ucare®

2024 Quality Program Description

03/12/2024: Approved by the Quality Improvement Council
03/21/2024: Approved by the Quality Improvement Advisory and Credentialing Committee
04/03/2024: Approved by the Board of Directors

U5843 (04/2023)

TABLE OF CONTENTS

Introduction

UCare's Quality Program Description serves as the guiding framework for formal processes aimed at evaluating and enhancing the quality and appropriateness of health care services along with improving the overall health status of the populations we serve. It also plays a pivotal role in advancing health and racial equity within UCare and ensuring culturally and linguistically appropriate services (CLAS) for our members. This program delineates the structure that applies to UCare's activities, including those conducted for the benefit of our members. It offers UCare the flexibility to direct its efforts towards addressing trends and priorities identified at community, state, regional, and national levels. The Quality Program establishes a structured approach to fostering excellence in all areas through continuous improvement, with a strong emphasis on population health management and promoting 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 them into our Quality Program and other organizational endeavors, with the overarching goal of advancing better health and health care within the communities we serve.

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

UCare's Quality Program Description applies to the products listed below:

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.

Vision and Values

UCare's vision – to lead the way in improving lives, supporting communities, and achieving health equity – is driven by these values:

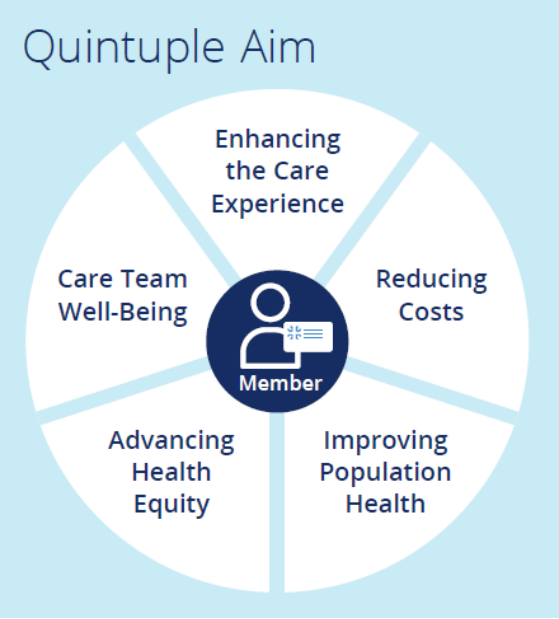
Integrity: UCare stands on its reputation. We are what we say we are; we do what we say we will do.
Community: UCare works with communities to support our members and to give back to the communities through UCare grants and volunteer efforts.
Quality: UCare strives to continually improve our products 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, geography, 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 quintuple aim from a population health management standpoint, while addressing health and racial equity and health disparities.



Improving Population Health:

- 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.
- Refine Population Health impact analyses that assess the effectiveness of the Population Health Program on cost, utilization, quality, 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.
- 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.
- 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. Achieve a 4.5 Star Rating for UCare Medicare and a 4 Star Rating for all other Medicare and Exchange products.

Advancing Health 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.
- Ensure there is parity in the administration of mental health and substance use disorders and medical/surgical benefits.
- 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 90% of members reporting satisfaction with language services provided by UCare.
- 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.
- Identify and decrease health care disparities between the Overall Average Rate and Black, Indigenous, and people of color (BIPOC) populations where disparities are present for key metrics for the organization, including but not limited to Prenatal and Postpartum Care, and Follow-up after Hospitalization for Mental Illness for PMAP and MnCare populations.
    - Postpartum Care – PPC: Reduce disparity gap between Overall Average Rate (56.75%) and Black/African American (54.29%) and Asian American/Pacific Islander (48.14%) populations by a net value of 50%.
    - Timeliness of Prenatal Care – PPC: Reduce disparity gap between Overall Average Rate (64.43%) and Non-Hispanic White (58.67%), Native American/Native Alaskan (63.8%) and Asian American/Pacific Islander (63.12%) populations by a net value of 50%.
    - Follow-up after Hospitalization for Mental Illness (FUH) – 30 days: Reduce disparity gap between Overall Average Rate (62.73%) and Black/African American (55.4%), Native American/Native Alaskan (48.43%), and Asian American/Pacific Islander (56.12%) populations by a net value of 50%.

Enhancing the Care Experience:

- Ensure a high-quality network through credentialing, peer review and contracting processes.
- Improve and manage member outcomes, experience, and safety.
- Monitor telehealth trends and demonstrate that UCare's telehealth network is providing safe, equitable and coordinated care by credentialed providers.
- Continuously improve the quality, appropriateness, availability, accessibility, coordination, and continuity of health care services to members across the continuum of care.
- Define, demonstrate, and communicate organization-wide commitment to improving the quality of care and patient safety.

Reducing Costs:

- Ensure medical, mental health, and substance use disorder (MH & SUD) services are delivered at an appropriate and medically necessary level of care in a timely, effective, and efficient manner.
- Ensure decisions are made by qualified healthcare professionals using appropriate clinical information and guidelines based on evidence-based clinical criteria as evidenced by annual Interrater Reliability (IRR) testing.
- Establish over/under utilization monitoring criteria with quarterly reporting to Utilization Management Workgroups (UM WGs) and committees. Include reporting of approval and denial rates quarterly and benefit exception approval rates annually to the UM WGs and committees.
- Select key utilization categories for monitoring that may include inpatient, emergent care, pharmacy, for medical, mental health and substance use disorder services. Study high-risk, high-volume, and high-cost services, conduct a comprehensive analysis, and perform special studies as appropriate.
- Develop processes and tools for authorization and other utilization management functions to improve efficiency and continuity of care.
- Promote continuous improvement by refining processes to monitor data, implement interventions, and measure the results of the interventions.
- 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.
- Coordinate quality improvement activities across all products to achieve efficiencies and reduce duplicative efforts.

Care Team Well-Being:

- Collaborate with providers to share best practices and implement coordinated strategies such as shared decision making to improve care coordination and quality.
- Improve provider experience and enhance UCare's understanding of key factors contributing to satisfaction.
- Leverage population health programs and community partners to engage members, provide health education, and get them in for needed care, thereby reducing the outreach burden on providers.
- Function as part of the care team to provide health education, care coordination, and case management support to members.
- Identify opportunities to improve communication and coordination of care between primary care providers, specialty care providers, mental health/SUD providers, and other care settings.
- Streamline provider processes (i.e., utilization management, credentialing) to enhance efficiency and reduce time spent on administrative functions.
- Provide training and resources to providers to support them in understanding the diversity of their patients and how to provide culturally informed care.

Regulatory:

- Maintain National Committee for Quality Assurance (NCQA) Health Plan Accreditation for all products.
- 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.

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 Health Service Quality and Operations 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.

