2023 Quality Program Description

03/14/2023: Approved by the Quality Improvement Council
03/16/2023: Approved by the Quality Improvement Advisory and Credentialing Committee
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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, as well as the structure for advancing health and racial equity at UCare and improving culturally and linguistically appropriate services (CLAS) for our member. 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 community, 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.

The National Standards for CLAS in Health and Health Care are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate services. The National CLAS Standards align with the Health and Human Services (HHS) Action Plan to Reduce Racial and Ethnic Health Disparities and the National Stakeholder Strategy for Achieving Health Equity, which aims to promote health equity through providing clear plans and strategies to guide collaborative efforts that address racial and ethnic health disparities across the country. UCare has adopted these Standards and integrated these Standards into our Quality Program and other organizational efforts to advance better health and health care in the communities we serve.

UCare maintains a company-wide commitment to quality, health equity 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 below listed products. It also applies to new products launched in 2023.

UCare Products	
Minnesota Health Care Programs	Prepaid Medical Assistance Program (PMAP)
	Minnesota Senior Care Plus (MSC+)
	UCare Connect Special Needs Basic Care (Connect)
	MinnesotaCare (MnCare)
Medicaid + Medicare	UCare's Minnesota Senior Health Options (MSHO)
	UCare Connect + Medicare
Medicare	UCare Medicare Advantage
	UCare Your Choice
	EssentiaCare
	UCare Medicare with M Health Fairview and North Memorial Health
	UCare Medicare Group Plans
	Institutional Special Needs Plans (I-SNPs)
Exchange	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. UCare is committed to eliminating health inequities and racial and ethnic health care disparities while improving the health of all members. The Quality Program supports efforts to understand populations served, in terms of race/ethnicity, language, disability, 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 program 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 evidence-based health promotion, disease management, care coordination and care management programs to support members in achieving their best health and well-being.
- Develop Population Health impact analyses that assess the effectiveness of the Population Health Program on cost, utilization, member satisfaction, health and racial equity, and Health Related Quality of Life (HRQoL).
- Increase the number and types of opportunities for member and community input into population health initiatives and interventions to address disparities in care and outcomes.

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.

- Reduce barriers to care by providing language services to members with limited English proficiency during encounters with UCare staff and during health care encounters. Achieve a goal of 85% of members reporting satisfaction with language services provided by UCare.
- Identify and decrease health care disparities between the White and Black, Indigenous, and people of color (BIPOC) populations where disparities are present for key metrics for the organization, including but not limited to Child and Adolescent Well Visits and Follow-up after Hospitalization for Mental Illness for PMAP and MnCare products. Focus areas and populations below were identified through data analysis*.
  - Child & Adolescent Well Visits (WCV): Eliminate WCV disparity gap between Non-Hispanic White population (40.46%) and Native American/Native Alaskan population (36.84%). For all other populations, maintain no disparity gap compared to Non-Hispanic White population.
  - Follow-up after Hospitalization for Mental Illness (FUH) – 30 days: Reduce FUH disparity gap between Non-Hispanic White population (66.36%) and Black/African American (53.87%), Native American/Native Alaskan (47.59%), and Asian American/Pacific Islander (55.21%) populations by a net value of 50%. For all other populations, maintain no disparity gap compared to Non-Hispanic White population.

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. The goal is that 80% of CAHPS survey respondents respond that they Always or Usually received health care services in a language they can understand and that they felt health care staff were sensitive to their cultural needs.
- Monitor telehealth trends and demonstrate that UCare's telehealth network is providing safe, equitable and coordinated care by credentialed providers.
- Expand use of virtual visits by identifying and addressing disparities, educating providers on consultative coding, and advocating both locally and nationally for continued virtual benefits.

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.
- Continue to include quality metrics and integrate population health priorities into value-based provider agreements to move to outcome-based measures that demonstrate improved health.
- 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, experience 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.
- Achieve and maintain NCQA Health Equity Accreditation for Medicaid products.
- 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.

**Data analysis based on DHS Withhold Calculation – 2022 Managed Care Withhold Specifications – Contract Year 2022 – January 2023 Rates Preview.*

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 and mental health and substance use disorder 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 mental health and substance use disorder 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.
- Intervene on 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.

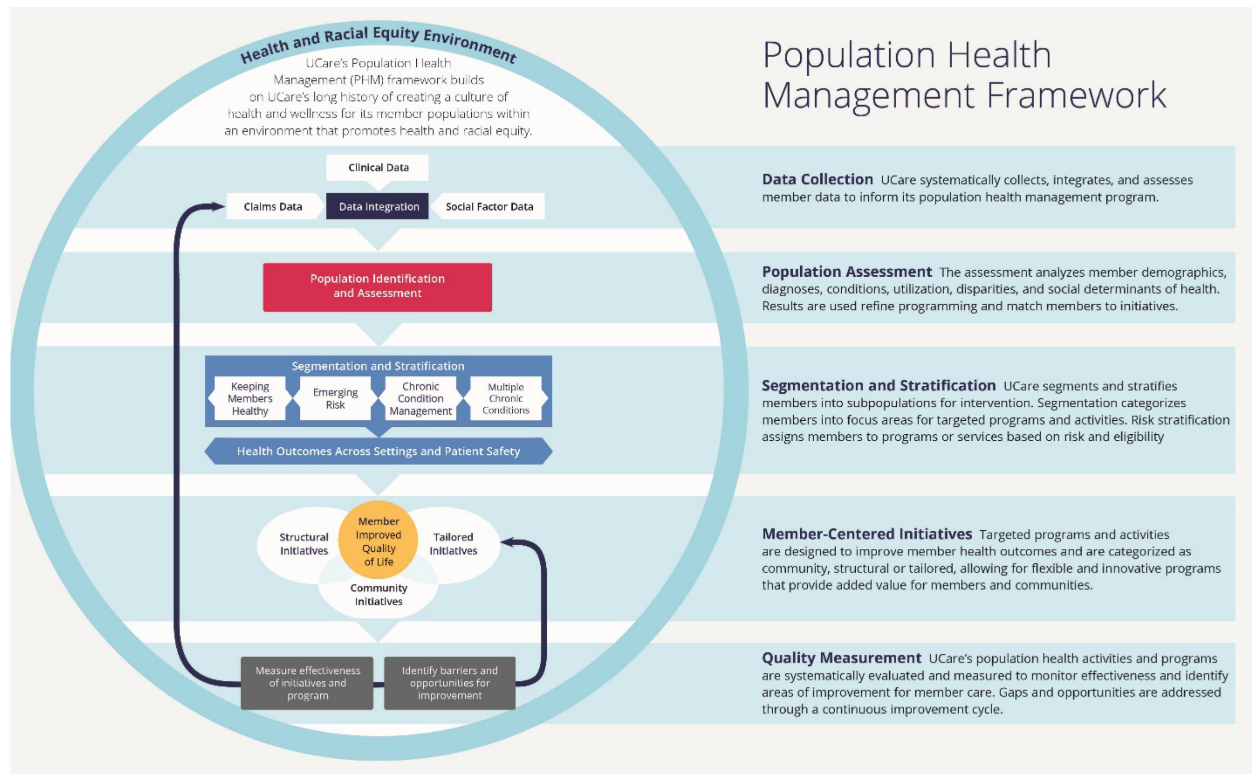
Population Health Strategy and Structure

