Five physicians appointed from the faculty of the Department of Family Medicine
 One member appointed by the Dean of the University of Minnesota Medical School
 One at-large member elected from the community

Frequency of Meetings: The Board meets every two months throughout the year.

Quality Improvement Advisory and Credentialing Committee (QIACC)

The Quality Improvement Advisory and Credentialing Committee (QIACC) oversees and directs the Quality Program for the organization and promotes the provision of optimal, achievable patient care and service by providing guidance to UCare on the quality of care provided to its members. The committee reports to the Board of Directors. Responsibilities include:

- Directs the development and approves the annual Quality Program Description, Quality Work Plan, and Quality Program Evaluation and makes recommendations for changes and/or improvements.
- Approves the quality improvement guidelines and standards for patient care activity, including review of key clinical surveys and interpreting results.
- Advises the corporation on appropriate strategies and procedures for assurance of such quality standards.
- Reviews and provides input on clinical improvement activities, including review of patient care evaluation studies.
- Advises UCare on provider-related standards for quality assurance.
- Oversees the activities of the Quality Improvement Council, Population Health Program Council, and Health Services Management Council.

Membership consists of:

The Chairperson is appointed by the Board Chair from among the committee’s members.
 External participants include 5 to 10 professionals participating in the UCare network, including representatives of primary care disciplines such as:

Family Medicine, Internal Medicine, Pediatrics, OB-GYN, Geriatrics, Neurology and Psychiatry.
 Additional provider representatives who serve ethnic communities representative of UCare’s membership are also encouraged.

In addition, the following UCare staff attends:

SVP, Chief Medical Officer
 SVP, Provider Relations and Chief Legal Officer
 SVP, Public Affairs and Chief Marketing Officer
 VP, Clinical Services
 VP, Chief Informatics Officer
 VP, Marketing and Product Management
 VP, Provider Relations and Contracting
 VP, Quality Management and Population Health
 Medical Directors

AVP, Mental Health and Substance Use Disorder and SNBC
 AVP, Pharmacy
 Health Equity Officer
 Associate Director, Quality Improvement
 Assistant General Counsel
 Population Health Program Manager
 Quality Improvement Specialist

Frequency of Meetings: The committee meets quarterly throughout the year.

Health Services Management Council (HSMC)

The Health Services Management Council (HSMC) seeks to improve the health of members through oversight to ensure appropriate cost, utilization and efficacy of clinical services. The HSMC coordinates utilization management, clinical policy development, delegated services and other health services management initiatives

that support UCare population health objectives. The HSMC also monitors, evaluates and recommends, as needed, modifications to initiatives. The committee reports to the Quality Improvement Advisory and Credentialing Committee. Responsibilities include:

- Assesses cost, utilization and appropriateness of clinical services, including medical, mental health and substance use disorder, pharmacy, dental, chiropractic and physical therapy care. Based on this assessment, the Annual Health Services Management Report and Plan are developed.
- Reviews and approves the Annual Health Services Management Report, which identifies opportunities to improve Total Cost of Care and reduce over and under-utilization of clinical services.
- Annually reviews and approves the Health Services Management Plan, which contains initiatives to address opportunities identified in the Health Services Management Report.
- Monitors and evaluates the Health Services Management Plan initiatives and suggests modifications to initiatives as appropriate.
- Provide oversight to Quality of Care.

Membership consists of:

Chair: SVP, Chief Medical Officer	Associate Director, Mental Health and Substance
SVP, Chief Financial Officer	Use Disorder and SNBC
VP, Chief Informatics Officer	AVP, Pharmacy
VP, Clinical Services	Director, Financial Analytics
VP, Provider Relations and Contracting	Director, Strategy and Product Management
VP, Quality Management and Population Health	Associate Director, Health Care Analytics
AVP, Mental Health and Substance Use Disorder and SNBC	Director, Clinical Services
Medical Directors	Medicaid Product Manager
	Health Equity Officer

Frequency of Meetings: The committee meets monthly throughout the year.

Clinical (CLS) Utilization Management Committee

Utilization Management (UM) is an organization-wide, interdisciplinary approach to balancing quality, risk, and affordability concerns in the provision of member care. UM is accomplished through proactive data analysis, utilization review, case management, and referral management. It is the process of reviewing the medical necessity, appropriateness, and efficiency of health care services. The purpose of this work group is to identify, monitor, and evaluate utilization metrics and trends that may have an impact on resources, services, and member outcomes related to medical, or pharmacy services. This group is responsible for implementing strategies and/or interventions that impact utilization. The committee reports to the Health Services Management Council.

Responsibilities include:

- Review key utilization metrics, trends, and accompanying analysis. Key metrics may include but are not limited to: ambulatory care sensitive conditions, preference sensitive conditions, inpatient and emergency utilization, and pharmaceutical.
- Evaluate and recommend utilization benchmarks for adoption by the Health Services Management Council.
- Identify opportunities for additional analysis and recommend the development of initiatives to ensure appropriate utilization of medical and pharmaceutical services.
- Assign sub-groups to study, develop and prioritize strategies to impact utilization.
- Analyze data for over and underutilization on a scheduled and ad-hoc basis and report results at least annually to Health Services Management Council for further review and action.
- Study organizational monitoring activities including utilization reports, cost/trend reports, and other data and make recommendations to Health Services Management Council.
- Monitor studies, new findings, and emerging utilization trends for potential impact on UCare utilization.
- Provide recommendations to the Health Services Management Council.

Membership consists of:

Co-Chair: Director, Clinical Services - Operations	Clinical Intake Manager
Co-Chair: Director, Care Management	Associate Director, Quality Improvement
Vice Chair: Director, Clinical Services - Care Management	Stars Program Manager
Utilization Review Manager - Medical Services	Quality Improvement Specialist
Clinical Pharmacy Manager	Associate Director, Provider Relations and Contracting
Medical Directors	Health Care Analyst (Ad Hoc)
Associate Director, Health Care Analytics	Disease Management Manager (Ad Hoc)
Health Care Analytics Manager	Health Promotion Program Manager (Ad Hoc)
Health Services Analysts	

Frequency of Meetings: The committee meets every two months throughout the year.

Mental Health and Substance Use Disorder Services (MSS) and SNBC UM Committee

Mental Health and Substance Use Disorder Services and SNBC (MSS) Utilization Management (UM) is an organization-wide, interdisciplinary approach to balancing quality, risk, and cost concerns in the provision of member care. MSS UM is accomplished through proactive data analysis, utilization review, case management, and referral management. It is the process of reviewing the medical necessity, appropriateness, and efficiency of health care services. The purpose of this workgroup is to identify, monitor, and evaluate utilization metrics and trends that may have an impact on resources, services, and member outcomes related to mental health, substance use, or pharmacy services. The committee reports to the Health Services Management Council. Responsibilities include:

- Review key utilization metrics, trends, and accompanying analysis. Key metrics may include but are not limited to: mental health diagnosis trends, outpatient programs, inpatient and emergency utilization, substance use disorder services, HEDIS or Star measures and pharmaceutical services.
- Evaluate and recommend mental health and substance use disorder utilization benchmarks for adoption by the Health Services Management Committee.
- Identify opportunities for additional analysis and recommend to the Health Services Management Committee the development of initiatives to ensure appropriate utilization of mental health, substance use disorder, and pharmaceutical services.
- Assign sub-groups to study, develop and prioritize strategies to impact mental health and substance use disorder utilization.
- Analyze over and underutilization data on a scheduled and ad-hoc basis and report results at least annually to Health Services Management Committee for further review and possible action.
- Review and analyze cost saving initiatives taken by the MSS Department.