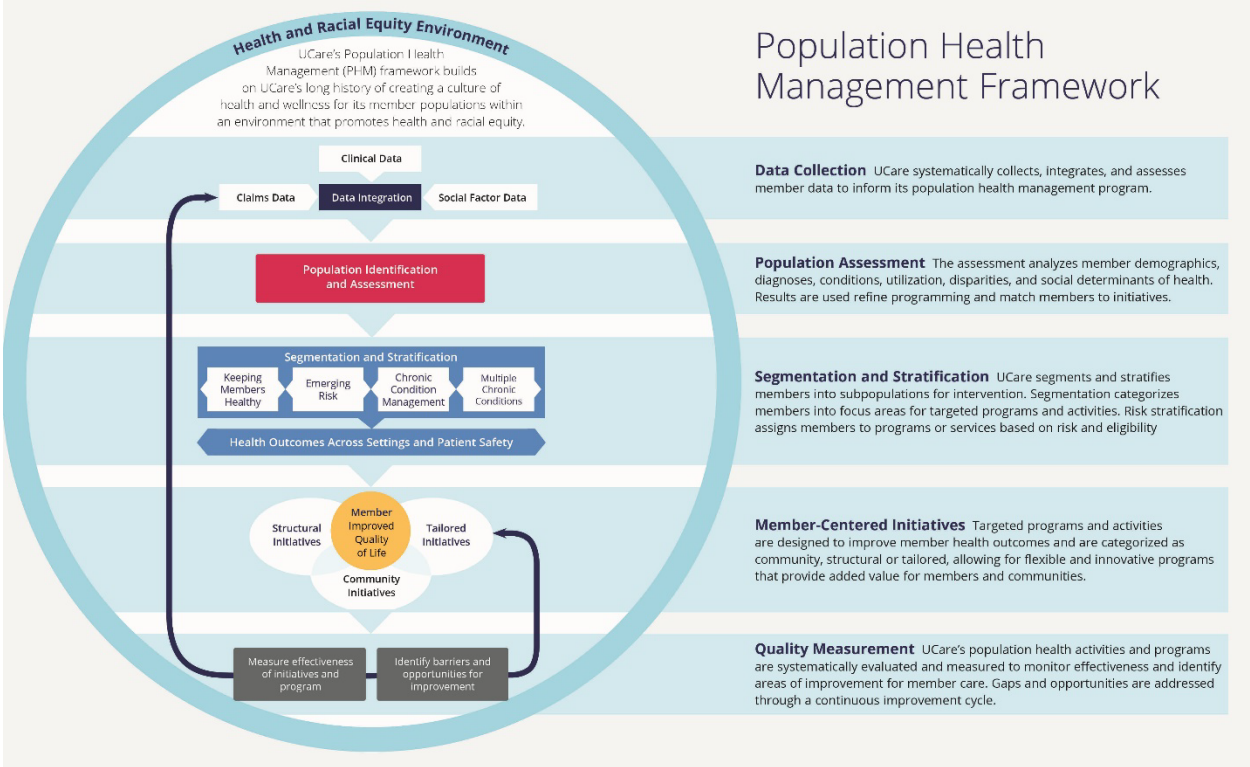
Population Health Strategy and Structure

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 emphasis on health and racial equity.

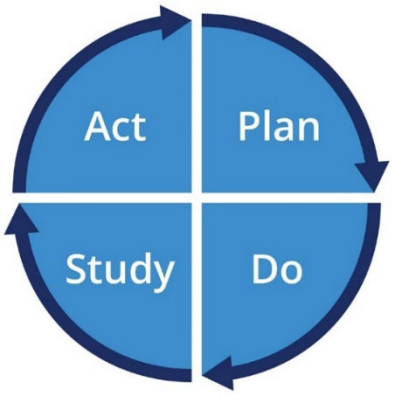
PHM program activities are coordinated by a PHM team who is responsible for facilitating the oversight and direction for designing, implementing, and supporting PHM activities across the organization. Data and information flow between areas to achieve program objectives, with dedicated support from teams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

UCare's 2023 Quality Program Evaluation is organized within this framework, with quality improvement initiatives segmented in the following categories: Structural Interventions, Community Resources, and Tailored Initiatives.



Quality Improvement Framework

UCare designs interventions to meet the Quintuple Aim by improving quality of care, and member and provider experience while reducing costs and advancing health equity. 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:

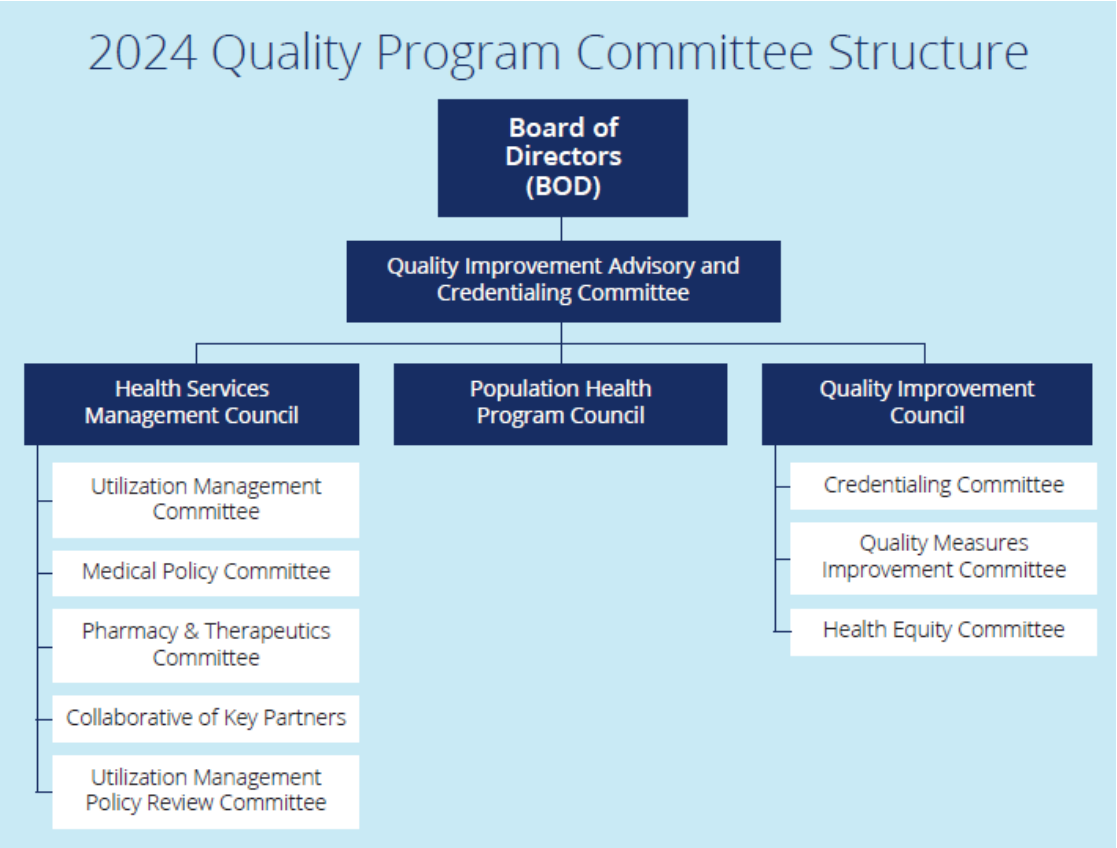
- **Plan:** Identify the objectives of the project and make predictions about what will happen. This step includes answering the following questions:
    - What are we trying to accomplish based on the data points and identified interventions?
    - How will we know a change led to improvement (i.e.,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

- The Chair and Vice Chair are selected and appointed by the Board and shall serve a term of up to three (3) years.
- At least 40% of Directors are elected as consumer members who are UCare enrollees.
- The remaining Directors are At-Large Directors who are elected by the full Board of Directors

Frequency of Meetings: The Board meets at least 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 equity 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:
EVP, Chief Medical Officer
Director, Quality and Population Health
Medical Directors
VP, Clinical Services
VP, Health Services Quality and Operations
VP, Senior Medical Director
VP, Mental Health, and Substance Use Disorder Services
VP, Pharmacy
VP, Care Coordination and LTSS
Legal Department Representative

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, and health equity related to delivery of care and outcomes. The HSMC coordinates utilization management, oversight of delegated utilization management services, utilization and medical policy development. The committee reports to the Quality Improvement Advisory and Credentialing Committee. Responsibilities include:

- Assesses cost, utilization, health equity, 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 Utilization Management Report and Plan are developed.
- Annually reviews the health equity analysis of prior authorizations conducted by the Health Services Utilization Management Committee.
- Oversight of mental health parity initiatives and utilization management delegate performance.
- Reviews and approves the Annual Utilization Management Report, which provides an overview of the end-to-end process of the utilization management program, evaluates the effectiveness and appropriateness of the program, and identifies opportunities for improvement.
- Monitors and evaluates the Utilization Management Plan initiatives and suggests modifications to initiatives as appropriate.
- Provides oversight to the Quality of Care program.
- Provides oversight to standing sub-committees except the Pharmacy & Therapeutics Committee.