UCare's Population Health Management (PHM) strategy seeks to improve the health and well-being of our members, families, and the communities in which they live through a comprehensive population health approach. The PHM strategy is an action plan that describes our population health activities, designed to directly impact member health and well-being across the continuum of care, in the community and across all product lines. The PHM strategy defines a roadmap to ensure the PHM program aligns with UCare's organizational strategic priorities and to communicate program goals and activities.

The foundation of the PHM strategy is a continuous improvement framework that guides the refinement of program activities. The framework supports collaboration and synchronization of PHM efforts across the organization, allowing for flexibility to respond to member needs, thus creating a culture of health and wellness for member populations. Elements of the framework include data collection, population identification and assessment, member segmentation and stratification, member-centered initiatives, and quality measurement of effectiveness, within an environment of health and racial equity.

PHM program activities are coordinated by a PHM team who is responsible for facilitating the oversight and direction for designing, implementing, and supporting PHM activities across the organization. Data and information flow between areas to achieve program objectives, with dedicated support from teams across the enterprise.

UCare's 2022 Quality Program Evaluation is organized within this framework, with quality improvement initiatives organized in the following categories: Structural Interventions, Community Resources, and Tailored Initiatives.



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:

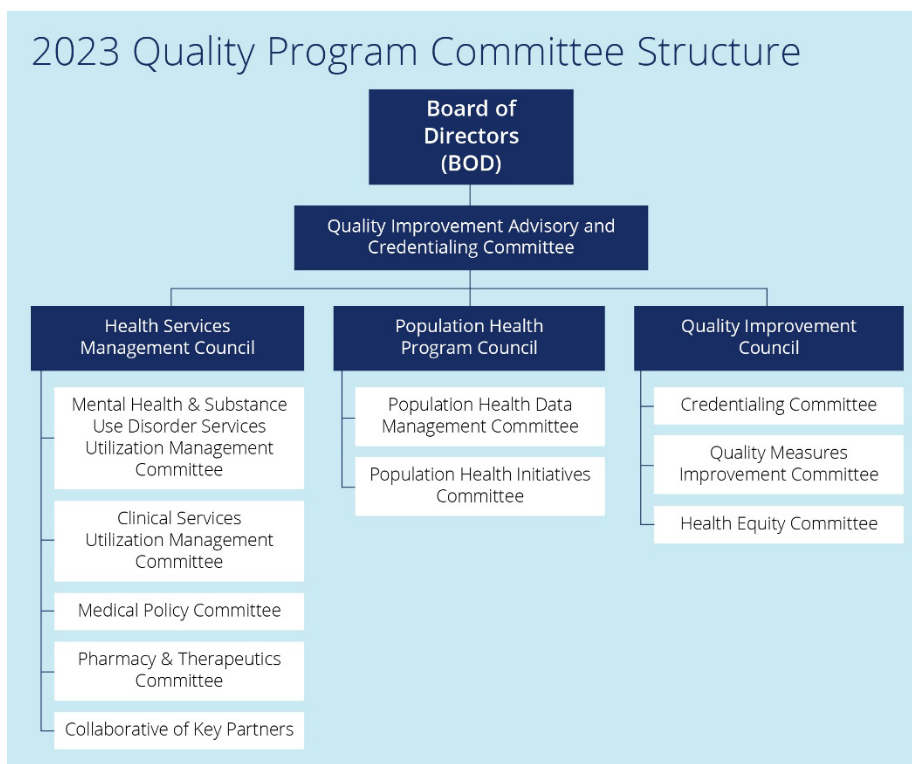
- **Plan:** Identify the objectives of the project and make predictions about what will happen. This step includes answering the following questions:
  - What are we trying to accomplish based on the data points and identified interventions?
  - How will we know a change led to improvement (i.e. quantitative 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 incorporates 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?

Organizational Structure

To promote quality and health equity 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.
- The Board of Directors reviews, evaluates and approves the Quality Program Description, annual Quality Work Plan, and the annual Quality Program Evaluation.

- The Board of Directors reviews 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 enrollees
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 UCare's Quality Improvement Program, promotes the provision of optimal, achievable patient care and service, and identifies and addresses health disparities 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 Program Work Plan, Quality Program Evaluation, Utilization Management Program Description, and Utilization Management 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 UCare 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, Health Services Management Council, and Population Health Program Council.
- Oversees the approval, denial and discipline of practitioners and providers subject to credentialing in accordance with UCare's Credentialing policy.

Membership consists of:

The Chairperson is appointed by the Board Chair from among the committee's members.
The Vice Chair is appointed by the Chairperson from among the committee's members.
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 communities representative of UCare's membership are also encouraged.

In addition, the following UCare staff attends:
AVP, Senior Medical Director
Director, Quality Improvement
EVP, Chief Medical Officer
Medical Directors
Representative, Legal Department
VP, Clinical Services
VP, Equity and Inclusion
VP, Mental Health and Substance Use Disorder and SNBC
VP, Pharmacy
VP, Quality Management and Population Health

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

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

Clinical (CLS) Utilization Management Committee

The Clinical (CLS) Utilization Management Committee identifies, monitors, and evaluates 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 Counsel.
- 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 Counsel 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 Counsel.

- Monitor studies, new findings, and emerging utilization trends for potential impact on UCare utilization.
- Provide recommendations to the Health Services Management Counsel.