Membership consists of:

Chair: Associate Director, Mental Health and Substance Use Disorder and SNBC	Clinical Manager(s), Mental Health and Substance Use Disorder and SNBC
Vice Chair: Clinical Manager, Mental Health and Substance Use Disorder and SNBC	Supervisor(s), Mental Health and Substance Use Disorder and SNBC
Clinical Pharmacy Manager	Associate Director, Health Care Analytics
Medical Director, Mental Health and Substance Use Disorder and SNBC	Health Care Analytics Manager
Operations Manager, Mental Health and Substance Use Disorder and SNBC	Health Care Analyst(s)
	Quality Improvement Specialist
	Provider Relations and Contracting Network Manager

Frequency of Meetings: The committee meets monthly throughout the year.

Pharmacy and Therapeutics (P&T) Committee

The Pharmacy and Therapeutics (P&T) Committee is comprised of practicing physicians and other clinicians, plus pharmacists who oversee formulary management, prior authorization, step therapy, quantity limitations and other drug utilization activities on the pharmacy and medical benefit. The Committee may also advise UCare on other pharmacy matters to continuously improve the delivery and quality of drug therapies administered through the pharmacy or medical benefit. The committee reports to the Health Services Management Council. Responsibilities include:

- Clinically evaluate drugs and therapeutic guidelines to determine medication inclusion or exclusion on all UCare formularies. Decisions for formulary inclusion or exclusion made by the P&T are binding. Information to support this responsibility shall include:
 - Clinical evidence and efficacy: drug formulary monographs, established practice guidelines, peer reviewed literature.
 - Medication safety: adverse drug reactions, drug-drug & drug-food interactions, therapy monitoring, unusual administration or stability issues and potential for medication error.
 - Comparable data: evaluation of a drug's efficacy, safety, convenience, and costs with those of therapeutic alternatives.
- Review all drug formularies and therapeutic classes at least annually.
- Make reasonable effort to review a new FDA approved drug product (or new FDA approved indication) within 90 days and will make a decision on each new FDA approved drug product (or new FDA approved indication) within 180 days of its release on to the market, or clinical justification will be provided if this timeframe is not met. Drugs or new indications for drugs within the Centers for Medicare & Medicaid (CMS) classes of clinical concern are subject to expedited review under CMS provisions, and a decision shall be made within 90 days.
- Review all Utilization Management Programs (Prior Authorizations and Step Therapy) annually for both the pharmacy and medical benefits. This includes part B step therapy requirements through Medicare part B.
- P&T Committee will review the Transition of Care policy to ensure transition decisions are appropriately reviewed and are aligned with regulatory requirements.
- P&T Committee will review policies and procedures applicable to drug related coverage determination requests for both the pharmacy and the medical benefit.
- Substantially all Protected Classes (e.g. anticonvulsants, antipsychotics, antidepressants, antineoplastic medication, antiretroviral agents and immunosuppressants), will be added to all Medicare Formularies and be reviewed as expeditiously as possible.
- Oversee maintenance of drugs currently included in the formulary (e.g. new generic, new indication, new formulation) and minimize duplication of basic drug types, or drug entities within specific medication classes.

Membership consists of:

Chair: Plan Medical Director
Vice Chair: Plan AVP, Pharmacy

Internal UCare Members:

Medical Director(s) - non-voting
AVP, Pharmacy - non-voting
Clinical Pharmacy Manager - non-voting
Clinical Pharmacists(s) - non-voting

External Members (6-10 members):

Membership will consist of a majority of practicing physicians representing a broad range of primary care and specialty areas including, but not limited to: Endocrinology, Gastroenterology, Family Medicine, Internal Medicine, Pediatrics, Cardiology, and Pulmonology. Other practice areas such as Psychiatry, Rheumatology, and Oncology, will be available for consultation. Membership will include at least one practicing physician and one practicing pharmacist who is an expert in geriatrics or disabled persons. Credentialing status is in good standing.

Frequency of Meetings: The committee meets at least quarterly throughout the year.

Medical Policy Committee (MPC)

The purpose of the Medical Policy Committee (MPC) is to oversee the development, evaluation and publication of medical policies. The Committee will evaluate the clinical evidence of topics and issues related to medical necessity of new and emerging health technologies, assess its safety and effectiveness, establish clinical indications for evidence-based application of the service, procedure or treatment and develop and update medical policies as new evidence is published at intervals not to exceed 12 months. The committee reports to the Health Services Management Council. Responsibilities include:

- Sets priority for medical policy development and implementation through a systematic, structured decision analysis.
- Evaluates clinical evidence and assesses the safety and effectiveness of new and emerging technologies, as well as new applications of existing technologies to determine their impact on health status and disease outcome. Medical policies are based upon published peer-reviewed clinical evidence, where such evidence exists and uses input from clinicians, UCare participating specialists and professional staff.
- Reviews and recommends appropriate indications for use of relevant services, procedures, or treatments.
- Approves UCare’s medical policies for content.
- Guides monitoring and evaluation of the medical policies to assess their utility and impact.
- Oversees assessments that ensure medical policies are effectively achieving anticipated outcomes and objectives.
- Revises and updates the policies in a consistent and timely manner.
- Considers nationally accepted consensus statements and expert opinion and incorporates where appropriate based upon clinical evidence.
- Reviews policies and procedures for case adjudication where affected by medical policies and recommends changes if needed.

Membership consists of:

SVP, Chief Medical Officer

Medical Directors

Medical Director, Mental Health & Substance Use Disorder Services and SNBC

VP, Clinical Services or Delegate

AVP, Mental Health and Substance Use Disorder and SNBC or Delegate

Coverage Policy Program Manager

SVP, Chief Legal Officer and Corporate Secretary or Delegate

Director, Clinical Services - Operations

Pharmacy Clinical Manager

Coding Manager

Director, Product Management

HCE Business Analyst

Physician Expert (optional)

Product Managers (optional)

Configuration Manager (optional)

Director, Customers Services (optional)

SVP, Public Affairs and Chief Marketing Officer (optional)

Frequency of Meetings: The committee meets on an ad hoc basis throughout the year.

Collaborative of Key Partners

The intent of the Collaborative of Key Partners is to promote bi-directional communication and integration of care between Mental Health and Substance Use Disorder Services and medical care practitioners and the health plan. We use a cross-sectional group of practitioners and key partners in our collaborative. The collaborative reviews UCare information and provides insight from experiences and ideas on improving the continuity and care of our members as they receive care by both medical and mental health and substance use disorder services practitioners. The group will help identify opportunities and activities to achieve this goal and come prepared to discuss and participate in collaborative interchange. The Collaborative of Key Partners reports to the Health Services Management Council. Responsibilities include:

- The group will focus on understanding service needs and challenges as well as identifying opportunities to strengthen collaboration between health care providers and practitioners through the exchange of information and coordinated work with members.
- Discuss data on the access of care for the diagnosis, treatment and referral of mental health or substance use disorders with recommendations for process improvement.
- Discuss information pertaining to the appropriate use of psychotropic medications, as well as other adjunctive therapies.
- Discuss information pertaining to psychotherapy and other modalities of treatment and the efficacies for patient outcomes.
- Discuss the effectiveness of the management of coexisting medical and mental health or SUD conditions.
- Identify possible mental health and substance use disorder prevention initiatives based on community needs.
- Identify supportive efforts directed toward continuity of care for members with serious and persistent mental illness (SPMI) and other mental health conditions, as well as substance use disorders.
- Identify opportunities within the community to address mental health and substance use disorders and problem solve together regarding ways to address the same concerns.
- The group will consider issues concerning specific populations, such as children, adolescents and their families, as well as seniors, and any specific treatments and interventions related to those populations.
- Address issues related to culturally responsive practices, and the unique needs of specific cultural groups.
- Possible review of ongoing key metrics to inform the group regarding utilization patterns, and any blossoming or waning utilization trends.

