2017

Quality Program Description

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

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

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

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

Values (UCare's Philosophy)
Integrity: UCare stands on its reputation. We are what we say we are; we do what we say we will do.
Community: UCare works with communities to support our members and to give back to the communities through UCare grants and volunteer efforts.
Quality: UCare strives to continually improve our products and operations to ensure the highest quality of care for our members.
Flexibility: UCare seeks to understand the needs of our members, providers and purchasers over time, and to develop programs and services to meet those needs.
Respect: UCare respects its members by providing quality care and services that recognize their unique needs. UCare respects its employees by providing a supportive work culture that encourages their development and embraces their diversity.

Quality Program
The Quality Program is a commitment to innovation, affordability, professional competence and continuous learning, teamwork and collaboration. The clinical aspects of the Quality Program are structured from evidence-based medicine. The Quality Program also ensures health services needs of members, including those with limited English proficiency and diverse cultural and ethnic backgrounds are met. The Quality Program supports efforts to understand the population served, in terms of age groups, disease categories and special risk status through analysis, monitoring and the evaluation of processes. 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:
• Maintain Excellent NCQA accreditation.
• Improving member health through Medicare Star Ratings and Medicaid measures through innovative initiatives.
• Coordinate quality improvement activities across all products to achieve efficiencies and reduce duplicative efforts.
• Continuously improve the quality, appropriateness, availability, accessibility, coordination and continuity of health care services to members across the continuum of care.
• Define, demonstrate and communicate the organization-wide commitment to improving the quality of patient safety.
• Foster a partnership among members, caregivers, providers, and community, which allows UCare to promote effective health management, health education and disease prevention, as well as encourage the appropriate use of health care and services by members and providers.
• Ensure a high quality network through credentialing, peer review and contracting processes.
• Collaborate with providers to share ideas and implement strategies to improve quality.
• Improve and manage member outcomes, satisfaction and safety.
• Maintain 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.
• Ensure UCare’s organizational initiatives related to cultural competency and diversity for members and providers meet the needs of the UCare membership.
• Improve member and provider satisfaction and enhance UCare’s understanding of key factors contributing to satisfaction.

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

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

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

• Education of members regarding their role in receiving safe and effective services through member newsletters, web site and direct mailing.
• Distribution of Clinical Practice Guidelines to practitioners.
• Education of providers regarding improved safety practices in their clinical practice through provider newsletters and web site.
• Evaluation for safe clinic and/or medical office environments during office site reviews.
• Education to members regarding safe practices through home health education and discharge planning.
• Intervention for identified safety issues as identified through care management, potential quality of care assessment, and the grievance and clinical case review process.
• Dissemination of information to providers and members regarding activities in the network related to safety and quality improvement.
Organizational Structure
To promote quality throughout the UCare organization, specific relationships and linkages between the Board of Directors, program committees, operational departments and UCare employees are described on the following pages. UCare has created committees to provide oversight and implementation of all quality improvement activities.

Quality Program Committee Structure

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. The BOD meets every other month and its responsibilities include:

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

Membership consists of:
Chairperson: Head of the Department of Family Medicine and Community Health at the University of Minnesota Medical School;
Finance Officer, Department of Family Medicine at the University of Minnesota Medical School;
Six elected UCare health plan members;
Five physicians appointed from the faculty of the Department of Family Medicine; One member appointed by the Dean of the University of Minnesota Medical School; One at-large member elected from the community

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

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

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

**Membership consists of:**
The Chairperson is appointed by the Board Chair from among the committee’s members. Externnal participants include 5 to 10 professionals participating in the UCare network, including representatives of primary care disciplines such as: Family Medicine, Internal Medicine, Pediatrics, OB-GYN, Geriatrics, and Behavioral Health. Additional provider representatives who serve ethnic communities representative of UCare membership are also encouraged.