Membership consists of:

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

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

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

The Mental Health and Substance Use Disorder Services (MSS) and SNBC UM Committee identifies, monitors, and evaluates 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 and substance use diagnosis trends, outpatient programs, inpatient and emergency utilization, substance use disorder services, Healthcare Effectiveness Data and Information Set (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 service 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: Director, Clinical Operations, Mental Health and Substance Use Disorder and SNBC
Vice Chair: Utilization Manager, Mental Health and Substance Use Disorder and SNBC
Health Care Analyst(s)
Manager(s), Clinical, Mental Health and Substance Use Disorder and SNBC
Manager, Contracted Network
Manager, Operations, Mental Health and Substance Use Disorder and SNBC
Manager, Quality Analytics
Medical Director, Mental Health and Substance Use Disorder
Operations Analyst, Mental Health and Substance Use Disorder and SNBC
Principal Analyst
Quality Improvement Specialist(s)
Regulatory Specialist, Mental Health and Substance Use Disorder and SNBC
Senior Manager, Clinical Pharmacy
Senior Manager, Enterprise Analytics
Senior Manager, Oversight, Mental Health and Substance Use Disorder and SNBC
Supervisor, Regulatory and Appeals Pharmacy
Supervisor(s), Mental Health and Substance Use Disorder and SNBC

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 Medicare Part D 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.
- P&T Committee will review Medicare Part D Opioid Drug Management Policy annually to ensure management practices are in line with regulatory requirements.
- 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 Senior Medical Director
Vice Chair: Plan VP, Pharmacy
External Members (6-10 members):
Membership will consist of a majority practicing physicians, practicing pharmacists, or both. Physician members include 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.

Internal UCare Members (non-voting):
VP, Pharmacy
Clinical Pharmacists(s)
Medical Director(s)
Senior Manager, Clinical Pharmacy

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 Medical Policy Committee's clinical decisions about safety, efficacy and appropriateness of medical treatment or devices are developed without reference to specific products. The member's coverage policies and documents provide information about benefits, cost sharing and other aspects of coverage. The committee reports to the Health Services Management Council. Responsibilities include:

- Sets priority for medical policy development and publication 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.
- 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:

Chair: AVP, Senior Medial Director
Coding Analyst Senior
Coverage Policy Program Lead
Director, Operations, Clinical Services or Delegate
Director, Enterprise Data and Provider Finance
EVP, Chief Legal Officer or Delegate
EVP, Chief Medical Officer
Manager, Coverage Policy Program
Medical Director, Mental Health & Substance Use Disorder Services
Medical Directors
Senior Manager, Clinal Pharmacy
VP, Clinical Services or Delegate
VP, Mental Health and Substance Use Disorder Services and SNBC or Delegate
VP, Product Management
Configuration Manager (optional)
Director, Customers Services (optional)
Physician Experts (optional)
Product Managers (optional)
VP, 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, substance use disorder (SUD) and medical care practitioners and the health plan. The collaborative includes a cross-sectional group of practitioners and key partners. The collaborative reviews UCare information and provides insight from experiences and ideas on improving the continuity, care and health equity of UCare members as they receive care by both medical and mental health & SUD 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 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: VP, Mental Health and Substance Use Disorder Services and SNBC
Vice Chair: Director, Operations, Mental Health and Substance Use Disorder Services and SNBC
Advocacy Organization Leadership
Certified Community Behavioral Health Clinic (CCBHC) Organization Leadership
Child and Adolescent Organization Provider
Community and Provider Liaison, Mental Health and Substance Use Disorder Services and SNBC
Community Family Practice Physician
Community Mental Health Center Leadership
Community Pediatric Nurse Practitioner
Community Psychiatrist
Community Psychiatric Nurse Practitioner
Community Psychologist
County Government Relations
County Partner Representative
Culturally Specific Organizational Leadership
EVP, Chief Medical Officer
EVP, Public Affairs and Chief Growth Officer
Healthcare System Mental Health Nurse Practitioner
Law Enforcement Representative
Manger, Provider Experience
Manager(s), Clinical, Mental Health and Substance Use Disorder Services and SNBC
Manager, Operations, Mental Health and Substance Use Disorder Services and SNBC
Manager, Utilization Management, Mental Health and Substance Use Disorder Services and SNBC
Medical Director, Mental Health & Substance Use Disorder Services and SNBC
Mental Health Clinic Leadership
MN DHS Managed Care Liaison
Program and Policy Coordinator, Mental Health and Substance Use Disorder Services and SNBC
Provider Contracting Principal
Quality Improvement Specialist
Specialty Treatment Provider Leadership
Substance Use Disorder Provider
Supervisor, Utilization Management, Mental Health and Substance Use Disorder Services and SNBC
UCare Government Relations Staff
UCare Product Staff
VP, Chief Compliance and Ethics Officer
VP, Government Relations
VP, Provider Relations and Contracting

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 factors impacting health. The Council provides executive review and guidance for the enterprise Population Health Management 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. PHPC 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: EVP, Chief Medical Officer
Clinical Informaticist Lead
Director, Quality improvement
EVP, Chief Financial Officer
EVP, Public Affairs, Chief Growth Officer
Manager, Population Health
Manager, Health Services Analytics
Medical Director
Specialist, Population Health
VP, Chief Customer Experience Officer
VP, Chief Informatics Officer
VP, Clinical Services
VP, Equity and Inclusion
VP, Product Management
VP, Mental Health and Substance Use Disorder Services and SNBC
VP, Pharmacy
VP, Product Management
VP, Provider Relations and Contracting
VP, Strategic Partnerships
VP, Quality Management and Population Health

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

Population Health (PH) Data Management Committee

The Population Health (PH) Data Management 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:

- Identify 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 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: VP, Chief Informatics Officer
Vice Chair: VP, Quality Management and Population Health
Associate Director, Enterprise Analytics
Clinical Informaticist Lead
Director, Quality Improvement
Health Services Data Analyst
Manager, Health Services Analytics
Manager, Population Health
Medical Director
Principal Data Scientist
Senior Manager, Enterprise Analytics
Senior Manager, Quality Analytics
Specialist, Population Health
VP, Clinical Services
VP, Mental Health and Substance Use Disorder Services and SNBC
VP, Pharmacy

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

Population Health (PH) Initiatives Council

The Population Health (PH) Initiatives Committee oversees the development and implementation of initiatives 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 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 initiatives to ensure they support the needs of members to achieve their best health.
- Develop recommendations for the coordination of initiatives across the care continuum to ensure the highest priority member needs are addressed first.
- Ensure the development and implementation of data-driven, evidence-based internal initiatives and services, community collaborations, and provider/vendor contracting to meet the needs of member populations and address health equity.
- Review performance goals and metrics for each initiative.