Membership consists of:

Chair: AVP, Mental Health and Substance Use Disorder Services and SNBC
 Vice Chair: Associate Director, Mental Health and Substance Use Disorder Services and SNBC
 SVP, Chief Medical Officer
 Medical Director, Mental Health & Substance Use Disorder Services and SNBC
 Community Psychologist
 Community Psychiatric Nurse Practitioner
 Community Pediatric Nurse Practitioner
 Community Family Practice Physician
 Community Psychiatrist
 Advocacy Organization Leadership
 County Partner Representative
 Substance Use Disorder Provider
 Child and Adolescent Organization Provider
 CCBHC Organization Leadership
 Culturally Specific Organizational Leadership
 Community Mental Health Center Leadership
 UCare Government Relations Staff
 UCare Product Staff

Mental Health Clinic Leadership
 VP, Government Relations
 VP, Provider Relations & Contracting
 County Government Relations
 AVP and Public Affairs Officer
 MN DHS Managed Care Liaison
 Specialty Treatment Provider Leadership
 Healthcare System Mental Health Nurse Practitioner
 Mental Health and Substance Use Disorder Services and SNBC Operations Manager
 Mental Health and Substance Use Disorder Services and SNBC Clinical Manager(s)
 Provider Contracting Principal
 Mental Health and Substance Use Disorder Services and SNBC Community and Provider Liaison
 Mental Health and Substance Use Disorder Services and SNBC Program and Policy Coordinator
 Quality Improvement Specialist
 Provider Experience Manager
 Law Enforcement Representative

Frequency of Meetings: The committee meets at least quarterly throughout the year.

Population Health Program Council (PHPC)

The Population Health Program Council (PHPC) seeks to improve the health and well-being of members while also addressing health disparities and social risk factors impacting health. The Council provides executive review and guidance for the enterprise Population Health Program. Working with communities and providers, the program creates data-driven, evidence-based, scalable and financially sustainable initiatives that improve the health of

UCare members. PHC reports to the Quality Improvement Advisory and Credentialing Committee. Responsibilities include:

- Establish organization goals for measuring the improved health and well-being of UCare members.
- Oversee the aggregation and management of data from multiple sources.
- Oversee the data-driven annual assessment of the characteristics and needs of the member population, including an analysis of the relevant social factors impacting health.
- Oversee the segmentation and risk stratification of the enrolled population into meaningful subsets for targeted interventions.
- Oversee the development of evidence-based internal programs and services, community collaborations and recommendations for provider/vendor contracting to meet the identified needs of the member population.
- Ensure programs and services are coordinated to address the highest need for each member in the pursuit of improved health.
- Oversee ongoing, data-driven evaluation of all programs against the established objectives and goals.

Membership consists of:

Chair: SVP, Chief Medical Officer	AVP, Mental Health and Substance Use Disorder
SVP, Chief Financial Officer	Services and SNBC
VP, Chief Informatics Officer	Director, Product Management
VP, Quality Management and Population Health	Director, Financial Analytics
VP, Clinical Services	Director, Pharmacy
VP, Provider Relations and Contracting	Associate Director, Quality improvement
VP, Marketing and Product Management	Population Health Program Manager
Health Equity Officer	

Frequency of Meetings: The committee meets every two months throughout the year.

Population Health (PH) Data Management Committee

The Population Health (PH) Data Management Committee oversees the data management strategy supporting population health management across UCare. The committee provides direction to the collection, analysis and management of data that directs population health activities and evaluates the effectiveness of the program. The committee will also manage and direct the activities of vendors supporting the population health program. The committee reports to the Population Health Program Council. Responsibilities include:

- Identifying all data sources to be included in the population health program.
- Manage the aggregation and management of data from multiple sources.
- Manage the data-driven annual assessment of the characteristics and needs of the member population, including an analysis of the impact of relevant social factors and health and racial equity impacting health.
- Manage the segmentation and risk stratification of the entire enrolled population into meaningful subsets for targeted interventions.
- Manage the distribution of data in support of population health program.
- Direct and prioritize the work of data vendors supporting the population health program.
- Data quality issues/findings will be reported to data governance.

Membership consists of:

Chair: Medical Director	Director, Financial Analytics
Vice Chair: VP, Chief Informatics Officer	Associate Director, Health Care Analytics
VP, Quality Management and Population Health	Population Health Program Manager
VP, Clinical Services	Health Services Data Analytics Manager
AVP, Mental Health and Substance Use Disorder	Health Care Analytics Manager
Services and SNBC	Associate Director, Quality Improvement
VP, Pharmacy	Principal Data Scientist

Frequency of Meetings: The committee meets monthly throughout the year.

Population Health (PH) Initiatives Council

The Population Health (PH) Initiatives Committee oversees the development and implementation of member programs to improve the health of all UCare members by addressing the needs identified through the ongoing analysis of UCare's membership across products. This includes, but is not be limited to, benefit design, provider contracts, clinical programs, wellness programs and collaboration with community and government programs. The committee reports to the Population Health Program Council. Responsibilities include:

- Conduct routine reviews of programs to ensure they support the needs of members to achieve their best health.
- Develop and implement evidence-based internal programs and services, community collaborations and recommendations for provider/vendor contracting to meet the needs of member populations and address health and racial equity.
- Coordinate programs across the care continuum to ensure the highest priority member needs are addressed first.
- Establish performance goals and metrics for each program.

Membership consists of:

Chair: Medical Director	AVP, Pharmacy
VP, Quality Management and Population Health	Director, Product Management
VP, Clinical Services	Health Services Data Analytics Manager
VP, Chief Informatics Officer	Population Health Program Manager
VP, Provider Relations and Contracting	Health Care Analytics Manager
Medical Director(s)	Associate Director, Quality Improvement
AVP, Mental Health and Substance Use Disorder Services and SNBC	GR County Manager

Frequency of Meetings: The committee meets monthly throughout the year.

Quality Improvement Council (QIC)

The Quality Improvement Council provides direction regarding the planning, design, implementation and review of improvement activities. The Quality Improvement Council ensures that quality activities align with the strategic objectives of the organization. QIC reports to the Quality Improvement Advisory and Credentialing Committee. Responsibilities include:

- Provides oversight and direction to initiatives that improve population health and member experience.
- Reviews quality improvement activities to achieve objectives.
- Reviews organizational monitoring activities including surveys, audits, rates, and Star ratings; provides direction regarding improvement opportunities.
- Reviews reports from quality committees that report directly to the Quality Improvement Council.
- Reviews and makes recommendations for the Quality Program Description, annual Quality Program Evaluation and annual Quality Work Plan.
- Works in collaboration with the Health Services Management Council to achieve "Triple Aim" goals.

Membership consists of:

Co-Chair: VP, Quality Management and Population Health	VP, Clinical Services
Co-Chair: VP, Chief Informatics Officer	VP, Marketing and Product Management
President and Chief Executive Officer	VP, Government Relations
SVP, Chief Medical Officer	VP, Compliance and Internal Audit
SVP, Provider Relations and Chief Legal Officer	VP, Provider Relations and Contracting
SVP, Chief Administrative Officer	Medical Director(s)
SVP, Chief Financial Officer	AVP, Mental Health and Substance Use Disorder Services and SNBC

AVP, Customer Service
AVP, Membership Billing and Enrollment
SVP, Public Affairs and Chief Marketing Officer
AVP, Pharmacy

Associate Director, Quality Improvement
Stars Ratings Manager
Member Experience Manager
Health Equity Officer

Frequency of Meetings: The committee meets every two months throughout the year.