In addition, the following UCare staff attends:
- SVP, Chief Medical Officer
- SVP of Public Affairs and Chief Marketing Officer
- SVP and Chief Financial Officer
- SVP of Provider Relations and Chief Legal Officer
- VP and Chief Nursing Officer
- VP and Chief Informatics Officer
- VP, Marketing and Product Management
- VP, Provider Relations and Contracting
- VP, Quality
- Medical Director
- AD, Pharmacy
- Quality Improvement Manager

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

**Medical Management Committee**
The Medical Management Committee provides oversight and direction to improve utilization of appropriate medical care and ensure cost containment of medical services. The Medical Management Committee coordinates utilization management activities, medical policy development, and other medical management actions that support the strategic objectives of the organization. The Medical Management Committee ensures these strategies are implemented, evaluated, monitored, and reviewed for effectiveness and expanded or modified as appropriate. Responsibilities include:

- Oversees medical management strategies and interventions, including the activities of various sub-committees and work groups.
- Sets priority of medical management strategies for the organization and assigns to work groups or sub-committees for action.
- Approves the Utilization Management Plan annually.
ORGANIZATIONAL STRUCTURE

- Reviews and approves the Annual Utilization Management Report, identifies potential opportunities for development of corresponding strategies/interventions, and assigns to respective sub-committees and work groups.
- Evaluates key utilization initiatives and approves recommendations of work groups and sub-committees that support appropriate utilization of medical, behavioral, dental and other related health care services and monitor results.
- Study organizational monitoring activities including utilization reports and accompanying cost/trend reports, make recommendations for action, and reviews benchmark data against UCare trend/cost.
- Monitor utilization of pharmacy drug trends and new/emerging drugs and medication therapies.

Membership consists of:
- Chair: VP, Chief Nursing Officer
- SVP, Chief Medical Officer
- SVP, Chief Finance Officer
- VP, Chief Informatics Officer
- VP, Provider Relations and Contracting
- Associate Medical Director

Behavioral Health Medical Director
AD, Pharmacy
Utilization Management Manager
Behavioral Health Manager

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

Utilization Management Work Group
Utilization Management (UM) is an organization-wide, interdisciplinary approach to balancing quality, risk, and cost concerns in the provision of member care. UM is accomplished through proactive data analysis, utilization review, case management, and referral management. It is the process of reviewing the medical necessity, appropriateness, and efficiency of health care services. The purpose of this committee is to identify, monitor, and evaluate utilization metrics and trends that may have an impact on resources, services, and member outcomes related to medical, behavioral or pharmacy services. The UM Committee reports to the Medical Management Committee.

Responsibilities include:
- Reviews key utilization metrics, trends, and accompanying analysis. Key metrics may include but are not limited to; ambulatory care sensitive conditions, preference sensitive conditions, inpatient and emergency utilization, behavioral health, and pharmaceutical.
- Evaluates and recommends utilization benchmarks for adoption by the MMC.
- Identifies opportunities for additional analysis and recommend the development of initiatives to ensure appropriate utilization of medical, behavioral, and pharmaceutical services.
- Assigns sub-groups to study, develop and prioritize strategies to impact utilization.
- Analyzes over and under utilization data on a scheduled and ad-hoc basis and reports results at least annually to MMC for further review and action.
- Studies organizational monitoring activities including utilization reports, cost/trend reports, and other data and make recommendations to MMC.
- Monitors studies, new findings, and emerging utilization trends for potential impact on UCare utilization.

Membership consists of:
- Chair: VP and Chief Nursing Officer
- Vice Chair: Utilization Review Manager
- SVP, Chief Financial Officer
- VP, Chief Informatics Officer
- AD, Pharmacy

Medical Director
Behavioral Health Manager
HCE Manager
UR Supervisor

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

Pharmacy and Therapeutics Committee (P&T)
The Pharmacy and Therapeutics Committee is comprised of practicing physicians and pharmacists who oversee formulary management, prior authorization, step therapy, quantity limitations and other drug utilization activities.
The Committee may also advise UCare on other pharmacy matters to continuously improve the delivery and quality of the drug benefit. Responsibilities include:

- Clinically evaluates 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 includes:
  - 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
- Reviews all drug formularies and therapeutic classes at least annually
- Makes reasonable effort to review a new FDA approved drug product (or new FDA approved indication) within 90 days and makes 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 is 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 is made within 90 days
- Reviews all Utilization Management Programs (Prior Authorizations, Step Therapy, and Quantity Limits) annually. P&T recommendations are advisory only and not binding.
- P&T Committee reviews the Transition process of non-formulary medical reviews and provides recommendations to regarding the procedure to ensure transition decisions are appropriately reviewed.
- Ensures that in Protected Classes (e.g. anticonvulsants, antipsychotics, antidepressants, antineoplastic medication, antiretroviral agents and immunosuppressants), substantially all medications are covered by Medicare Formularies
  - Oversees 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: Medical Director  
Vice Chair: Assistant Director of Pharmacy  
Internal UCare Members:  
Medical Director  
VP, Quality  
AD, Pharmacy  
Clinical Pharmacists(s)  

External Members (6-10 members):  
Membership consists of a majority of practicing physicians representing a broad range of primary care and specialty areas including, but not limited to:  
Endocrinology, Gastroenterology, Family Practice, Internal Medicine, Gerontology, Pediatrics, Cardiology, and Pulmonology. Other practice areas such as Psychiatry, Rheumatology, and Oncology, are available for consultation. Membership includes at least one practicing physician and one practicing pharmacist who is an expert in geriatrics or disabled persons. Credentialing status is in good standing.

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

**Medical Policy Committee**
The Medical Policy Committee reports to the Medical Management Committee. The purpose of the Medical Policy Committee (MPC) is to oversee the development, evaluation and implementation of medical policies. The Committee evaluates the clinical evidence of topics and issues related to medical necessity of new and emerging health technologies, assesses its safety and effectiveness, establishes clinical indications for evidence-based application of the service, procedure or treatment, and develops medical policies in a consistent and timely manner. UCare medical policies are used within UCare to direct or clarify benefit design, coverage determinations and/or medical management operational issues; they are used externally as clinical guidance for UCare providers and as a reference for members. Responsibilities include:
ORGANIZATIONAL STRUCTURE

- Sets priority for medical policy development and implementation through a systematic, structured decision analysis.
- Evaluates clinical evidence and assesses the safety and effectiveness of new and emerging technologies as well as new applications of existing technologies to determine their impact on health status and disease outcome. Medical Policies are based upon published peer-reviewed clinical evidence, where such evidence exists, and uses input from clinicians and professional staff.
- Reviews and recommends appropriate indications for use of relevant services, procedures or treatments.
- Approves UCare's medical policies for content.
- Guides monitoring and evaluation of the medical policies to assess their utility and impact.
- Oversees assessments that ensure that medical policies are effectively achieving anticipated outcomes and objectives.
- Revises and updates the policies in a consistent and timely manner.
- Assesses evidence supporting disease specific clinical guidelines.
- Reviews externally licensed guidelines for clinical accuracy.
- Considers nationally accepted consensus statements and expert opinion, and incorporates where appropriate and when based upon clinical evidence.
- Supports incorporation of medical policies and knowledge into protocol-based program recommendations for care of selected conditions such as low back pain management or treatment regimens incorporating complex drug regimens.
- Reviews policies and procedures for case adjudication where affected by medical policies and recommends changes if needed.
- Oversees medical policy implementation activities.

**Membership consists of:**

- Chair: Medical Director
- SVP and Chief Medical Officer
- VP and Chief Nursing Officer
- Associate Medical Director(s)
- Customer Services Director
- Behavioral Health Medical Director
- Product Management Assistant Director
- Coding Manager
- AD, Pharmacy
- Utilization Review Manager
- Medicare and Medicaid Benefits Manager
- Provider Payment Manager
- Medical Policy Specialist
- Optional Attendees:
  - AD, Provider Enrollment and Systems Configuration
  - Associate Counsel
  - Medicare and Medicaid Payment Manager

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

**Clinical Integration & Innovation Sub-Committee**

The Clinical Innovation Committee reports to the Medical Management Committee. This committee is responsible to identify, explore and/or implement clinical initiatives or programs that positively impact member health by improving one of the following: member care experience, individual or population health, or reducing medical costs. This committee evaluates clinical initiatives or proposed new clinical programs and recommends to implement or discontinue. Responsibilities include:

- Evaluates external and internal care integration activities and clinical initiative proposals.
- Utilizes internal thought leaders to explore and evaluate clinical processes and initiatives to address new chronic condition programs, clinical technology, etc.
- Ensures outcome measurement criteria are utilized to evaluate clinical initiatives.
- Acts as a reviewing body for provider clinical initiatives.