Membership consists of:

Chair: VP, Clinical Services
EVP, Chief Medical Officer
EVP, Chief Financial Officer
VP, Care Coordination and LTSS
VP, Chief Informatics Officer
VP, Clinical Services
VP, CCO
VP, Health Services Quality and Operations
VP, Mental Health and Substance Use Disorder Services
VP, Pharmacy
VP, Product
VP, Provider Relations and Contracting
VP, Sr. Medical Director
Medical Directors
Medical Director, Mental Health and Substance Use Disorder Services
Health Equity Officer
Director, Mental Health and Substance Use Disorder Services
Director, Quality Operations
Director, Utilization Management
Sr. Manager, Mental Health and Substance Use Disorder Services
Associate Director, Health Care Analytics
Product Manager

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

Utilization Management Committee

The Health Services Utilization Management Committee uses an interdisciplinary approach to balancing quality, risk, affordability, access, and equity in the provision of member care. The purpose of this work group is to identify, monitor, and evaluate utilization metrics and trends that may have an impact on resources, services, and member outcomes related to physical health, mental health, substance use, or pharmacy services.

- Review key utilization metrics, trends, and accompanying analysis to identify issues related to quality, risk, affordability, access, and equity. Key metrics may include but are not limited to physical health, mental health, inpatient and emergency utilization, substance use disorder services, and pharmaceutical services.
- Identify opportunities for additional analysis and recommend the development of initiatives to ensure appropriate utilization of physical health, mental health, substance use disorder, and pharmaceutical services.

- Recommend data driven initiatives that support appropriate utilization to the Health Services Management Council and conduct ongoing effectiveness evaluations of initiatives.
- Conduct ongoing evaluation of end-to-end prior authorization process, including appeal uphold rates and CMS overturn rates.
- Annually review prior authorization strategy, including competitor analysis, claims spend reporting, program performance, and health outcomes.
- Provide oversight of the review and implementation of regulatory changes impacting the prior authorization program.

Membership consists of:

Co-Chair: Director, Utilization Management
Analyst, Health Care
Associate Director, Care Coordination
Associate Director, Clinical Pharmacy
Director, Clinical Services
Director, Health Services Operations
Director, Mental Health, and Substance Use Disorder Services Operations
Director, Provider Relations and Contracting
Manager, Health Services Analytics
Manager, PRC Projects and Reporting
Manager, Utilization Management
Medical Director
Sr. Manager, Appeals and Grievances
Sr. Manager, Enterprise Analytics
Sr. Manager, Intake

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

Utilization Management Policy Review Committee

The Utilization Management Policy Review Committee annually reviews all utilization management policies and ensure they are consistent with Medicare's current national and local coverage decisions and guidelines. The committee reports to the Health Services Management Council. Responsibilities include:

- At least annually, review the policies and procedures for all utilization management (UM), including prior authorization, used by the Medicare Advantage (MA) plans. Such review must consider: the services to which the utilization management applies; coverage decisions and guidelines for traditional Medicare, including NCDs, LCDs, and laws; and relevant current clinical guidelines.
- Approve only utilization management policies and procedures that: use or impose coverage criteria that comply with Medicare requirements and standards; for prior authorization policies, comply with Medicare requirements and standards; and apply and rely on medical necessity criteria that comply with Medicare requirements.
- Revise the utilization management policies and procedures as necessary to comply with the standards in this regulation, including removing requirements for UM for services and items that no longer warrant UM.
- Clearly articulate and document processes to determine that the Medicare requirements have been met. This includes the determination by an objective party about whether disclosed financial interests are conflicts of interest and the management of any recusals due to such conflicts.
- Document in writing the reason for its decisions regarding the development of UM policies and make this documentation available to CMS upon request.

Membership consists of:

External voting members of the UCare QIACC. The UM committee will:

(1) Include a majority of members who are practicing physicians.
(2) Include at least one practicing physician who is independent and free of conflict relative to the MA organization and MA plan.
(3) Include at least one practicing physician who is an expert regarding care of elderly or disabled individuals.
(4) Include members representing various clinical specialties (for example, primary care, behavioral health) to ensure that a wide range of conditions are adequately considered in the development of the MA plan's utilization management policies.

Internal non-voting members:
EVP and Chief Medical Officer
Medical Directors
Director, Health Services Operations
Director, Utilization Management
Managers, Utilization Management
VP, Health Services Quality and Operations
VP, Pharmacy
VP, Senior Medical Director

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

Pharmacy and Therapeutics (P&T) Committee

The Pharmacy and Therapeutics 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.
- Review coverage of applicable medical devices that are administered through the pharmacy benefit (e.g., diabetic test strips and continuous glucose monitors).
- 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 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
6-10 External 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:
Clinical Pharmacist(s) – non-voting
Medical Director(s) – non-voting*
Sr. Manager, Clinical Pharmacy – non-voting
VP, Pharmacy– non-voting*
*Chair or Vice Chair will vote in the event of a tie.

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 will revise and maintain policies subject to review by the Utilization Management Policy Review Committee, which will annually review and approve the use of any policies for Medicare members as required by the 2024 CMS Final Rule. 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.
- Ensures that any policies applying to Medicare members do not limit coverage that is established through Medicare statutes, regulations, NCDs, or LCDs.
- 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.
- Ensures policies are written and formatted to be transparent to providers and members, including a summary of applicable evidence used in their development and the rationale for the coverage criteria adopted.
- The development of specific Benefit Design, Payment/Reimbursement Policy, Coverage Policies, Prior Authorization and Customer Service Instructions are outside of the scope of this committee.
- Clinical criteria for pharmaceuticals for both the pharmacy and medical benefit falls under P&T's scope.