Credentialing Committee

The Credentialing Committee is responsible for credentialing decisions, standards of care, effectiveness of the credentialing program, and review and approval of the credentialing policies and procedures. The Committee will review credentialing and recredentialing files that do not meet the established criteria documented in the UCare Credentialing Plan and approve or deny provider's request for network participation. The Committee oversees and coordinates the provider credentialing appeals as specified by the UCare Credentialing Plan. The Credentialing Committee reports to the Quality Improvement Council. Responsibilities include:

- Provides oversight and direction to UCare's credentialing functions.
- Reviews case files for credentialing and makes decisions regarding whether a professional subject to the UCare credentialing process shall be credentialed.
- Sends a designee to Quality Improvement Council (QIC) to provide a summary report on the activities of the Committee, at least quarterly.
- Makes decisions on new credentialing delegates based on information and recommendations from the credentialing delegation coordinator with input from Provider Relations and Contracting. (PRC)
- Advises Credentialing and PRC staff on delegation issues, including issues with pre-delegation and annual oversight audits.
- Reviews and makes recommendations regarding NCQA, MDH, and CMS requirements for credentialing, including current trends.

Membership consists of:

Chair: Medical Director(s)
Associate General Counsel
Assistant General Counsel
SVP, Chief Legal Officer
VP, Quality Management and Population Health
Associate Director, Quality Operations
Credentialing Manager
Credentialing Delegated Coordinator

Credentialing Regulatory and Compliance Specialist
PRC representative

External Members: Family Medicine, Internal Medicine, Pediatrics, OB-GYN or Geriatrics, plus Psychiatry. Special consideration will be given to providers from community clinics and clinics serving ethnic communities representative of UCare membership.

Frequency of Meetings: The committee meets monthly throughout the year.

Quality Measures Improvement Committee (QMIC)

The Quality Measures Improvement Committee (QMIC) identifies areas of opportunity for performance improvement, operational efficiency, and increased program integrity for all UCare products. QMIC monitors UCare's quality performance in Star Ratings, NCQA Accreditation and Ratings, Quality Rating System (QRS), Performance Improvement Projects (PIPs) and quality initiatives related to SPP (State Public Program) performance and goals. QMIC reports to the Quality Improvement Council. Responsibilities include:

- Reviews and advises on project action plans and performance targets for initiatives related to quality measures.
- Allocates resources to projects, to include oversight of quality project budget.
- Annually develop a Star Ratings Program Strategy designed to maintain and/or improve UCare's overall Star Rating for all product lines.
- Monitor program performance for each measure as defined in the overall program strategy.
- Assess effectiveness of previous years' interventions and goals.

Membership consists of:

Chair: Associate Director, Quality Improvement
 VP, Chief Informatics Officer
 VP, Clinical Services
 VP, Marketing and Product Management
 VP, Provider Relations and Contract
 VP, Quality Management and Population Health
 AVP, Sales
 AVP, Mental Health and Substance Use Disorder
 Services and SNBC
 Account Services Manager
 AVP, Pharmacy
 Associate Director, Mental Health and Substance
 Use Disorder Services and SNBC
 Clinical Project Coordinator Stars Measures
 Director, Clinical Services - Care Management
 Director, Clinical Services - Operations
 Director, Customer Service

Customer Services Workforce Manager
 Federal Government Relations Manager
 Health Promotion Manager
 Health Services Analytics Manager
 HEDIS Manager
 Medical Directors
 Member Experience Manager
 Member Experience Specialist
 Pharmacy Clinical Manager
 Pharmacy Quality Manager
 Product Management Director
 Quality Analytics Manager
 Quality Improvement Specialists
 Associate Director, Quality Operations
 Stars Program Manager

Frequency of Meetings: The committee meets monthly throughout the year.

Health Equity Committee

The purpose of the Health Equity Committee is to ensure that UCare's organizational initiatives work to eliminate health disparities and reach health and racial equity for all. This will help to advance the health of all UCare membership and help reach UCare's quality goals. The Committee will initiate and support internal diversity training activities as appropriate. The Committee will develop, implement and evaluate health care initiatives and unique partnerships aimed at reducing the disparities in health status among targeted UCare populations. The Health Equity Committee reports to the Quality Improvement Council. Responsibilities include:

- Ensure that UCare policies and programs work to eliminate health disparities and reach health and racial equity for all our members.
- Connect with the diverse communities that UCare serves.
- Create annual CLAS (Culturally and Linguistically Appropriate Services) standard work plan developed by the U.S. Department of Health and Human Services Office of Minority Health.
- Promote diversity and cultural competency initiatives for our members and providers.
- Maintain, disseminate and annually review the Limited English Proficiency (LEP) plan for the MN Department of Human Services.
- Explore opportunities to coordinate efforts and larger initiatives to reduce health disparities/improve health and racial equity.

Membership consists of:

Chair: Health Equity Officer
 SVP, Public Affairs and Chief Marketing Officer
 Operations Manager, Mental Health and
 Substance Use Disorder and SNBC
 Medical Director
 Community Outreach Manager
 Community Relations Supervisor
 Communications Lead
 Customer Service Manager
 Employee Experience Manager

Associate Director, Government Relations
 Government Relations County Manager
 Marketing Analyst
 Medicaid Product Manager
 Member Billing and Enrollment Production
 Manager
 Member Experience Manager
 Associate Director, Quality Improvement
 Privacy Officer, Corporate Compliance
 Product Specialist

Provider Data & Analytics Manager
Associate Director, Provider Services
Senior Pharmacy Operations Coordinator
SNP Sales Representative

Special Needs Plan Product Manager
Star Ratings Manager
State Government Relations Specialist
State Public Programs Communications Lead

Frequency of Meetings: The committee meets quarterly throughout the year.

Member Experience Steering Committee

The purpose of the Member Experience Steering Committee is to provide strategic direction to the organization in the prioritization and ongoing review of Member Experience Program improvement opportunities. The Member Experience Steering Committee reports to the Quality Improvement Council. Responsibilities include:

- Oversees and monitors the progress outcomes of Member Experience Program improvement activities at UCare.
- Reviews, evaluates and monitors Member Experience Program initiatives, work plans and dashboard metrics.
- Serves as focus group or advisor for and prioritizes efforts impacting member experience.
- Monitors member experience/satisfaction data to prioritize and direct UCare member experience improvement efforts, including CAHPS scores, member survey results, focus group findings, Appeals and Grievances, and Customer Service call analytics.
- Addresses and ensures significant member-facing changes are brought to the steering committee.
- Serves as the governing body for select performance improvement efforts geared toward improving member experience, such as the member correspondence rapid improvement event; directs work to departments, committees and work groups focusing on efforts to improve member satisfaction/experience including but not limited to the Quality Measures Improvement Committee and the Member Experience Work Group.
- Each committee member is encouraged to attend a least one member-facing event each calendar year and share insights about the experience with the committee.

Membership consists of:

Chair: Member Experience Manager
SVP, Public Affairs and Chief Marketing Officer
SVP, Chief Administrative Officer
VP, Clinical Services
VP, Marketing and Product Management
VP, Quality Management and Population Health

AVP, Customer Service Director
AVP, Membership Billing and Enrollment
Marketing Analysis Manager
Member Experience Manager
Privacy Officer

Frequency of Meetings: The committee meets monthly throughout the year.

Quality Program Resources

The resources that UCare devotes to the Quality Program and specific quality improvement activities are broad and include cross-departmental staff, potentially delegated business services, clinical quality staff, data sources, and analytical resources such as statistical expertise and programs. Evaluation of quality improvement resources is determined through evidence that the organization is completing quality improvement activities in a thorough and timely manner per the quality work plan.

An annual assessment of UCare's current quality program occurs through the review of the annual Quality Program Evaluation by the Quality Improvement Council, the Quality Improvement Advisory and Credentialing Committee, and the Board of Directors. Throughout the year, UCare monitors its performance and progress as it relates to numerous quality-related activities and key metrics.