**Membership consists of:**

- Chair: VP Clinical Services, Chief Nursing Officer
- Manager, Disease Management
- Manager, Quality Improvement
- Manager, Provider Relations and Contracting
- Product Manager
- Clinical Services Stars Coordinator
- Associate Medical Director
- Health Promotion Manager
- Assistant Director, Care Management
**Frequency of Meetings:** The committee meets every two months.

**Quality Improvement Committee (QIC)**
The Quality Improvement Committee provides direction regarding the planning, design, implementation and review of improvement activities. The Quality Improvement Committee ensures that quality activities align with the strategic objectives of the organization. Responsibilities include:

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

**Membership consists of:**
- Co-Chair: VP, Quality
- Co-Chair: VP, Chief Informatics Officer
- SVP, Chief Medical Officer
- SVP of Provider Relations and Chief Legal Officer
- SVP, Chief Financial officer
- SVP, Chief Administrative Officer
- SVP, Public Affairs and Chief Marketing Officer
- VP of Clinical Services, CNO
- VP of Marketing and Product Management
- VP, Government Relations
- VP of Compliance and Internal Audit
- VP of Provider Relations and Contracting
- Director, Customer Service
- Pharmacy Assistant Director
- Medical Director
- Associate Medical Director
- Manager, Quality Improvement
- Medicare Stars Program Manager

**Frequency of Meetings:** The committee meets every two months.

**Credentialing Committee**
The Credentialing Committee reports to the Quality Improvement Committee and is responsible for credentialing decisions, standards of care, effectiveness of the credentialing program, peer review and review and approval of the credentialing policies and procedures. The committee reviews credentialing and recredentialing files that do not meet the established criteria documented in the Credentialing Plan and approves or denies provider’s request for network participation. The Committee oversees and coordinates the provider credentialing appeals as specified by the UCare Credentialing Plan. The Committee is also responsible for oversight of quality of care case file reviews and associated credentialing decisions. Responsibilities include:

- Provides oversight and direction to UCare’s credentialing and quality of care review functions.
- Reviews case files for credentialing and makes decision regarding whether a professional subject to the UCare credentialing process shall be credentialed.
- Reviews quality of care cases and makes decisions regarding the safety and quality of health care services provided to enrollees. Identified quality or utilization concerns may be subject to peer review to provide an opinion on the care received by a member. UCare may utilize an independent review organization that includes provider specialty or procedure in the case and is based on the reviewer’s expertise.
- Reviews and approves changes to credentialing and quality of care policies and procedures.
- Makes decisions on new credentialing delegates based on information and recommendations from the credentialing delegation specialist with input from Provider Relations and Contracting.
- Advises credentialing and PRC staff on delegation issues, including issues with pre-delegation and annual oversight audits.
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- Reviews and makes recommendations regarding NCQA, MDH, and CMS requirements for credentialing and quality of care, including current trends.
- Oversees and coordinates provider quality and credentialing appeals, including appeal hearings as appropriate.

Membership consists of:
Chair: Associate Medical Director
Medical Director
Associate Counsel
VP, Quality
AD, Quality Operations
Credentialing Supervisor
Credentialing Specialist, Senior
PRC Contract Network Manager

External Members
4 to 6 members representing the primary care disciplines, such as: Family Medicine, Internal Medicine, Pediatrics, OB-GYN or Geriatrics, plus Psychiatry. Special consideration is given to providers from community clinics and clinics serving ethnic communities representative of UCare membership.