Membership consists of:
EVP, Chief Medical Officer
EVP and Chief Legal Officer or Delegate

Medical Directors
Medical Director, Mental Health and Substance Use Disorder Services
VP, Clinical Services or Delegate
VP, Health Services Quality and Operations
VP, Mental Health and Substance Use Disorder Services or Delegate
Director, Utilization Management
Coverage Policy Program Manager
Associate Director, Clinical Pharmacy
Coding Analyst Lead
Coverage Policy Operations Lead
VP, Product Management
Enterprise Data and Provider Finance Director

Optional:
Physician Experts
Product Managers
Configuration Manager
Customer Services Director
VP, Chief Marketing and Digital Officer

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

Key Partners Collaborative

The intent of the Key Partners Collaborative 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, using 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 our members as they receive care by both medical and mental health and substance use disorder (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 Key Partners Collaborative 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 severe and persistent mental illness 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
Vice Chair: Director, Mental Health & Substance Use Disorder Services

External Members:
Advocacy Organization Leadership
CCBHC Organization Leadership
Community Family Practice Physician
Community Mental Health Center Leadership

Community Psychiatrist
Community Pediatric Nurse Practitioner
Community Psychiatric Nurse Practitioner
Community Psychologist
County Partner Representative(s)
Culturally Specific Organizational Leadership
Health Care System Mental Health Nurse Practitioner
Mental Health Clinic Leadership
MN DHS Managed Care Liaison
Provider, Child and Adolescent Organization
Provider, Substance Use Disorder
Specialty Treatment Provider Leadership

UCare Members:
Community and Provider Liaison, Mental Health & SUD
Government Relations Staff
Manager, County, Tribal and Public Health
Manager, Mental Health and SUD Operations
Manager, Mental Health and SUD Clinical
Manager, Provider Experience
Manager, Utilization Management
Medical Director, Mental Health and SUD
Principal, Provider Contracting
Product Staff
Specialist, Quality Improvement
Supervisor, Utilization Management Mental Health and SUD
SVP, Chief Medical Officer
VP, Chief Compliance and Ethics Officer
VP, Government Relations
VP, Provider Relations

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 equity and social factors impacting health. The Council provides executive review and guidance for the enterprise Population Health Management Program. The PHPC reports to the Quality Improvement Advisory and Credentialing Committee. Responsibilities include:

- Establish organizational goals for measuring the improved health and well-being of UCare members for each population health category Keeping Members Healthy, Emerging Risk, Chronic Condition Management, and Multiple Chronic Conditions.
- Oversee the data-driven annual assessment of the characteristics and needs of the member populations including an analysis of health equity and the relevant social factors impacting health.
- Oversee the development and recurring evaluation of evidence-based internal programs and services, community collaborations and recommendations for provider/vendor contracting to meet the identified needs of the member population and improve health outcomes.
- Oversee the segmentation and risk stratification of the enrolled population into meaningful subsets for program placement and targeted interventions.
- Review and make recommendations for the annual Population Health Strategy, Population Assessments, Population Health Impact Analysis, and Population Health Work Plan.
- Work in collaboration with Health Services Management Council and Quality Improvement Council to achieve the Quintuple Aim goals.

Membership consists of:

Chair: EVP, Chief Medical Officer
EVP, Chief Financial Officer
EVP, Chief Growth Officer
EVP, Public Affairs, Chief Strategy Officer
Director, Mental Health and Substance Use Disorder Services Operations
Director, Quality and Population Health
Manager, Population Health
Medical Director
Officer, Health Equity
Sr. Manager, Clinical Informaticist
Specialist, Population Health
VP, Care Coordination and LTSS
VP, Chief Customer Experience Officer
VP, Chief Informatics Officer
VP, Clinical Services
VP, Health Services Quality and Operations
VP, Provider Relations and Contracting

VP, Mental Health and Substance Use Disorder Services
VP, Pharmacy
VP, Product Management

Frequency of Meetings: The committee meets quarterly 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, address health disparities, and improve member experience.
- Reviews quality improvement activities to achieve objectives.
- Reviews organizational monitoring of accreditation and quality improvement activities including NCQA accreditation, surveys, audits, rates, and Health Plan 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 Quintuple Aim goals.

Membership consists of:

Chief Executive Officer
Co-Chair: VP, Chief Informatics Officer
Co-Chair: VP, Health Services Quality and Operations
Director, Quality and Population Health
Manager, Customer Experience
Manager, Stars Program
Manager, Quality Improvement
Medical Director(s)
EVP, Chief Administrative Officer
EVP, Chief Financial Officer
EVP, Chief Growth Officer
EVP, Chief Information Officer
EVP, Chief Legal Officer
EVP, Chief Medical Officer
EVP, Public Affairs and Chief Strategy Officer
VP, Billing and Enrollment
VP, Care Coordination and Long-Term Services and Supports
VP, Chief Compliance and Ethics Officer
VP, Chief Experience Officer
VP, Clinical Services
VP, Configuration and Claims Operations
VP, Customer Services
VP, Government Relations
VP, Mental Health and Substance Use Disorder Services
VP, Product Management
VP, Pharmacy
VP, Provider Relations and Contracting and Provider Services
VP, Senior Medical Director

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: VP, 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):
Assistant/Associate General Counsel
Director, Health Services Operations
Provider Relations and Contracting Representative
Specialist, Credentialing Delegation
Specialist, Credentialing Audit
Sr. Manager, Credentialing
VP, Health Services Quality and Operations

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

Quality Measures Improvement Committee (QMIC)

Identify areas of opportunity for performance improvement, adequate measurement, elimination of health care disparities, operational efficiency, and increased program integrity for all UCare products. To monitor UCare's quality performance in Star Ratings, NCQA Accreditation and Health Plan Ratings, Quality Rating System, Performance Improvement Projects (PIPs), DHS Withhold measures, dental access benchmark, population health program, stakeholder community engagement, 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 and the data sources used to report them.
- 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 and Health Plan Rating for all product lines.
- Annually develop a strategy to address DHS State contract requirements (e.g., Performance Improvement Projects (PIPs), withhold measures, dental access benchmark, population health strategy, DHS stakeholder community engagement initiative, 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.
- Oversees the activities of the QMIC Workgroups including Prevention, Emerging Risk, Enrollee Experience, Provider Quality, Appeals and Grievances, Call Center, Special Needs Plans, Hospitalizations, and Mental Health.
- Oversee the activities, initiatives, and priorities of the cross functional task force on Electronic Clinical Data Systems (ECDS) readiness to support HEDIS reporting.

Membership consists of:

Chair: Director, Quality and Population Health
Decision Making Body
VP, Care Coordination and LTSS
VP, Chief Informatics Officer
VP, Clinical Services
VP, Customer Service
VP, Health Services Quality and Operations
VP, Mental Health and Substance Use Disorder Services
VP, Pharmacy
VP, Provider Relations and Contracting
VP, Product Management
QMIC Members
Associate Director, Marketing
Specialist, Customer Experience
Director, Clinical Services
Director, Health Services Operations
Director, Mental Health & Substance Use Operations
Manager, Account Services– Aspirus
Manager, Clinical Informaticist Senior
Manager, Customer Experience
Manager, Customer Service Workforce
Manager, Disease Management
Manager, Federal Government Relations
Manager, Health Improvement
Manager, Health Promotion
Manager, HEDIS
Manager, Market
Manager, Population Health
Manager, Product Manager
Manager, Project
Manager, Quality Improvement
Manager, Stars Program
Medical Directors
Officer, Health Equity
Specialist, Quality Improvement
Sr. Manager, Customer Service Support
Sr. Manager, Member Services
Sr. Manager, Pharmacy Quality
Sr. Manager, Quality Analytics
VP, Chief Customer Experience Officer
VP, Sales
VP, Senior Medical Director

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

Health Equity Committee

The purpose of the UCare Health Equity Committee is to establish and lead organizational health equity priorities, goals, and metrics to guide UCare towards advancing health equity for the members and communities we serve. Specific committee responsibilities include:

- Formalize institutional vision for and accountability to health equity at UCare including UCare products, initiatives, policies, and procedures.
- Develop an annual work plan and ensure sufficient support for organizational and department level success in achieving health equity goals.
- Facilitate collaboration across and within departments to maximize opportunities to prioritize and advance health equity priorities.
- Evaluate and report the progress in addressing health inequities and closing disparities of health outcomes in the annual quality documents.
- Establish format, process, and accountability for departments to use the Health Equity Assessment to identify and address equity opportunities, define metrics, and develop an action plan to reduce barriers to equity.
- Share lessons learned internally and externally to reflect and refine the vision for health equity.

