2025 Quality Program Description

03/11/2025: Approved by the Quality Improvement Council
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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 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 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. 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	
State Public Programs	Prepaid Medical Assistance Program (PMAP)
	Minnesota Senior Care Plus (MSC+)
	UCare Connect Special Needs BasicCare (Connect)
	MinnesotaCare (MnCare)
	UCare's Minnesota Senior Health Options (MSHO)
	UCare Connect + Medicare
Medicare	UCare Medicare Advantage
	Medicare Supplement Plans
	Institutional Special Needs Plans (I-SNPs)
Partner Products	EssentiaCare
	UCare Medicare with M Health Fairview & North Memorial Health*
Marketplace and Direct from UCare (Off-exchange)	UCare Individual and Family Plans (IFP)
	UCare Individual and Family Plans with M Health Fairview

*UCare Medicare with M Health Fairview & North Memorial Health plans closed the end of 2024

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 care needs of members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, are met. UCare is committed to eliminating health inequities, 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

UCare's Quality Program focuses on achieving the quintuple aim through a population health management approach, with an emphasis on advancing health equity and reducing health disparities. Activities conducted to achieve these goals are described in the Quality Improvement Activities section.

Enhancing the Care Experience: *Demonstrate organization-wide commitment to improving the quality of care and member satisfaction by ensuring a high-quality and accessible provider network, resolving concerns raised by members, and building strong partnerships with providers.*

- Exceed national and state averages for measures within Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Qualified Health Plan (QHP) Enrollee Experience Survey, focusing on measures including access to care, health care quality, care coordination, and filling prescription drugs.
- Maintain and improve member experience through Medicare and Individual and Family Plan (IFP) Star Ratings and NCQA Health Plan Ratings:
    - Improve performance in Rating of Health Plan and Rating of Drug Plan by a statistically significant amount for Medicare Advantage and SNP members.
    - Maintain a 5 Star Rating for Enrollee Experience category for the QRS Star Ratings program for Exchange.
    - Maintain a rating of 4.5 in the Patient Experience category for the NCQA Health Plan Rating programs for Medical Assistance (Medicaid).

Reducing Costs: *Ensure medical, mental health, and substance us disorder services are delivered at an appropriate and medically necessary level of care in a timely, effective, and efficient manner through implementation of an effective utilization management program and population health management programs.*

- Increase completion of preventive care services to promote early detection and proactively manage health conditions to reduce emergency room visits, inpatient stays, and hospital readmissions.

Improving Population Health: *Improve overall health and wellness for UCare members by implementing a data-driven Population Health Management program to identify members' needs, develop and evaluate tailored initiatives and programs, and identify resources to support each member in improving their health.*

- Increase the percentage of members who experience the greatest disparities in care that receive at least one wellness visit during the year from 21.1% to 21.7% by supporting members to get in for care.
- Maintain and improve member health through Medicare and Individual and Family Plan (IFP) Star Ratings and NCQA Health Plan Ratings:
    - Have at least 80% of UCare Medicare Advantage and SNP members in a plan that has a CMS Star rating of 4 or higher.
    - Maintain a 4 Star Rating for Exchange products for the QRS Star Ratings program.
    - Maintain a rating of 4 for Medical Assistance for the NCQA Health Plan Rating program.

Advancing Health Equity: *Advance health equity among UCare members by identifying, implementing, and measuring health equity strategies aimed at reducing health disparities and improving culturally and linguistically appropriate services.*

- Identify and decrease health care disparities where disparities are present for key metrics for the organization, including but not limited to Prenatal and Postpartum Care, Follow-up after Hospitalization for Mental Illness, Adult Wellness Visits, and Well Child Visits for PMAP and MnCare populations:
    - <u>Timeliness of Prenatal Care (PPC):</u>
        - Achieve a statistically significant improvement in Timeliness of Prenatal Care for Indigenous population from 52.07% to 69.96%.
    - <u>Postpartum Care (PPC):</u>
        - Achieve a statistically significant improvement in Timeliness of Prenatal Care for Indigenous population from 51.24% to 69.20%.
        - Achieve a statistically significant improvement in Timeliness of Prenatal Care for Black population from 52.28% to 56.08%.
        - Achieve a statistically significant improvement in Timeliness of Postpartum Care for Asian population from 49.90% to 56.06%.
    - <u>Follow-up after Hospitalization for Mental Illness (FUH) – 30 days</u>
        - Achieve a statistically significant improvement in Follow-up after Hospitalization for Mental Illness (FUH) – 30 days for Black population from 56.27% to 64.66%.
        - Achieve a statistically significant improvement in Follow-up after Hospitalization for Mental Illness (FUH) – 30 days for Asian population from 62.63% to 80.91%.