Senior Vice President, Chief Medical Officer

The Senior Vice President (SVP), Chief Medical Officer (CMO), Vice President, Quality Management and Population Health, and Quality Management staff hold primary responsibility for UCare's Quality Program. The Chief Medical Officer reports to the Chief Executive Officer and serves as a member of UCare's senior management team, participating in strategic planning and policy direction for the organization, providing leadership and guidance on clinical strategic initiatives and operations to ensure high quality, cost-effective care for UCare members. UCare's Chief Medical Officer manages relationships with contracted care systems to ensure implementation of UCare's utilization and quality management strategies. In addition to these key responsibilities, the Chief Medical Officer supports the development, implementation, maintenance, and evaluation of quality improvement, population health, utilization review, and care management activities of the health plan in conjunction with staff in Clinical Services, Quality Management and Population Health, Mental Health and Substance Use Disorder Services and SNBC, and Provider Relations and Contracting departments.

The Chief Medical Officer serves on the following committees: The Quality Improvement Advisory and Credentialing Committee, the Quality Improvement Council, the Health Services Management Council the Population Health Program Council, and the Medical Policy Committee.

Vice President of Quality Management and Population Health

The Vice President (VP) of Quality Management and Population Health is a member of UCare's leadership team, reporting to the SVP, Chief Medical Officer. The primary objective of this position is to provide strategic direction and oversight for UCare's Quality Management and Population Health strategic initiatives. This position provides leadership for the development, implementation, and evaluation of UCare's Quality Program and Population Health Program. In addition, this position is responsible for the strategic planning and oversight of the Chronic Condition Management Program, Star Ratings Programs and NCQA Accreditation. This position also ensures achievement of operational goals for Credentialing and Appeals & Grievances.

Quality Management and Population Health Department

The Quality Management and Population Health department includes Appeals & Grievances, Credentialing, Population Health, Quality Improvement, NCQA Accreditation, HEDIS chart retrieval and abstraction, Stars Ratings, Health Services Analytics, and Disease Management. The functions of each of these areas is described in the table below. There are unique synergies realized with the grouping of these areas in one department. Quality Improvement, Star Ratings, NCQA Accreditation, benefit administration and compliance are shared responsibilities across the organization and there is a great deal of collaboration which is evident in the high ratings realized by UCare.

Quality Management and Population Health Department	
A&G (Appeals and Grievances)	The A&G team receives, processes and resolves all appeals and grievances from members or member representatives.
Credentialing	The Credentialing team manages data in the credentialing database, processes every practitioner's/provider's credentialing and recredentialing, and conducts delegation oversight.
Population Health	The Population Health team develops, implements and evaluates UCare's Population Health Program. The team develops and maintains our population health strategy that provides an inventory of all programs to support the needs of our members.
QI (Quality Improvement), NCQA (National Committee for Quality Assurance), HEDIS (Health Effectiveness Data and Information Set) & Stars	The QI team designs, develops, implements, evaluates and reports on evidence-based health improvement programs as they relate to UCare's strategic and annual quality plan addressing all Star rating programs for each of UCare's product lines. The QI team facilitates NCQA accreditation for the organization and ensures compliance with these standards. The HEDIS team develops and implements initiatives that enhance the organization's medical record review functionality for HEDIS hybrid measures and other Quality Management needs.
Health Services Analytics	The Health Services Analytics team develops analyses and reporting that support the organization to understand and monitor performance, breakdown key drivers, and identify opportunities for improvement.
Disease Management	The Disease Management team develops, implements, and evaluates disease management programs and associated clinical initiatives focused on prevention, early identification, and intervention in the chronic disease process.

Quality Improvement Associate Director

The Quality Improvement Associate Director reports to the Vice President of Quality Management and Population Health and is responsible for the development, management and accountability of quality improvement initiatives within the department in support of the organizational Quality Program. This position provides leadership for related projects, surveys, reports and audits. Provides oversight to each of UCare's Star Ratings programs. Additional responsibilities include, development and management of the Quality Improvement team, ensuring timeliness of overall quality initiatives, and managing Performance Improvement Projects development and regulated quality requirements. This position also ensures compliance with NCQA accreditation standards and HEDIS chart retrieval data.

Quality Operations Associate Director

The Quality Improvement Associate Director reports to the Vice President of Quality Management and Population Health and is responsible for the oversight of operational processes related to provider credentialing and Appeals, and Grievances (A&G), which includes creating optimal performance, quality assurance, and efficiencies. In addition, this position is responsible for assuring that the credentialing and A&G meet all regulatory and accreditation requirements based on legislative mandates and UCare's strategic direction.

Population Health Program Manager

The Population Health Program Manager reports to the Vice President of Quality Management and Population Health and is responsible for the oversight and direction for designing, implementing and evaluating an organizational-wide Population Health Management (PHM) Program. This position collaborates with departments

throughout the organization to implement the PHM Program and ensures compliance with related regulatory requirements. In addition, this position is accountable for key PHM metrics including quality measures, utilization measures, and financial measures.

Health Services Analytics Manager

The Health Services Analytics Manager reports to the Vice President of Quality Management and Population Health and is responsible for operational readiness with the required level of analytics-based performance, supporting UCare’s goals around improved quality of care, appropriate utilization, program evaluations and metrics that target areas for improvement. In addition to developing analyses and reports to support quality improvement efforts, this position plays a key role in ensuring member health data is clean, normalized, and accurate.

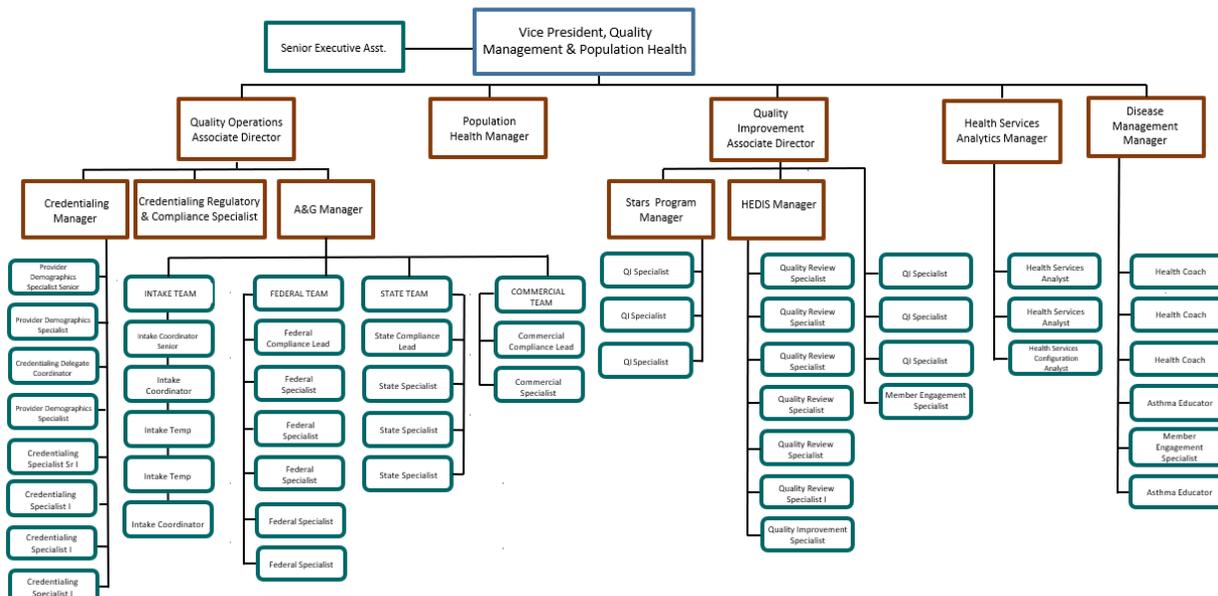
Disease Management Manager

The Disease Management Manager reports to the Vice President of Quality Management and Population Health and is responsible for managing UCare’s disease management programs and ensuring alignment with overall health services management strategies. This role is accountable for the development, implementation, and evaluation of disease management programs and associated clinical initiatives for all UCare products. This includes ensuring state and federal mandates for select disease management programs are in compliance with UCare’s contractual obligations.