Membership consists of:

Chair: Officer, Health Equity
EVP, Chief Growth Officer
Associate Director, Marketing
Director, Quality and Population Health
EVP, Chief Strategy Officer
Manager, County, Tribal & Public Health
Manager, Health Services Analytics
Manager, HEDIS
Manager, Population Health
Manager, Provider Relations and Contracting
Sr. Manager, Community Relations
VP, Billing and Enrollment
VP, Business Development
VP, Chief Customer Experience Officer

VP, Chief Human Resources Officer
VP, Chief Informatics Officer
VP, Chief Marketing & Digital Officer
VP, Clinical Services
VP, Configurations and Claims Operations
VP, Customer Service
VP, Government Relations
VP, Health Services Quality and Operations
VP, Mental Health and Substance Use Disorders
VP, Pharmacy
VP, Product Management
VP, Provider Relations and Contracting

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)
Current Medicare Members (22 members)
Current Disability Members (14 members)
Communications Lead, Marketing
Sr. Manager, Community Outreach
Manager, Customer Experience
Manager, Product - State Public Programs
Specialist, Specialist

Frequency of Meetings: The State Public Program, Medicare, and Disability committees meet three times per year and the Minnesota Senior Health Options and Individual and Family Plan meet on an ad hoc basis 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, Health Services Quality and Operations, and Health Services Quality and Operations staff hold primary responsibility for UCare's Quality Program. The EVP, CMO 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 EVP, CMO 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 other Medical Directors and staff in Clinical Services, Health Services Quality and Operations, Mental Health and Substance Use Disorder Services, Pharmacy, and Care Coordination and Long Term Services and Supports.

The EVP, CMO 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 Health Services Quality and Operations

The Vice President (VP) of Health Services Quality and Operations is a member of UCare's leadership team, reporting to the EVP, CMO. The primary objective of this position is to provide strategic direction and oversight for UCare's Health Services Quality and Operations 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 Disease Management Program, Star Ratings Programs, and NCQA Accreditation. This position also ensures achievement of operational goals for Credentialing, Appeals and Grievances, Health Services Analytics, and Utilization Management.

Health Services Quality and Operations Department

The Health Services Quality and Operations department includes Appeals and Grievances, Credentialing, Population Health, Quality Improvement, NCQA Accreditation, Health Improvement, HEDIS chart retrieval and abstraction, Stars Ratings, Clinical Informatics, Disease Management, Health Equity, and Utilization 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 by UCare.

Health Services Quality and Operations Department	
A&G (Appeals and Grievances)	The A&G team receives, processes and resolves all appeals and grievances from members or member representatives. This team also facilitates Quality of Care.
Clinical Informatics	The Clinical Informatics team oversees the clinical documentation system, health services data and technology strategies, as well as supports teams across the organization in designing, developing business processes, systems, and reporting tools.

Credentialing	The Credentialing team processes practitioner's/provider's credentialing and recredentialing, manages data in the credentialing database, and conducts delegation oversight.
Disease Management	The Disease Management team develops, implements, and evaluates disease management programs and initiatives focused on prevention, early identification, and intervention in the chronic disease process.
Health Equity	The Health Equity team facilitates the data collection, tracking and reporting of health outcomes; collaborates with internal and external stakeholders to co-develop, implement and evaluate targeted community partnerships; equips UCare leaders with knowledge of health disparities, health equity and community health and evaluates and monitors progress toward organizational health equity goals.
Health Improvement	The Health Improvement team conducts culturally congruent member outreach to educate members on preventive care, access to care, and benefits. The team also supports cross function health education materials for our members including IVR calls, mailings, and emails, etc. The team is also present at UCare community events to engage with our members.
HEDIS (Health Effectiveness Data and Information Set)	The HEDIS teams supports the facilitation of data collection, tracking and reporting for all hybrid measures. The HEDIS team develops and implements initiatives that enhance the organization's medical record review functionality for HEDIS hybrid measures and other quality-related needs.
QI (Quality Improvement)	The QI team designs, develops, implements, and evaluates evidence-based health improvement programs and member experience initiatives as they relate to UCare's strategic initiatives and annual quality plan. The QI team also facilitates National Committee for Quality Assurance (NCQA) accreditation for the organization and ensures compliance with these standards.
Population Health	The Population Health team develops and maintains the population health strategy, population assessments, and supports an inventory and evaluation of programs to support the needs of our members.
Stars Program	The Stars team designs, develops, implements, and evaluates 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.
Project Administration	This team supports an equitable, standardized, focused, and specialized approach to the collective Health Services Departments. The team will eliminate duplication of work, maximize efficiencies, and minimize differences amongst team resources, and build synergy as we support growth/expansion. The centralized teams include project management, training & development, administrative functions, and vendor management to support HQO, CLS, MSS, CCL, Pharmacy, and the Medical Directors.

Utilization Management	The Utilization Management team implements an evidence-based utilization management program and evaluates and monitors the use of non-behavioral health and behavioral health care services to assess their appropriateness and quality.

Health Services Operations Director

The Health Services Operations Director reports to the Vice President of Health Services Quality and Operations and is responsible for the oversight of operational processes related to Credentialing, Appeals and Grievances (A&G) and Project Administration, 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. In addition, this position providers leadership for the project administration team, including training, vendor management, and special projects.

Quality and Population Health Director

The Quality and Population Health Director reports to the Vice President of Health Services Quality and Operations and is responsible for the development, management and accountability of quality improvement initiatives within the department in support of the organizational Quality and Population Health 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 and Population Health teams, ensuring timeliness of overall quality initiatives, and managing regulated quality and population health requirements. This position providers oversight of the Star Ratings Programs, NCQA accreditation, HEDIS chart retrieval data, and member engagement activities through the Health Improvement Team.

Health Equity Officer

The Health Equity Officer reports to the Vice President of Health Services Quality and Operations. The Health Equity Officer develops and leads the planning, development, and implementation of UCare's health equity program and work plan that promotes and advances health equity for the members and communities we serve. Key responsibilities include partnering with UCare and community leaders to review population and community data sources, defining health equity priorities and outcomes, developing health equity initiatives, and evaluating progress towards organizational health equity goals. Additionally, the Health Equity Officer works closely with the UCare Foundation to support the design, implementation and evaluation of health equity grant funding strategies.

Clinical Informatics Senior Manager

The Clinical Informatics Senior Manager reports to the Vice President of Health Services Quality and Operations and is responsible for product managing 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 and technology strategies. This position is also 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. This position also oversees the development of analyses and reports to support quality and population health efforts.