Membership consists of:

Chair: Medical Director
Vice Chair: VP, Provider Relations and Contracting
Associate Director, Healthcare Economics
Associate Director, Marketing
Clinical Informaticist Lead
Director, Care Management
Director, Product Management
Director, Specialist Needs Plans Care Management
Director, Quality Improvement
Manager, Disease Management
Manager, Government Relations County, Tribal and Public Health
Manager, Health Services Analytics
Manager, Population Health
Officer, Equity and Inclusion
Principle Data Scientist
Senior Manager, Enterprise Analytics
Senior Manager, Mental Health and Substance Use Disorder Services Oversight
Senior Manager, Product
Senior Manager, Public Affairs and Community Outreach
Specialist, Population Health
VP, Chief Informatics Officer
VP, Clinical Services
VP, Quality Management and Population Health
VP, Mental Health and Substance Use Disorder Services and SNBC
VP, Pharmacy

Frequency of Meetings: The committee meets every two months 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. The council reports to the Quality Improvement Advisory and Credentialing Committee. Responsibilities include:

- Provides oversight and direction to initiatives that improve population health, addresses health disparities and improves member experience.
- Reviews quality improvement activities to achieve objectives.
- Reviews organizational monitoring of quality improvement 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 annual Quality Program Description, Quality Program Evaluation and Quality Work Plan.
- Works in collaboration with the Health Services Management Council and Population Health Program Council to achieve "Triple Aim" goals.

Membership consists of:

Co-Chair: VP, Chief Informatics Officer
Co-Chair: VP, Quality Management and Population Health
AVP, Senior Medical Director
Director, Quality Improvement
Manager, Member Experience
Manager, Population Health
Manager, Stars Program
Medical Director(s)
President and Chief Executive Officer
EVP, Chief Administrative Officer
EVP, Chief Financial Officer
EVP, Chief Information Officer
EVP, Chief Legal Officer
EVP, Chief Medical Officer
EVP, Public Affairs and Chief Growth Officer
VP, Chief Compliance and Ethics Officer
VP, Chief Experience Officer
VP, Clinical Services
VP, Customer Services
VP, Equity and Inclusion
VP, Government Relations
VP, Member Billing and Enrollment
VP, Mental Health and Substance Use Disorder Services and SNBC
VP, Marketing and Product Management
VP, Pharmacy
VP, Provider Relations and Contracting and Provider Services

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 Specialist 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: AVP, Senior Medical Director or Designee
External Members (4 to 6 members):
Representing primary care disciplines such as: 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.

Internal Members (voting):
Medical Director(s)

Internal Members (non-voting):
Associate General Counsel
Credentialing Audit Specialist
Credentialing Delegation Specialist
Director, Quality Operations
EVP, Chief Legal Officer
PRC representative
Senior Manager, Credentialing
VP, Quality Management and Population Health

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, eliminating health care disparities, 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, PIPs, DHS Withhold measures, population health program, and quality initiatives related to all products 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.
- Annually develop a strategy to address DHS State contract requirements (e.g., Performance Improvement Projects (PIPs), withhold measures, population health strategy etc.) with an emphasis on decreasing health care disparities.
- 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: Director, Quality Improvement
<u>Decision Making Body</u>
VP, Chief Informatics Officer
VP, Clinical Services
VP, Customer Service
VP, Marketing and Product Management
VP, Mental Health and Substance Use Disorder Services and SNBC
VP, Pharmacy
VP, Provider Relations and Contract
VP, Quality Management and Population Health
<u>Committee Attendees</u>
Associate Director, Marketing
AVP, Sales
AVP, Senior Medical Director
Clinical Informaticist Lead
Clinical Project Coordinator Stars Measures
Director, Clinical Services - Care Management
Director, Clinical Services – Operations
Director, Clinical Services – Special Needs Plans
Director, Mental Health and Substance Use Disorder Services – Operations
Director, Quality Operations
Health Equity Officer
Manager, Account Services
Manager, Customer Services Workforce
Manager, Federal Government Relations
Manager, Health Promotion
Manager, Health Services Analytics
Manger, HEDIS
Manager, Member Experience
Manager, Population Health
Manager, Product
Manager, Stars Program

Manager Sr., Pharmacy Quality
Manager Sr., Quality Analytics
Medical Directors
Member Experience Specialist
Quality Improvement Specialists

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

Health Equity Committee

The purpose of the UCare Health Equity Committee is to assist in developing, implementing and evaluating organizational initiatives and unique partnerships aimed at reducing health disparities and achieving health and racial equity for the members and communities we serve. The Committee also supports internal diversity training activities as appropriate. Specific committee responsibilities include:

- Develop, implement, monitor, and evaluate work plan activities related to health equity and CLAS.
- Maintain, disseminate and annually review the Limited English Proficiency (LEP) plan for the MN Department of Human Services.
- Explore opportunities to connect with and solicit feedback from UCare's diverse communities on organizational initiatives.
- Support departmental and organizational initiatives that reduce health inequities and improve health and racial equity for the members and communities we serve.
- Promote diversity and culturally responsive initiatives for our members, employees and providers.
- Identify ways to embed health and racial equity within UCare policies and programs

Membership consists of:
Chair: Health Equity Officer
Associate Director, Provider Services
Communications Lead
Communications Lead, State Public Programs
Director, Government Relations
Director, Operations Member Billing and Enrollment
Director, Quality Improvement
EVP, Public Affairs and Chief Growth Officer
Manager, Community Outreach
Manager, County, Tribal and Public Health
Manager, Employee Experience
Manager, Operations Mental Health and Substance Use Disorder and SNBC
Manager, Stars Program
Medical Director
Privacy Officer, Legal
Product Manager, Medicaid
Product Specialist
SNP Sales Representative
Specialist, State Government Relations
Sr. Manager, Customer Experience
Sr. Manager, Provider Data and Analytics
Sr. Marketing Analyst
Sr. Product Manager, Special Needs Plan
Supervisor, Customer Service
Supervisor, Pharmacy Operations
Vice President, Equity and Inclusion

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

Member Advisory Committees

UCare also has an advisory function that seeks advice from people and members of the community that reflect diversity of our membership. UCare's advisory committees presents the voices of many communities that are impacted by health inequities our membership, including racial and ethnic minority groups, rural members, members with disabilities, etc. The member advisory committee brings both expertise on a range of health topics and the lived experiences of their respective geographic/cultural communities. The knowledge and expertise of our advisory committee is used to enhance the work, design, and implementation of interventions to advance health equity for all communities within the membership that UCare serves. There are plans to expand the member advisory committees into outstate Minnesota, write committee charters for all committees, increase diverse representation and strengthen community participation (individuals and organizations) in gathering feedback, reviewing data, and co-creating strategies and activities to improve health outcomes for our member populations.