        - Achieve a statistically significant improvement in Follow-up after Hospitalization for Mental Illness (FUH) – 30 days for Indigenous population from 62.50% to 80.40%.
    - Adult Wellness Visit (AWV)
        - Achieve a statistically significant improvement in Adult Wellness Visit (AWV) for Indigenous population from 12.47% to 14.75%.
        - Achieve a statistically significant improvement in Adult Wellness Visit (AWV) for Asian population from 21.47% to 22.55%.
    - Well Child Visit (WCV)
        - Achieve a statistically significant improvement in Well Child Visit (WCV) for Indigenous population from 39.14% to 42.97%.
        - Achieve a statistically significant improvement in Well Child Visit (WCV) for Pacific Islander from 46.38% to 60.32%.
        - Achieve a statistically significant improvement in Well Child Visit (WCV) for Asian population from 47.09% to 48.46%.
- Achieve a goal of 90% of members reporting satisfaction with language services by providing high quality language services to members with limited English proficiency during encounters with UCare staff and during health care encounters.
- Achieve a goal of 80% of CAHPS survey respondents responding that they received health care services in a language they can understand (current rate 72.8%) and that they felt health care staff were sensitive to their cultural needs by enhancing the ability of our provider network to meet members' needs and preferences (current rate 71.5%).

Care Team Well-Being: *Improve provider satisfaction and care team well-being by streamlining heath plan processes, supporting care teams through member engagement activities and health education, and providing supportive resources and training.*

- Engage 3,500 practitioners in Violet Health cultural competency training opportunities to support care teams in providing culturally congruent care.
- Achieve 5 stars or identified NCQA percentile benchmarks for provider groups in a value-based agreements, demonstrating UCare's partnership with providers in supporting holistic care for members.

Regulatory: *Exceed compliance with local, state, and federal regulatory requirements, and accreditation standards demonstrating UCare's commitment to the highest quality of care and service.*

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

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.

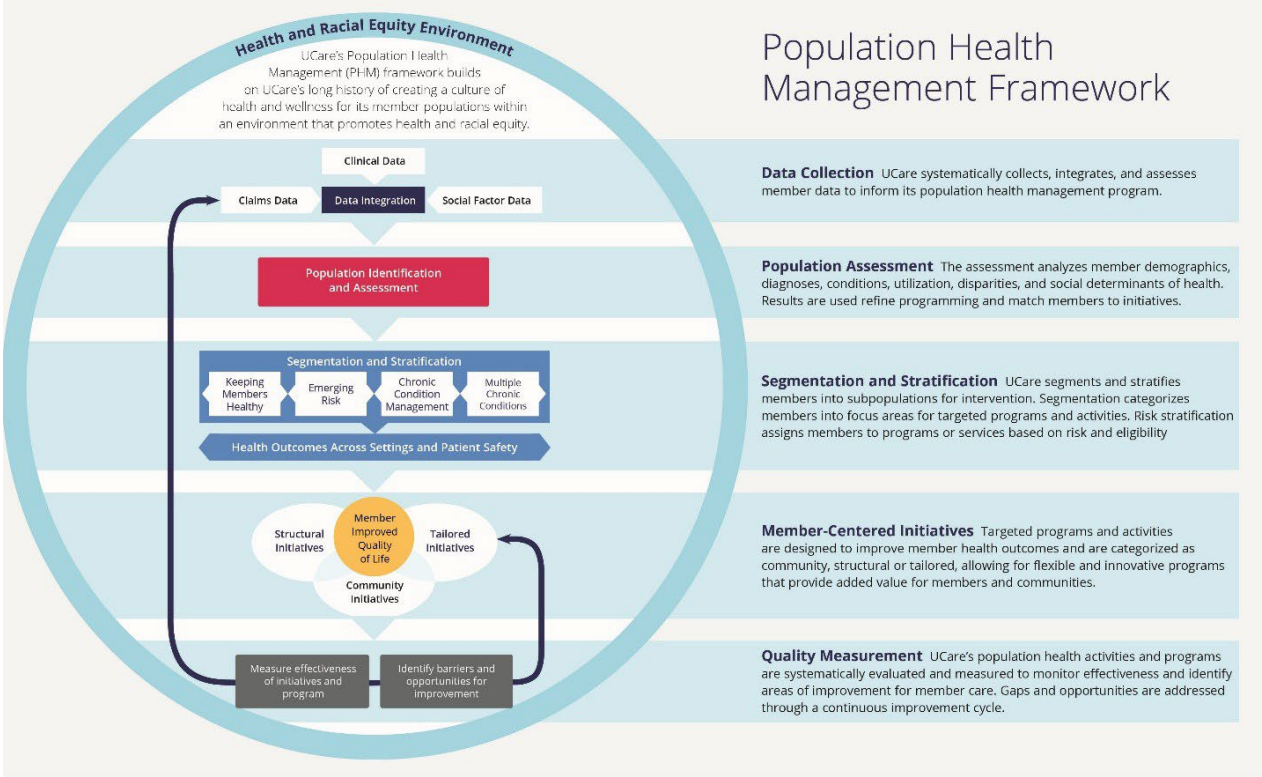
Population Health Strategy and Structure