Quality Management and Population Health Department Staff

The Quality Management and Population Health Department staff are responsible for implementation, analysis and reporting on quality improvement activities. They also provide support for all departments in the organization for quality improvement projects. Working with the Chief Medical Officer, the Medical Directors and UCare leadership, the department coordinates the quality committees and provides direction related to quality programs. Quality Management and Population Health Department staff work with improvement teams and committees to ensure that quality improvement activities are executed. The majority of the QI staff have at least masters-level education and extensive experience in quality.

Quality Management and Population Health



Additional Resources

The following individuals and departments provide additional key resources and guidance to UCare's overall Quality Program:

CEO	VP, Government Relations and staff
Medical Director, Mental Health and Substance Use Disorder Services and SNBC	VP, Chief Informatics Officer and staff
VP, Clinical Services and staff	VP, Marketing and Product Management and staff
VP, Compliance and Internal Audit and staff	VP, Provider Relations and Contracting
AVP, Customer Service and staff	

Mental Health and Substance Use Disorders Services

UCare partners with professionally trained and licensed mental health and substance use disorder service practitioners to improve the overall mental health and substance use disorder outcomes of its members. UCare enlists the expertise of trained psychiatrists by means of the Quality Improvement Advisory and Credentialing Committee. Physicians and licensed clinical social workers provide key input and insights, assisting UCare in building a strong, robust mental health and substance use disorder service program that supports all members.

Mental health and substance use disorder services are provided by UCare staff for eligible health plan members. Mental health and substance use disorder QI activities are integrated into the QI program through regular reporting and through regularly scheduled workgroup meetings, which provide ongoing monitoring of mental health and substance use disorder services. Mental health and substance use disorder QI documents, including the QI Work Plan, Program Evaluation, and Program Description are reviewed and approved annually.

Medical Director, MSS and SNBC

The Medical Director of Mental Health and Substance Use Disorder Services (MSS) and Special Needs BasicCare (SNBC) is responsible in collaboration with SVP, Chief Medical Officer (CMO), AVP, MSS and SNBC, and Medical Directors to oversee the mental health and substance use disorder needs of the membership and administration of the mental health and substance use disorder services managed or contracted by UCare. This position reports to the SVP, CMO. This position serves as UCare's visible leader and subject matter expert for the clinical and policy aspects of mental health and substance use disorder. This position serves as primary health plan medical director for utilization management, disease management, complex case management, and quality of care investigations for mental health and substance use disorder services.

Associate Vice President, MSS and SNBC

The Associate Vice President (AVP) of Mental Health and Substance Use Disorder Services (MSS) and Special Needs BasicCare (SNBC) is responsible to oversee MSS and SNBC. This position reports to the SVP, Chief Medical Officer. This includes strategic planning, clinical and operational quality and efficiency, budgeting and fiscal management, supervision of the department management team and evaluation and improvement. This position ensures that MSS and SNBC program identifies and meets member needs and meets contractual and regulatory requirements of federal, state and local agencies. This position provides oversight of the development and management of community and provider partnerships in order to deliver on MSS and SNBC strategies and goals.

Associate Director, MSS and SNBC

The Associate Director of Mental Health and Substance Use Disorder Services (MSS) and Special Needs BasicCare (SNBC) is responsible to assist with the planning, organizing, directing, and managing the functions and services of the MSS area. This position reports to the AVP, MSS and SNBC. This position leads staff members in conjunction with the MSS and SNBC managers and supervisors. This position consults with staff, medical directors and others on member problems, interpretation of regulations, and engages with community partners to represent UCare. This position maintains performance improvement activities within the MSS and SNBC area and participates in the

oversight of utilization and care management activities. This position develops the annual MSS and SNBC budget by working collaboratively with key stakeholders.

Adequacy of Quality-Related Resources

UCare's Quality Program is resourced through the annual budget process. Quality program resource requirements are evaluated to ensure that staffing, materials, analytic resources and information systems are adequately resourced for the upcoming year per the completion of the previous year's work plan, upcoming key quality metric initiatives, and audit/survey findings.

Members with Complex Health Needs

UCare uses a population health approach to developing strategies to support member health care needs to focus on the health and overall wellness of the broader population it services. UCare designs initiatives to focus on the continuum of care from keeping members healthy, supporting members with emerging risk, patient safety and outcomes across setting, as well as managing members with chronic conditions and complex health needs. UCare works to improve the health and quality of life for all UCare's members with complex health conditions. All members, including members with complex health conditions, vary greatly in population characteristics, demographics, experiences with care, social drivers of health, etc.

Addressing member vulnerabilities, especially those driven by social drivers of health, is a rapidly evolving field within health care, and practices and outcomes vary widely among various population groups (e.g. racial/ethnic make-up, gender, age, etc.). When members experience poor health and/or chronic conditions, this results in negative health outcomes and an increase in utilization of services. Members who experience multiple or chronic health conditions may also be more likely to experience negative health outcomes, due to historical and current systemic racism, while encountering barriers to health care. For example, barriers may lead to chronic health conditions and members with chronic medical problems may face barriers to getting and staying well.

UCare works to improve the health and quality of life for all UCare's members with complex health needs by the strategies and objectives described below.

Data Analysis

UCare utilizes multiple sources of data to identify members with special health care needs. We use data to identify population characteristics, needs and programs to align with member health care needs. Our data sources also assist UCare in understanding the social drivers of health/social risk factors that impact our populations, and helping identify ways to reduce healthcare-related costs and avoid preventable health-related conditions. Data can also assist with identifying which members we should reach out to, how they prefer to communicate and engage, what programs and services we should invest in developing, and much more.

One of the innovative ways we support this work is through use of Carrot Health, a vast database of consumer insights and predictive modeling. This intelligence enables UCare to meet members where they are in their healthcare journey, and powers effective risk identification, member engagement and health management. Carrot Health has created the "Social Risk Grouper" (SRG)[™], a proprietary taxonomy for social determinants of health. SRG helps UCare understand, identify, measure, and quantify the social barriers and circumstances in which people live. SRG highlights SDOH risks for nearly all consumers in the country and feeds into a library of models that predict healthcare costs, utilization, and behaviors. UCare uses these aggregated insights available via Carrot Health's dynamic MarketView Health[™] reporting dashboards, along with member-level data outputs, to gain a deeper understanding of our covered populations and uncover opportunities to improve population health at multiple levels.

Utilization Analysis

UCare reviews member utilization for data trends and patterns to make sure health care services are used appropriately and efficiently. The goal of utilization review is to ensure members are getting the care that they need, and that it is administered via proven methods, provided by an appropriate health care provider, and delivered in an appropriate setting. UCare uses the following strategies for utilization review:

- We do a monthly analysis of our Special Health Care Needs reports (e.g. hospital admissions and readmission, emergency department utilization) as a mechanism to detect undesirable utilization patterns. We analyze trends in activity and if activities are outside of the calculated control limits, we may pull additional data for further review at the discretion of UCare's Health Services Management Council. UCare takes appropriate action, as needed, based on findings.
- We do a monthly review of key data trends including emergency department utilization, hospital admissions and readmission rates. Data is broken down and reviewed by race/ethnicity, gender, age, geographic location, care system level, etc. When analyses show areas of concern, we ensure members are receiving the right coordination of care (e.g. telephonic outreach, educational mailings on services and resources), are referred to internal care management programs, etc.