The membership advisory committees include:

- Senior Member Advisory Committee (Medicare products)
- Member Advisory Committee—Medicare products
- Disability Advisory Committee—Connect/Connect+ Medicare
- Minnesota Senior Health Options (MSHO)/Minnesota Senior Care (MSC+)
- Individual and Family Plan (IFP) Member Advisory Committee

Membership consists of:

Current State Public Program Members (12-15 members)
Communications Lead, Marketing
Community Outreach Manager
Customer Experience Manager
Product Manager – State Public Programs
Product Specialist

Frequency of Meetings: The committee meets ad hoc 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, 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.

Executive Vice President, Chief Medical Officer

The Executive Vice President (EVP), 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 Equity and Inclusion.

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

Quality Management and Population Health Department

The Quality Management and Population Health department includes Appeals and Grievances, Credentialing, Population Health, Quality Improvement, NCQA Accreditation, Health Improvement, 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 Health Plan and Health Equity Accreditation, Health Equity, member engagement, benefit administration and compliance are shared responsibilities across the organization and there is a great deal of collaboration which is evident in the high performance 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.
Clinical Informatics	The Clinical Informatics team oversees the clinical documentation system, data integration and data governance strategies, as well as supports teams across the organization in designing and developing clinical programs.
Credentialing	The Credentialing team manages data in the credentialing database, processes every practitioner's/provider's credentialing and recredentialing, and conducts delegation oversight.
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.
Health Equity	The Health Equity team supports the development and evaluation of culturally and linguistically appropriate services (CLAS) activities and collaborates with teams across the organization to reduce health disparities through targeted community partnerships and equity-centered initiatives.
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.
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 and Health Improvement**	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. The Health Improvement team conducts culturally congruent member outreach to educate members on preventive care, access to care, and benefits.

Quality Operations Director

The Quality Operations Director reports to the Vice President of Quality Management and Population Health and is responsible for the oversight of operational processes related to Credentialing and Appeals and Grievances (A&G), which includes creating optimal performance, quality assurance, and efficiencies. In addition, this position is responsible for ensuring that 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.

Quality Improvement Director

The Quality Improvement 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. In addition, this position provides oversight to UCare's Star Ratings programs. Additional responsibilities include, development and management of the Quality Improvement team and Health 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.

Health Equity Officer

The Health Equity Officer reports to the Vice President of Quality Management and Population Health. The Health Equity Officer is responsible for reviewing organizational programs and initiatives, identifying barriers to health and racial equity and working with department leaders to embed health and racial equity within programs, products, policies and/or processes. Additionally, the Health Equity Officer works to integrate the clinical and social needs of UCare members through community partnerships and initiatives so that members have a fair and just opportunity to live a healthy life.

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.

Clinical Informatics Manager

The Clinical Informatics Manager reports to the Vice President of Quality Management and Population Health and is responsible for overseeing UCare's Electronic Health Record (EHR) platform, as well as providing clinical and technical expertise in the design and development of workflows, clinical programs, data integrations, and data governance strategies.

Disease Management Manager

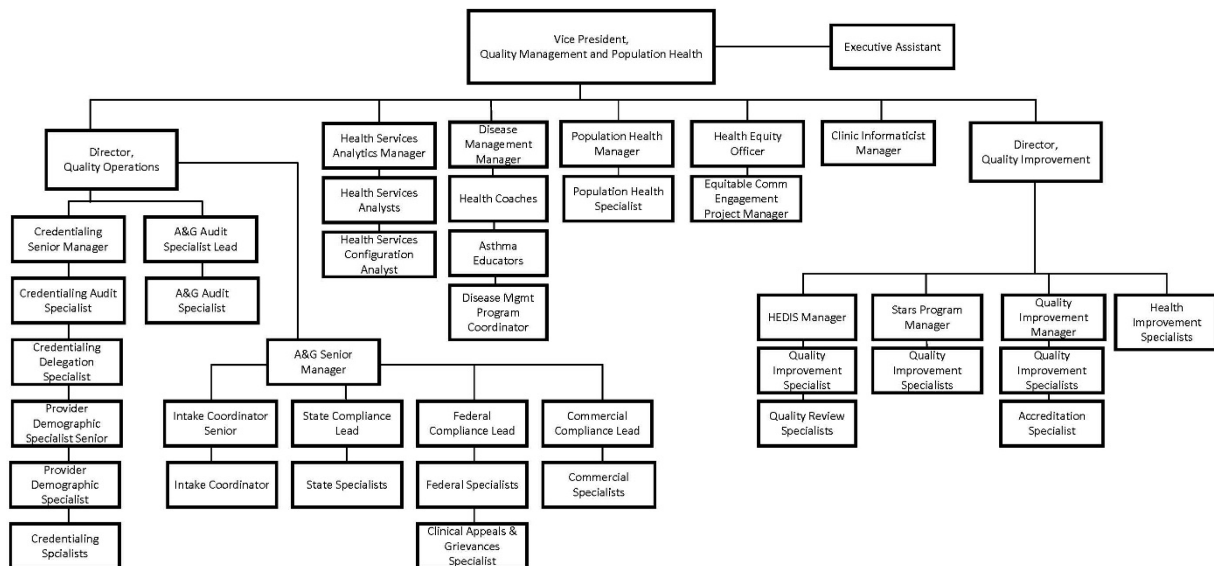
The Disease Management Manager reports to the Vice President of Quality Management and Population Health and is responsible for managing UCare's disease management programs and ensuring alignment with overall

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 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 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:

- President and Chief Executive Officer
- Medical Directors
- VP, Chief Compliance and Ethics Officer and staff
- VP, Chief Experience Officer
- VP, Customer Service and staff
- VP, Equity and Inclusion and staff
- VP, Chief Informatics Officer and staff
- VP, Clinical Services and staff
- VP, Government Relations and staff
- VP, Mental Health and Substance Use Disorder Services and SNBC
- VP, Pharmacy and staff
- VP, Product Development and staff
- VP, Provider Relations and Contracting and Provider Services and staff

Medical Directors

The Medical Directors are responsible for supporting the day-to-day medical management and lead ongoing improvement in collaboration with the teams in Health Services. Medical Directors provide support and consult for utilization management (medical, pharmacy), appeals, medical and coverage policy (development and

maintenance), quality of care, and quality improvement (Star Ratings, National Committee for Quality Assurance). Medical directors ensure that UCare members receive care that is safe, timely, effective, efficient, member-centered, and equitable. They support and help to lead aspects of regulatory compliance that relate to clinical functions and programs. In addition, they provide clinical support as needed to staff throughout UCare, including complex case management, disease management, clinical care management programs, and delegates.