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 outlines our population health activities that are designed to 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 provides a framework for continuous improvement 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 equity.

PHM program activities are coordinated by the Population Health team who is responsible for providing oversight, direction and support for the design, and implementation of PHM activities across the organization. Data and information flow between areas is critical to achieve program objectives which involves dedicated support from teams across the enterprise.

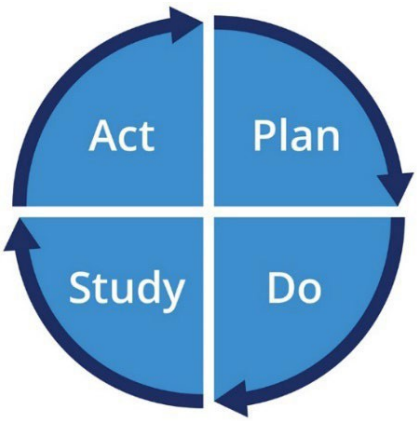
UCare's 2024 Quality Program Evaluation is organized within this framework, with quality improvement initiatives segmented in the following categories: Structural Interventions, Community Resources, and Tailored Initiatives.



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:



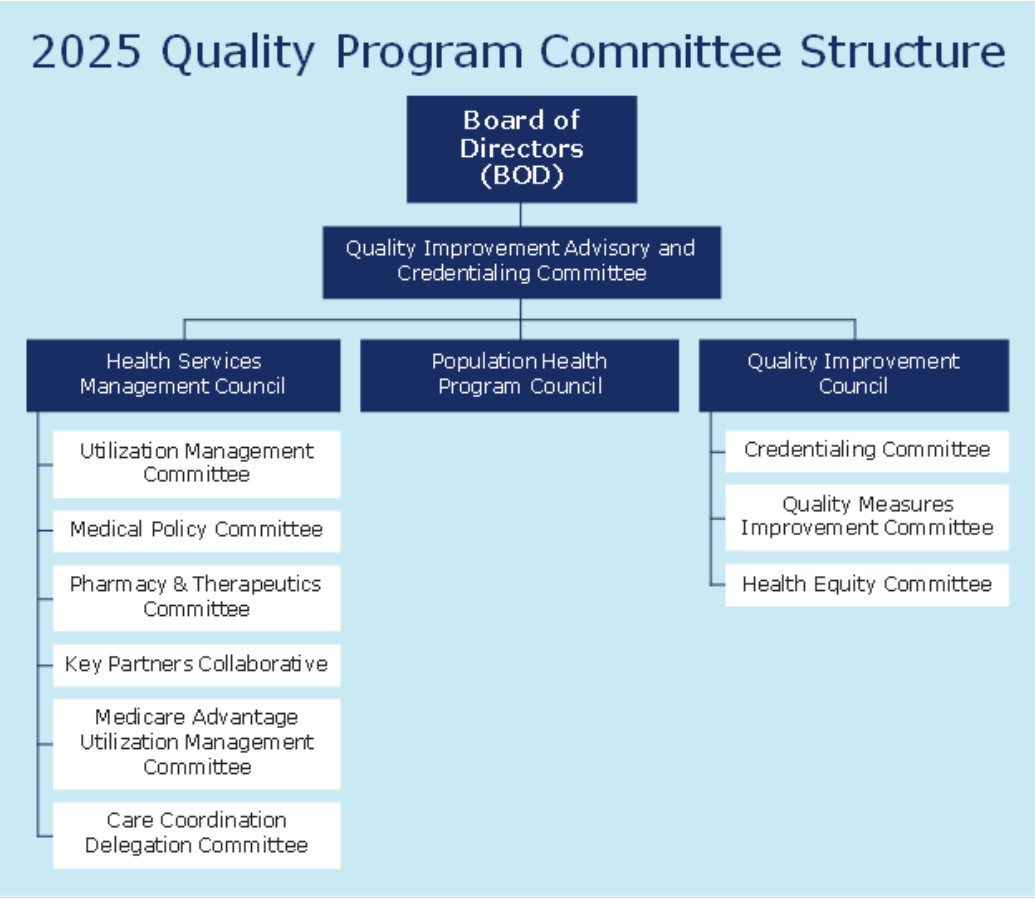
- **Plan:** Identify the objectives of the project and make predictions about what will happen. This step includes answering the following questions:
    - What are we trying to accomplish based on the data points and identified interventions?
    - How will we know a change led to improvement (i.e.,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