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

Quality Measures Improvement Committee
The Quality Measures Improvement Committee (QMIC) reports to the Quality Improvement Committee. The Committee identifies areas of opportunity for performance improvement, operational efficiency and increased program integrity for all UCare products. It monitors the Star Ratings program performance and goals and additionally identifies activities, timelines and other goals. Responsibilities include:

- Reviews and advises on project action plans and performance targets for initiatives related to quality measures, to include QRS, NCQA Accreditation and related quality programs
- Annually develops a Star Ratings Program Strategy designed to maintain and/or improve UCare's overall Star Rating.
- Monitors program performance for each measure as defined in the overall program strategy.
- Assesses effectiveness of previous years’ interventions and goals

Membership consists of:
Co-Chair: Medicare Stars Program Manager
Co-Chair: Quality Improvement Manager
VP, Marketing and Product Management
VP, Government Relations
VP and Chief Informatics Officer
VP and Chief Nursing Officer
VP, Provider Relations and Contracting
VP, Quality

Government Relations Manager
Pharmacy Assistant Director
Medical Director
Customer Services Director
Quality Analytics Manager
Strategic Quality Analyst
Clinical Project Coordinator

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

Diversity and Cultural Competency Committee
The purpose of the Diversity and Cultural Competency Committee is to ensure that UCare’s organizational initiatives related to cultural competency and diversity for members and providers meet the needs of the UCare membership and UCare's quality goals. The Committee also supports the internal diversity training activities. The Committee develops, assures, implements and evaluates health care initiatives aimed at reducing the disparities in health status among targeted UCare populations. The Committee develops an annual work plan that is presented to the Senior Management Team. The work plan addresses Culturally and Linguistically Appropriate Services (CLAS) standards developed by the Office of Minority Health. The plan outlines diversity initiatives and cultural competency initiatives for members and providers.

Membership consists of:
Chair: SVP, Public Affairs and Chief Marketing Officer
Customer Service Workforce Manager
PA & Community Outreach Administrator
AD Communications & Public Relations
Vice President, Quality
**Member Experience Steering Committee**

Provides strategic direction to the organization in the prioritization and ongoing review of member experience improvement opportunities. Responsibilities include:

- Oversees and monitors the progress and outcomes of member experience improvement activities at UCare.
- Reviews, evaluates and monitors member experience initiatives, work plans and data analytics.
- Coordinates and monitors member experience/satisfaction data, including CAHPS scores, member survey results, focus group findings, and CAG and call analytics, to prioritize and direct member experience improvement efforts throughout UCare.
- Addresses and ensures that significant member-facing changes are brought to the steering committee.
- Acts as a resource for, and at times direct work to, departments, committees and groups focusing on efforts to enhance member satisfaction/experience.
- Each committee member individually obtains at least one direct interaction with members each quarter and shares insights about the experience with the committee.

**Membership consists of:**

- Chair: Member Experience Manager
- SVP Public Affairs & Marketing
- VP and Chief Information Officer
- VP and Chief Nursing Officer

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

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**Quality Program Resources**

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

An annual assessment of UCare’s current quality program occurs through the review of the annual Quality Program Evaluation by the Quality 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.

**SVP/Chief Medical Officer**

The Chief Medical Officer, the VP, Quality and Quality Management staff hold primary responsibility for UCare’s Quality Program. The Chief Medical Officer reports to the Chief Executive Officer and serves as a member of UCare’s senior management team, participating in strategic planning and policy direction for the organization, providing leadership and guidance on clinical strategic initiatives and operations to ensure high quality, cost-effective care for UCare members. UCare’s Chief Medical Officer manages relationships with contracted care systems to ensure implementation of UCare’s utilization and quality management strategies. In addition to these key responsibilities, the Chief Medical Officer supports the development, implementation, maintenance, and evaluation
of quality improvement, utilization review, disease and high-risk population management, and care management activities of the health plan in conjunction with staff in Clinical Services, Quality Management, Behavioral Health, Pharmacy Services and Provider Relations and Contracting Departments.

The Chief Medical Officer serves on the following committees: the Quality Improvement Advisory and Credentialing Committee, the Quality Improvement Committee, the Medical Management Committee, Medical Policy Commity, Women’s Health Committee, and the Diversity and Cultural Competency Committee,

**Vice President of Quality**

The Vice President of Quality is a member of UCare’s leadership team, reporting to the SVP, Chief Medical Officer. The primary objective of this position is to provide strategic direction and oversight for UCares’ quality management and pharmacy operations. Provides leadership for the development, implementation, and evaluation of UCare’s Quality Program. Responsible for the strategic planning, project implementation and fiscal management for all pharmacy operations, medication management and clinical pharmacy programs.