Vice President of Clinical Services

The Vice President of Clinical Services is a member of UCare's leadership team, reporting to the EVP, Chief Medical Officer. This position is responsible to oversee Clinical Services and ensure overall execution of clinical programs for UCare members. This position is responsible for ensuring achievement of program outcomes, contract goals, service delivery within budget, and compliance of regulatory requirements. This position provides leadership for design, implementation, and oversight activities and workflows related to utilization management, care management, delegate compliance, and clinical initiatives. This position supports physicians and cross-functional teams in facilitating member care to enhance the quality of clinical outcomes and member experience while managing the cost of care and providing timely and accurate information to the organization, senior leaders, providers, delegates, and regulators.

Vice President of Pharmacy

The Vice President of Pharmacy is a member of UCare's leadership team, reporting to the EVP, Chief Medical Officer. This position is responsible for strategic planning, project implementation and fiscal management for pharmacy operations, medication management and clinical pharmacy programs. This position ensures compliance with state and federal requirements related to the prescription drug benefit. In addition, this position oversees the business relationship and contract performance of the pharmacy benefits manager (PBM), medical drug management vendor, and specialty pharmacy vendor, and partners with senior management to develop appropriate goals and strategic plans for all aspects of drug product benefit coverage and reimbursement. This position provides leadership on pharmacy benefits and supports the Chief Medical Officer on clinical pharmacy issues.

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 and Collaborative of Key Partners. 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 EVP, Chief Medical Officer (CMO), VP, 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 Associate Vice President and Senior Medical Director. 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.

Vice President, MSS and SNBC

The Vice President (VP) 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 EVP, 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.

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. To support UCare's growth and quality goals, new positions were added to the Quality Improvement team beginning in 2023 including the Quality Improvement Manager, Accreditation Program Specialist, and Quality Review Specialist. In addition, beginning in 2023 UCare transitioned the Health Equity Officer and Equitable Community Engagement Project Manager to the Quality Management and Population Health Department to further goals related to health equity, community engagement, and reduction of health disparities.

Community Resources and Engagement

UCare ensures that we actively engage with our racially/ethnically and linguistically diverse populations. At a minimum, UCare involves individuals and organizations representing racial/ethnic and linguistic groups that constitute at least 5% of our membership. Our data shows that our Asian and Pacific Islander, Black/African-American and Hispanic populations comprise over 5% of our entire UCare Medicaid population. No non-English languages are spoken by 5% or more of our membership. Below is a list of the key organizations with whom we engage. Engagement includes, but is not limited to, frequent meetings to gain input on UCare's health equity strategy and related activities, targeted member outreach, grant funding, trinket/supply donations, partnership on flu and COVID-19 vaccine clinics, sponsoring and participating in events, and partnering on health screenings and Healthmobile.

- Asian or Pacific Islander: Karen Organization of Minnesota, CAPI (formerly Centre for Asian and Pacific Islanders), CHW Solutions, Center for Victims of Torture, WellShare, Certified Community Behavioral Health Clinic (CCBHC)/Behavioral Health Homes (BHH), Community Dental Care, Adult Day Centers
- Black or African/American: Hue-MAN, JK Movement, WellShare, Certified Community Behavioral Health Clinic (CCBHC)/Behavioral Health Homes (BHH), Community Dental Care, Adult Day Centers, African Babies Coalition, Hennepin Healthcare (doula and social work)
- Hispanic: St. Mary's Clinic, Children's Health Network (CHW), Certified Community Behavioral Health Clinic (CCBHC)/Behavioral Health Homes (BHH), Community Dental Care

Other notable community partnerships include: Islamic Civic Society, YMCA of the North, Minnesota Indian Women's Resource Center, Pathways Community Hub, and BioIQ.

In addition, UCare engages internal staff (i.e. Member Engagement Specialists – Somali, Hmong, Spanish, Native American) who work directly with these diverse populations for feedback and insight so that we are continually improving services provided to members and meeting their cultural and linguistic needs and preferences.

Our active partnerships with our diverse populations helps improve the organizations' benefit offerings, population health programs and member interventions, and internal processes and procedures so that we improve health outcomes and become a more equitable and inclusive organization.

Members with Special Health Care Needs

UCare uses a population health approach to develop strategies to support member health care needs to focus on the health and overall wellness of the broader population it serves. UCare designs initiatives across the entire continuum of care from keeping members healthy, supporting members with emerging risk, managing members with chronic conditions, complex health needs as well as patient safety and outcomes across settings. 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 and special health care needs, vary greatly in population characteristics, demographics, experiences with care, and social drivers of health.

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 emergency services and hospitalizations. Members who experience multiple 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 and special health care needs by the strategies and objectives described below.

Data Analysis

UCare uses multiple data sources to identify members with special health care needs. We use data to identify population characteristics to drive the creation and refinement of existing programs to match member health care needs. Our aggregated data allows us to understand the social drivers of health that impact our populations and identify ways to reduce health care-related costs and avoid preventable health-related conditions. We also use data to identify members for outreach, preferred communication method, and what programs and services we should invest in.

UCare makes considerable efforts to integrate new data sources as they become available to provide deeper analysis of sub-populations. For example, UCare uses Unite Us Insight, which is a vast database of consumer insights and predictive modeling. This intelligence enables UCare to meet members where they are in their health care journey and powers effective risk identification, member engagement and health management.

Population Assessment

At least annually, UCare assesses its entire member population to examine characteristics and needs of members and sub-populations of members to support their access to care and services. This assessment includes multi-dimensional analysis of member demographic data, diagnoses and chronic conditions, utilization patterns and social drivers of health (see further description in the table below). The results of this regular assessment, including noted disparities, care gaps or populations disproportionately impacted, are used to drive the creation of or refine existing programs and match member needs to appropriate interventions. In addition to programming developed to meet individual member needs, the population assessment is used to focus community partnerships and population-level interventions. Finally, the population assessment is used to develop and refine risk stratification models (described in detail below) to appropriately weigh risk factors noted in our populations and address gaps anddisparities.