- Does it consider health equity? If so, how?
- What does the current or historical data tell us about existing health 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 UCare, 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, Population Health Work Plan, Population Health Evaluation, Population Health Strategy, Population Health Assessments, 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
EVP, Chief Legal Officer
VP, Care Coordination and LTSS
VP, Health Services Quality and Operations
VP, Integrated Care Management
VP, Pharmacy
VP, Senior Medical Director
Medical Directors
Director, Quality and Population Health
Legal Department Representative

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:

Co-Chair: VP, Chief Informatics Officer
Co-Chair: VP, Health Services Quality and Operations
Chief Executive Officer
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, Chief Strategy Officer
VP, Billing and Enrollment
VP, Care Coordination and LTSS
VP, Chief Compliance and Ethics Officer
VP, Chief Experience Officer
VP, Configuration and Claims Operations
VP, Customer Services
VP, Government Relations
VP, Integrated Care Management
VP, Product Management
VP, Pharmacy
VP, Provider Network Management
VP, Senior Medical Director
Medical Director(s)
Director, Quality and Population Health
Senior Manager, Stars Program
Manager, Customer Experience
Manager, Quality Improvement

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 Network Management. (PNM)

- Advises Credentialing and PNM 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.
- Reviews and approves Policies & Procedures involving Credentialing criteria.

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

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 & Health Plan Ratings, Quality Rating System, Performance Improvement Projects (PIPs), DHS Withhold measures, Model of Care, dental access benchmark, population health program, healthcare equity 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.
- Monitor and provide feedback on measure owner progress for each measure performance and goal.
- Annually develop a strategy to address DHS State contract requirements (e.g., Performance Improvement Projects (PIPs), withhold measures, dental access benchmark, population health strategy, healthcare equity 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, Call Center, Special Needs Plans, Hospitalizations, and Mental Health and SUD.
- 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 Customer Experience Officer
VP, Chief Informatics Officer
VP, Customer Service
VP, Health Services Quality and Operations
VP, Integrated Care Management
VP, Pharmacy
VP, Product Management

VP, Provider Network Management
VP, Sales
VP, Senior Medical Director
QMIC Members
Medical Directors
Director, Integrated Care Management
Director, Health Services Operations
Director, Provider Relations & Contracting
Director, Strategic Partnerships
Director, Utilization Management
Associate Director, Care Coordination
Associate Director, Delegated Oversight
Associate Director, Marketing
Associate Director, Pharmacy Quality
Officer, Health Equity
Senior Manager, Clinical Informaticist
Senior Manager, Configuration
Senior Manager, Customer Service Support
Senior Manager, HEDIS
Senior Manager, Member Services
Senior Manager, Quality Analytics
Senior Manager, Stars Program
Manager, Account Services– Aspirus
Manager, Business Development
Manager, Coverage Policy Program
Manager, Customer Experience
Manager, Disease Management
Manager, Federal Government Relations
Manager, Health Improvement
Manager, Health Promotion Program
Manager, Medicare Team
Manager, Population Health
Manager, Product
Manager, Quality Improvement
Manager, Supplemental Benefits & Special Projects
Customer Experience Project Manager
Electronic Clinical Data Project Lead
Health Improvement Coordinator
Health Improvement Team Lead
Market Manager
Specialist, Customer Experience
Specialist, Population Health
Specialist, Quality Improvement
Strategic Partnerships Implementation Lead
Voice of the Customer Analyst