**Quality Improvement Manager**

The Quality Improvement Manager reports to the Vice President of Quality and is responsible for the development, management and accountability of quality improvement initiatives within the department in support of the organizational Quality Program. This position provides leadership for related projects, surveys, reports and audits. Additional responsibilities include, development and management of the Quality Improvement team, ensuring timeliness of overall quality initiatives and managing Performance and Quality Improvement Project development and regulated quality requirements.

**Quality Department Staff**

The Quality Department Staff are responsible for implementation, analysis and reporting on quality improvement activities. They also provide support for all departments in the organization for quality improvement projects. Working with the Chief Medical Officer, the Medical Director, the Associate Medical Directors and UCare leadership, the Quality Department coordinates the quality committees and provides direction related to quality programs. Quality Department staff works with improvement teams and on committees to ensure that quality improvement activities are carried out. The majority of the QI staff have at least masters-level education and extensive experience and many of them received their CPHQ certification. In addition, the Health Care Economics department provides analytics support.
Additional Resources
The following individuals and departments provide additional key resources and guidance to UCare’s overall Quality Program:

- CEO
- Behavioral Health Medical Director
- Clinical Services Vice President and staff
- VP, Compliance and staff
- Customer Service Director and staff
- VP, Government Relations and staff
- VP and Chief Informatics Officer and staff
- VP, Marketing and Product Management and staff
- VP, Provider Services and Operations and staff
- VP, Provider Relation and Contracting

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

Behavioral Health Services are provided by UCare staff for eligible Health Plan members. Behavioral health QI activities are integrated into the QI program through regular reporting and through regularly scheduled workgroup meetings, which provide ongoing monitoring of behavioral healthcare services. Behavioral health QI documents, including the QI Work Plan, Program Evaluation, and Program Description are reviewed and approved annually.

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

Members with Complex Health Needs
UCare works to improve the health and quality of life for all UCare’s members with complex health conditions by the following strategies and objectives:

Strategies
- Health promotion and disease prevention.
- Disease and care management.
- Complex case management.

Objectives
- Encouraging self-management techniques.
- Improving the member’s understanding of their conditions.
- Facilitating processes to actively assist members and providers with the management of complex conditions.
- Maintaining, reviewing and updating, as needed, complex case management processes and resources to address member’s needs.
- Maintaining a case management system which supports the complex case management program by providing necessary, evidence-based, clinical guidelines, algorithms, assessments and documentation.
In addition, the identification and management of members with Special Health Care Needs (SHCN) is an integral part of the medical management of UCare members. The program identifies persons with special health care needs, assists identified members with access to care, and monitors their treatment plan for positive behavior change. All Minnesota Health Care Programs (MHCP) members are eligible for case management through this program.

Health Plans within the UCare network may offer Medicare Special Needs Plans (SNP), including the Special Needs Plan for Dual-Eligible Beneficiaries based on the CMS requirements for the SNP Model of Care. The Model of Care approach is based on effective population health management with the goal of achieving optimum outcomes for enrollees. Through early identification and predictive modeling, UCare can anticipate a member’s potential health state and intervene accordingly. Special focus is designed for meeting the needs of the frail/disabled enrollees, meeting the needs of members with multiple chronicity and meeting the needs of members as the end-of-life.