Disease Management Manager

The Disease Management Manager reports to the Vice President of Health Services Quality and Operations and is responsible for managing UCare's disease management programs and ensuring alignment with overall population health management strategies. This role is accountable for the development, implementation, and evaluation of

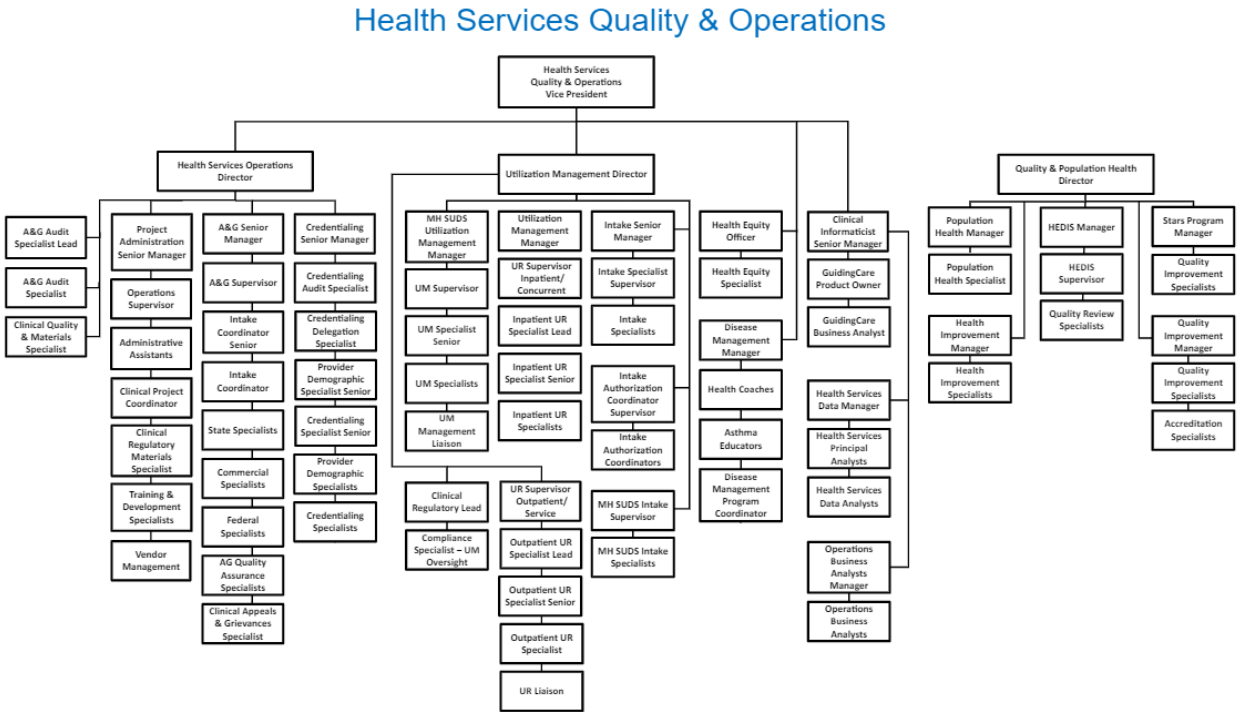
disease management programs and initiatives for all UCare products. This includes ensuring state and federal mandates for disease management programs are in compliance with UCare's contractual obligations.

Utilization Management Director

The Utilization Management Director reports to the Vice President of Health Services Quality and Operations and is responsible for the oversight of operational processes related to Utilization Management for both clinical and mental health and substance use disorder services, which includes creating optimal performance, quality assurance, and efficiencies. This position is responsible for ensuring that Utilization Management meets all regulatory and accreditation requirements based on legislative mandates and UCare's strategic direction.

Health Services Operations and Quality Department Staff

The Health Services Operations and Quality 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 and populations health programs. Health Services Operations and Quality staff work with improvement teams and committees to ensure that quality improvement activities are executed. The majority of the Quality Improvement staff have at least masters-level education and extensive experience in quality.



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, Care Coordination and Long-Term Services and Supports and staff
VP, Chief Compliance and Ethics Officer and staff
VP, Chief Experience Officer
VP, Clinical Services and staff
VP, Customer Service and staff

- VP, Equity and Inclusion and staff
- VP, Chief Informatics Officer and staff
- VP, Government Relations and staff
- VP, Marketing and Digital Officer and staff
- VP, Mental Health and Substance Use Disorder Services
- VP, Pharmacy and staff
- VP, Product Development and staff
- VP, Provider Relations and Contracting and Provider Services and staff

Vice President and Senior Medical Director

The Vice President and Senior Medical Director is a member of UCare's leadership team, reporting to the EVP, Chief Medical Officer. This position is responsible for leadership of the Medical Directors and Coverage Policy teams. Responsibilities include day-to-day medical management and leading ongoing improvement in collaboration with Chief Medical Officer and others in Health Services. This position provides support and consultation for utilization management, appeals, medical policy, quality improvement (e.g., Medicare Stars, National Committee for Quality Assurance), claims and coding, and other non-clinical UCare departments. This position is responsible for ensuring that UCare members receive care that is safe, timely, effective, efficient, patient-centered, and equitable. This position leads aspects of regulatory compliance that relate to clinical functions and programs. In addition, this position provides clinical support to staff throughout UCare including complex case management, disease management vendors and delegates.

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, NCQA). 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 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.

Vice President of Care Coordination and Long-Term Services and Supports

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 for the strategic direction and oversight of the care coordination and long-term service and supports (LTSS) department. This includes strategic planning, clinical and operational efficiency, budgeting, and fiscal management. Provide leadership and vision to ensure appropriate execution of Special Needs Plans (SNP) and member centric care coordination programs that adhere to contractual and regulatory requirements of Federal, State and accreditation agencies. Ensure achievement of operational goals, program outcomes, contract measures, service delivery within budget, and compliance of regulatory requirements. Provide leadership for internal and external delegated business activities and initiatives, oversee operational interfaces, and facilitate cross-departmental initiatives involving care coordination delegation activities. Develop innovative clinical care models and partnerships while leading quality improvements for the department.

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 quality improvement activities are integrated into the Quality 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 activities are integrated into the annual Quality Program Description, Quality Program Evaluation, and Quality Program Work Plan.

Medical Director, Mental Health and Substance Use Disorders Services

The Medical Director of Mental Health and Substance Use Disorder Services (MSS) is responsible in collaboration with EVP, Chief Medical Officer (CMO), VP, Senior Medical Director, VP, Mental Health and Substance Use Disorder Services, 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 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.

Director, Mental Health and Substance Use Disorders Services

The Director of Mental Health and Substance Use Disorder Services (MSS) is responsible to oversee MSS. 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 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 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. At the end of 2023, UCare transitioned the Utilization Management team,

including clinical services and mental health and substance use disorder services, to the Health Services Quality and Operations Department (previously Quality and Population Health Department) to further medical management and health care quality goals. As part of this change, a new team was developed to focus on special projects, vendor management, staff training, and development led by the Project Administration Senior Manager. Additional support was also added to the Health Services Quality and Operations Department related to data and operational analytics. The Population Health Management team was transitioned under the Quality and Population Health team (previously Quality Improvement team) to support better alignment and further population health and quality goals. New positions were added to the Quality and Population Health team beginning in 2024 including an Electronic Clinical Data Project Lead and a Health Improvement Specialist Team Lead.

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 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)/Targeted Case Management (TCM), 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)/Targeted Case Management (TCM), Community Dental Care, Adult Day Centers, African Babies Coalition, Hennepin Health care (doula and social work), Steps of Strategy, Route 1 MN
- Hispanic: St. Mary's Clinic, Children's Health Network (CHW), Certified Community Behavioral Health Clinic (CCBHC)/Behavioral Health Homes (BHH)/Targeted Case Management (TCM), Community Dental Care, CLUES, Communities Organizing Latino Power and Action, Bountiful Basket
- Native American: Reimaging Indigenous Leadership, Mewinzha Ondaadiziike Wilgaming

Other notable community partnerships include Islamic Civic Society, Somali Community Resettlement Services, Pathways Community Hub, and Everly Health.