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: Health Equity Officer
EVP, Chief Growth Officer
EVP, Chief Strategy Officer
VP, Billing and Enrollment
VP, Business Development
VP, Care Coordination & LTSS
VP, Chief Customer Experience Officer
VP, Chief Human Resources Officer
VP, Chief Informatics Officer
VP, Chief Marketing & Digital Officer
VP, Configurations and Claims Operations
VP, Customer Service

VP, Government Relations
VP, Health Services Quality and Operations
VP, Integrated Care Management
VP, Pharmacy
VP, Product Management
VP, Provider Relations and Contracting
Medical Director
Director, Integrated Care Management
Director, Quality and Population Health
Associate Director, Marketing
Senior Manager, Community Relations
Senior Manager, HEDIS
Manager, County, Tribal and Public Health
Manager, Health Services Analytics
Manager, Population Health
Manager, Provider Relations and Contracting

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

Quality Program Resources

The resources that UCare devotes to the Quality Program and specific quality improvement activities are broad and include cross-departmental staff, 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), the Vice President, Health Services Quality and Operations, and all 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, care coordination, and care management activities of the health plan in conjunction with other Medical Directors and staff in Integrated Care Management, Health Services Quality and Operations, 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, Medicare Advantage Utilization Management Committee, 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 responsibility 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, Health Equity, 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.
Health Services Analytics	The Health Services Analytics 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-functional 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

Health Services Quality and Operations Department	
	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	The Project Administration team supports an equitable, standardized, focused, and specialized approach to the collective Health Services Department. The team eliminates duplication of work, maximizes efficiencies, and minimizes differences amongst team resources. The centralized teams include project management, training and development, administrative functions, and vendor management.
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 Quality Improvement, Stars, Population Health, HEDIS, and Health Improvement teams, ensuring timeliness of overall quality initiatives. This position also ensures compliance with NCQA accreditation standards for both Health Plan and Health Equity Accreditation. The Quality and Population Health Director is responsible for management and oversight of program effectiveness as it relates to the SNP program to determine program success or refinement of initiatives to support health outcomes for this population.

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.