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

Data and Information Support

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

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

Our data warehouse solution allows for a variety of tools to connect to the system such as SQL, SAS, or various Microsoft tools to perform analytics and reporting functions (see Figure D.1-1). Additionally, our EDW environment contains Business Objects™ and MedeAnalytics™ analytics tools that provide flexibility and definition for integrating and analyzing data. We utilize Business Objects™ ETL tools to extract, transform and load data to and from the EDW from multiple disparate sources and to obtain and share data with external partners. We use John Hopkins ACG™ resource utilization bands to define several strata of illness levels ranging from perfectly healthy to critically ill, and multiple categories of increasing levels of illness in between these two strata. Our NCQA-Certified HEDIS software calculates and measures results, and UCare retains a longitudinal history of member-level quality measure results for ongoing analysis. Examples of the analysis performed include:

- Measure and compare providers (utilization and financial performance).
- Measure rates and look at patterns of utilization.
- Help develop guidelines and disease management programs.
- Assess provider compliance with clinical practice guidelines.
QUALITY IMPROVEMENT ACTIVITIES

- Measure and analyze customer service interactions.
- Produce HEDIS reports and dashboards that are used to measure quality improvement projects, effectiveness of care, utilization, and to provide comparison data.
- Store provider demographics in a central database that can be easily and quickly accessed.
- Communicate informal complaints to the appropriate department for resolution.

External audits and surveys also provide useful information to assess overall quality. Examples include:

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

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

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

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

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

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

Quality Improvement Activities
There are a number of ways that actions are taken to improve the care or services UCare provides. These include:
DELEGATION OF QUALITY MANAGEMENT FUNCTIONS

- Establishing plans and policies to address quality. Examples include development of strategic plan goals, the annual Quality Work Plan and the Credentialing Plan.
- Monitoring compliance with policies, standards and practice guidelines. Monitoring activities include the medical record standards audit, the HEDIS audit, guideline compliance audits, survey activities and the credentialing and recredentialing process.
- Monitoring adequate access to care including availability of services, coordination and continuity of care, and appropriate coverage and authorization of services and taking action when appropriate.
- Monitoring compliance with UCare medical record keeping standards, including confidentiality and accuracy and taking action when appropriate.
- Monitoring adequate access to medical and behavioral health care, including availability of services, coordination and continuity of care and appropriate coverage and authorization of services, and taking action when appropriate.
- Monitoring member safety through on-going review of reports and data.
- Investigating and resolving concerns from members, providers and regulators.
- Identifying recurring patterns of problems or areas of concern by analyzing trends and patterns from various sources of data and taking action. Data sources include surveys, medical record audits, member and provider contacts, utilization data, complaint data, grievance and appeal data and standardized reports such as the CMS Star Ratings and HEDIS®.
- Conducting a chronic care improvement program that includes methods for identifying enrollees with multiple or sufficiently severe chronic conditions that would benefit from participating in a chronic care improvement program and mechanisms for monitoring enrollees that are participating in the chronic care improvement program.
- Conducting quality improvement projects (QIPs), performance improvement projects (PIPs) and Quality Improvement Strategies (QIS) that are expected to have a beneficial effect on health outcomes and enrollee satisfaction, and include a focus on significant aspects of clinical care and non-clinical services, assessing performance under the plan using quality indicators, performance assessment on the selected indicators based on systematic ongoing collection and analysis of valid and reliable data, achieving demonstrable improvement and being able to report the status and results of each project to regulatory bodies as requested.
- Improving clinical and business processes through informal and formal process improvement teams that define, measure, analyze, implement and evaluate changes made.
- Instituting system interventions as warranted.
- Providing feedback and educational interventions to both members and providers.

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

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

- Quality of clinical care
- Quality of service
- Safety of clinical care
- Program scope
- Yearly objectives
- Yearly planned activities
QUALITY IMPROVEMENT ACTIVITIES

- Time frame within which each activity is to be achieved
- The staff member responsible for each activity
- Monitoring previously identified issues
- Evaluation of the QI program

The Quality Improvement Committee, 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 evaluated annually by the Quality Improvement Committee, Quality Improvement Advisory and Credentialing Committee and the Board of Directors. The quality and utilization improvement activities outlined in the Quality Program Evaluation are evaluated for appropriateness and effectiveness in assessing and improving the quality of care and service UCare’s members received. Evaluations and recommendations from regulatory agencies and other external quality review organizations are also considered in assessing the strength of UCare’s Quality Program. When substantial 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’ Medicare Managed Care Manual, chapter 5
Policy CCD021 Delegation Management
Policy PEC007 Provider Credentialing
Organizational Structure
Utilization Management Plan