Population Health Strategies

UCare implements its population health program using the following strategies to support members across the continuum of care:

- Stratification and segmentation of our population into high, medium, and low risk groups to identify them for enrollment in appropriate health promotion, disease prevention and case management programs.
- Health promotion and disease prevention including providing educational resources and incentives to engage members in programs.
- Disease management programs that include health literacy programming, member-centered and member-directed disease management services, and remote monitoring for disease management.
- Medical case management and coordination services that include:
 - Comprehensive assessments using standard screening tools (e.g. PHQ-2 depression screening, GAD-2 generalized anxiety screening, CAGE alcohol screening).
 - Monitoring members using the Center for Disease Control and Prevention Healthy Days assessment tool.
 - Transition to a lower level of care when appropriate – health coaching program.
- Mental health and substance use case management and coordination of services.
- Maternal health case management and coordination of services.
- Pharmacy Care Coordination
 - Medication Therapy Management (MTM) services.

The identification and support of members with Special Health Care Needs (SHCN) is an integral part of the medical management of UCare members. Our program identifies member with special health care needs, assists them with access to care, and monitors their treatment plan. All Minnesota Health Care Program (MHCP) members are eligible for case management through this program.

Health plans within the service area may offer Medicare Special Needs Plans (SNP), including the Special Needs Plan for Dual-Eligible Beneficiaries based on the CMS requirements for the SNP Model of Care. The Model of Care approach is based on effective population health management with the goal of achieving optimum outcomes for members. Through early identification and predictive modeling, UCare can anticipate a member's potential health state and intervene accordingly.

These programs are designed to optimize the quality of the health care system for members while maintaining cost effective utilization of services. This is accomplished by actively pursuing opportunities for improvement through systematic monitoring and evaluation of services provided.

Data Sources and Infrastructure

UCare's ability to understand and meet the unique health needs of our members is supported by our capabilities to effectively access, integrate, and analyze data. We have built and continue to invest in our people and technology to support industry-leading capabilities in data analytics and our Enterprise Data Warehouse (EDW). UCare's data warehouse supports data integration from a variety of sources and can support data and analytics solution needs. Our experienced Health Care Economics (HCE) team includes 30 staff members responsible for the data mining, statistical analysis, quality improvement reporting, clinical support, and actuarial analysis. The HCE team includes certified actuaries and analysts with degrees in statistical analysis. Our deep understanding of health care analytics and statistics enables us to develop and adjust standard methodologies and achieve targeted and accurate results. We apply industry standards and statistical precision to support our analyses including: attribution, clinical measures, cutoffs or continuous variable frameworks, confidence intervals and data sufficiency minimums, particularly as it relates to clinical program evaluations, product pricing, and quality program measurement.

We continue to expand our state-of-the-art EDW that consolidates and stores clinical and non-clinical data for all members, providers and products. UCare's EDW houses data including, but not limited to: enrollment, member, eligibility, claims, provider, clinical, regulatory, legal, and financial data. UCare's EDW integrates non-clinical member and claim information with additional clinical data including lab values, health risk assessments, provider-submitted patient histories, and medical record review abstractions to perform a broad range of analytics. Our EDW is updated daily with data from UCare's core systems and from vendor files as soon as they are available. This schedule ensures UCare is able to create and distribute timely information both internally and externally. While the transactional data originates from other source systems, the EDW is UCare's primary source of data for UCare's analytics and reporting. Data quality programs are in place to rigorously check and confirm the quality and timeliness of the EDW data, including completeness and consistency with originating data sources.

Our data warehouse solution allows for a variety of tools to connect to the system such as SQL, SAS, or various Microsoft tools to perform analytics and reporting functions. Additionally, our EDW environment contains Business Objects™ and MedAnalytics™ analytics tools that provide flexibility and definition for integrating and analyzing data. We utilize Business Objects™ ETL tools to extract, transform and load data to and from the EDW from multiple disparate sources and to obtain and share data with external partners. We use John Hopkins ACG™ resource utilization bands to define several strata of illness levels ranging from perfectly healthy to critically ill, and multiple categories of increasing levels of illness in between these two strata. Our NCQA-Certified HEDIS software calculates and measures results, and UCare retains a longitudinal history of member-level quality measure results for ongoing analysis. Examples of the analysis performed include:

- Measure and compare providers (utilization and financial performance).
- Measure rates and look at patterns of utilization.
- Analyze data trends and identification of populations through the use of data segmentation, social drivers of health, disparities across populations and measures.
- Help develop guidelines and disease management programs.
- Assess provider compliance with clinical practice guidelines.
- Measure and analyze customer service interactions.
- Produce HEDIS reports and dashboards that are used to measure quality improvement projects, effectiveness of care, utilization, and to provide comparison data.
- Store provider demographics in a central database that can be easily and quickly accessed.
- Communicate informal complaints to the appropriate department for resolution.

As part of its nightly update process, the EDW runs validation checks for both the completeness and the integrity of the data. In addition, since the EDW serves as the basis for a variety of audited regulatory reporting (HEDIS, risk adjustment, encounter submission), its accuracy is further evaluated during the audits of those processes. Finally, as the data backbone of most operational clinical, quality, and financial reporting, it is regularly scrutinized through

routine investigation of performance and trends. External audits and surveys also provide useful information to assess overall quality. Examples include:

- DHS Triennial Compliance Audit
- Medicare and Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys
- Disenrollment Surveys and Comments
- Health Outcomes Surveys (HOS)

GuidingCare

UCare implemented Altruista Health’s GuidingCare platform in 2020, which integrates all activities and functions required for optimal population health management and care coordination, including case management, disease management, mental health and substance use disorder, health promotions, utilization review and appeal and grievance cases. The platform is designed around the concept of a patient-centric and team-driven model of care. All users along the care continuum, including but not limited to case managers, health coaches, member engagement specialists, clinical pharmacists, and utilization reviewers, interact, collaborate and share a single member record. The member record includes case management programs and activities, disease management programs and activities, health promotion activities, prior authorizations requests, appeals and grievances, and medical and pharmacy claims*. From the perspective of UCare, the tool offers one place to see all the member’s activities, thereby making care coordination more comprehensive and effective in meeting the needs of the member.

**Pharmacy claims is being implemented this year.*

Carrot Health

UCare partners with Carrot Health, a consumer analytics company serving the health industry. Carrot Health supports a more effective and equitable healthcare system that ensures all consumers have access to the support needed to live their healthiest lives. Recognizing each individual plan member is more than a series of clinical diagnoses and procedure codes, Carrot consumer data provides a full 360-degree view, highlighting unique member preferences, behaviors, and social determinants of health. By utilizing the Carrot MarketView platform, UCare has an enhanced view of every healthcare consumer by leveraging a vast database of consumer insights and predictive models. This intelligence enables UCare to meet members where they are in their healthcare journey, powering effective risk identification, member engagement, and health management.

MarketView Health shines the bright light of data on every consumer in America to help health plans understand the underlying social determinant of health (SDoH) risks that impact the populations they manage. SDOH accounts for approximately 60-80% of an individual’s health outcomes and healthcare-related costs, resulting in billions of dollars of preventable health-related expenses annually.

Effective and efficient population health solutions require a deeper understanding of consumers and underlying social determinants of health. UCare utilizes MarketView to identify who is targeted, how they’re communicated to and engaged, what programs and services are developed and invested in, and much more. MarketView Health is a HIPAA compliant, web-based platform that surfaces the insights from the underlying data and predictive modeling. Users of MarketView can securely access the interactive dashboards through most web browsers and use the dashboards to uncover insights, inform program strategy, and plan targeted outreach.

At the core of the MarketView solution is a vast consumer database comprised of thousands of data points on every adult in the U.S. Using this data, Carrot Health has created the “Social Risk Grouper” (SRG)™, a proprietary taxonomy for social determinants of health. SRG helps health plans and organizations understand, identify, measure, and quantify the social barriers and circumstances in which people live. SRG highlights SDOH risks for every consumer in the country and feeds into a library of models predicting healthcare cost, utilization, and behaviors. UCare uses these aggregated insights through dynamic MarketView Health reporting dashboards along with member-level data outputs to gain a deeper understanding of the covered populations and uncover opportunities to improve population health at multiple levels.