Disease Management Manager

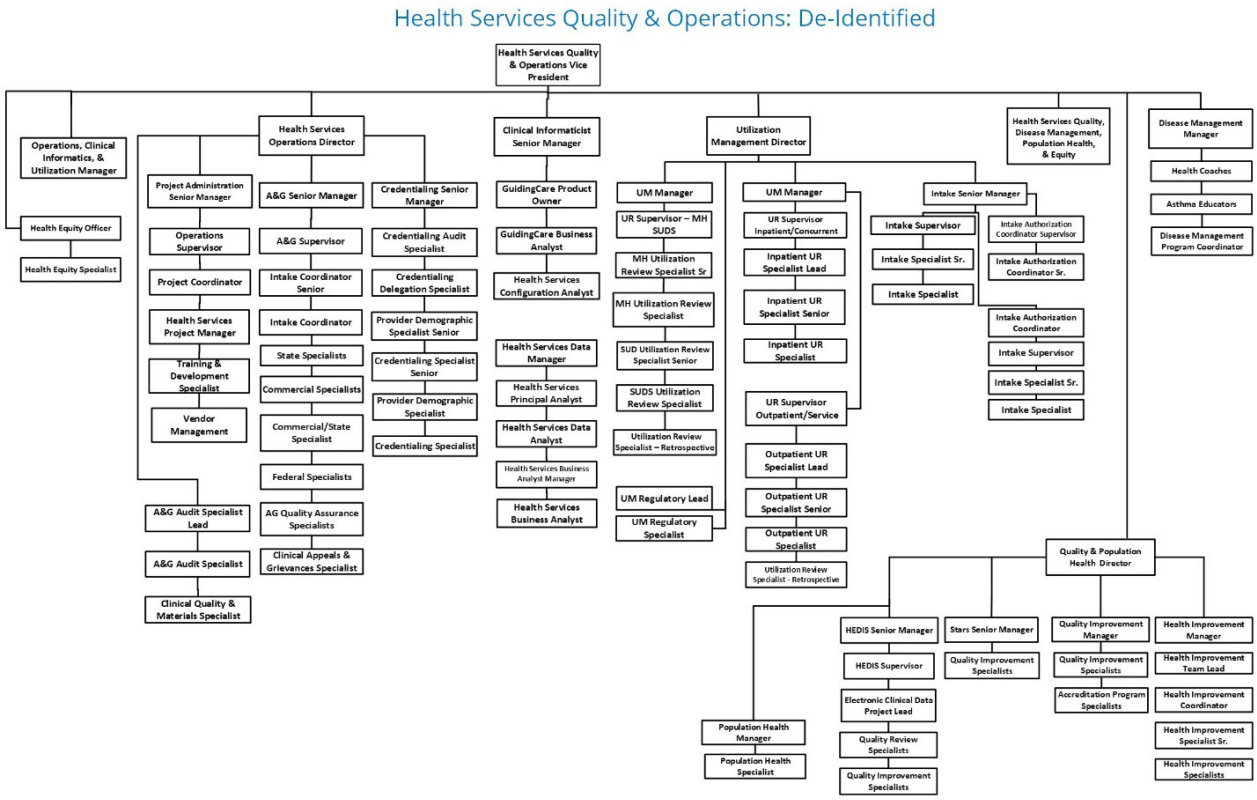
The Disease Management Manager reports to the Vice President of Health Services Quality and Operations and is responsible for managing UCare's disease management programs and ensuring alignment with overall population health management strategies. This role is accountable for the development, implementation, 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 teams and committees to ensure that quality improvement activities are executed, and programs are measured to determine effectiveness Most of the Quality and Population Health 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, Billing and Enrollment
- VP, Business Development
- VP, Care Coordination and Long-Term Services and Supports and staff
- VP, Chief Compliance and Ethics Officer and staff
- VP, Chief Experience Officer
- VP, Chief Informatics Officer
- VP, Configuration and Claims Operations
- VP, Customer Service and staff
- VP, Equity and Inclusion and staff
- VP, Health Care Economics and Chief Informatics Officer and staff
- VP, Integrated Care Management and staff
- VP, Government Relations and staff
- VP, Marketing and Digital Officer and staff
- VP, Pharmacy and staff
- VP, Product Development and staff
- VP, Product Management
- VP, Provider Network Management 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 case management, care coordination, disease management, 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, 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 case management, care coordination, disease management, and delegates. Medical Directors participate in Quality Improvement Advisory and Credentialing Committee, Health Services Management Committee, Utilization Management Committee, Medical Policy Committee, Pharmacy and Therapeutics Committee, Medicare Advantage Utilization Management Committee, Population Health Program Council, Quality Improvement Council, Credentialing Committee, Quality Measures Improvement Committee, and Health Equity Committee.

There is a Medical Director that is responsible for overseeing 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 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. This Medical Director participates in Quality Improvement Advisory and Credentialing Committee, Health Services Management Committee, Utilization Management Committee, Key Partners Collaborative, Medicare Advantage Utilization Management Committee, and Credentialing Committee.

Vice President of Integrated Care Management

The Vice President of Integrated Care Management is a member of UCare’s leadership team, reporting to the EVP, Chief Medical Officer. This position is responsible to oversee the Integrated Care Management program and ensure overall execution of both clinical and behavioral health care management 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.

Integrated Care Management Services and Practitioner Participation

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

Case management and mental health and substance use disorder services are provided by UCare staff for eligible health plan members. Related quality improvement activities are integrated into the Quality Program through regular reporting and through regularly scheduled workgroup meetings, which provide ongoing monitoring of case management mental health and substance use disorder services. Activities, including mental health and substance use disorder activities, are integrated into the annual Quality Program Description, Quality Program Evaluation, and Quality Program Work Plan.

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. In 2024, there were no significant changes to the Health Services Quality and Operations department or organizational quality-related resources.

Community Resources and Member Engagement

Member Advisory Committees

UCare has advisory committees that seeks feedback from members and the community that reflect diversity of our membership. Through its advisory committees, UCarecollects the voices of communities that are experiencing health inequities, including racial and ethnic minority groups, rural members, members with disabilities, etc. The member advisory committees 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 committees 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 number of members from greater Minnesota, 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 five times per year and the Minnesota Senior Health Options and Individual and Family Plan meet in small focus groups on an ad hoc basis throughout the year.