UCare engages internal staff (i.e., Health Improvement Specialists – Somali, Hmong, Hispanic, 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.

In addition, UCare internal staff from across the organization meet bi-weekly to engage in a workgroup designed to gather, discuss, and apply feedback from the community to improve member health outcomes. This work began in response to DHS contract requirements in 2023 but has evolved into a permanent workgroup called Community Voices. The work of Community Voices will continue to focus on lifting the voices of community and embedding them into the work that we do to increase our ability to serve our members and meet their unique needs.
Our active partnerships with diverse populations help 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 that support members with special health care needs. We work with members across the continuum of care by designing programs to keep members healthy, support members with emerging health risks, and manage care of members with chronic conditions and complex health needs. By working with members across the continuum of care, we are positioned to quickly identify and support members with complex health and chronic 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.

In addition to our focus on clinical excellence and managing care, UCare puts supports in place to address members' social determinants of health (SDOH). Strategies for member identification and engagement are informed by UCare's population health reporting which includes, but is not limited to, analysis of health outcomes and trends by race, language, ethnicity, age, geography, and disability. UCare recognizes that poor health and adverse outcomes are often a result of complex social and medical factors, and we design person-centered interventions to meet our members' needs. Community health workers are part of UCare's care delivery model and UCare achieves strong internal and external collaboration to provide members with resources like culturally aligned mental health and substance use disorder resources, wellness incentives, and care management assessments that are specifically designed to address SDOH needs. Interventions like these help our members succeed in their communities.

Recognizing the unique challenges members with special health care needs face, UCare uses a holistic approach to managing the care of these members. We incorporate population health data at all levels of program design and implementation, work to improve outcomes across care settings by leveraging strong relationships with providers, and empower our teams to support members in a deeply caring and person-centered way.

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 and disparities.

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. Separately, UCare has a segmentation model that places members into segments based on clinical complexity.

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.

The segmentation model is designed to group members based on medical complexity in order to help determine what level of programming may be most appropriate for the member. Segmentation classifies members into a four-level hierarchy based on their mix of chronic conditions (Very High Condition Impact, High Condition Impact, Moderate Condition Impact and Low Condition Impact). The segmentation algorithm looks at members' mix of chronic conditions during the preceding twelve months and weighs the number of conditions, the severity of conditions, and the number of different body systems and/or categories affected. As a rule of thumb members classified as Very High Condition Impact typically have high impact conditions in three or more different major categories and would be more appropriate for complex case management and members classified as High Condition Impact typically have a single high impact condition or a combination of many moderate impact conditions and may be better suited for disease management programs.

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 and multiple 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 in accessing care and monitors their care plan to support improved outcomes. 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, MSC+, Advocate Choice, Advocate Plus, Connect, and Connect+Medicare members to have special health care needs and assigns them a care coordinator for ongoing support.

Health plans within the service area may offer Special Needs Plans (MSHO, Connect+ Medicare Advocate Choice and Advocate Plus) based on the CMS requirements for the Special Needs Plan's Model of Care. The Model of Care 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 eighteen 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.
- Hospital readmissions within 14 days for same or similar conditions.
- Individual members whose claims reach $100,000 at any point during the calendar year.
- Home Care utilization for one occurrence of any of these codes: X5284, T1030, T1000, or T1031 on a service line.

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.
- Hospital readmissions within 14 days for same or similar conditions.
- 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, sexual orientation and gender identity, psychosocial, cognitive, functional, and mental health needs. The HRAs enable UCare to identify a member's unique needs and connect them to appropriate programs and support 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 members 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.

Long-Term Services and Supports

Long-Term Services and Supports (LTSS) are the services and supports provided to members who have functional limitations and/or chronic conditions that have the primary purpose of supporting the opportunity to achieve person-centered goals and supporting the ability of members to live or work in the setting of their choice.

Care coordinators are assigned to members with the purpose and goal of improving health care outcomes. Care coordinators work with members in a variety of ways to identify and implement an appropriate and person-centered support plan. LTSS needs are identified through completion of a Health Risk Assessments (HRA). Care coordinators work as a part of an interdisciplinary care team (ICT) and support members experiencing transitions of care.

A description of the services and functions provided are described below:

Health Risk Assessment
The HRA provides the care coordinator the ability to gather pertinent information related to all member's medical, functional, cognitive, social drivers of health, psychosocial and mental health needs. The HRA provides insight into how well the member feels they are managing their health, if they have the support they need to manage their overall health, and if there are concerns the member has which they are seeking assistance with such as LTSS. Care coordinators engage members and caregivers (as appropriate) in the assessment process to ensure that the member's health care needs are appropriately documented. Appropriate identification of risk to the member is one of the critically important success factors in achieving optimal clinical outcomes and is the foundation of a sound care coordination program. Conducting the health risk assessment is the first step in the process to identify the comprehensive needs and potential LTSS services that may be beneficial to the member.

The information gathered through the HRA is used to identify gaps and to identify formal and informal social supports to assist members in maintaining independence at the highest possible level.

Support Plan

The HRA identifies the member's health care needs, and the support plan helps identify member generated goals used to solve for the needs from the assessment. The Support Plan contains many critical elements in addressing the member's care and health needs. The care coordinator discusses at length the goals of the member and the services that will allow the member to meet their needs in the setting of their choice. The care coordinator is also careful to offer the member choice in services and service provider.

Examples of LTSS services that members may choose to receive include, but are not limited to home making, home health aide, adult day care services, transportation, home delivered meals, personal emergency response system, companion services, individual community living support and consumer directed community supports (CDCS).

UCare requires care coordinators to use an approved care plan template to document the individualized care plan for each member. This ensures all required LTSS care plan elements are met. UCare conducts an annual care plan audit to ensure compliance with completing all required documents. Oversight of care plans helps to ensure that all member's needs are addressed and documented. The care plan is then used to assist in communication between ICT members to coordinate care. Identified needs on the Support Plan are discussed and prioritized with the member and sent to the care team. The care coordinator works to set up services to address the identified needs using the most appropriate services including LTSS.

Interdisciplinary Care Team

UCare defines the Interdisciplinary Care team (ICT) as a team of people involved with a member to coordinate and provide health care services. At a minimum, the ICT includes the care coordinator, the member and/or member's family/authorized representative, caregiver (as applicable), and the PCP. ICT members may also include other health and LTSS service providers as needed, as long as they are involved in the member's care for current health problems. Members may also request another family member, friend, or spiritual advisor to be part of the ICT.

Members of the ICT are determined as those providers and/or individuals involved in the member's care, based on needs and goals identified in the HRA and ICP. These may include but are not limited to specialty care providers, social workers, mental health providers, nursing facility or group home staff, and others performing a variety of specialized functions designed to meet the member's physical, emotional, and psychological needs.

Care coordinators assume the responsibility as the leader of the ICT and serve as the liaison of the ICT with all other identified ICT members. The care coordinator along with the member/caregiver(s) determines who should participate in the ICT after conducting an assessment and during the support plan development process. The care coordinator discusses with the member/caregiver what the ICT's function is and recommended services and supports that are indicated by the results of the HRA. With input from the care coordinator, the member/caregiver determines who would be best suited to be part of the ICT. The care coordinator, drawing on information gathered in the HRA and support plan process, assesses who would be best to participate on the ICT based on identified needs such as, medical, psychosocial, functional, cognitive, mental health, substance use and social service, as well as prioritized goals and member requests obtained from the HRA and support plan.