Multidimensional analysis of member populations includes, but may not be limited to, thefollowing categories:

Category	Examples
Demographics	• Race, Language and Ethnicity • Age and sex • Disability status and disability type • Geographic distribution • Living status • Eligibility/benefit group • Attributed care system
Diagnoses and Chronic Conditions (includes mental health diagnoses)	• Chronic conditions • Severe and persistent mental illness • Dominant psychiatric conditions • ACG patient needs groups • Markers of frailty
Utilization	• Segmentation • Per Member Per Year cost • Emergency department visits • Inpatient utilization • Outpatient encounters • Pharmacy utilization • Preventive care and screenings
Social Drivers of Health	• Food insecurity • Housing insecurity • Transportation • Social isolation/loneliness • Others available
Other special population analysis	• Children, adolescent, adult, and elderly members • Pregnancy • Members with disabilities • Members with severe and persistentmental illness (SPMI) • Members with specific chronic conditions

Refining the Population Assessment

At least annually, modifications to the population health assessments are reviewed and evaluated. Efforts to improve the assessment include integration of new data sources as they become available, deeper analysis of sub-populations to identify and address barriers to care and best outcomes, and to provide more meaningful information overall for better data connections and interpretations.

Risk Stratification and Segmentation

Population segmentation and risk stratification occurs across the entire UCare membership or may be targeted to certain population segments/conditions such as members with special health care needs. The goal is to assess all members routinely and effectively for appropriate programs and services, while preserving the flexibility to respond to changing needs and trends in our membership. UCare’s model for member stratification assesses each member’s risk in two dimensions: medical risk and risk of factors impacting ability for self-management.

The medical risk score is designed to predict members at high risk for potentially avoidable cost. It excludes "necessary" costs such as pharmacy and long-term supports, and prioritizes hospitalization, ED use, mental health, and substance use treatment. The model is age-adjusted and uses predictors from the Johns Hopkins Adjusted Clinical Grouping such as the probability of hospitalization in the coming twelve months, the probability of persistent high utilization, the existence of severe polypharmacy, and the presence of severe and persistent mental illness anddominant medical conditions. Validated against our member's actual claims experience year over year, it serves as a highly effective differentiator of mortality, cost, hospitalization, ED use, and chronic condition prevalence.

The self-management risk score is designed to differentiate those members who are most able to effectively manage their health conditions from those who are less able likely. It uses social risk factors, evidence of cognitive frailty, preventive service and wellness indicators, medication adherence, and various evidence of chronic illness management to derive an initial score. This score is further adjusted to account for the risk of poor care coordination and for any recent disruptions to the member's normal pattern of care.

UCare informs the design of its stratification model through its population assessment work and related analytics, identifying ways in which traditional cost- and utilization-based stratification models are prone to various forms of racial and cultural bias. To mitigate against these forms of bias, UCare implements safeguards in the calculation of each axis such as excluding services known to have high benefit or differentiating missing data from poorly matched data.

Population Health Strategies

UCare takes a population health approach through strategies that account for the health and overall wellness of the broader populations we serve. UCare supports members across the continuum of care through prevention efforts to keep members healthy, manage emerging risks, improve patient safety and outcomes across settings, and manage members with chronic conditions and complex health conditions, including MH and SUD.

An integral part of UCare's medical management services is to identify and support members who benefit from the Special Health Care Needs program. UCare assists these members to access care and monitor their treatment plan. All Minnesota Health Care Program (MHCP) members are eligible for case management through this program to optimize the quality of health care available for members while maintaining cost effectiveness. Additionally, UCare considers all MSHO and MSC+ members to have special health care needs and assigns them a care coordinator for ongoing case management.

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. UCare continuously improves our existing programs and provides innovative strategies to work with our members.

Special Health Care Needs Analysis

UCare identifies adults and children with special health care needs by regularly analyzing claims data for specific diagnoses and utilization patterns as well as through screenings, requests for services and other mechanisms or "triggers". UCare has established monthly rolling 13 months and year to date monitoring reports. These reports include:

SHCN - Adults:

- Acute inpatient claims of eligible members who are over the age of 18 and have one of the following conditions as the primary admission reason to acute care: bacterial pneumonia, dehydration, urinary tract infection, adult asthma, congestive heart failure, hypertension or chronic pulmonary disease.
- Hospital emergency department utilization.
- Acute inpatient admissions for diagnoses such as multiple traumas.
- Acute hospital admission with length of stay greater than six days.
- Individual members whose claims reach $100,000 at any point during the calendar year.

SHCN - Pediatrics:

- Members between the ages of 0 to 17 that had ER visits for the following conditions as their primary diagnosis: otitis media, upper respiratory infection, fever, gastrointestinal and traumatic injury.
- Hospital emergency department utilization.
- Hospital admissions for members who are greater than seven days old to 17 years old for any admission.
- Acute hospital admission with length of stay greater than six days.
- Individual members whose claims reach $50,000 at any point during the calendar year.

Members identified as having special health care needs are screened for case management, disease management, or referred to specialists, county services or other services that may assist them. Members who may potentially benefit from case management are assessed to determine their needs, and a plan of care is developed with member input if the member is deemed to need services and voluntarily agrees to care management. UCare members have direct access to specialists in the network.

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 the 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:

- Review Special Health Care Needs reports (e.g., hospital admissions and readmission, emergency department utilization) as a mechanism to detect utilization patterns. Analyze trends in activities and if activities are outside of the calculated control limits, pull additional data for further review at the discretion of UCare's Health Services Management Council. UCare takes appropriate action, as needed to make the necessary program improvements.
- Quarterly review of key data trends including emergency department utilization, hospital admissions and readmission rates. Data are aggregated and reviewed by race/ethnicity, gender, age, geographic location, care system level, etc. UCare uses these aggregated views to identify gaps and areas of concerns to help members receive the right coordination of care (e.g., phone outreach, educational mailings on services and resources) and make referrals to care management programs.

Health Risk Assessments

All members are offered an annual Health Risk Assessment (HRA). These robust assessments help us identify the member's medical, psychosocial, cognitive, functional and mental health needs. The HRA assessments allow UCare to identify a member's unique needs and connect them to appropriate programs and supports available. The HRA data results are combined with population health assessments for further analysis of our members.

UCare takes the following approach to work with members and/or refer members into additional value-add UCare programs, based on the member's response(s):

- **Member identifies as having depression:** Connect the member to a Mental Health care manager and provide integrated medical and mental health care coordination support.
- **Member is diagnosed with diabetes:** Refer the member to our Disease Management team for health coaching support.
- **Member reports using tobacco products:** Provide the member with resources from our Health Promotion

team for smoking cessation assistance.