Community Engagement

UCare ensures that we actively engage with our racially/ethnically and linguistically diverse populations. At a minimum, UCare engages individuals and organizations representing racial/ethnic and linguistic groups that constitute at least 5% of our membership. Our data show that our Asian and Pacific Islander, Black/African American and Hispanic/Latine populations comprise over 5% of our entire UCare Medical Assistance population. No non- English languages are spoken by 5% or more of our membership. 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 use of the Healthmobile. Below is a list of the key organizations with whom we engage.

- 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 American Babies Coalition, Hennepin Health care (doula and social work), Steps of Strategy, Route 1 MN
- Hispanic/Latine: 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 Wiigaming

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 monthly 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.

Long-Term Services and Supports

Long-Term Services and Supports (LTSS) are a broad range of services and supports provided to members who have functional limitations and/or chronic conditions that impact their activities of daily living or instrumental activities of daily living. LTSS help older adults and people with disabilities live at home or community settings of their choice while improving health outcomes and maximizing independence.

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 each member's medical, functional, cognitive, psychosocial and mental health needs. The HRA provides insight into how well the member feels they are managing their health, and if they have the support needed to manage their care. Care coordinators engage members and caregivers (as appropriate) in the assessment process to ensure that the member's health care needs are appropriately documented and managed. 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. Appropriate identification of risk to the member is an important success factor 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 of identifying the comprehensive needs and potential LTSS that may be beneficial to the member.

Support Plan

The HRA identifies the member's health care needs, and the support plan documents member generated goals that support the needs identified during the assessment. The support plan contains many critical elements in addressing the member's health care and psychosocial needs. The care coordinator discusses the goals of the member, helps them to prioritize the goals and discusses the services that allow the member to meet their needs in the setting of their choice. The care coordinator offers the member choice in services and service provider.

The support plan is then used to assist in communication between interdisciplinary care team (ICT) members to coordinate commination and care. The care coordinator works to set up services to address the identified needs using the most appropriate services including LTSS.

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

UCare conducts an annual care plan audit to oversight compliance with completing all required documents. Oversight of HRAs and support plans helps to ensure that all member's needs are addressed and documented.

Interdisciplinary Care Team (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 support plan. 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. Members may also request another family member, friend, or spiritual advisor to be part of the ICT. The care coordinator discusses the ICTs function and purpose to the member. Care coordinators serve as the liaison of the ICT as a main point of contact with all other identified ICT members.

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. Care coordinators facilitate safe transitions, supporting the member from the moment they are notified of an admission through the entire 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 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 statistical analysis, quality improvement reporting, data mining in support of clinical and case management staff, and actuarial analysis. The HCE team includes certified actuaries and healthcare analysts with advanced degrees in Public Health and Statistics. Our deep understanding of healthcare analytics and statistics, and 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, membership, member eligibility, claims, provider, clinical, regulatory, legal, and financial data. UCare's EDW integrates non-clinical member information with claims data and additional clinical data including lab values, health risk assessments, provider-submitted patient histories, medical record review abstractions, and supplemental data to perform a broad range of analytics. UCare is an active participant of Minnesota Community Measurement's (MNCM) Common Health Information Reporting Partnership (CHIRP), which offers a facilitated data sharing program, streamlining the bi-directional sharing of patient-level data between health care payers and providers. Our EDW is updated daily with data from UCare's core systems and 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, and 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 TEL tools to extract, transform, and load data to and from the EDW from multiple 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, gap closures, or annual quality ratings (Stars, QRS, Medical Assistance). 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 two 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 National Committee for Quality Assurance (NCQA)-certified HEDIS (Healthcare Effectiveness Data and Information Set) software vendor that supports, calculates, and measures HEDIS results. UCare contracts with Advent Advisory, an NCQA accredited audit firm, to perform auditing of final rates prior to reporting them to NCQA. Press Ganey is the vendor used to conduct standard surveys and analyses for CAHPS (Consumer Assessment of Healthcare Providers and Systems), QHP (Qualified Health Plan) Enrollee Survey and HOS (Health Outcomes Surveys) Survey.