Transitions of Care

Care coordinators remain involved in the member's care across care settings to assure continuity of care. The goal of our care coordination approach is to engage, collaborate, and support UCare members through each transition to prevent unplanned or unnecessary readmissions, emergency department (ED) visits, and adverse outcomes. Our assigned care coordinators facilitate safe transitions from one setting to another, supporting the member from the moment we are notified of an admission through the entire transition process, including transfers between institutional to community settings. Care coordinators collaborate with the members, their family, the facility, service providers, and others on the member's interdisciplinary care team. This collaboration allows the care

coordinator to thoroughly assess the member's needs and coordinate services to facilitate effective transitions of 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 sixty 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 Microsoft SQL Server Management Studio, SAS, Azure Data Studio, Visual Studio Code to perform analytics and reporting functions. Additional analytic tools used to enhance analytical capabilities and allow for flexibility in analyzing data include Business Objects™, Python ™, 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. UCare is using Python ™ to automate SQL code and export it to Excel sheets for reporting, and statistical analysis. Potential use cases include forecasting, gaps closures or annual quality ratings (Stars, QRS, Medicaid). Tableau ™ allows connection to data and visualization using a combination of dashboard views to get richer insight.

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 strata. The Data Center of Excellence (CoE) is a cross-functional team (HCE & IT) designed to support the ongoing 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 (Health Care 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. r Press Ganey is the vendor used to conduct standard surveys and analyses for CAHPS (Consumer Assessment of Health Care 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 and report results of project improvement plans to DHS.
- Measure rates and look at patterns of utilization.
- Quantify gaps in care using equity-focused quality measurements to help narrow or eliminate racial, ethnic, and other social determinants of health (SDOH) 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 used to measure and track 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's current and 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 Health Care 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 social connector 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 health care journey, powering effective risk identification, member engagement, and health management.

Social connector leverages consumer data 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 health care-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. Social Connector is a HIPAA compliant, web-based platform that surfaces the insights from the underlying data and predictive modeling. Licensed users can securely access the interactive dashboards through most web browsers and use the dashboards to uncover insights, inform program strategy, and plan targeted outreach.

Systems for Communication

Effective communication of Quality Program activities is achieved through systematic reporting to the appropriate committees and the utilization of a variety of mechanisms, as outlined below:

- Regular reporting of quality improvement activities to the Quality Measures Improvement Committee, the Quality Improvement Council, the Quality Improvement Advisory and Credentialing Committee, and other relevant committees or workgroups.
- Providers are kept informed through multiple channels, including the Provider Manual, Provider Portal, newsletters, oversight meetings, site visits, contracts, direct correspondence and feedback, and electronic communication.
- Members receive information 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, All Employee Meetings, 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.
- Monitoring 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 that address the areas of focus outlined in the Home and Community-based (HCBS) Quality Framework. These areas include 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 various approaches taken to enhance the quality of care and services provided by UCare. These include:

Population Health:

- Refining our data-driven Population Health Management program to identify members' needs, develop programs, and identify resources to support each member in improving their health. Data will be reviewed and identified by the top three trends for cost, utilization, quality and SDoH for each product to better develop tailored initiatives and programs.
- Enhancing the impact of Disease and Care Management programs, with a focus on prevention, early identification, and intervention in the chronic disease management.
- Improving population health assessments through the integration of new data sources as they become available, conducting deeper analysis of sub-populations to identify and address barriers to care, and providing more meaningful information for better data connections and interpretations.
- Implementing multi-pronged and integrated approach that includes segmentation, stratification, and predictive analysis to create meaningful and actionable insights that drive program design, measurement, evaluation, and innovation.

Health Equity:

- Utilizing the Health Equity Improvement Plan (HEIP) tool to assess health equity efforts to improve member health outcomes and measure progress towards health and racial equity efforts at UCare.
- Identifying, implementing and measuring effectiveness of health equity strategies aimed at reducing health disparities in key clinical metrics related to prevention, chronic disease management, prior authorization, and utilization.
- Identifying, implementing and measuring effectiveness of strategies to improve culturally and linguistically appropriate services (CLAS).
- Collaborating with internal and external stakeholders that mirror UCare's diverse membership in data collection, analysis and reporting efforts to gain a better understanding of social needs and barriers to care for UCare members.
- Engaging in community (e.g., focus groups, community events, member advisory groups, surveys, interviews, etc.) to gather feedback, gain insights into health care needs within diverse populations, and implement feedback to improve UCare programs, policies and services
- Partnering with the Public Affairs team to identify legislative bills that have positive, neutral, or negative impact on UCare members' health and health outcomes.
- Reviewing population health and community health needs assessments to align clinical and community health priorities.

Access:

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

Quality of Care and Patient Safety:

- Establishing plans and policies to address quality, including the development of strategic plan goals, the annual Quality Work Plan, and the Credentialing Plan.
- Monitoring compliance with policies, standards, and clinical practice guidelines, including activities such as 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 raised by members, providers, and regulators.

- Identifying recurring patterns of problems or areas of concern by analyzing trends and patterns from various data sources 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, DHS withholds, 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 expected to have a beneficial effect on health outcomes and enrollee satisfaction. This includes a focus on significant aspects of clinical care and non-clinical services, assessing performance under the plan using quality indicators, and ongoing performance assessment based on systematic collection and analysis of valid and reliable data, with a focus on achieving demonstrable improvement and reporting 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 taking appropriate actions.
- Ensuring compliance with all NCQA Health Plan Accreditation and Health Equity Accreditation requirements.

Delegation of Quality Management Functions

UCare does not currently 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 actively engages in collaborative quality improvement activities across various health care sectors, including primary care providers, the Department of Human Services (DHS), and other managed care organizations. UCare identifies opportunities for improvement based on a range of data sources, including Health Care Effectiveness Data and Information Set (HEDIS), Star Ratings, Quality Rating System (QRS), NCQA Health Plan Ratings, Consumer Assessment of Health Care 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 initiatives.

UCare's collaboration with primary care providers in the community includes measures such as HEDIS, Stars, QRS, CAHPS, ECHO, HOS, and HRQoL measures. This collaboration focuses on activities such as providing action lists for addressing care gaps, as well as education and training to improve measures and health outcomes for members. UCare's work with other managed care organizations involves designing and developing interventions for Performance Improvement Projects (PIPs) and internal quality projects. UCare also works with the state to enhance withhold measures for improved health outcomes. UCare reports to internal QI committees, including QIACC, QIC and QMIC, as necessary, regarding collaborative activities.

Annual Quality Work Plan

The Quality Work Plan outlines the quality improvement activities UCare will undertake in the upcoming year. This 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, the evolving health care landscape, and regulatory requirements. The Work Plan serves as 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 the goals identified in the work plan throughout the year, including goals related to CLAS. QIACC delegates key oversight activities to Health Services Management Council, Population Health Program Council, Quality Improvement Council, and their related sub-committees, as indicated in the Work Plan. Committees and Councils meet at the frequency established in the charters to provide updates on key activities and collaborate on solutions to address 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 for each activity to be achieved
- Staff member responsible for each activity
- Monitoring of 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 received by UCare members. Additionally, 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