- **Member is at risk of falling within their home:** Provide the member with a Strong & Stable Kit (TheraBand resistance band strength kit, helpful falls prevention tip sheet, tub grips, nightlights, medication box) and additional information from Health Promotion about falls prevention.
- **Members identified for case management or care coordination:** Work with the member to develop a member-centered care plan that identifies their goals and priorities, addresses their health risks and ways to achieve a healthier lifestyle, and support healthy outcomes.
- **Member's open to case management or care coordination:** Share the agreed-upon care plan with the member's interdisciplinary care team identified as having a critical role in the member's care.

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 over fifty staff members responsible for the data mining, statistical analysis, quality improvement reporting, data mining in support of clinical and case management staff, and for actuarial analysis. The HCE team includes certified actuaries and health care analysts with advanced degrees in Public Health and Statistics. Our deep understanding of health care analytics, statistics, and our ability to effectively use programming and modeling tools, such as Python and R, 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 information with claims data and 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 that UCare can 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. Additional analytic tools used to enhance analytical capabilities and allow for flexibility in analyzing data include Business Objects™, and Tableau™. We also 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 (Adjusted Clinical Groups)™ 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. The Data Center of Excellence (CoE) is a cross functional team (HCE & IT) designed to support the on-going enablement and growth of enterprise data management capabilities. This includes support of key processes, technologies, and governance structures.

CareSeed is UCare's NCQA-Certified HEDIS (Healthcare Effectiveness Data and Information Set) software vendor that supports, calculates, and measures HEDIS results. UCare contracts with Advent Advisory, an NCQA (National Committee for Quality Assurance) accredited audit firm, to perform auditing of final rates prior to reporting them

to NCQA. SPH Analytics is the vendor used to conduct standard survey and analyses for CAHPS (Consumer Assessment of Healthcare Providers and Systems), QHP (Quality Health Plan) Enrollee Experience Survey and HOS (Health Outcomes Surveys) Survey.

UCare retains a longitudinal history of member-level quality measure results to be used for ongoing analysis of comparing different periods of time. Examples of the analysis performed include efforts to:

- Measure and compare providers (utilization and financial performance).
- Measure rates and look at patterns of utilization.
- Quantify gaps in care using equity-focused quality measurements to help narrow or eliminate racial and ethnic health and access to health care disparities.
- Provide data to help in developing 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, the effectiveness of care, utilization, and to provide comparison data.
- Provide analytical support and predictive modeling to inform senior leadership about UCare predicted performance.
- Store providers' 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 (Department of Human Services) Triennial Compliance Audit
- Medicare and Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys
- Disenrollment Surveys and Comments
- Health Outcomes Surveys (HOS)

GuidingCare® Platform

UCare utilizes Altruista Health's GuidingCare® platform to integrate all activities and functions required for optimal population health management and care coordination, including complex/case management, disease management, mental health and substance use disorder management, health improvement activities, utilization review and appeals and grievances. 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 complex/case management programs and activities, disease management programs and activities, health improvement activities, prior authorizations requests, appeals and grievances, admit, discharge and transfer messages, 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.

Unite Us Insights (formerly Carrot Health)

UCare partners with Unite Us, a consumer analytics company serving the health industry. Unite Us supports a more effective and equitable health care system that ensures all consumers have access to the support needed to live their healthiest lives. Recognizing each individual member is more than a series of clinical diagnoses and procedure codes, Unite Us consumer data provides a full 360-degree view, highlighting unique member preferences, behaviors, and social determinants of health. By utilizing the MarketView platform, UCare has an enhanced view of every health care 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 are 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, Unite Us 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, the Quality Improvement Advisory and Credentialing Committee, and other communities or workgroups as appropriate.
- 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, audits, 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 experience.
- Provider 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, 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.
- Refining population health assessments through the integration of new data sources as they become available, deeper analysis of sub-populations to identify and address barriers to care and best outcomes and providing more meaningful information overall for better data connections and interpretations.
- Implementing multi-pronged and integrated approach of segmentation, stratification and predictive analysis that creates meaningful and actionable information that drives program design, measurement, evaluation, and innovation.

Health Equity:

- Applying Health and Racial Equity Assessment to planning, development, and implementation of new and existing quality improvement initiatives and programs.
- Identifying, implementing and measuring effectiveness of strategies to reduce disparity gaps in key clinical metrics related to prevention, chronic disease management and utilization.
- Identifying, implementing and measuring effectiveness of strategies to improve culturally and linguistically appropriate services (CLAS).
- Collaborating with community organizations and stakeholders that are reflective of UCare's diverse membership in data collection, analysis and reporting efforts to better understand social needs and barriers to care for UCare members and sub-populations.
- Conducting focus groups with individuals (or member advisory councils when appropriate) in the community to capture feedback and understand health care needs within diverse populations.
- Reviewing population assessments and county community health needs assessments to align priorities amongst UCare, provider groups and community stakeholders.

Access:

- Monitoring adequate access to medical, specialty, dental, and mental health and substance use disorder care including availability and accessibility of services, coordination and continuity of care, appropriate coverage and authorization of services and acting when appropriate.
- Monitoring provider network to ensure it can meet the cultural and linguistic needs of members and acting when appropriate.

Quality of Care and Patient Safety:

- Evaluating any long-term COVID-19 impacts on the 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, NCQA Health Plan 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.
- Analyzing key mental health and substance use disorder performance metrics, including HEDIS measures, utilization measures, and provider and member experience measures, to identify and act on opportunities for improvement.

Regulatory:

- Monitoring compliance with UCare medical record keeping standards, including confidentiality and accuracy and acting when appropriate.
- Ensure compliance with all NCQA Health Plan Accreditation and Health Equity Accreditation 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), NCQA Health Plan Ratings, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Health Outcomes Survey (HOS), Experience of Care and Health Outcomes (ECHO), Health-

Related Quality of Life Survey (HRQoL), 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, HOS, and HRQoL 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 Quality Improvement Advisory and Credentialing Committee (QIACC) is responsible for monitoring overall progress against goals identified in the work plan throughout the year, including CLAS-related goals and activities. QIACC delegates key oversight activities to Health Services Management Council, Population Health Program Council, and Quality Improvement Council and related sub-committees, as indicated in the Work Plan. Committees and Councils meet at the frequency established in the charters to provide updates and progress on key activities and develop collaborative solutions to identified barriers.

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
Population Health Management Strategy