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

- Measure and compare providers (utilization and financial performance).
- Measure and report results of project improvement plans to Department of Human Services (DHS).
- Measure rates and look at patterns of utilization.
- Quantify gaps in care and identify 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 Triennial Compliance Audit
- Medicare and Medicaid CAHPS Surveys
- Disenrollment Surveys and Comments
- Health Outcomes Surveys (HOS)

GuidingCare® Platform

UCare utilizes the HealthEdge GuidingCare® platform to integrate all activities and functions required for 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 authorization 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 members' activities, thereby making care coordination more comprehensive and effective in meeting the needs of the members.

Unite Us

UCare partners with Unite Us, a consumer analytics company serving the health industry. Unite Us supports a more effective and equitable healthcare system that ensures all consumers have access to the support needed to live their healthiest lives. Recognizing that each individual plan 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 drivers of health. By utilizing the Social Connector platform, UCare has an enhanced view of every healthcare consumer by leveraging a vast database of consumer insights and predictive models. This intelligence enables UCare to meet members where they are in their health care journey, powering effective risk identification, member engagement, and health management.

Social Connector provides data on a large number of consumers in America to help health plans understand the underlying social drivers of health (SDoH) risks that impact the populations they manage. SDoH accounts for approximately 60-80% of an individual's health outcomes and healthcare-related costs, resulting in billions of dollars of preventable health-related expenses annually.

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

At the core of the Social Connector solution is a vast consumer database comprised of thousands of data points on every adult in the U.S. Using this data, Unite Us has created the "Social Needs Score" (SNS), a proprietary taxonomy for social drivers of health. SNS helps health plans and organizations understand, identify, measure, and quantify the social barriers and circumstances in which people live. SNS highlights SDoH risks for every matched consumer in the country and feeds into a library of models predicting healthcare cost, utilization, disease likelihood, and behaviors. UCare uses these aggregated insights through dynamic Social Connector reporting dashboards along with member-level data outputs to gain a deeper understanding of the covered populations and uncover opportunities to improve population health at multiple levels.

Systems for Communication

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 and meet our Quality Program goals. These include:

Improving Population Health:

- Utilize population health segmentation, stratification, and predictive analysis to create meaningful and actionable insights that drive initiative design, measurement, and evaluation.
- Foster partnerships among members, caregivers, providers, and communities.
- 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.
- 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.
- Conduct Performance Improvement Projects (PIPs), the Quality Improvement Strategy (QIS), and focused studies with interventions focused on social drivers of health and reducing health care disparities to positively impact health outcomes and enrollee satisfaction.
- Analyze 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.

Advancing Health Equity:

- Ensure UCare's organizational initiatives are data-driven, equity-centered, community-informed, culturally appropriate, and responsive to meet the needs of UCare members through the use of the Health Equity Improvement Plan (HEIP) tool.
- Identify, implement, and measure health equity strategies aimed at reducing health disparities in key clinical metrics related to prevention and chronic disease management.
- Identify, implement, and measure the effectiveness of strategies to improve culturally and linguistically appropriate services (CLAS).

- Engage 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.
- Partner with the Public Affairs team to identify legislative bills that have positive, neutral, or negative impact on UCare members' health and health outcomes.
- Address social factors that influence health, health care and health inequities to improve overall health outcomes of our members.

Enhancing the Care Experience:

- Monitor 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.
- Monitor telehealth trends and demonstrate that UCare's telehealth network is providing safe, equitable and coordinated care by credentialed providers.
- Strengthen provider partnerships to collaboratively ensure members are getting in for needed care.
- Monitor compliance with policies and standards including activities such as the medical record standards audit, HEDIS audit, survey activities, and the credentialing and recredentialing process.
- Investigate and resolve concerns raised by members, providers, and regulators.
- Identify 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.
- Ensure a high-quality network through credentialing, peer review and contracting processes.
- Continuously improve the quality, appropriateness, availability, accessibility, coordination, and continuity of health care services to members across the continuum of care.

Reducing Costs:

- 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.
- 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.
- 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., 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:

- 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, as well as local, state, and federal regulatory requirements through frequent audits.
- Provide oversight of delegated entities to ensure compliance with UCare standards as well as state and federal regulatory requirements and accreditation standards.

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 focuses on activities such as providing action lists for addressing care gaps, as well as education and training to improve quality measures and health outcomes for members. Additionally, UCare's work with other managed care organizations involves designing and developing interventions for Performance Improvement Projects (PIPs) and internal quality projects. Collaboration with the state includes efforts 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 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