Systems for Communication

Communication of the Quality Program activities is achieved through systematic reporting to the appropriate committees and utilizing a variety of mechanisms as follows:

- Quality improvement activities are reported regularly to the Quality Measures Improvement Committee, the Quality Improvement Council, and the Quality Improvement Advisory and Credentialing Committee.
- Providers are informed through the Provider Manual, Provider Portal, newsletters, oversight meetings, site visits, contracts, direct correspondence and feedback, and electronically.
- Members are informed through newsletters, direct correspondence, Member Guides, the UCare website and in collaboration with community and public health partners.
- UCare employees are informed through the Intranet, updates at All Employee Meetings, updates at department staff meetings, orientation and training, and internal correspondence.
- Regulatory agencies are informed through reports, site visits, and meetings.

Scope of Activities

The Quality Program encompasses all aspects of care and service delivery. Components of UCare's quality improvement activities include:

- Clinical components across the continuum of care from acute hospitalization to outpatient care. Pharmaceutical, dental and mental health aspects of care are also included within this scope.
- Organizational components of service delivery such as referrals, case management, discharge planning, prior authorizations, as well as other procedures or processes that affect care including access and provider reimbursement arrangements.
- Monitor initiatives in the population health strategy for improved health outcomes across the continuum of care.
- Key business processes that impact our members or providers of care such as claims, interpreter services, enrollment, customer services, credentialing/recredentialing, utilization management, provider contracting, care transitions, etc.
- Member satisfaction.
- Patient safety.
- UCare's delegated entities.

In addition, the UCare quality program includes activities which address the areas of focus outlined in the Home and Community-based (HCBS) Quality Framework that includes participant access, participant-centered service planning and delivery, provider capacity and capabilities, participant safeguards, participant rights and responsibilities, participant outcomes and satisfaction, and system performance.

Quality Improvement Activities

There are a number of ways that actions are taken to improve the care or services UCare provides. These include:

Population Health:

- Refining data-driven Population Health Management program to identify the needs of members and develop programs and identify resources to support each member in improving their health.
- Increasing member impact of Disease Management programs focused on prevention, early identification, and intervention in the chronic disease process.
- Conducting a chronic care improvement program that includes methods for identifying enrollees with multiple or sufficiently severe chronic conditions that would benefit from participating in a chronic care

improvement program and mechanisms for monitoring enrollees that are participating in the chronic care improvement program.

- Complete implementation of a Carrot Health module to further population health and quality efforts.

Health Equity:

- Applying Health and Racial Equity Assessment to planning, development, and implementation of new and existing quality improvement initiatives and programs.
- Refining Health Equity Committee purpose and activities to further health and racial equity organization priorities.
- Identifying, implementing and measuring effectiveness of strategies to reduce disparity gaps in key HEDIS metrics related to prevention, chronic disease management and utilization.

Access:

- Monitoring adequate access to medical, specialty, dental, and mental health and substance use disorder care including availability of services, coordination and continuity of care, appropriate coverage and authorization of services and acting when appropriate.

Quality of Care and Patient Safety:

- Evaluating effects of the COVID-19 pandemic on Star ratings program and other quality improvement initiatives and modify work plans as needed.
- Establishing plans and policies to address quality. Examples include development of strategic plan goals, the annual Quality Work Plan and the Credentialing Plan.
- Monitoring compliance with policies, standards and clinical practice guidelines. Monitoring activities include the medical record standards audit, HEDIS audit, guideline compliance audits, survey activities and the credentialing and recredentialing process.
- Monitoring member safety through on-going review of reports and data.
- Investigating and resolving concerns from members, providers, and regulators.
- Identifying recurring patterns of problems or areas of concern by analyzing trends and patterns from various sources of data and taking action. Data sources include surveys, medical record audits, member and provider contacts, utilization data, appeals and grievances data and standardized reports such as the CMS Star Ratings, Marketplace Star Ratings and HEDIS®.
- Conducting performance improvement projects (PIPs) and the Quality Improvement Strategy (QIS) with interventions that emphasize social drivers of health and health care disparities that are expected to have a beneficial effect on health outcomes and enrollee satisfaction, and include a focus on significant aspects of clinical care and non-clinical services, assessing performance under the plan using quality indicators, performance assessment on the selected indicators based on systematic ongoing collection and analysis of valid and reliable data, achieving demonstrable improvement and being able to report the status and results of each project to regulatory bodies as requested.
- Improving clinical and business processes through informal and formal process improvement teams that define, measure, analyze, implement and evaluate changes made.
- Instituting system interventions as warranted.
- Providing feedback and educational interventions to both members and providers.

Regulatory:

- Monitoring compliance with UCare medical record keeping standards, including confidentiality and accuracy and acting when appropriate.
- Ensure compliance with all NCQA requirements.

Delegation of Quality Management Functions

UCare does not delegate Quality Management functions. If Quality Management functions are delegated in the future, UCare will oversee and have final responsibility for all delegated quality management activities. At a minimum, the delegated entity will be evaluated annually to ensure that activities are conducted in compliance with UCare's expectations.

Collaborative Activities

UCare works on collaborative quality improvement activities across other health care sectors (e.g. primary care providers, the Department of Human Services (DHS), etc.) and other managed care organizations. UCare identifies opportunities for improvement based on Healthcare Effectiveness Data and Information Set (HEDIS), Star Ratings, Quality Rating System (QRS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Health Outcomes Survey (HOS), Experience of Care and Health Outcomes (ECHO) and Minnesota Department of Human Services (DHS) withhold measures to develop quality improvement activities.

UCare's work with primary care providers in the community includes HEDIS, Stars, QRS, CAHPS, ECHO, and HOS measures focusing on but not limited to, providing action lists for gaps in care, and education and training for how to improve measures and health outcomes for members. UCare's work with other managed care organizations includes designing and developing interventions for Performance Improvement Projects (PIPs) and internal quality projects. UCare also works with the state on making improvements to withhold measures for improved health outcomes. UCare reports to internal QI committees, including QIACC, QIC and QMIC, as needed on collaborative activities.

Annual Quality Work Plan

The Quality Work Plan specifies quality improvement activities UCare will undertake in the upcoming year. The plan includes goals and objectives based on the strengths and weaknesses identified in the previous year's evaluation, issues identified in the analysis of quality metrics, evolving health care landscape, and regulatory requirements. The Work Plan is a mechanism for tracking quality improvement activities and is updated as needed to assess the progress of initiatives. The Work Plan includes:

- Quality of clinical care
- Quality of service
- Safety of clinical care
- Member Experience
- Program scope
- Yearly objectives
- Yearly planned activities
- Time frame within which each activity is to be achieved
- Staff member responsible for each activity
- Monitoring previously identified issues
- Evaluation of the QI program

The Quality Improvement Council, Quality Improvement Advisory and Credentialing Committee, and the Board of Directors review and approve the annual Quality Work Plan.

Annual Quality Program Evaluation

The Quality Program Evaluation is produced annually and approved by the Quality Improvement Council, Quality Improvement Advisory and Credentialing Committee and the Board of Directors. The quality and utilization improvement activities outlined in the Quality Program Evaluation are evaluated for appropriateness and effectiveness in assessing and improving the quality of care and service UCare's members received. Evaluations and recommendations from regulatory agencies and other external quality review organizations are also considered in assessing the strength of UCare's Quality Program. When changes are made to the Program Description, documents are filed with the Minnesota Department of Health.

Supporting Documents

Bylaws of UCare Minnesota

Committee Charters

Minnesota Rules, parts 4685.1110, .1115, .1120, .1125, and .1130

CMS's Medicare Managed Care Manual, chapter 5

Policy CCD021 Delegation Management

Policy QCR007 Credentialing Plan

Organizational Structure

Utilization Management Plan